Therapist Competencies necessary for the delivery of Compassion Focused Therapy:

A Delphi Study

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Declaration

The current thesis is an original piece of work and has not been submitted for any other academic award.

Target Journals for Publication

The target journals for publication are:

- Literature Review – *Clinical Psychology Review*

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Therapist Competencies necessary for the delivery of Compassion Focused Therapy: A Delphi Study

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Thesis Abstract

The literature review aimed to systematically review the effects of compassion-based interventions on wellbeing and distress in adults. Three electronic databases, reference lists and forward citations were searched. Fifteen papers met the inclusion criteria. Study quality was appraised and found to be weak overall. Interventions were predominantly group meditation programmes with non-clinical samples or Compassion Focused Therapy (CFT) informed augmentations to treatments of clinical samples. Findings showed that compassion-based interventions could be effective in reducing depression, anxiety and other psychological symptoms over time but between group differences were inconsistent or could not be assessed. Outcomes were similar when the compassion-based intervention was compared to active controls or alternative interventions. Further research is needed into mechanisms of action and with more robust clinical trials.

The aims of the research were to identify therapist competencies necessary to deliver CFT. The Delphi method was used to explore expert opinion in three rounds of data collection. Twelve CFT 'experts' were interviewed for round one. Data were analysed using Template Analysis to generate a draft Competency Framework and a survey. Fourteen participants in round two and seven in round three completed the survey. The CFT Competency Framework (CFT-CF) was produced, identifying twenty-five main competencies within six key areas of competence. The areas were: Competencies in Creating Safeness; Meta-skills; Non phase-specific skills; Phase-specific skills; Knowledge and Understanding; and Use of Supervision. Overall there was consensus regarding the necessity of 14 competencies and 21 exceeded the 80 per cent agreement level (*N*=7). Potential clinical and research applications of the CFT-CF are discussed. Reflections and a critical appraisal of the research project are presented.

<u>Acknowledgements</u>

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Thesis Abstract	268
Literature Review	6,823
Research Report	11,602
Critical Appraisal	3,168
Non-mandatory Appendices	4,948
Total word count (main texts and non-mandatory appendices)	26,541

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Wellbeing and distress outcomes for adults receiving a compassion-based

intervention: A systematic review

Abstract

Objective

The main aim of the current paper was to systematically review the effects of compassion-based interventions on wellbeing and distress in adults. The review aimed to focus on clinically relevant outcomes, synthesising recent research, including findings from uncontrolled trials. The review aimed to consider the outcomes of different types of interventions and their impact on clinical and non-clinical samples. A secondary aim was to conduct a detailed quality appraisal.

Method

Three electronic databases were searched covering peer-reviewed, English language studies published from January 2004 to June 2014. This elicited 212 articles. Following screening, relevant articles were manually checked for further suitable references and forward citations. Fifteen papers met the inclusion criteria and data were extracted.

Results

Studies were appraised using the Quality Assessment Tool for Quantitative Studies (Thomas *et al.*, 2004). Methodological quality was weak. Interventions were predominantly group meditation programmes with non-clinical samples or Compassion Focused Therapy informed augmentations to treatments with clinical samples. Compassion-based interventions could be effective in reducing depression, anxiety and other psychological symptoms over time but between group differences were inconsistent or could not be assessed. There was limited evidence to support compassion-based interventions improving wellbeing when compared to controls. Findings were comparable against active controls or alternative interventions.

Conclusions

Compassion-based interventions appeared to have potential in improving distress, although reviewed evidence suggested this was comparable to the researched alternatives. However, low methodological quality and considerable variation between interventions limit the conclusions that can be drawn. More methodologically robust research is required to establish the effects of compassion-based interventions. Further research is required to ascertain effective treatment mechanisms.

1 Introduction

There has been growing interest in utilising Buddhist concepts for psychological interventions including mindfulness, Loving-Kindness Meditation (LKM) and compassion. The current review focused specifically on compassion. Research suggests associations between self-compassion, wellbeing, distress, possible mechanisms of action and potential for compassion-based interventions (CBIs) to improve wellbeing and distress (Hofmann *et al.,* 2011). Psychological interventions have been developed based on this premise. The current systematic review aimed to provide a critical appraisal of the current status of published research reporting wellbeing and distress outcomes following CBIs.

Given the inter-related nature of concepts drawn from Buddhist teachings (Barnard & Curry, 2011), clarity regarding the constructs is needed. Compassion involves being open and sensitive to suffering with the desire to alleviate this. Self-compassion refers to directing this towards the self. Neff (2003) proposes three related aspects to self-compassion, with respective opposites: self-kindness rather than self-criticism; common humanity rather than isolation; and mindfulness rather than over-identification with feelings. Gilbert (2009) draws on evolutionary neuroscience and the development of compassion as a care-giving mentality. The author identified six interconnected attributes: sensitivity, sympathy, empathy, non-judgement, distress tolerance and care for well-being, embedded within warmth. Research supports that self-compassion is distinct from self-esteem (Neff & Vonk, 2009).

1.1 Definitions of Compassion

Other Buddhist practices used in psychological interventions include LKM and mindfulness. Loving-kindness involves an unselfish, unconditional kindness and concern for wellbeing towards all beings (Hopkins, 2001). Mindfulness has been defined as non-judgemental awareness and attention to the present moment (Kabat-Zinn & Hanh, 2009). The inclusion of mindfulness within the conceptualisation of compassion (Neff, 2003) acknowledges the need to attend to feelings in order to direct compassion. However, the desire to alleviate suffering distinguishes compassion from mindfulness. Loving-kindness and compassion both involve kindness and warmth; however loving-kindness involves a wish for wellbeing, whereas compassion is directed

towards the alleviation of suffering. The current paper reviews studies specifically targeting compassion, encompassing compassion directed towards self and other, although research has primarily investigated self-compassion (Barnard & Curry, 2011).

1.2 The relationship between compassion and wellbeing and distress

The potential for compassion to act as a factor underlying wellbeing and distress has prompted research into this relationship. Self-compassion has been positively correlated with positive affect in undergraduates (Neff *et al.*, 2007) even when controlling for self-esteem (Neff *et al.*, 2007). Neely *et al.* (2009) found that self-compassion was a significant predictor of wellbeing in students, explaining additional variance to other factors of goal management and stress. Leary *et al.* (2007) found that self-compassion moderated negative emotions in response to receiving ambivalent personal feedback, especially for participants with low self-esteem. Macbeth and Gumley (2012) conducted a systematic review and meta-analysis of the association between self-compassion and psychopathology defined as depression, anxiety and stress. Twenty samples, predominately undergraduate students, were identified. A large effect size (r=0.54) was observed, indicating that higher levels of compassion were associated with lower levels of common mental health symptoms. The authors highlighted that the review reflected associations and could not determine causality. They recommended that future research should address the processes underlying the relationship.

Laboratory-based research has experimentally assessed the impact of brief self-compassion interventions immediately following a difficult experience (Adams & Leary, 2007; Diedrich *et al.*, 2014; Lincoln *et al.*, 2013). In one study, following a negative mood induction, participants generating a compassion-focused image had significantly lower levels of negative emotion, higher self-esteem and fewer paranoid thoughts in comparison to participants using a neutral image (Lincoln *et al.*, 2013). The authors found that the effect of paranoid thoughts was mediated by reduced negative emotions, not increased self-esteem. Diedrich *et al.* (2014) compared a self-compassion condition to cognitive reappraisal, acceptance and a control. Reductions in depression were significantly greater in the self-compassion condition compared to the control. For those with lower levels of depressed mood, self-compassion had a significantly greater effect on mood than the alternative interventions. However, for higher levels of depressed mood, the cognitive appraisal condition showed significantly greater

improvements. In another study, a group of restrictive and guilty eaters were split into two groups (Adams & Leary, 2007). After consuming an unhealthy food preload, the group that had completed a self-compassion induction had significantly reduced distress compared to the control. Emerging evidence of self-compassion as a factor in wellbeing and distress suggests potential for clinical applications (Barnard & Curry, 2011).

1.3 Compassion-based interventions

Several interventions currently available with an emerging evidence base appear to involve increasing compassion, for example: Mindfulness-Based Cognitive Therapy, Acceptance and Commitment Therapy, Dialectical Behavioural Therapy and emotion-focused chair work. However they do not specifically aim to target compassion (Barnard & Curry, 2011). Two key interventions focus on cultivating compassion: Mindful Self-Compassion (MSC; Germer & Neff, 2013) and Compassion Focused Therapy (CFT; Gilbert, 2004, 2009). These interventions aim to alleviate distress and increase well-being by cultivating compassion using meditation and imagery techniques. MSC involves eight, weekly groups and a midway half-day retreat (Germer & Neff, 2013). The program guides participants in meditations and informal self-practices for mindfulness and self-compassion. CFT (Gilbert, 2004) involves psycho-education, formulation and Compassionate Mind Training (CMT). CMT involves experiential exercises including soothing rhythm breathing and compassionate imagery. CFT has shown promising early outcomes in clinical settings with individuals (Ashworth *et al.*, 2011; Mayhew & Gilbert, 2008) and in groups (Braehler *et al.*, 2013; Heriot-Maitland *et al.*, 2014).

1.4 Previous reviews

Several reviews have explored the concept of compassion and its potential applications. Cheng and Tse (2013) aimed to review the application of Chinese Buddhist ideas into Western mental health interventions. The authors described 13 studies investigating the application of 'meditation or mindfulness' as psychological therapies. Studies were published between 2003 and 2011, indicating a growing trend. Critical appraisal and synthesis of results was beyond the scope of their review. In a narrative review Barnard and Curry (2011) explored conceptualisations, correlates and self-compassion induction studies. Their findings supported the utility of increasing self-compassion as a clinical intervention. The authors also reviewed treatments considered to directly or indirectly

address compassion. They found four outcome studies for interventions targeting compassion reporting improvements in a range of clinical outcomes, particularly depression. They concluded that further research on outcomes with controlled trials was required. Hofmann *et al.* (2011) conducted a narrative review encompassing literature on compassion and LKM, considering origins, techniques, emotional and neuroendocrine effects, neurobiological correlates and interventions. They found that compassion and LKM were associated with increased positive affect and decreased negative affect. There was limited evidence to support favourable neuroendocrine effects. Some evidence suggested that compassion and LKM may increase activation of brain areas associated with emotional processing and empathy. They reviewed two outcome studies targeting compassion with favourable outcomes. The authors highlighted significant methodological issues, the preliminary nature of these findings and the difference between the clinical protocols used and the 'Buddhist approach' to meditation.

A more recent systematic review and meta-analysis was conducted by Galante *et al.* (2014) investigating the effects of 'kindness-based meditation' on health and well-being. This included LKM and compassion. The review was comprehensive in its search strategy but only included Randomized Controlled Trials (RCTs). They identified 22 studies that used a range of measures of health and wellbeing. Meta-analysis indicated that kindness-based meditations reduced self-reported depression, increased self-compassion, compassion and mindfulness, all with moderate effect sizes compared to passive controls. In comparison to active controls, findings were mixed. Galante *et al.* (2014) assessed methodological quality, finding studies to be low to moderate overall. They recommended further research including 'well-conducted' large scale RCTs.

1.5 Summary and Rationale

Given earlier findings regarding the potential of CBIs for clinical application, there was a need for a review of recent outcome studies. Early reviews (Barnard & Curry, 2011; Hofmann *et al.,* 2011) were narrative rather than systematic and few outcome studies were available. Although Galante *et al.* (2014) conducted a systematic review and meta-analysis of outcome studies, the authors used a broad definition that included LKM, rather than focusing on compassion *per se*. To date there has not been a systematic

review focusing specifically on CBIs. Galante *et al.* (2014) only included RCTs in their review, thereby omitting developments using non-randomised and uncontrolled designs, particularly in clinical settings. Therefore a systematic review was undertaken to address this by including controlled and uncontrolled trials, reflecting recent research developments. In contrast to existing reviews, the current review focused specifically on CBIs and clinically relevant outcomes of 'wellbeing' and 'distress'.

1.6 Aims of the present review

The overall aim of the current paper was to systemically review the current status of literature on outcomes of psychological 'wellbeing' and 'distress' following interventions focused on increasing compassion in adults.

Additional specific aims of the review were:

- to review outcomes of types of interventions; and
- to review outcomes on clinical and non-clinical samples.

The current review also aimed to systemically quality appraise the published research in order to suggest directions for future research and discuss clinical implications.

2 Method

2.1 Inclusion Criteria

The inclusion criteria for the review were that studies tested an intervention clearly described as directly targeting and promoting compassion in the individual receiving the intervention. Studies addressing compassion in staff or carers to indirectly affect wellbeing or distress in others were excluded. To reflect experimental conditions likely to be used as psychological interventions, one-off laboratory-based experiments were excluded. In order to compare outcomes, studies had to use a standardised self-report measure of psychological wellbeing or distress before and after the intervention. Studies that only reported related psychological constructs (e.g. self-criticism) were excluded. Whilst self-criticism may be correlated with distress, the emphasis was on outcomes considered to reflect clinical outcomes. In order to represent the range of research available in this area, samples could be taken from the general population or clinical populations. The current review focused on interventions with adults to facilitate comparisons.

2.2 Search Strategy

A scoping search was initially conducted to ascertain the breadth of available literature. Searches were conducted in July 2014 in three electronic databases: PsycInfo, Ovid and PubMed. The search strategy used a mixture of terms relating to the intervention and study design (e.g. compassion* OR loving-kindness AND trial or effective*, see Appendix A). Articles were restricted to adult samples, English language, peer-reviewed and published since 1st January 2004. Titles and abstracts were reviewed for relevance. Reference lists of relevant articles and reviews were manually checked for additional studies. More recent papers citing these articles were also sought using Google Scholar and electronic databases. This process was conducted iteratively until no new articles were found.

2.3 Study Selection

The process of study selection is outlined in Appendix B. The database searches elicited 212 articles. Following a review of titles, articles not relevant to the research question and duplicates were removed leaving 81 papers. Abstracts of the remaining papers were assessed for eligibility and full texts for 15 articles were ordered. Reference lists and forward citations were checked, eliciting a further 12 articles. Where there was ambiguity about inclusion the article proceeded to the next stage. Twenty-seven full texts were screened against the inclusion criteria. In order to compare findings from studies of greater design quality an additional quality criterion was applied excluding studies using a single n analysis. This resulted in 15 studies being included in the current review.

2.4 Data Extraction

Data were extracted from the 15 articles and entered directly into a Microsoft Excel spreadsheet for efficiency and to facilitate calculations and comparisons. Column headings for data extraction were designed based on the Cochrane Library guidance (Higgins & Green, 2011). Items specific to the research question were added. Key characteristics indicative of quality were included for later ease of reference and reporting. Headings were grouped around: general information; study design; sample; conditions; measures; and results (see Appendix C).

2.5 Quality Appraisal

The Effective Public Health Practice Project (EPHPP) 'Quality Assessment Tool for Quantitative Studies' (Appendix D, Thomas *et al.*, 2004) was used to quality appraise the 15 selected articles. The tool assesses quality in six domains: selection bias; study design; confounders; blinding; data collection method; and withdrawals and dropouts. Each domain is given a rating of weak, moderate or strong based on reported study characteristics. Additional prompts guide the researcher regarding intervention integrity and statistical analyses. The authors suggest the use of a global rating across all domains: 'strong' if all six domains are strong; 'moderate' if one domain is rated as weak; or 'weak' where two or more domains are considered weak. The tool allows comparisons across study designs including RCTs and uncontrolled trials, making it suitable for the current review. The tool has demonstrated good construct validity and inter-rater reliability (Thomas *et al.*, 2004) and been recommended for use within health research to address the difficulties of heterogeneous interventions and populations, where meta-analysis is often not possible (Jackson & Waters, 2005). Quality appraisal of studies using these ratings is summarized in Appendix E, along with pertinent quality characteristics that varied between studies.

3 Results

Fifteen studies met the inclusion criteria; key features are summarised in Appendix F. The majority of papers had been published in the last three years suggesting a recent increase in outcome research in this area. General characteristics of the studies and quality are summarised. Findings of the studies are then considered grouped around types of intervention.

3.1 Participants and Settings

There was a total of 2361 participants (range 9 to 1002) in the fifteen studies, with data analysed on 829 (range 6 to 228). Participants were drawn from adult populations with a range of 17-72 years across studies[1] and a mean age of 34.4 years[2]. The majority of participants were female (81.4 per cent)[3]. Three studies included only female

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[1] Based on six studies reporting age range.
[2] Based on mean ages reported in thirteen studies, not weighted.
[3] Based on thirteen studies reporting sex.

participants (Albertson *et al.*, 2014; Koopmann-Holm *et al.*, 2013; Smeets *et al.*, 2014). Seven studies reported ethnicity of the sample (Albertson *et al.*, 2014; Jazaieri *et al.*, 2014; Kelly *et al.*, 2009; Lucre & Corten, 2013; Neff & Germer, 2013; Shapira & Mongrain, 2010; Smeets *et al.*, 2014). Participants were predominantly White, Caucasian or European with percentages ranging from 71 to 100 per cent. Six studies originated from the UK (Beaumont *et al.*, 2012; Gale *et al.*, 2014; Gilbert & Procter, 2006; Judge *et al.*, 2012; Laithwaite *et al.*, 2009; Lucre & Corten, 2013), five from the United States (Albertson *et al.*, 2014; Desbordes *et al.*, 2012; Jazaieri *et al.*, 2014; Koopmann-Holm *et al.*, 2013; Neff & Germer, 2013), two from Canada (Kelly *et al.*, 2009; Shapira & Mongrain, 2010) and one from each of The Netherlands (Smeets *et al.*, 2014) and Sweden (Wallmark *et al.*, 2013). Studies did not report comparisons between sample characteristics and the target population.

Six studies involved clinical samples recruited from a range of mental health services (Beaumont *et al.*, 2012; Gale *et al.*, 2014; Gilbert & Procter, 2006; Judge *et al.*, 2012; Laithwaite *et al.,* 2009; Lucre & Corten, 2013). Nine studies used opportunity sampling to recruit non-clinical community samples from the local population, mainly through online and traditional advertising methods (Albertson *et al.*, 2014; Desbordes *et al.*, 2012; Jazaieri *et al.*, 2014; Kelly *et al.*, 2009; Koopmann-Holm *et al.*, 2013; Neff & Germer, 2013; Shapira & Mongrain, 2010; Smeets *et al.*, 2014; Wallmark *et al.*, 2013). Of these, three studies had samples predominantly using undergraduate students (Kelly *et al.*, 2009; Koopmann-Holm *et al.*, 2013; Smeets *et al.*, 2014). In the non-clinical studies, five reported using incentives (Albertson *et al.*, 2014; Kelly *et al.*, 2009; Neff & Germer, 2013; Shapira & Mongrain, 2010; Smeets *et al.*, 2014), one did not offer remuneration (Jazaieri *et al.*, 2014) and three did not report (Desbordes *et al.*, 2012; Koopmann-Holm *et al.*, 2013; Wallmark *et al.*, 2013).

3.2 Types of Studies and Interventions

Five studies were RCTs (Albertson *et al.*, 2014; Desbordes *et al.*, 2012; Jazaieri *et al.*, 2014; Neff & Germer, 2013; Wallmark *et al.*, 2013); five studies randomly assigned participants (Beaumont *et al.*, 2012; Kelly *et al.*, 2009; Koopmann-Holm *et al.*, 2013; Shapira & Mongrain, 2010; Smeets *et al.*, 2014); and five studies were uncontrolled trials (Gale *et al.*, 2014; Gilbert & Procter, 2006; Judge *et al.*, 2012; Laithwaite *et al.*, 2009; Lucre & Corten, 2013). In total the fifteen studies included thirty conditions,

ranging from one to four conditions per study. Four studies compared the intervention with a waitlist control only (Albertson *et al.*, 2014; Jazaieri *et al.*, 2014; Neff & Germer, 2013; Wallmark *et al.*, 2013); one study compared two interventions with a waitlist control (Kelly *et al.*, 2009). Four studies used an active control to compare with: one intervention (Smeets *et al.*, 2014); two interventions (Desbordes *et al.*, 2012; Shapira & Mongrain, 2010); or two interventions and a waitlist (Koopmann-Holm *et al.*, 2013). One study compared two interventions (Beaumont *et al.*, 2012).

All intervention conditions involved daily practices and homework exercises. Interventions ranged in duration from one to sixteen weeks, with the majority lasting eight weeks or more (see Appendices G, H and I). Most interventions were weekly, with the exception of Laithwaite *et al.* (2009) and Gale *et al.* (2014) where interventions involved 20 sessions over 10 and 16 weeks respectively. One study involved individual therapy sessions (Beaumont *et al.,* 2012); three studies delivered the intervention primarily through technology either in a laboratory (Kelly *et al.,* 2009) or using online resources (Albertson *et al.,* 2014; Shapria *et al.,* 2010). The remaining intervention conditions were delivered as group programmes.

3.3 Outcome Measures

Measures were taken pre- and post- intervention. Five studies measured outcomes at follow-up ranging from six weeks to twelve months (Albertson *et al.,* 2014; Laithwaite *et al.,* 2009; Lucre & Corten, 2013; Neff & Germer, 2013; Shapira & Mongrain, 2010). Consistent with the inclusion criteria, all studies used standardised self-report measures of psychological wellbeing or distress. All studies measured outcome in terms of psychological distress; predominantly in terms of depression and anxiety, using a range of outcome measures (see Appendices G, H and I). Three studies did not use depression or anxiety as an outcome: Albertson *et al.* (2014) focused on body dissatisfaction; Gale *et al.* (2014) investigated eating disorder symptomology and used a generic measure of clinical outcomes; and Koopmann-Holm *et al.* (2013) assessed a range of affective states. Five studies reported wellbeing outcomes as measured by the Subjective Happiness Scale, the Satisfaction with Life Scale and the Steen Happiness Index (Jazaieri *et al.,* 2014; Koopmann-Holm *et al.,* 2013; Neff & Germer, 2013; Shapira & Mongrain, 2014; Smeets *et al.,* 2014). Several studies also sought to measure psychological constructs hypothesized to relate to outcomes for example shame, self-

compassion, self-criticism and mindfulness. It was beyond the scope of the review to report these results.

3.4 Quality

All studies were given a global rating of 'weak' using the Quality Assessment Tool for Quantitative Studies (Thomas *et al.*, 2004), with two to five out of six domains rated as weak (Appendix E).

Selection bias

All studies were open to selection bias, predominantly through self-selection and opportunity sampling. Furthermore, studies did not compare their sample to the target population making it difficult to assess representativeness of the sample. Participants were predominantly women and studies were all conducted in North America or Western Europe, limiting generalisation.

Study design

The fifteen studies were evenly spread in terms of study design across RCTs, controlled trials and uncontrolled trials. Only two RCTs reported method of randomization (Jazaieri *et al.*, 2014; Wallmark *et al.,* 2013). One study identified itself as an RCT and weighted randomization so that 60 per cent were allocated to the intervention group (Jazaieri *et al.*, 2014). Studies with clinical samples tended to have uncontrolled designs. Therefore comparisons of effectiveness against other interventions could not be drawn.

Confounders

Regarding risk of bias from confounders, one was rated as moderate (Beaumont *et al.,* 2012) and the rest split evenly between weak and strong. Weak ratings were assigned due to lack of control group or not reporting possible confounding characteristics. In controlled trials, characteristics of the groups were compared but inconsistently reported. Three studies compared sample characteristics and baseline dependent variables to check for confounding variables (Albertson *et al.,* 2014; Kelly *et al.,* 2009; Shapira & Mongrain*,* 2010). Two studies only compared demographics variables (Jazaeiri *et al.,* 2014; Smeets *et al.,* 2014) and one study stated demographic had been compared but did not provide statistics (Neff & Germer, 2013). Two studies reported

important differences prior to intervention and addressed by using post hoc analyses (Beaumont *et al.,* 2012) or controlling with statistical analyses (Wallmark *et al.*, 2013).

Blinding

None of the studies described methods of blinding researchers. Researchers were often involved in delivering the intervention and data collection. It was unclear who administered the self-report measures or if they were blinded. Studies conducted over the internet may have reduced researcher bias. Studies were either unclear in reporting or omitted to describe participant blinding, increasing the potential for social desirability bias.

Data collection

Data collection methods were consistently rated as strong, reflecting the inclusion criterion of the current review that studies had to use a standardised measure. Measures used were varied, making direct comparison difficult.

Withdrawals and drop-outs

There were inconsistencies in reporting numbers and reasons for withdrawals or drop-outs. Drop-out rate overall was moderate, with the majority of studies retaining 60 per cent or more participants in any given condition (see Appendix E). Three studies (Albertson *et al.,* 2014; Gale *et al.,* 2014; Shapira & Mongrain, 2010) had poor retention rates. Transparency of reporting attrition figures and reasons for attrition varied between studies, as did comparisons between drop-outs and completers.

Intervention Integrity

Only one study described procedures to ascertain treatment integrity using an unstandardized tool (Jazaieri *et al.,* 2014). Three studies attempted to measure participant compliance with meditation practices using self-report methods (Kelly *et al.,* 2009; Koopman-Holm *et al.,* 2013; Neff & Germer, 2013). The remaining studies did not address treatment integrity or participant adherence to practices. Studies using the same practitioner to deliver different interventions were most likely to risk contamination. This could not be assessed due to lack of treatment integrity measures. A minority of studies commented on attendance rates and removed participant data where there was insufficient exposure to the intervention. Only three studies reported

participant levels of self-practice. These were mostly retrospective self-report records, although one study required an online log-in, possibly providing a more accurate measure of practice (Albertson *et al.,* 2014).

Analyses

Statistical analyses were generally appropriate. However only six studies calculated effect sizes (Albertson *et al.,* 2014; Gale *et al.,* 2014; Laithwaite *et al.,* 2009; Neff & Germer, 2013; Smeets *et al.,* 2014; Wallmark *et al.,* 2013). None of the studies reported conducting power calculations and it is likely that several studies were under-powered, especially those with multiple conditions. None of the studies used an intention-to-treat analysis, inflating the risk of Type I errors.

3.5 Effects of the Intervention

Studies aimed to test the effects of interventions targeting increases in compassion. Interventions varied in duration, scope and delivery. Results are grouped under three headings based on similarity of interventions: compassion meditation interventions (Appendix G); CFT informed interventions (Appendix H); and compassion exercises (Appendix I). These headings are for clarity of presentation rather than representing distinct groups of interventions. Under each heading, a summary of intervention characteristics is provided followed by intervention effects for wellbeing, depression anxiety/stress and 'other'.

3.5.1 Compassion Meditation Interventions

Seven studies compared interventions centred on learning and practising compassion meditations (Albertson *et al.,* 2014; Desbordes *et al.,* 2012; Jazaieri *et al.,* 2014; Koopmann-Holm *et al.,* 2013; Neff & Germer, 2013; Smeets *et al.,* 2014; Wallmark *et al.,* 2013). These were delivered in a weekly group format ranging from two to nine weeks with the exception of Albertson *et al.,* (2014) who used internet-based resources to provide instructions. Interventions tended to include an introductory session about mindful attention as a platform for other meditative practices. In line with the inclusion criteria, compassion was the main focus of the interventions, however they varied subtly in their use of other meditation practices. In total, there were ten comparison groups across the seven studies. Two studies compared the CBI with a mindfulness intervention (Desbordes *et al.,* 2012; Koopmann-Holm *et al.,* 2013). Three studies used an active

control, matching frequency and duration of group meetings to the intervention (Desbordes *et al.,* 2012; Koopmann-Holm *et al.,* 2013; Smeets *et al.,* 2014). Four studies used a waitlist control only (Albertson *et al.,* 2014; Jazaieri *et al.,* 2014; Neff & Germer, 2013; Wallmark *et al.,* 2013). All studies used completers analyses.

Wellbeing

Four studies measured wellbeing in terms of life satisfaction (Koopmann-Holm *et al.*, 2013; Smeets *et al.*, 2014), subjective happiness (Jazaieri *et al.*, 2014) or both (Neff & Germer, 2013). Analyses of variance showed a lack of significant effects of group for the majority of comparisons. One comparison found that life satisfaction increased significantly more in the CBI group compared to a waitlist control (Neff & Germer, 2013). The authors reported that the CBI group maintained gains after six months and these increased at twelve months. They were unable to make between group comparisons regarding follow-up. Smeets *et al.,* (2014) reported significant increases in life satisfaction over time for both the intervention and active control groups.

Depression

Two studies (Desbordes *et al.*, 2012; Neff & Germer, 2013) measured depression using versions of the Beck Depression Inventory. Neff & Germer (2013) found significant improvements in depression with a large effect size in the CBI group compared to waitlist. Desbordes *et al.,* (2012) found no significant effect of group in comparison to an active control. In exploratory analyses they found a significant within group difference in depression for the intervention group but not the control.

Anxiety/Stress

Five studies measured anxiety or stress using a range of measures (Desbordes *et al.,* 2012; Jazaieri *et al.,* 2014; Neff & Germer, 2013; Smeets *et al.,* 2014; Wallmark *et al.,* 2013). Two studies compared the intervention with a waitlist, finding significant between group differences in anxiety and perceived stress (Neff & Germer, 2013; Wallmark *et al.*, 2013). Both studies reported significant changes over time for the intervention group. Effect sizes ranged from small to large. Three studies comparing interventions with active controls did not find significant interactions between time and group on a range of anxiety/stress measures (Desbordes *et al.*, 2012; Jazaieri *et al.*,

2014; Smeets *et al.*, 2014). In follow-up t-tests, two of the three studies found significant decreases in anxiety or stress indicating changes over time in the intervention but not control groups (Desbordes *et al.*, 2012; Jazaieri *et al.*, 2014). Smeets *et al.* (2014) reported no significant within group differences in worry following a three week intervention.

Other

Albertson *et al.* (2014) found significantly greater reductions in body dissatisfaction in their intervention group compared to waitlist with a medium effect size. They also reported significantly greater gains in body appreciation in the CBI with a medium effect size. Koopmann-Holm *et al.* (2013) investigated differences in actual and ideal affect across four conditions. Their initial comparisons showed no significant differences between the CBI and the mindfulness intervention or between the active control and waitlist. Subsequent analyses were based on combining the intervention and control groups. They found no significant differences in actual affect between the pooled groups.

3.5.2 CFT Informed Interventions

Six studies trialled CFT-informed interventions in a range of clinical samples and therapy settings (Beaumont *et al.*, 2012; Gale *et al.*, 2014; Gilbert & Procter, 2006; Judge *et al.*, 2012; Laithwaite *et al.*, 2009; Lucre & Corten, 2013). CMT was usually added to existing treatments. Outcomes reflected the intervention overall, including existing treatment components that were not compassion-based (see Appendix H). Only one study had a control group: Beaumont *et al.* (2012) compared Cognitive Behavioural Therapy (CBT) with 'CBT plus CMT'. None of the studies investigated wellbeing outcomes.

Depression

Five studies used a measure of depression and reported significant improvements over time (Beaumont *et al.*, 2012; Gilbert & Procter, 2006; Judge *et al.*, 2012; Laithwaite *et al.*, 2009; Lucre & Corten, 2013). Beaumont *et al.* (2012) were unable to use the planned ANOVA to compare conditions, as the intervention group's baseline depression score was significantly greater than the comparison group. They conducted post hoc

analyses of amount of change, concluding that the 'CBT plus CMT' group had a significantly greater amount of change in depression than the CBT only group.

Anxiety/Stress

Four studies measured anxiety in various ways. Three studies found that anxiety significantly reduced over the course of the CBI (Beaumont *et al.* 2012; Gilbert & Proctor, 2006; Judge *et al.,* 2012). One study found significant reductions in stress but not anxiety as measured by the Depression Anxiety and Stress Scale (Lucre & Corten, 2013). Comparisons of CBT with 'CBT plus CMT' did not yield significant between group differences in anxiety (Beaumont *et al.,* 2012).

Other

Other measures of psychological distress and disorder-specific symptoms were explored by four studies (Beaumont *et al.*, 2012; Gale *et al.*, 2014; Laithwaite *et al.*, 2009; Lucre & Corten, 2013). Overall, within group comparisons showed improvements over time. However changes in symptoms of psychosis were only evident from the General Psychopathology subscale of the Positive and Negative Syndrome Scale (Laithwaite *et al.*, 2009). No significant between groups differences were found in planned analyses of CBT versus 'CBT plus CMT' (Beaumont *et al.*, 2012). Post hoc analyses of change scores on the trauma measure found between group differences for the avoidance subscale but not for other subscales or total score.

3.5.3 Compassion Exercises

Two studies conducted interventions characterised by the use of brief individually delivered compassion-based exercises (Kelly *et al.,* 2009; Shapira & Mongrain*,* 2010). Kelly *et al.* (2009) facilitated a letter-writing exercise and brief compassionate visualisations. Participants were asked to generate compassionate imagery and statements then practice them three times a day for two weeks. Shapira and Mongrain (2010) asked participants to write a brief letter to themselves from a compassionate stance daily for seven days. A limited rationale was provided. Both studies included a CBI, an alternative intervention and a control (Appendix I).

Wellbeing

One study measured wellbeing in terms of happiness, finding a significant time by group interaction (Shapira & Mongrain, 2010). Simple effects contrasts showed that happiness was greater for the self-compassion condition compared to the active control at three and six month follow-up but not post-intervention. The authors detected main effects from their alterative intervention 'optimism' contributing to the time by group interaction. The two interventions were not compared with one another.

Depression

Both studies measured depression, detecting significant time by group interactions (Kelly *et al.,* 2009; Shapira & Mongrain, 2010). Simple effects contrasts showed significant effects for the alternative interventions but not for the self-compassion condition immediately post intervention. One study reported significant differences in depression in the self-compassion condition compared to an active control at three and six month follow-ups (Shapira & Mongrain, 2010). However, comparisons were not made between the intervention groups. Kelly *et al.* (2009) compared the two interventions but this did not reach significance.

Other

Kelly *et al.* (2009) found greater reductions in acne-related emotional distress for both interventions compared to waitlist. There were no significant differences between the self-compassion and attack-resisting interventions.

4 Discussion

The aim of the current paper was to systematically review the effects of CBIs on wellbeing and distress in adults. The review focused on longer-term interventions with practices or exercises rather than one-off experimental inductions. Fifteen studies met the inclusion criteria. A range of study designs were included. CBIs were compared with alternative interventions, active and passive controls. Interventions varied in duration and format. Findings are discussed in relation to types of intervention and samples.

In order to compare interventions of greater similarity, experimental conditions were grouped. Studies classed as 'compassion meditation interventions' were characterised by a group programme designed to teach meditation practices, typically over eight to ten weeks in non-clinical settings. Whereas CFT informed interventions were delivered to clinical samples in naturalistic settings. Two studies with non-clinical samples were classified as 'compassion exercise' interventions as they focused more on specific exercises rather than meditation practice and were much less intensive interventions, lasting only one to two weeks. They also delivered the intervention individually through technology rather than in a group setting. Despite differences in format and duration, findings in studies using compassion exercises were comparable to meditation interventions in terms of significance. However, effect sizes were not reported by the majority of studies and findings were inconsistent.

Compassion meditation interventions looked at wellbeing outcomes whereas CFT informed interventions did not. This may be due to the clinical status of the samples, with wellbeing more commonly measured in non-clinical samples. Although wellbeing could increase, findings were inconsistent and significant differences were not found when compared to active controls or alternative interventions. There was some evidence of reductions in depression following compassion meditation interventions in controlled trials with non-clinical samples. Clinical samples using CFT-informed interventions demonstrated evidence of improvements in depression over time, however these tended to lack controls. One study had a control group but was unable to conduct the planned analyses due to baseline differences (Beaumont *et al.,* 2012). Decreases in anxiety or stress were found for CBIs when compared to passive but not active controls or alternative interventions.

Overall the findings were mixed. There was very little evidence to support improvements in wellbeing and this was only found in comparison to a waitlist. The majority of studies demonstrated reductions in depression over time, following a CBI. However, these studies either lacked controls or used a waiting list. Efficacy findings for studies using active controls or alternative interventions were comparable.

Tentative findings from the current review were consistent with a recent meta-analysis looking at kindness-based meditation (Galante *et al.*, 2014). A lack of conclusive

evidence supporting efficacy of CBIs when compared to active controls was also noted in the review of kindness-based meditation. However Galante *et al.,* (2014) reported improvements in wellbeing whereas the current review found limited evidence of this.

4.1 Quality Assessment

Overall methodological quality was weak, representing the current status of an emerging field. Study designs tended to be stronger in non-clinical samples utilising compassion meditation interventions or exercises. Studies that used stronger designs suggested that CBIs can be superior against passive controls and similar to the alternative interventions tested. The aim of the current paper was to review the current status of the literature, including evidence from uncontrolled trials. The addition of these papers showed that research into CBIs has started to investigate effects in clinical samples in naturalistic settings. Although comparison groups are needed to assess efficacy, early findings are promising. Further controlled trials with this intervention would be needed. All studies used completers analyses, opening them to Type I errors. In contrast, studies did not perform power calculations or demonstrate recruiting an appropriate sample size, making them potentially underpowered. Future research would benefit from addressing these limitations.

4.2 Strengths and Limitations of the Current Review

Strengths of the current review were that it was systematic, provided a detailed quality appraisal and focused on clinically relevant outcomes. A limitation of the review was the heterogeneity of interventions, their duration and format. A further limitation was the variation in outcome measures. Collective analysis of results may have occluded differences in intervention effects arising from variations in the interventions and measures. Psychological constructs thought to be associated with change were not explored, for instance self-compassion. Therefore a limitation of the review was that conclusions could not be drawn regarding mechanisms of actions.

4.3 Future Research

The current review highlighted the variety of CBIs under research. However, trends related to outcomes were unclear. Interventions of different types, duration and format showed potential but with inconsistent results. It is likely that several processes contribute to outcome, however investigating these was beyond the remit of the current

review. There is evidence that CBIs can increase self-compassion and reduce self-criticism and rumination (Mosewich *et al.*, 2013; Odou & Brinker, 2014). Additional research is needed to clarify the interaction between these variables and demonstrate the processes and contexts underlying any effects on wellbeing and distress.

An important component of CBIs is practicing the exercises or meditation. Only a minority of the reviewed studies assessed participant adherence to practices and this was predominantly reliant on retrospective self-report. There is evidence to suggest a direct relationship between amount of meditation practice and outcomes (Jazaieri *et al.*, 2013). Therefore it is likely that the effectiveness of interventions will be mediated by the amount of practice. Future research would benefit from systematically recording this and considering the impact of this variable on outcome. In a clinical context, in order for clients to benefit from CBIs they may need support and a clear rationale to incorporate compassionate practices into their lives. Future research could explore if the psycho-educational component and rationale included in CFT supports this process.

4.4 Clinical Implications

Overall, the reviewed studies suggested that CBIs may have potential for psychological interventions to reduce depression, anxiety, stress and other measures of psychopathology. However, it is difficult to draw firm conclusions regarding efficacy compared to other interventions as only a minority of studies compared the effects to another intervention and results were comparable. There was limited evidence of interventions improving 'wellbeing' on the measures used.

CBIs appear to have potential for use with clinical samples including clients presenting with trauma, personality disorder, psychosis and long-term mental health difficulties. Using CBIs as an augmentation of existing therapies or treatment programmes has shown potential, however further research with carefully considered controls is required. The majority of interventions were meditation programs or involved CFT-informed interventions. A minority of studies involved compassionate letter writing exercises, which may be of potential clinical utility in itself. In a mood induction study, Odou and Brinker (2014) found that self-compassionate writing significantly predicted improved mood, more so than writing in an emotionally expressive way.

Although investigating active treatment components is important to the development of effective psychological interventions, it may be unrealistic to separate mindfulness and compassion. Most meditation-based interventions included a mindfulness component prior to focusing on compassion. Therefore isolating the effect of specifically targeting compassion *per se* could be considerably challenging. Neff (2003) includes mindfulness within the definition of compassion, suggesting overlap in the concepts. Studies have shown that self-compassion can increase as a result of mindfulness interventions (Van Dam *et al.*, 2013). This may explain findings of comparable effects between compassion-based and mindfulness interventions included in the current review. Given the theoretical overlaps, research into effective CBIs needs to establish the processes that lead to improvements, which may differ between populations.

4.5 Conclusions

Conclusions regarding the evidence as a whole were tentative due to considerable variation between interventions and samples. Evidence reviewed in the current paper suggested that CBIs may lead to reductions in depression, anxiety and other symptoms of distress over time. However there was insufficient evidence to support the superiority of CBIs over other interventions. There was scarce evidence to support significantly greater improvements in wellbeing compared to controls. In studies where findings supported the effectiveness of the CBI there was either no comparison group or the control group was passive. When compared to alternative interventions and active controls, CBIs tended to produce similar improvements. Studies were of low methodological quality, therefore more robust research is required. Future research needs to address: facilitating and measuring engagement in compassionate practices; treatment integrity; and mechanisms of action.

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Therapist Competencies necessary for the delivery of Compassion Focused

Therapy: A Delphi Study

Abstract

Background

Clarification of therapist competencies facilitates training of therapists and contributes to definition of treatment fidelity for research trials. Compassion Focused Therapy (CFT) is a relatively new psychotherapy with potential for clinical use. Future research using controlled trials would benefit from clarity regarding competencies required to deliver CFT.

Aims

The primary aims were to identify the therapist competencies necessary to deliver CFT and to organise these into a framework.

Method

The Delphi method was used to explore and refine competencies for delivering CFT in three rounds of data collection. The first round involved interviews with 12 'experts'. Data were analysed using Template Analysis to generate a draft Competency Framework. The main competencies were used to create a survey for rounds two and three. Fourteen participants in round two and seven in round three rated the importance of competencies in delivering CFT. Data collected from the surveys was used to refine the competencies.

Results

A CFT Competency Framework (CFT-CF) was produced, comprised of twenty-five main competencies within six key areas of competence. The areas were: Competencies in Creating Safeness; Meta-skills; Non phase-specific skills; Phase-specific skills; Knowledge and Understanding; and Use of Supervision. The main competencies included several sub-competencies specifying knowledge, skills and attributes needed to demonstrate the main competence. Overall there was consensus on 14 competencies and 20 exceeded an 80 per cent agreement level ($N=7$).

Conclusions

The CFT-CF detailed the competencies considered necessary to deliver CFT. Areas of disagreement and overlaps with competencies in other therapies are discussed. The CFT-CF has potential for use as guidance for clinical practice, setting training curricula and supervision. The CFT-CF could also be used as the basis for a measure of therapist competence, which would help in the measurement of treatment fidelity in research trials.

1 Introduction

Compassion Focused Therapy (CFT) is a psychological therapy based on a trans-diagnostic model of affect regulation (Gilbert, 2009, 2014). CFT is rooted in an evolutionary understanding of social processes and the consequences for affect regulation. The therapy aims to reduce shame and self-criticism by increasing soothing in an affiliative context. This is partly achieved through Compassionate Mind Training (CMT) which involves a range of exercises.

The theory behind CFT has been developing for the past 30 years with growing evidence to support the links between compassion, depression, anxiety and stress (MacBeth & Gumley, 2012). CMT has been introduced to different clinical populations in small-scale studies. In a review of CFT outcome studies it was suggested that larger-scale trials are needed to demonstrate the efficacy of CFT (Leaviss & Uttley, 2014). The current study aimed to identify therapist competencies necessary for the delivery of CFT. In what follows, evidence for the role of compassion in mental health and CFT are outlined. Issues regarding treatment fidelity and competence are considered. Existing research on competence, and methods for developing competencies, and the Delphi method are explored.

1.1 Evidence for the role of compassion in mental health

There is growing evidence to support the significance of compassion for improving mental health and well-being. MacBeth and Gumley (2012) conducted a meta-analytic review of literature on compassion and mental health, finding an inverse relationship between psychopathology (anxiety, depression and stress) and self-compassion. Across the 20 samples, a large effect size ($r=0.54$) was observed demonstrating higher levels of compassion associated with lower levels of anxiety, depression and stress. They concluded that increasing self-compassion had potential for clinical application, however further research was needed into mechanisms of action. In a laboratory-based negative mood induction, participants were asked to generate either a compassion-focused image or a neutral one. In comparison to participants using a neutral image, those who used the compassion-focused image had significantly lower levels of negative emotion, higher self-esteem and fewer paranoid thoughts (Lincoln *et al.,* 2013). Self-compassion inductions have been shown to reduce depressed mood

compared to a control (Deidrich *et al.,* 2014) and reduce distress in restrictive eaters, leading to healthy changes in eating behaviour (Adams & Leary, 2007). Barnard and Curry (2011) conducted a review of self-compassion correlates, induction and outcome studies. Findings supported the potential for targeting compassion as a clinical intervention, particularly for depression. They concluded that there was insufficient evidence and outcome research with controlled trials was required.

1.2 Compassion Focused Therapy

CFT was developed to address difficulties in people with mental health difficulties such as anxiety and depression who found that traditional cognitive and behavioural therapies (CBT) made logical sense but did not change how the felt (Gilbert, 2009). For people who find CBT ineffective for this reason, CFT targets high levels of shame and self-criticism. It integrates evolutionary psychology and attachment theory with humanistic and cognitive-behavioural therapy approaches. The approach uses a Buddhist-derived definition of compassion as "being sensitive to the suffering of self and others with a deep commitment to try to prevent and alleviate it" (Gilbert & Choden, 2013, p.xviii). Compassion is considered to involve a range of attributes and skills embedded within warmth (Gilbert, 2010).

CFT is grounded in an evolutionary perspective on the development of emotions and their functions within the context of social motivations (Gilbert, 2014). Different social motivations are considered to link to mental health and wellbeing. Competition is seen to activate threat, whereas caring can stimulate soothing. A competitive mentality is thought to be associated with shame and self-criticism, which are often high in people with mental health problems. Whereas a compassionate caring mentality has the potential to reduce shame and self-criticism and increase soothing.

The CFT model describes three affect regulation systems. The development of these systems is understood through the individual's relational experiences, evolutionary psychology and social mentalities. The model conceptualises difficulties as arising from an imbalance of the three systems and a limited ability to activate the soothing system. CFT uses compassion to facilitate development of soothing capacities through CMT (Gilbert & Irons, 2005).

As an integrative framework, a range of interventions drawn from other approaches can be used to activate the soothing system. In addition, the language used in the model is designed to minimise self-criticism and feelings of shame for instance 'protective strategies' instead of 'maladaptive cognitions' (Gilbert & Irons, 2004).

1.3 Evidence for CFT

As a trans-diagnostic approach, research into CFT has started to show positive outcomes on a range of measures in a range of client groups. CFT interventions have demonstrated improvements in depression and anxiety in specialist community mental health services (Gilbert & Proctor, 2006; Judge *et al.,* 2012). CFT interventions have also been shown to lead to improvements in symptoms for those with a diagnosis or symptoms of: Post Traumatic Stress Disorder (Beaumont *et al.,* 2012); eating disorder (Gale *et al.* 2012); personality disorder (Lucre & Corten, 2012); and schizophrenia or psychosis (Braehler *et al.*, 2013; Heriot-Maitland *et al.*, 2014; Laithwaite *et al.*, 2009; Mayhew & Gilbert, 2008). CFT interventions have been delivered individually or in groups. The majority of the emerging evidence base predominantly reflects group programmes, including augmentations of existing evidence-based approaches. CFT outcome research has been conducted in routine clinical services, demonstrating high ecological validity. However, outcome research has predominantly been in uncontrolled trials. A recent review acknowledged that there is emerging evidence for the potential use of CFT, however larger controlled trials are required to consider it 'evidence-based' (Leaviss & Uttley, 2014).

1.4 Treatment Fidelity

One of the difficulties in researching new therapies is that of treatment fidelity, especially where therapies draw from other traditions. Integrative approaches, by their nature, have considerable overlaps with other therapies therefore the risk of conflation is high. In order to demonstrate efficacy, future research trials would benefit from greater clarity on aspects of treatment fidelity. Treatment fidelity has been described as including both adherence and competence (Fairburn & Cooper, 2011). Adherence pertains to aspects of the therapy that need to be present to demonstrate the therapy and the absence of those practices that are not part of the therapy. Competence addresses the aptitude with which the therapy is implemented. Identifying and measuring treatment fidelity offers a way to validate research trials, which allows research to be more

specific in developing effective therapies. To date, much has been written about the content of CFT (Gale *et al.,* 2014; Gilbert 2009; Gilbert, 2014; Gilbert & Irons, 2004; Gilbert & Proctor, 2006,). However, little has been written about therapist competencies.

1.5 Therapist Competence

The last ten years have seen an increasing shift towards a 'culture of competence' in professional psychology (Kaslow, 2004). Within this context, competence 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, p.227). Competence can be operationalized through definition of specific elements or competencies that address knowledge, skills, attitudes and their integration (Kaslow, 2004). Professional competence can be considered as constituting global and limited-domain intervention competence (Barber *et al.,* 2007). The authors propose that global competence relates to the clinical acumen of the therapist. Limited-domain competence focuses on the therapist's ability to work with a range of clinical problems to assist clients in meeting their treatment goals, usually by using a specific intervention. Whilst global competence is important in its own right, the current study concerns limited-domain competence. It is acknowledged that limited-domain intervention competence includes aspects generic to most psychotherapies and specific to the intervention.

One rationale for exploring competencies has been to establish a minimum threshold required for ethical practice. This has been important for informing training programmes. It has been suggested that a developmental model may be useful in considering the acquisition of competence. Sharpless and Barber (2009) suggested a five stage model of intervention competence adapted from work in education. The five stages were: novice, advanced beginner, competence, proficiency and expertise. Benefits of clarifying competencies include facilitating curricula development, effective training and public protection (Sharpless & Barber, 2009).

The implementation of a particular therapy involves both generic competencies and those specific to the therapy or intervention (Rector & Cassin, 2010). Identifying and measuring treatment fidelity offers a way to validate research trials, which allows

research to be more specific in developing effective therapies. Competence measures are often used alongside or integrated with adherence measures. Measures of competence can also be used to ensure therapy quality in the dissemination of therapies from research trials to routine clinical practice through supervision, training and evaluation. This promotes quality delivery of evidence-based therapies in routine clinical practice.

Whilst there are likely to be generic psychotherapeutic competencies relevant to CFT, it is possible that there are model-specific aspects and that the combination of these is important in capturing the way CFT is delivered. Thus far, competencies in delivering CFT have not been explored, described or clarified.

1.6 Methods for developing therapist competencies

The development of therapist competencies has rested upon those individuals at the forefront of developing a new model. At the early stages of a new therapeutic model, the core concepts and assumptions of the model are translated into practice and tested in effectiveness studies and randomized controlled trials (RCTs). In order to ensure that the therapy being researched is being conducted in these trials, the lead researchers: (1) define the competencies that are needed to adequately deliver the therapy; (2) describe how these would be observable; and (3) devise a measure to demonstrate this (e.g. Young & Beck, 1980). Attempts have then been made to test validity and reliability and refine as necessary (e.g. Barber *et al.,* 2010; Blackburn *et al.,* 2001).

Recent developments in clarifying therapist competencies have drawn from the evidence-base, compiling competencies based on manuals, protocols and competency measures used in research trials of effective therapies (Roth & Pilling, 2007). The authors aimed to provide competency frameworks as guidance, so that the evidence-based interventions can be applied in routine clinical practice to the same standard, thus promoting positive clinical outcomes. Experts were typically consulted through an iterative process to develop a useful and coherent competence framework. This work has resulted in expansive competence 'maps' that can be used to inform 'curricula'.

The CBT competence map focused on evidence for adults with anxiety and depression (Roth & Pilling, 2007, 2008a). The maps included five 'headers' or groups of

competencies: generic therapeutic competences; basic competences; specific techniques; problem-specific skills; and metacompetences. Competencies were further subdivided within this framework. Generic therapeutic competences refers to competencies that span most, if not all, psychotherapies. The remaining CBT competencies were grouped under the umbrella 'ability to work in a collaborative manner' which represented the therapeutic stance. 'Basic' CBT competencies described competencies relevant to implementing most CBT interventions, whereas specific techniques and problem-specific competences were dependent upon the individual client. Finally, metacompetences were more 'abstract' competences describing "the procedural rules that enable therapists to implement therapy in a coherent and informed manner, and to apply an intervention in a manner that is responsive to the needs of an individual client" (Roth & Pilling, 2008a, p.40). Metacompetences were divided into CBT-specific and generic.

The structure of this outline model with generic competences and a model-specific stance encompassing four further groups of competencies has been similarly applied to competencies in other evidence based approaches including: 'Psychoanalytic/ psychodynamic' (Lemma *et al.,* 2008); Systemic (Pilling *et al.,* 2010) and Humanistic (Roth *et al.,* 2009). Intervention-specific therapist competencies have also been detailed: Interpersonal Psychotherapy (IPT, Lemma *et al.,* n.d.) and Dynamic Interpersonal Therapy (Lemma*,* n.d.). Supervision competence has also been addressed (Roth & Pilling, 2008b). Details of these 'maps' are available online (www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm). Empirically-supported competence maps have also been developed for CBT for children and adolescents (Sburlati *et al.,* 2011) and IPT with adolescents (Sburlati *et al.,* 2012).

Where the evidence base is less well developed, expert opinion has been used to develop a list of competencies for Acceptance and Commitment Therapy (ACT, Walser *et al.,* 2013), infant mental health (Quay *et al.,* 2009) and sexual addiction counselling (Hagedorn, 2009). Measures of therapist competence have been devised based on expert opinion and rating therapy tapes for Cognitive Analytic Therapy (CAT, Bennet & Parry, 2006) and Brief Psychodynamic Investigation (Tadic *et al.,* 2013). These studies have predominantly used a systematic survey of expert opinion based on the Delphi method.

1.7 The Delphi Method

The Delphi method has been described as a method of structuring group communication that allows groups of individuals, as a whole, to deal with a complex problem (Linstone & Turoff, 2002). Although originally the method sought to obtain a consensus, this has shifted towards seeking agreement amongst participants with an acknowledgement that reporting the variance in opinion also provides useful information (Gordon, 1994). It is especially useful at the beginning of a research endeavour when little scientific evidence exists (Jones & Hunter, 1995).

The Delphi method involves a series of 'rounds' or phases to gather initial opinions from participants. An outside party anonymises and collates the data. Opinions of the group from the first round can then be shared with other participants in an anonymous format. When used as intended – for exploratory purposes – the first round optimally uses open-ended questions to acquire qualitative data from expert participants. This data is then analysed to generate a survey. The survey is quantitative, typically asking the level of agreement with each item using a Likert scale. In round two, participants are asked to comment on the survey instrument generated from the first round. Participants provide this feedback to the researcher who then collates and anonymises the data. In round three, the researcher sends the group level data to participants along with their individual response to round two. Participants are asked to review their response and revise in light of the group data if they wish to, by completing another set of Likert scales. The researcher analyses the revised responses to complete round three. As an iterative process, this could be repeated numerous times until the desired agreement level is reached. However, three rounds is generally thought to be sufficient and further rounds to be too labour-intensive for participants (Iqbal & Pipon-Young, 2009).

An advantage of the Delphi method is that as an anonymous process facilitated by a co-ordinator (the researcher), it reduces bias towards dominant viewpoints that would occur through other interactions (Iqbal & Pipon-Young, 2009). This may facilitate greater creativity and honesty (De Meyrick, 2003). It is also practical in facilitating group communication that would not be possible due to geography, time or other constraints (Landetta, 2006). The Delphi method has been used in clinical psychology to identify: professional competencies in Clinical Psychology training (Green & Gledhill, 1993); developments in a Doctoral training curriculum (Graham & Milne,

2003); treatment elements for behavioural difficulties in children (Garland *et al.,* 2008); essential components of CBT for psychosis (Morrison & Barratt, 2010) and essential elements of an Early Intervention in Psychosis Service (Marshall *et al.*, 2004).

1.8 Adapting the Delphi method

Whilst round one is usually questionnaire-based, the use of interviews could address two key limitations of the method – the reliance on written communication and difficulty engaging participants to respond to the questionnaire. Using interviews to explore competencies and generate ideas provides rich data that when analysed systematically, is likely to provide a more coherent framework than simply listing competencies. Using the Delphi method to generate a survey from round one interviews and putting this to participants in two further rounds provides a method of obtaining feedback that facilitates development beyond interviews alone. This is similar to the method used to develop an outcome measure for CBT for psychosis (Greenwood *et al.,* 2010).

1.9 Rationale

Although promising, the effective application of CFT has yet to be established in the research literature. In terms of conducting rigorous research with high treatment fidelity, it is important to ensure that further research into CFT reflects the core components of the therapy and that these are adequately and competently applied in trials. Literature on CFT has outlined what the model is and the phases of therapy, however the competencies required to implement these have not been explored. To demonstrate treatment fidelity and quality, an understanding of the competencies necessary to deliver CFT is required. A framework clarifying these could then be used as a basis for a therapist rating scale to be used in clinical trials. In terms of safe and accountable practice, clarity over the competencies would assist supervision, training programs and evaluation in routine clinical practice.

The exploration of competencies in a new therapeutic model would benefit from a systematic approach that takes into account the opinions and experiences of clinicians applying the model in a range of settings. The Delphi method facilitates anonymous communication across a group of experts to share opinions and ascertain agreement levels.

1.10 Aims

Primary Aims

- To identify therapist competencies necessary for the delivery of Compassion Focused Therapy.

- To develop a structure to organise the therapist competencies necessary for the delivery of Compassion Focused Therapy.

Secondary Aims

- To explore the degree of agreement or disagreement between participants on competencies identified in the study.

- To provide the basis of items for a measure of therapist competencies necessary to deliver CFT.

2 Method

2.1 Design

In line with the aims of obtaining and sharing expert opinions the study was conducted using the Delphi method. Three rounds of data collection were considered appropriate in order to gather information about CFT therapist competencies and develop a framework. In order to explore competencies within a relatively new model and gather rich, detailed information, a qualitative method was preferred to generate the initial competencies. Round one therefore involved interviewing participants. Given the critical realist position taken by the researcher and the aim of the research to elicit *competencies* rather than *experiences*, Template Analysis (King, 2004, 2012) was used to identify themes from the interview data. These themes were then used to develop a draft competency framework. Two further rounds using surveys were included to develop the competency framework and to ascertain agreement across participants.

2.2 Participants

Participants were recruited based on two sets of inclusion criteria: 'expert' sample and 'practitioner' sample.

'Expert' sample

In order to ensure development of a competency framework that was consistent with CFT it was important for participants involved in the first stage to have had significant experience in developing, delivering, supervising or training others in CFT. Therefore the following inclusion criteria were applied:

- Membership of the Compassionate Mind Foundation (CMF) board or directly trained and supervised in the practice of CFT by a member of the CMF board;

- Has supervised, focused practice in CFT for a minimum of three years;

- Has been involved in the development of CFT treatment protocols or supervising or training others in practising CFT.

Of 16 possible participants identified as meeting the criteria, 12 consented to participate. All 12 were interviewed for round one, of these seven completed the round two survey and four completed the round three survey.

'Practitioner' sample

In order to gain opinions from a broader group of practising CFT therapists on the ideas generated, the sample was extended for rounds two and three. The inclusion criteria for the 'practitioner' sample was that they had been trained in CFT and had supervised, focused practice in CFT for a minimum of one year. Seven participants consented and completed the round two survey and three of these also completed round three.

2.3 Recruitment

Potential participants for the 'expert' sample were contacted via the CMF with information about the study and contact details of the researcher. The researcher was provided with contact details of those wishing to participate. The 'practitioner' sample was recruited through snowballing via the 'expert' participants. Due to low numbers of participants recruited through this method, information about the study was also made available at a CFT Conference.

2.4 Materials

Semi-structured interview

A semi-structured interview (Appendix J) was designed. A standard introduction to the interview was used to orientate the participant to the aims of the interview and research project. Questions began broadly, in order to allow participants to generate their own

ideas. A definition of competencies using knowledge, skills and attitudes was used as guidance to enquire about the range of areas. Specific prompts about therapist qualities and self-practice were also included.

Round Two Survey

Results from the interviews in round one were presented as a draft competency framework. Each of the higher order headings indicated a competency and were phrased as an item in the survey (see Appendix K).

Round Three Survey

Amendments and suggestions from round two were incorporated into a redraft of the competency framework. This was presented along with an outline, remit assumptions and main amendments. Survey items were amended or added accordingly (see Appendix L). Each item included in the second round was presented with the participant's previous response and the group's response as a percentage.

2.5 Procedure

2.5.1 Round One: Generating the draft Competency Framework

Interviews

Participants identified as meeting the inclusion criteria for the 'expert' sample were informed of the study and agreed to be contacted by the researcher. The researcher emailed participants with information about the study and a consent form. Participants opted in to the study and interviews were arranged at suitable times and locations. Interviewing took place over a two month period. The majority of interviews were conducted online, using 'Adobe Connect'. Interviews were audio recorded on a digital recording device. The video of online interviews were also recorded automatically by the software, then converted to audio as analysis of the visual was not required. Each interview lasted approximately one hour. Interviews were conducted by the lead researcher, using the semi-structured interview schedule (Appendix J). After each interview, the researcher emailed the participant to thank them for their time, provide an update on progress and remind them of the next steps in the method.

Analysis

Audio recordings were transcribed verbatim. Nine were transcribed by a professional transcription service and three by the lead researcher. All transcriptions were checked against the recording of the interview for accuracy and to ensure familiarity with the data. Qualitative analysis of the data was conducted from a critical realist perspective using Template Analysis (King, 2004, 2012). Analysis involved several stages. Initially, *a priori* themes were identified from the literature on CFT and from competency frameworks in CBT (Roth & Pilling, 2008a). Four transcripts were selected to inform the development of the template. They were chosen on the basis of: clarity of expression of competencies; representing a range of professional backgrounds, roles and clinical contexts; and containing a range of ideas representative of the data set as a whole and some unique ideas. Selection of these four transcripts aimed to provide an initial template that would 'fit' the data overall as closely as possible. From this subset of interview data, suggested competencies were identified and grouped into ideas for themes. Overlapping concepts using differing language were identified, grouped and named. Attention was given to the relationships between competencies and groups of competencies. Through an iterative process of arranging and re-arranging data into themes, an initial template was developed, representing the key competencies (see Appendix M). The remaining eight transcripts were then reviewed against the initial template. Ideas arising from the remaining data set that were not adequately covered by the initial template were noted and the template amended accordingly, resulting in the final template. This was presented as the draft Competency Framework (Appendix K).

Quality

In order to ensure quality as part of the qualitative analysis, the development of the template was discussed in supervision and repeatedly linked back to the data. Guidance was also sought from an expert in Template Analysis regarding selection of the transcripts used to develop the template. An audit trail of the process was kept throughout (Appendix M).

2.5.2 Round Two: Developing the draft Competency Framework

Survey development

The draft Competency Framework identified six broad themes or key areas of competence. Analysis of data also highlighted therapy content integral to the model and related competencies. Although the focus was on competencies, therapy content was provisionally retained for clarity to guide participants. Twenty-three main competencies (see Appendix N) within the six key areas were phrased as statements to construct a survey. Participants were asked to rate their agreement with statements relating to each of the twenty-three competencies (e.g. 'Knowledge and understanding of the difficulties and disorders being worked with is necessary to deliver CFT'). Participants were given five options with clear descriptors, to enable comparison across participants. The options were: 'no, this would be counter-CFT'; 'no this is not needed/required'; 'can be a helpful addition'; 'important but not essential'; and 'yes, absolutely essential to CFT'. Each item had a free text box to allow participants to comment on the item. Participants were also asked to comment on the overall structure and any omissions.

Data collection

'Expert' participants that had participated in round one and the 'practitioner' sample were emailed the Round Two Survey, which included the draft Competency Framework (Appendix K). Participants were asked to respond within two weeks. Due to a low response rate the 'expert' participants were given an additional response time of five weeks. Due to low uptake from those meeting the 'practitioner' sample criteria, the recruitment period was extended. Participants recruited later into the study were given a response time of two weeks. Where there had been no response, email reminders were sent on the deadlines. All responses were collated, irrespective of meeting the deadlines. Individual thank you emails were sent to participants on submission of their round two data. In total, fourteen participants completed round two: seven from the 'expert' sample and seven 'practitioner' participants.

Analysis

Completed surveys were reviewed by the researcher. Comments and item ratings were considered and amendments made to the draft Competency Framework. Ratings of competencies in the survey were entered into a Microsoft Excel spreadsheet and

percentage agreement with each competency calculated. Items with the most disagreement were closely considered and amendments made in accordance with percentage endorsement and comments.

2.5.3 Round Three: Refining the Competency Framework

Survey development

Analysis of data from round two resulted in an amended draft competency framework. Similarly to round two, a survey (Appendix L) was compiled with items for each of the competencies identified from round one and round two. Six additional competencies were suggested and two competencies were integrated into one, resulting in twenty-eight competencies. Part one of the survey addressed the six additional competencies and participants were asked to provide their opinion on the necessity of the competency, as in round two. Part two of the survey addressed amendments to the previously rated competencies included in round two. Participants were provided with their own response to round two and the group response to the item (e.g. 100 per cent indicated 'yes absolutely essential to CFT'). Participants were asked to consider the amendments and group opinion and to indicate their response in light of the new information. Where specific questions had been raised in round two about the details of the competency, these were posed to participants with a free text box.

In response to feedback from participants in round two, additional information was provided with the survey. Questions had been raised about 'generic skills'. Therefore information was provided with the survey to clarify the remit of the competency framework. Given the detail of the framework and comments about the amount of information presented, an outline of the framework was provided. A brief description of the main changes was included to orientate the participant.

Data Collection

The fourteen participants who had completed round two were emailed the round three survey. The researcher also offered to contact the participants at a convenient time, if they wished to discuss the document. Participants were initially given two weeks to respond. An email reminder was sent on the deadline, encouraging participants to

respond within the next week. Due to a low response rate, a further email prompt was sent and responses were collated after a further three weeks.

Analysis

Of the fourteen respondents to round two that were contacted for round three, seven participants completed round three. Comments and Likert ratings were used to refine the framework. Agreement ratings were entered into a Microsoft Excel spreadsheet and percentage endorsement calculated.

3 Results

3.1 Participants

Twelve expert participants completed interviews for round one. They were mostly male, White British and based in the UK. Participants had a minimum of three years CFT-specific experience and some had been involved in the early stages of developing the model. Participants were experienced therapists with a mean of 15 years post-qualification experience (range 5 - 34 years). Participants had various and often multiple roles involving CFT including: clinician, supervisor, clinical trainer, academic lecturer and researcher.

The response rate of the 'expert' sample between rounds one and two was 58 per cent. The recruitment of the 'practitioner' sample increased the total sample for rounds two and three. Between rounds two and three, the response rate was 50 per cent. The response rate was approximately equivalent across the two groups of participants.

Participants	Round One	Round Two	Round Three
'Expert'	12	7	4
'Practitioner'	-	7	3
Total	12	14	7

Table 1. Number of participants

3.2 CFT Competency Framework (CFT-CF)

Remit Assumptions

The CFT-CF covered what was necessary for CFT and is therefore inclusive of competencies considered 'generic' or drawn from other models as well as those specific to CFT. The CFT-CF addressed competence but not adherence. Although some therapy content was included in the earlier stages of development, this was only for guidance and subsequently removed. As there are a variety of ways CFT can be delivered, the CFT-CF focused on the competencies that are shared across modalities. Competencies specific to different client groups, 'interventions or techniques' or working with couples, families or groups may also be required in addition to the CFT-CF. These were not included as they were beyond the scope of the current framework. It was assumed that a clinical assessment of psychological need had been conducted, identifying that CFT would be helpful. Assessment skills were considered necessary for this process but were beyond the scope of the current framework.

The results section includes: an outline model of the framework; description of consensus levels which presents a summary of the percentage agreement collected from the surveys; and a detailed description of each of the key areas of competence.

3.3 Outline Model

The CFT-CF comprised of six key areas of competence, each with several main competencies listed within them.

Key areas of Competence

- Competencies in creating safeness
- Meta-skills
- Non phase-specific skills
- Phase-specific skills
- Knowledge and understanding
- Use of supervision

Some areas of competence encompassed others indicating that these competencies applied to the way the competencies within them were demonstrated (Figure 1).

'Competencies in creating safeness' were a required as a context for therapy in which the other skills are delivered. Meta-skills related to the way that other skills were applied. Non phase-specific skills are required across all therapy phases and phase-specific skills related to different components of the therapy. Supervision was considered to support ongoing development of skills and competencies in creating safeness. 'Knowledge and understanding' informed the other key areas of competence.

Competencies in creating safeness

Meta-skills

Non phase-specific skills

Phase-specific skills

Knowledge & understanding

Supervision
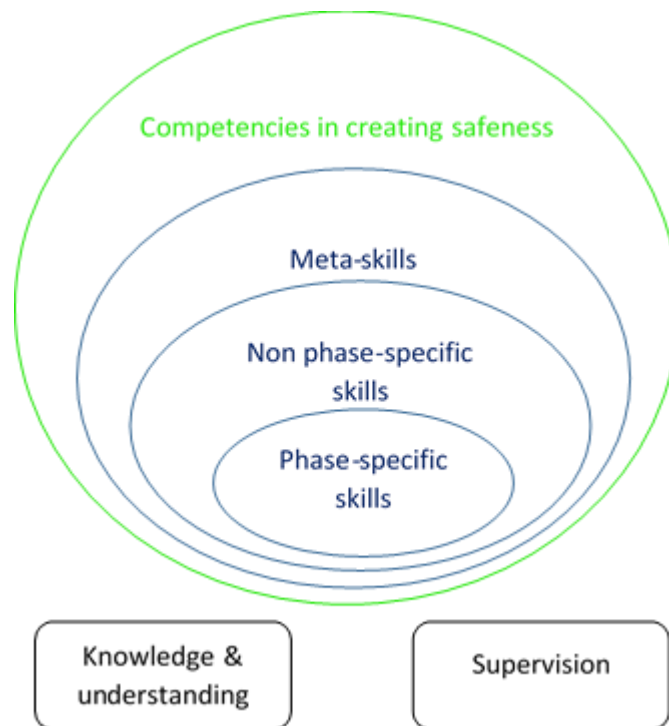
Figure 1. Compassion Focused Therapy Competence Framework Outline Model

The CFT-CF (Figure 2) contained 25 main competencies, within the structure of the six key areas. The CFT-CF represented the main competencies, some of which involved many sub-competencies to demonstrate the main competency, these are listed in Appendix O.

3.4 Consensus levels

The final framework represented developments following the third round of data collection. The agreement ratings from participants therefore represent the earlier iteration of the competencies (see Appendix N).

Competencies in Creating Safeness

Builds and maintains the therapeutic alliance

Maintains appropriate professional therapeutic boundaries

Fosters collaborative engagement

Demonstrates core skills

Provides a safe context

Models the Compassionate Self:

Authentically demonstrates qualities conveying the compassionate self

Demonstrates a personal motivation & commitment to the model

De-shames:

Conveys a sense of common humanity 'we're all in the same boat'

Conveys the 'not your fault' message

Meta-skills

Works flexibly within the framework

Notices affects and responses as they arise in the client and therapist

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Non phase-specific skills

Focuses on affect

Facilitates experiential learning by exploring and eliciting experiences and reflections with the client

Distinguishes between shame-based self-criticism and compassionate self-correction

---

Phase-specific skills

Accessibly introduces understanding of the model as it relates to the client

Develops an individualised CFT formulation with the client

Facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance

Facilitates the client in cultivating a compassionate identity

Facilitates clients in using compassion to engage with difficulties & promote change

Facilitates the use of compassion beyond therapy

Knowledge & Understanding of:

Difficulties & problems specific to client group

Compassion Focused Therapy – theoretical *and* personal understanding of concepts in relation to the therapist

---

Uses supervision to:

Develop skills

Reflect on difficulties in the therapeutic relationship

Develop a personal understanding of the model as it relates to the therapist

Figure 2. Compassion Focused Therapy Competency Framework (CFT-CF)

Overall, agreement was high in rounds two and three. Responses to the survey items indicated that the suggested competencies were consistent with their views. None of the items were rated as 'no, this wou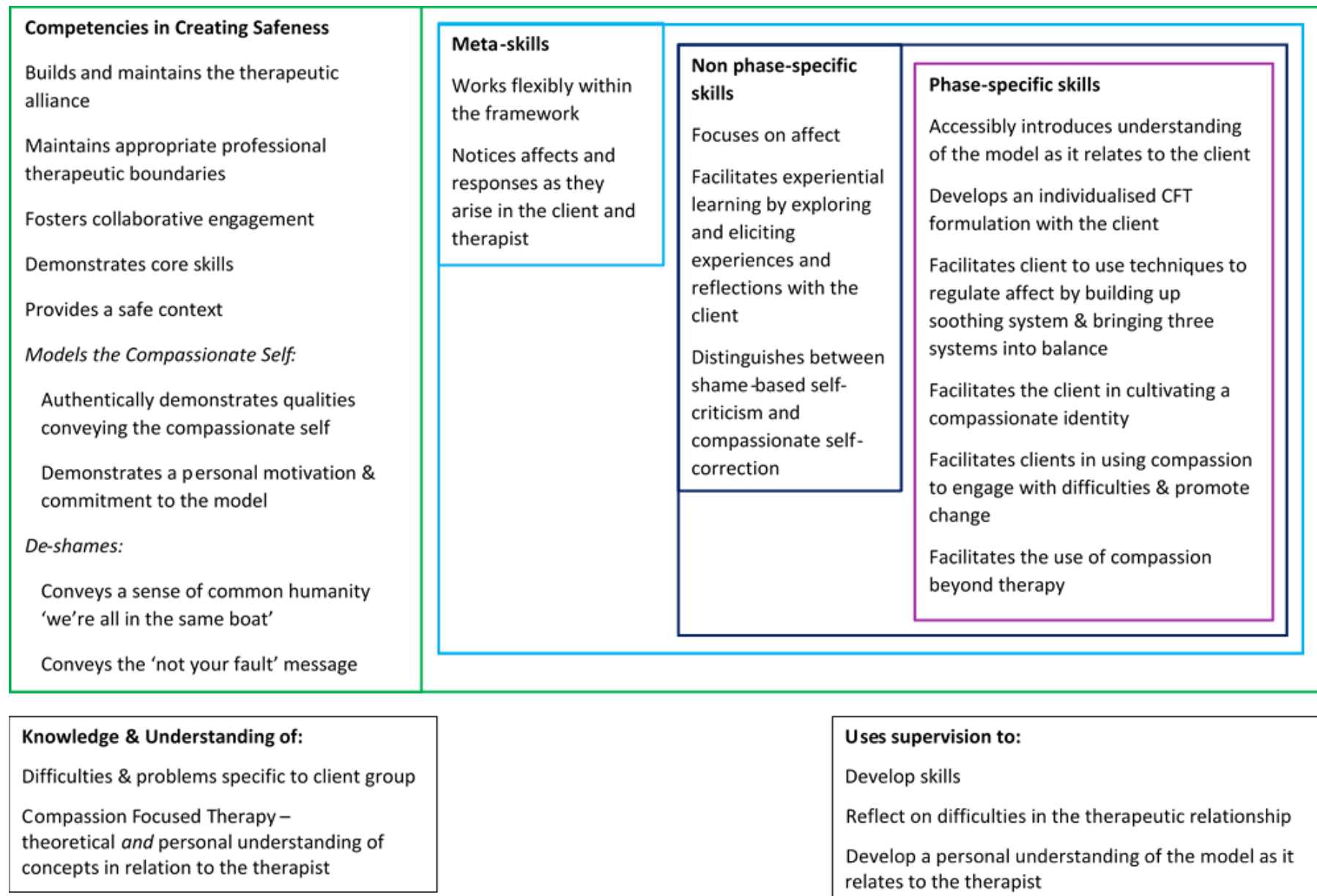ld be counter-CFT' or 'no this is not needed or required'. All competencies were rated as 'can be a helpful addition', 'important but not essential' or 'yes absolutely essential to CFT' (Table 2).

Consensus levels were moderate to high in round two with 11 out of 23 competencies exceeding the 80 per cent agreement level. In round two, the range of participants rating a competency as necessary 'yes absolutely essential to CFT' was between 43 per cent and 100 per cent of participants (N=14). Participant ratings for all competencies shifted between rounds two and three. A greater percentage of participants rated the competencies as necessary in round three compared to round two. In round three, 21 of the 26 competencies exceeded the 80 per cent agreement level with a range of 57 to 100 per cent (N=7). Fourteen competencies reached full consensus i.e. 100 per cent of participants agreed that the competency was necessary. At the end of round three, only three competencies included a rating of 'can be a helpful addition'. These were significantly revised based on the qualitative feedback provided.

The surveys included items for 'Assessment skills' and 'Group skills' in order to gauge participants' views regarding these skills in relation to CFT competencies. Qualitative data showed that views were consistent with the assumptions made about these skills being necessary if conducting assessments or groups, but beyond the remit of the framework to elaborate upon. The quantitative ratings given by participants did not reflect this, giving mixed and misleading data. Therefore the data has not been included (see Appendix P).

Competency rated in the survey	Participant ratings of necessity of competencies (percentage of participants per round)					
	Round Two (*N*=14)			Round Three (*N*=7)		
	Can be a helpful addition	Important but not essential	Essential to CFT	Can be a helpful addition	Important but not essential	Essential to CFT
Competencies in Creating Safeness						
Builds & maintains therapeutic alliance	0	14	86	0	14	86
Maintains professional therapeutic boundaries	0	29	71	0	14	86
Fosters collaborative engagement	7	7	86	0	0	100
Demonstrates core skills	0	7	93	0	0	100
Provides a safe context	21	36	43	14	29	57
Models the Compassionate Self - authentically demonstrates qualities conveying the compassionate self	0	7	93	0	0	100
Models the Compassionate Self - demonstrates a personal motivation & commitment to the model	0	29	71	0	14	86
De-shames - conveys a sense of common humanity	7	0	93	0	0	100
De-shames - conveys the 'not your fault' message	0	0	100	0	0	100
Meta-skills						
Works flexibly within the framework	0	29	71	0	0	100
Splits attention between client & therapist affect & response	-	-	-	29	14	57
Aware of & reflects (in session) on therapists' three circles and impact on therapeutic interaction*	-	-	-	14	14	71
Non phase-specific skills						
Focuses on affect	7	0	93	0	0	100
Facilitates experiential learning**	7	14	79	0	0	100
Explores and elicits reflections**	0	0	100	-	-	-
Distinguishes between shame-based self-criticism & compassionate self-correction	-	-	-	0	0	100

Phase-specific skills						
Accessibly introduces understanding of the model as it relates to the client	7	29	64	0	14	86
Develops an individualised CFT formulation	-	-	-	0	29	71
Facilitates use of techniques to regulate affect	0	14	86	0	0	100
Facilitates the client in cultivating a compassionate identity	-	-	-	0	0	100
Facilitates clients in using compassion to engage with difficulties & promote change	7	21	71	0	14	86
Facilitates the use of compassion beyond therapy	-	-	-	0	43	57
Knowledge and Understanding of:						
Difficulties & problems specific to client group	0	14	86	0	0	100
CFT - theoretical & personal understanding of concepts	0	0	100	0	0	100
Uses supervision to:						
Develop skills	0	21	79	0	0	100
Reflect on difficulties in the therapeutic relationship	0	21	79	0	14	86
Develop a personal understanding of the model as it relates to the therapist	7	43	50	0	29	71

Table 2. Participant ratings of competencies

*Integrated into one competency after round three

**Integrated into one competency between rounds two and three.

Dashed lines indicate that the competency did not feature as an item in the survey.

3.5 Competencies in the CFT-CF

The following sections describe the competencies within each of the key areas.

Competencies in creating safeness

Competencies in creating safeness were about the CFT therapist providing an experience of a compassionate other in a safe way, through the therapeutic relationship. The use of the term 'safeness' drew from the CFT distinction between safeness and safety, where safeness meant feelings of being safe linked to soothing, contentedness and affiliation. This was contrasted with 'safety' that arises from threat-based safety-seeking. Several competencies reflected the importance of the therapeutic relationship: builds and maintains the therapeutic alliance; maintains appropriate professional therapeutic boundaries; fosters collaborative engagement; demonstrates core skills; and provides a safe context. Core skills was a label used to refer to active listening, pacing, voice tone and pitch. With the exception of 'safe context' these competencies were rated as necessary by 86 to 100 per cent of participants in round three. 'Provides a safe context' received significant development from survey feedback. It was initially labelled 'room set-up' then 'safe environment' before further comments from round three were provided. The agreement levels reflect information available when it was conceptualised as 'safe environment' rather than what has subsequently been developed. In round three 57 per cent of participants rated this as necessary, 29 per cent as important but not essential and 14 per cent as a helpful addition.

Feelings of safeness were considered to arise from therapist competencies in both 'being' and 'doing'. Key to providing an experience of a compassionate other was the ability to model the 'compassionate self'. Therefore an important competency for CFT therapists was to authentically demonstrating the attributes, qualities and skills of the compassionate self that are taught to the client. This was rated in round three as necessary by 100 per cent of participants. Modelling the compassionate self also included 'personal motivation and commitment to the model'. This competency was considered necessary by 86 per cent of participants in the final round. CFT was frequently described as an 'inside out' model as intrinsic to the theory is the idea of 'common humanity'. Therefore therapists modelling this would create safeness through de-shaming clients, by conveying a sense of common humanity and the 'not your fault'

message. In round three the two competencies related to de-shaming achieved consensus (i.e. 100 per cent of participants rated it necessary to CFT (*N*=7)).

Meta-skills

Meta-skills were competencies that involved taking an observational stance in order to guide the therapist in implementing the therapy. It was identified that CFT therapists needed to work flexibly within the framework, so that although there are 'phases' these are not considered rigidly linear, rather provide guidance about an approximate sequencing of therapeutic activities. Participants described the need to use informed clinical judgement to shift between phases in response to client need. This competency reached near consensus in round two (79 per cent, *N*=14) and full consensus in round three (*N*=7).

It was also considered important for therapists to be able to notice the affects and responses as they arose in the room for both the client and the therapist. These feelings were understood within the CFT model (i.e. the therapist's own affect regulation systems getting triggered). It was also important to understand how the feelings arose and the potential impact on therapeutic interactions. This competency therefore encompassed several processes centring on the need for emotional awareness and reflection in-session. The round three survey included these as two separate 'new' items. Qualitative feedback in the questionnaire suggested changing the wording and collapsing into one item. Prior to these changes, the two items were rated 'necessary' by 57 per cent and 71 per cent of participants (*N*=7).

Non phase-specific skills

The three non phase-specific competencies were broad skills with many sub-competencies within them. They highlighted important aspects of the delivery of CFT – that it is emotion-focused and promotes learning through experience. Agreement levels were high in round two for 'focuses on affect' (93 per cent, *N*=14) and for the two items that were then condensed into 'facilitates experiential learning by exploring and eliciting experiences and reflections with the client' (79 and 100 per cent, *N*=14). The two items were collapsed into one to reflect competencies rather than therapy content. This was separated out in the draft competency framework in the Round Three Survey

(Appendix L). The combined competency achieved consensus in round three (100 per cent, $N=7$).

A third competency was the ability to distinguish between shame-based self-criticism and compassionate self-correction - recognising, identifying and addressing this as it arises in therapy. This competency was introduced in round three following suggestions in round two. Full consensus was reached (100 per cent of participants, $N=7$).

Phase-specific skills

Six non-linear 'phases' of CFT were identified, each with detailed sub-competencies specific to that phase (see Appendix O). They are presented in the order considered as a guideline for the progression of therapy. Phase-specific therapy content was identified by participants alongside details of each phase-specific competency (see Appendix Q).

The competency 'to accessibly introduce an understanding of the model as it relates to the client' was considered necessary by 86 per cent of participants ($N=7$). Skills in developing an individualised formulation were considered necessary by 71 per cent and important but not essential by 29 per cent ($N=7$). Consensus was reached for competence in 'facilitating techniques to regulate affect by building up soothing system and bringing the three systems into balance'. Consensus was also reached for competence in 'facilitating the cultivation of a compassionate identity'. Sub-competencies were generated in the final round of data collection therefore have not been reviewed by participants.

Competence in 'facilitating clients to use compassion to engage with difficulties and promote change' represented the ability to deliver techniques or interventions designed to address specific clinical problems. Eighty-six per cent of participants ($N=7$) agreed that using compassion to engage with difficulties and promote change was a necessary competency. Given the diversity of techniques and the need for more specific competencies in each of these areas, exploring this in detail was beyond the remit of the current framework. Competence in facilitating the use of compassion beyond therapy was also considered important. This was introduced in round three as 'follow up/ relapse prevention' and sub-competencies were generated in the final stage. Therefore

details in the full framework were not available when the participants rated the item. Fifty-seven percent of participants (*N=7*) said it was necessary and forty-three per cent (*N=7*) rated it as important but not essential.

Knowledge and Understanding

It was identified that CFT therapists require competence in the form of knowledge and understanding. Two broad areas were distinguished: knowledge of difficulties and problems specific to the client group; and knowledge of CFT. Knowledge of difficulties and problems specific to the client group included understanding how these problems affect emotions, relate to the therapy process and relate to the model. The full competency list detailed several areas of knowledge and understanding of CFT necessary for competence in CFT (Appendix O). In the round one interviews it was stressed that this knowledge was not just intellectual, but also reflected understanding from personal experience. Both competencies received a high endorsement in round two and full consensus in round three.

Use of Supervision

As part of competently delivering CFT, participants highlighted the need for ongoing supervision. Therefore it was considered important that CFT therapists had the ability to make use of supervision in three main ways: to develop skills; to reflect on difficulties in the therapeutic relationship; and to develop a personal understanding of the model as it applies to themselves. Using supervision to develop skills was considered necessary by a majority in round two (79 per cent, *N=14*) and reached consensus in round three (100 per cent, *N=7*). Competence in reflecting on the therapeutic relationship involved transference and counter-transference issues and the therapist's avoided affect and 'shadow' side. This was rated as necessary by most participants, increasing from 79 per cent (*N=14*) in round two to 86 per cent (*N=7*) in round three. Competence in 'developing a personal understanding of the model as it applies to themselves' was developed and renamed following qualitative feedback from the surveys. The earlier version of the competence was named 'using supervision to develop the compassionate self' and was rated necessary by 50 per cent of participants in round two (*N=14*) and 71 per cent in round three (*N=7*).

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4 Discussion

The primary aims of the current study were to identify therapist competencies necessary for the delivery of CFT and to develop a structure to organise these. Twelve participants with expertise in CFT were interviewed and themes developed using Template Analysis. The resulting themes were framed as potential competencies and converted into items for a survey. Two further rounds of data collection using surveys contributed to the development of the competencies and framework. Twenty-five competencies within six key areas were identified and their relationships with one another carefully considered. The six key areas were: competencies in creating safeness; meta-skills; non phase-specific skills; phase-specific skills; knowledge and understanding; and use of supervision. Consensus levels were high in both survey-based rounds. Following final changes, 14 of the 24 competencies achieved full consensus.

The primary aims of the study were met in the construction of the CFT-CF, which represented opinions of necessary CFT competencies. However, it was inevitable that there would be differences in opinion. Therefore a secondary aim was to explore the degree of agreement or disagreement between participants. This is addressed in the discussion. Comparisons with literature on therapist competencies are discussed. Clinical and research applications of the CFT-CF are considered.

4.1 Areas of Agreement and Disagreement within Competencies

Participant agreement levels varied across competencies. This is a typical challenge in identifying essential competencies (Lichtenberg *et al.,* 2007). This section discusses factors that may have contributed to agreement and disagreement. Competencies that achieved consensus tended to either be cohesive and well developed or distinctively characteristic of CFT. Disagreement regarding some competencies reflected differences in opinion relating to how 'inside out' the model was considered and therapist level of experience. As round three data was only collected for seven participants, agreement levels and qualitative data from rounds two and three are considered.

Competencies that were considered cohesive and well-developed early in the development of the CFT-CF received higher consensus ratings. These competencies

were: 'knowledge', 'core skills', 'works flexibly in the framework', 'focuses on affect' and 'facilitates experiential learning by exploring and eliciting experiences and reflections with the client'. By contrast, some competencies were less well developed or only introduced in the final round of data collection. Subsequently these competencies required significant development in rounds two and three. These were: 'provides a safe context'; 'notices affects and responses as they arise in the client and therapist'; and 'facilitates the use of compassion beyond therapy'. The competencies shown in the CFT-CF were developed following round three suggestions. Therefore agreement with the final framework was not ascertained. If a further round were conducted, higher levels of agreement would be anticipated.

Competencies that could be considered 'distinctive' of CFT reached higher agreement levels. These competencies were: 'models the compassionate self', 'de-shames' and 'distinguishes between shame-based self-criticism and compassionate self-correction'. The current study did not aim to identify distinctive or CFT-specific competencies. However, some participants did comment on this in the survey, which may have influenced their decision to endorse the competency as 'necessary'.

There was disagreement about main competencies and sub-competencies relating to demonstrating an 'inside out' approach. It was consistently acknowledged that the common humanity philosophy of the approach meant that the CFT model applied to both clients and clinicians. However, there was disagreement about the extent this applied to two specific therapist activities. The first was 'self practice', which sits within 'models the compassionate self – personal motivation and commitment to the model'. The second was 'de-shames - engages in practices alongside clients and shares reflections'. Variation in opinion was more apparent from survey comments than percentage endorsement.

Competencies relating to use of supervision raised some disagreement. The competency 'uses supervision to develop a personal understanding of the model as it relates to the therapist' included items that were developed with trainees in mind, for example 'tolerating skill development'. Therefore certain sub-competencies may be more appropriate to trainees than to experienced CFT practitioners. This highlights the

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difficulty in identifying necessary competencies across different levels of professional development and experience (Lichtenberg *et al.,* 2007). Therefore a developmental model of skill acquisition may help to guide practical applications of the CFT-CF.

4.2 Comparisons with literature on therapist competencies

The remit of the CFT-CF included both generic and specific competencies. Given the integrative nature of CFT, it was expected that many CFT competencies would overlap with competencies identified by other therapeutic models. This section discusses each of the six key areas of competency in the CFT-CF in the context of existing literature on competencies in related approaches.

Competencies in creating safeness

The main competencies under 'Competencies in creating safeness' included those needed to establish and maintain a therapeutic relationship that could be considered generic and 'specific' to CFT. Competencies that could be considered 'generic' were: 'builds and maintains the therapeutic alliance', 'maintains appropriate professional boundaries' and 'fosters collaborative engagement'. These overlap with the generic competencies identified by Roth and Pilling (2007) and humanistic competencies within 'ability to maintain and develop therapeutic relationship' (Roth *et al.,* 2009) and 'psychoanalytic/psychodynamic' competencies under 'ability to identify and respond to difficulties in the therapeutic relationship' (Lemma *et al.,* 2008). The competency 'fosters collaborative engagement' includes some sub-competencies more closely related to CBT and the concept of collaborative epricism (Tee & Kazantzis, 2011). The overlaps reflect CFT as an integrative psychological therapy, set within the therapeutic relationship. This is in contrast to other Buddhism-informed interventions that focus more on teaching meditation practices of mindfulness (Germer & Neff, 2013) or loving-kindness (e.g. Kearney *et al.,* 2013; Shahar *et al.,* 2014).

'Competencies in creating safeness' also included two headings each with two main competencies that highlighted a CFT-specific emphasis: 'models the compassionate self' and 'de-shames'. The competency 'authentically demonstrates qualities conveying the compassionate self' included therapist qualities that overlap with evidence of therapist qualities consistent with developing a strong working alliance (Ackerman &

Hilsenroth, 2001, 2003). The CFT-specific emphasis was guided by the Buddhist definition of compassion. In CFT, compassion includes courage and commitment to address suffering in self and others. This was reflected in the competence 'personal motivation and commitment to the model'. Participants identified that a CFT therapist needed to demonstrate compassionate motivation and action. This modelling of the therapeutic approach has been explicitly identified as a competence for using ACT (Walser *et al.,* 2013). The CFT-CF also identified self-practice as part of commitment to the model. Similarly, it has been suggested that skill acquisition and development can be improved in CBT therapists through practicing cognitive behavioural strategies, self-reflection and mindfulness (Bennett-Levy *et al.,* 2003; Bennett-Levy & Thwaites, 2007).

The competency heading 'de-shames' consisted of conveying two distinct messages central to the theoretical underpinnings of CFT. This could also be considered an extension of the therapist modelling the approach. A sub-competence identified within this was the use of 'carefully considered personal examples'. This has also been identified as a competence in ACT: 'the therapist is willing to self disclose about personal issues when it serves the interest of the client' (Walser *et al.,* 2013).

Competencies in creating safeness conveyed both 'generic' competencies relevant to other therapies and the compassion-focused emphasis in delivering them. It was important that this encompassed other competencies and was not separated from phase-specific skills in order to reflect the nature of CFT as a therapy with an interpersonal context, as opposed to a set of techniques. Similarly, existing work on evidence based competencies has asserted that groups of generic and model-specific competencies should be considered in parallel (Roth & Pilling, 2007).

Meta-skills
The CFT competency framework included two meta-skills, which applied to the way other skills were used. These were: 'works flexibly within the framework' and 'notices affects and responses as they arise in the client and therapist'. Similarly, Roth and Pilling (2007) identified 'meta-competencies' and separated these into generic and model-specific. The two generic meta-competencies the authors identified map closely

onto the CFT meta-skill of 'working flexibly within the framework'. The second CFT meta-skill 'notices and responds to affects as they arise in the client and therapist' is similar to humanistic meta-competencies and competencies under 'working with relational processes' (Roth *et al.,* 2009). There are considerable overlaps with the competence 'ability to work with the counter-transference' identified for 'psychoanalytic/psychodynamic therapy' (Lemma *et al.,* 2008) and DIT (Lemma, n.d.). However, the term counter-transference has purposely not been used in the CFT-CF, as it has a range of definitions and connotations that may lead to incorrect assumptions.

Non phase-specific skills.

Three competencies sat within non phase-specific skills. 'Focuses on affect' corresponded more closely to humanistic competencies under 'approaches to work with emotions and emotional meaning' (Roth *et al.,* 2009). 'Facilitates experiential learning by exploring and eliciting experiences and reflections with the client' captured competencies similar to those in the CBT map labelled 'Guided discovery and Socratic questioning'. However the CFT competency was broader, as it also included CBT-derived skills in setting and reviewing homework and getting feedback. An emphasis in CFT that was not included in other therapy competencies was the ability to 'distinguish between shame-based self-criticism and compassionate self-correction'. As a primary target of the intervention it was identified that CFT therapists need to recognise shame, identify with the client and address this throughout therapy.

Phase-specific competencies

There were six phase-specific skills in the CFT-CF. These are presented in the approximate order that therapy is likely to progress.

The phase-specific CFT competency 'Accessibly introduces understanding of the model as it relates to the client' reflected the large psycho-educational component in CFT. Other competency frameworks have not explicitly identified this, however implicit to this phase was the ability to build a rationale. The competence 'ability to explain and demonstrate a rationale' featured in CBT (Roth & Pilling, 2008a) and humanistic approaches (Roth *et al.,* 2009). The second 'phase' involves developing a formulation,

which is common to several therapies. Formulation has been identified as a competency within CAT (Bennett & Parry, 2006) and CBT (Roth & Pilling, 2008a).

Two competencies could be considered CFT-specific as they focus specifically on developing compassion and do not appear in other competence frameworks. They are: 'facilitates client to use techniques to regulate affect by building up soothing system and bringing three systems into balance' and 'facilitates the client in cultivating a compassionate identity'. This maps onto the CMT phase of therapy which includes components used by other therapies. For example, Mindfulness is used in several therapies (Baer, 2006) and competence has been conceptualised by ACT under the domain 'present moment' (Walser *et al.,* 2013).

The next phase-specific competence reflects the use of compassionate self work in addressing particular problems. The framework acknowledges that therapy content is specific to the client's problem. This is similar in structure to the evidence-based competence maps that list problem-specific specific protocols (Roth & Pilling, 2007).

 The final 'phase' related to relapse prevention. Competencies in helping clients maintain therapy gains were common to CBT and CFT, although the emphasis was slightly different. For CFT, it was suggested that some experiences that might be considered 'relapses' could instead be considered as part of the 'flow of life' (Gilbert, 2009) and that a compassionate response would be helpful rather than considering it a 'relapse' with the implicit attribution that therapy has 'failed' as this could lead to further self-criticism and worsening symptoms. However, it was considered important to distinguish between situations that could be self-managed or required additional support from services.

Knowledge and Understanding
Knowledge and understanding of the client's presenting problems and the therapeutic model are considered essential for the delivery of psychological interventions (Fairburn & Cooper, 2011). It is considered a generic competence in the evidence-based maps (Roth & Pilling, 2007).

Use of Supervision

The therapist's ability to make use of supervision was included as a generic competence in the evidence-based maps (Roth & Pilling, 2007). Within the CFT competency of using supervision, emphasis is placed on attending to process issues in the therapeutic relationship in order to prevent it from interfering with the therapeutic effects of the intervention. This is similar to the generic supervision competence 'ability to use supervision to discuss the personal impact of the work, especially where this reflection is relevant to maintain the likely effectiveness of clinical work' (Roth & Pilling, 2007). Supervision also offers a chance for CFT therapists to develop their understanding of the model as it relates to themselves. The explicit understanding that the model applies to therapist as well as the client reflects the 'common humanity' philosophy of CFT. Similarly, it has been suggested that in supervision of couples and family therapy, therapists or trainees need to develop self-awareness and reflect on their own personal and family experiences and how they influence formulation (Celano *et al.,* 2010).

Competencies not included in the CFT-CF

In comparing the CFT-CF with other competency work, it became apparent that some areas of competence had not been suggested in the current study. This section outlines omissions that may be useful to consider in the development of the CFT-CF.

It may be useful to incorporate competencies derived from the evidence-base as outlined by Roth & Pilling (2007). For example, under generic competencies the authors identified the 'ability to manage endings'. One CBT-specific meta-competence not clearly highlighted in the CFT framework was a capacity to manage obstacles to therapy. Given that in the interviews participants talked about the importance of working with the fears of and blocks to compassion as in integral part of the work, it is perhaps an omission of the framework that this is not more prominent. This aspect of therapy was acknowledged within therapy content but the therapist's ability to work with this was not elaborated upon. The 'ability to use measures and self-monitoring to guide therapy and to monitor outcome' was identified as a CBT competence (Roth & Pilling, 2008a). This was not discussed in the current study. It would be interesting to explore this idea further in relation to CFT.

Some competencies identified by other therapies do not appear due to the specified remit of the CFT-CF. For example, abilities in conducting a generic clinical assessment. Evidence-based competency maps also included a generic competency 'knowledge of and ability to operate within professional and ethical guidelines' (Roth & Pilling, 2007). This could be considered 'professional' rather than 'intervention-specific' competence. This demonstrates the challenge of putting a boundary around work on competencies.

The CFT-CF was designed with a limited remit and an acknowledgment that additional competencies would be needed, for example in facilitating groups. Other competency work on competencies has not highlighted this as it has focused on individual therapy. However, as resources in the NHS become increasingly limited, group-based interventions are increasingly used. Caution may be needed if competencies derived from individual interventions are applied to group-based interventions.

4.3 Strengths and limitations of the research

The current study had strengths in that the method was systematic, iterative and adaptable. However, the sample size was a major limitation.

A major strength of the Delphi method was the flexible way it was applied. The current study adapted the Delphi by conducting interviews to collect data for round one. This generated engagement and resulted in 12 interviews that provided in-depth information used to generate the majority of competencies. The current study used Template Analysis to analyse and structure the interview data, which minimised repetition and overlaps in competencies – a limitation of the Cognitive Therapy Scale (Young & Beck, 1980) identified by Blackburn *et al.* (2001). The current study included two survey-based rounds in addition to interview data. This provided validation of the qualitative analysis and additional development of ideas.

A further strength of the study was the remit that included generic and specific competencies – rather than trying to focus on those 'unique' to CFT. This represented CFT more completely and is consistent with evidence-based competence work that acknowledges the importance of generic competencies.

The main limitation of the study was the small sample size for rounds two and three. As only a small number of people could meet the 'expert' criteria for round one, a more relaxed criteria was suggested for rounds two and three. There were problems with recruitment of the practitioner sample. There were also higher rates of attrition than ideal. This combination of low recruitment and retention rates resulted in a small final sample size for round three[4].

4.4 Clinical Implications

The CFT-CF provided greater clarity about CFT competencies, which would be useful in clinical practice, training and research.

Uses in clinical practice

The CFT-CF could be used as guidance on how to deliver CFT in clinical practice. This adds to existing literature on CFT theory and content (Gilbert, 2014). The CFT-CF reflected competencies common to working with different client groups, problems and individuals or groups. Therefore it is highly applicable to a range of settings. Competencies specific to working with groups or specific problems could be considered in addition if required.

CFT offers an integrative framework and flexibility in the use of problem-specific 'techniques' or 'intervention'. Such interventions should be consistent with the philosophical approach to CFT, but can be drawn from a range of therapies. The CFT-CF accommodated this by not specifying problem-specific intervention competencies. In practice it would be expected that clinicians would have the competencies necessary to deliver these specific interventions. Perhaps a risk of being so integrative is that practitioners coming from different backgrounds may emphasise competencies related to their therapeutic backgrounds more than those that are not, thereby losing the genuine integration. The framework could be useful in identifying, exploring and addressing such issues.

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[4] These concerns are considered in more detail in the Critical Appraisal.

Uses in training

The CFT-CF would be useful guidance for those training others to deliver CFT, similar to the way that Roth and Pilling (2007) describe their competence maps as useful for setting curricula. The CFT-CF could be a useful resource to facilitate teaching, address 'gaps' in generic competencies and scaffold development of CFT-specific competencies. However the framework should not be 'taken apart' or specific competencies taken in isolation, as this risks reducing the therapy to parts and losing the context of the therapeutic alliance.

Uses in research

The CFT-CF could be used as the basis for a measure of competence in CFT. Each competence could be operationalised with observable features with a scale to rate therapists' abilities. The measure of competence could be used in combination with a measure of adherence to assess treatment fidelity. This would provide a quality check for research trials. In trials comparing two or more therapies this would be particularly important to provide evidence of the validity of the trial.

4.5 Links with the wider literature

The current study explored expert opinions of competencies required for CFT. This may be useful in CFT research trials to explore the association between competence and outcome. Evidence of the relationship between competence and outcome is unclear. Research suggests that treatment-specific competence can be predictive of outcome in Cognitive Therapy for depression (Strunk *et al.,* 2010) and social phobia (Ginzburg *et al.,* 2012). However, in a meta-analytic review of 17 competence-outcome studies the effect size estimate was non-significant (Webb *et al.,* 2010). The authors concluded that due to the significant heterogeneity of studies caution should be used in interpreting the mean effect sizes. A common limitation in competence-outcome research is that studies do not control for other factors, including the therapeutic alliance.

The therapeutic alliance has been shown to be moderately and consistently associated with outcome (Horvath *et al.,* 2001; Martin *et al.,* 2000). Factors affecting the therapeutic alliance include therapist factors, client factors and therapist-client interactions. Research suggests that therapist factors play a greater role in the alliance-

outcome relationship than client factors (Baldwin *et al.,* 2007; Del Re *et al.,* 2012). Several therapist behaviours, characteristics and interactions have been linked to improved therapeutic alliances (Ackerman & Hilsenroth, 2001, 2003). These aspects have been integrated into the 'generic' competencies (Roth & Pilling, 2007, 2008). A narrative review found that Rogerian therapist variables of empathy, non-possessive warmth, positive regard and genuineness were associated with outcome in CBT (Keijsers *et al.,* 2000). Therefore generic rather than treatment-specific competence may lead to improved clinical outcomes through the therapeutic relationship. It has been recommended that research is used to inform 'evidence-based therapy relationships' (Norcross & Wampold, 2011). Competencies in the CFT-CF that may contribute to outcome through the effects of the therapeutic alliance include 'Modelling the Compassionate Self' and 'De-shames'. Further research would be needed to explore the contribution that these competencies may have on the therapeutic alliance.

In one study, a therapist-completed measure of therapist burden was negatively correlated with client-rated alliance growth (Nissen-Lie *et al.,* 2013). The authors suggested that therapist distress may inadvertently be communicated to clients. This suggests that therapist self-care may be relevant to building strong therapeutic alliances and promoting outcomes. Further research would be needed to explore the role of self-practice in CFT therapists and the impact this has on their wellbeing, the therapeutic alliance and outcome.

4.5 Future Research

The CFT-CF agreement levels were good, however some competencies were developed following the last round. There may also be some important omissions that need to be added. It would be useful to add to, refine and confirm amendments with a focus group of experts.

The CFT-CF was developed to provide clarity and definition, in order to provide the basis for a therapist rating scale. Future research could build upon the identified competencies by operationalising them. It would help to clarify the use of the scale i.e. training or research and consider rating therapists along a developmental trajectory

(Sharpless & Barber, 2009). In line with the development of previous rating scales (Bennett & Parry, 2006; Blackburn *et al.,* 2001), it may help to identify 'exemplars' of skills from recordings of therapy sessions. A therapist rating scale would then need to be tested for reliability and validity.

In research trials assessing competence or relating competence to outcome, care should be taken to include 'generic' therapeutic competencies as well as those 'limited-domain intervention competencies' attached to the adherence to a specific protocol. Competence may play a role via the context of the therapeutic relationship as well as intervention specific aspects. Outcome research should include measures of the therapeutic alliance alongside intervention-specific competence measures. Further exploration is needed into the mechanisms and contexts within which particular therapist characteristics and activities (i.e. competencies) contribute to outcome through promoting a stronger working alliance.

4.6 Conclusions

The current study identified therapist competencies thought to be necessary to deliver CFT and organised them into a coherent framework. Feedback from participants demonstrated high levels of agreement with the framework, with minor disagreements. A strength of the method was that it involved a thorough qualitative analysis as well as a systematic method of anonymous communication between participants that validated the qualitative analysis. In considering evidence-based competence maps, there was considerable overlap between CFT and CBT, as well as with humanistic competencies. Recognition of generic competencies and the importance of the therapeutic alliance helps to clarify CFT as a therapy rather than a set of techniques. The framework could be useful guidance for clinicians, training programmes and researchers. The framework could be used to develop a therapist rating scale, promote learning and assess competence in clinical trials. Further research would be needed to ascertain the effects of CFT competencies thought to contribute to the therapeutic alliance.

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Critical Appraisal

This section offers critical appraisal and reflection on the research process and interactions with personal professional development. The first part focuses on the research process which includes: the decision to explore competencies; epistemological position; experiences of qualitative analysis; using the Delphi method; and challenges in identifying and defining competencies. The second part explores interactions between research CFT competencies and personal and professional development. This covers my initial interest, developing understanding of Compassion Focused Therapy (CFT), the role of self-practice and influence on clinical development.

1 Research process

1.1 The decision to explore competencies

My personal motivation for the project was primarily an interest in CFT. Exploring competencies seemed interesting in that it would help me to develop a greater understanding of what delivering CFT involves and perhaps therapy more broadly. It was hoped that exploring competence might eventually relate to outcome in some way, contributing to a wider research aim of improving therapeutic experiences and outcomes for the people receiving psychological therapy.

I was aware of critiques about the implementation of manualised treatments. In particular, concerns that poorer quality therapy would be offered if the focus was on technique-specific aspects of therapies, for example focusing on thought challenging without attention to counselling skills or building the therapeutic alliance. This contributed to the decision to cover all aspects of competence common to doing CFT in a variety of contexts. It was hoped that this would be a more useful platform for: comparing similarities and differences with other therapies; adding on any technique-specific competencies; and representing the therapy as a whole. It was important for me to represent the therapy overall, as I had been working in adult mental health where there was an awareness of CFT but a lack of clarity of what it really involved. I wanted to know what it took to be a CFT therapist, how important self-practice was considered and provide an answer to the question posed by some clinicians I had met: *'aren't we all compassion focused therapists anyway?'*

1.2 Epistemological position

The development of the research project was in parallel with teaching on systemic therapy and community and critical psychology. I also conducted a qualitative service evaluation of an arts in mental health project, which was far removed from structured psychological therapies. These experiences influenced my development as a clinician, becoming increasingly social constructionist in my ideas and epistemology. At times, this felt very at odds with the research project. Over time, I was able to reconcile my ideas by adopting a 'critical realist' position (Robson, 2002), which fitted for me as a pragmatic compromise. It was helpful to explore literature on the 'critical realist' position in preparation for conducting the Template Analysis. The epistemological journey has perhaps been circular, but helpful as it has encouraged me to appreciate alternative perspectives.

1.3 Experiences of qualitative analysis

Upon commencing the Template Analysis, I felt quite confident due to previous experience of Thematic Analysis using the method outlined by Braun and Clarke (2006). Given the material, Template Analysis seemed an appropriate fit and a way to be more efficient. The methods did not differ significantly, apart from the use of *'a priori'* themes and the introduction of a template, which allowed a thematic map to be introduced much earlier in the exploration of the raw data (King, 2012). In practice, *a priori* themes were identified but not significantly influential in the initial development of the themes. This was probably owing to my previous experience of thematic analysis being very much grounded in the data. It was interesting to note that despite the *a priori* themes playing a limited explicit role in development of themes, many were apparent in the results of the Template Analysis and in the final competency framework. It is possible that they informed the process implicitly, highlighting the constructed nature of qualitative methods.

A decision was made to base the initial template on four interviews. This was much more manageable than using all twelve. There was sufficient breadth and depth in these four interviews to develop ideas for themes and their relationships to one another. The additional eight interviews contributed a few additional ideas and some clarification, but mostly fitted with the initial template. The time saved was appreciated, not least because

I was behind schedule from difficulties in recruiting and scheduling interviews. This was one example of decision making in the research process that involved ensuring the quality of the research whilst balancing pragmatic concerns.

Overall, I enjoyed the process of the qualitative analysis, especially deliberating over ideas and themes and seeing how they might fit together in different ways. I got quite engrossed in the analysis, spending hours poring over the ideas with post-it notes, scribbles on white boards and lists upon lists. I was frustrated when things did not quite fit, delighted when they did and relieved when I felt I could take a break to 'pause'. Given the immersive nature of qualitative methods, these 'pauses' were vital to keep track of the process thus far and facilitated a 'step-back' for reflection. They helped to keep the process and decision-making clear. From this I learned how to purposefully step in and out of the data. There was an awareness that at different times I addressed the data in a 'bottom-up' or 'top-down' way and adjusted this according to the needs of the research.

Qualitative analysis is usually described as iterative and the current project was no exception. Having had some previous experience and a good 'sense' of the data, it was interesting to be able to note that each iteration felt like it represented 60 per cent or 85 per cent of the data, as a rough estimate. A common difficulty with qualitative analysis is stopping as the iterations could go on forever. Therefore it was useful that I had to stop in order to progress the research to the survey-based rounds of the Delphi method.

1.4 Using the Delphi method

From the earliest stages of proposing to use the Delphi method, I was aware of the well-documented disadvantages of the method. However, I justified that these would be offset by the advantages and that the disadvantages could be overcome. The main advantage of using the Delphi method was to garner additional feedback on the qualitative analysis of the interview data. This validated the Template Analysis and contributed substantial developments to the CFT-CF. Despite efforts to address concerns about the method, the disadvantages presented more of a problem than I had hoped.

Recruitment and Retention

The main problem was high attrition of participants. Literature on implementing the Delphi method suggested that attrition could be reduced by conducting the rounds closer together in time. This was the original plan, however recruiting and scheduling round one interviews was challenging due to the professional commitments of participants. This led to delays between rounds one and two. For round two, response times were longer than anticipated, therefore the deadline was extended to facilitate additional responses and time for recruitment. Thus the time between rounds two and three was longer than intended. Participants may have lost interest between rounds and subsequently adversely affected response rates and recruitment through snowballing.

One factor that I had hoped would facilitate participant retention was the participants' interest in the research question. However, the survey demanded time and consideration, which may have been unrealistic for participants to offer. Throughout the data collection period I was conscious of the work pressures of participants and hesitant about adding to that. I also felt the pressure of adequately completing the research. Consequently I found collecting data for rounds two and three quite a challenging experience. This was exacerbated by the pressure to obtain sufficient numbers in a situation over which I felt I had little control. For this reason, I would have reservations about using this method again in the future.

Constructing the Survey

In constructing the first survey (round two) two possibilities were considered: to include Likert scales for all the main and sub-competencies or just the main competencies. The first option involved 146 survey items. This would have provided detailed feedback in the form of agreement ratings. There were three limitations to this. Firstly, participants may have been discouraged from responding due to the task demand of rating so many items. Secondly, if participants did respond, a long tick-list may have produced less well considered answers. Thirdly, due to the large number of items it would be unreasonable to ask participants to comment and provide qualitative feedback. This would mean that there would be limited data on the reasoning behind responses or suggestions for developing the competencies. The second option involved 23 survey items. Each item would be clarified with the list of sub-competencies and participants

would be asked to comment if any sub-competencies did not 'fit'. There were two advantages to the second option. Firstly, it was thought that this would reduce the task demand thereby increasing responses. Secondly that it would provide more detailed comments that could inform developments to the draft framework.

The assessment of advantages and disadvantages of the two options led to the decision to use the second option. For me, it was more important to understand the reasoning behind participants' rating of the importance of the competencies than to have additional quantitative data without any context. This choice reflected my epistemological position.

The survey could have been constructed using either option. If it were possible to do the study again but use the alternative, it would be interesting to see how this influenced the development of the CFT Competency Framework in terms of content and the research process. One potential consequence of asking for carefully considered comments may have been that the task demand was too high leading to a low response rate. It is possible that alternative ways of constructing the survey could have overcome this difficulty and produced a larger the sample size. This has taught me how important it is to make participation in research easy for participants and how difficult that can be to balance with the need for research integrity.

1.5 Challenges in identifying and defining competencies

A challenge in the interviews was helping participants to name *competencies* rather than describe therapy content. Participants sometimes struggled to articulate how they were doing therapy as these skills had become automatic. This was most evident when participants would give an example of something they might say to a client in the form of a question but up until that point they may not have mentioned Socratic questioning. To facilitate reflection on competencies, participants were encouraged to reflect on therapy behaviours or skills that they wanted CFT trainees or supervisees to develop. This may have contributed to disagreement about the necessity of competencies based on stage of training.

In the research of competence, defining competence and determining appropriate minimal levels has been considered challenging (Lichtenberg, 2007). The current research focused on expert opinion of what is '*necessary*'. This meant that the Likert rating 'important but not essential' could mean it was not a minimal necessary requirement and therefore not relevant to CFT. Alternatively it could be extremely relevant but considered an 'advanced skill' rather than a minimal requirement. These issues could have been addressed in advance by piloting the survey. It may have helped to conceptualise the research question within a skills development framework (Sharpless & Barber, 2009).

2 Interactions between researching CFT competencies and personal and professional development

2.1 Initial Interest

My interest in CFT began prior to training, whilst working as an assistant psychologist in a CBT centre. The role of cognitions in appraisal and meaning making was clearly important, however I felt CBT underplayed the power and prominence of emotions. As someone prone to intellectualising difficulties, I was concerned that CBT could often lead to lack of an emotional shift. This was an observation Paul Gilbert had also made and had contributed to the development of CFT (Gilbert, 2009). My qualified colleagues were using mindfulness and compassion-focused exercises to stabilise clients before doing trauma-focused work. I was intrigued and began to explore Paul Gilbert's work. I found that the conceptual framework integrated several aspects of psychology I had previously come across and that made sense to me: evolutionary psychology, attachment theory and the neurophysiology of emotions. CFT also presented me with something new: Buddhism. What really stood out was the common humanity message, which I found refreshing against a backdrop of labels pathologising people with medical 'disorders'. I could apply the affect regulation model to myself easily and it helped to make sense of different emotional states.

Throughout training I continued to explore mindfulness and CFT by attending courses, reading and intermittently practicing exercises. I also went to the local Buddhist Centre to develop a broader understanding than the distilled versions offered as psychological

therapies. What I learned and experienced shaped my professional and personal understanding.

2.2 Developing an understanding of CFT

Developing the competencies highlighted what I already knew of CFT, provided evidence of some impressions I had and brought to light aspects I had not previously appreciated. There were some areas of competence that were relatively easy to define from the beginning: knowledge; de-shaming language; psycho-education, formulation and Compassionate Mind Training (CMT). From the introductory training I knew CFT was delivered with a mix of information sharing and guided discovery and that it focused attention on affective and somatic experiences. However, as I was not actively using CFT in my clinical work these ideas became less prominent in my mind. There was a need to have enough knowledge about CFT to make sense of the data whilst being aware that my construction of CFT would influence the Template Analysis. This was something I repeatedly reflected upon.

One of the competencies or ideas in the Template Analysis that was tricky to pull together, was around the idea of motivation. In the final framework it is the second part of 'models self-compassion' and summarised by the title 'personal motivation and commitment to the model'. During the analysis, I sat amidst colour-coded post-it notes with codes scribbled on them. They were like 'left-overs' from the more obvious bits about modelling compassion and therapist qualities. I could see that they mostly belonged together, but I struggled to find the best words to convey their collective meaning. I decided to take a pause to reflect, during which I recalled learning about the Buddhist tradition of dedicating meditations with a heartfelt wish for self and others to be happy and free from suffering. This understanding of compassionate motivation helped to make sense of the interview data. Further reading supported this emphasis in the understanding of compassion (Gilbert & Choden, 2013).

This experience of the research process has highlighted how subjective qualitative research is and the need for constant reflection. It took longer to identify this theme because I did not really understand it the way that the participants did. Once I had developed this way of understanding it, I went back to the original data to ensure that

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the 'motivation' component was present in the data, rather than imposed. Thus the research has contributed to a growing understanding of compassion and CFT.

2.3 The Role of Self-Practice

I was curious about the extent to which CFT practitioners would take the common humanity philosophy of CFT with regard to self-practice. I wondered if they thought it made them better clinicians and if so how or why. I was intrigued as to whether competence in CFT might require practitioners to have their own self-practice. Perhaps this was about me seeking an answer for myself about how to be a better clinician. I did not get a consensus on this. I did not even get a definitive yes or no from some participants. I did get a range of reasons why individuals can find it helpful or experiences that showed it had been helpful in certain situations. I was careful to reflect this in a balanced way in the reporting of the data.

Participants suggested two main reasons that self-practice was essential or at least important for competence. Firstly, it provided insight into the benefits and obstacles to practice. It was suggested that conveying the benefits and empathy about obstacles was therefore more genuine. It was suggested that practice therefore provided an additional source of knowledge or understanding that had greater depth than theory alone. This could help in anticipating obstacles to practice and finding ways to helpfully adapt practices, whilst staying true to their intended function. The second reason that self-practice was considered helpful was for its benefits in regulating the therapist's affect in response to the client by facilitating reflection rather than reaction. Some participants suggested that this could lead to an improved ability to act as a secure base for the client. Further research would be required to support these hypotheses and their relation to outcome.

2.4 Influences on Clinical Development

The CFT Competency Framework did not reach full consensus and would benefit from further development. However, the need to complete the project meant that I had to accept that the framework was not 100 per cent agreed. It was inevitable that areas of disagreement would exist due to the variety of backgrounds and opinions of the participants. Perhaps the project has thus facilitated growth in holding in mind different

perspectives, tolerating the uncertainty about whether something is 'right' or not, therefore greater tolerance of incomplete answers. This has clear overlaps with clinical skills therefore I believe the research process has also helped me to become a better clinician.

During the course of the research, I was training and learning about other models and ways of working clinically. I commenced the interviews stage of the research whilst developing understanding of systemic and community psychology models. During this stage of training I was unsure about the therapeutic model or modality I wished to pursue beyond training. Each placement or model felt like trying on a different set of clothes, some that fit or I could grow into, some that were itchy or uncomfortable or some that were fine for a day but I did not want to wear all the time. In conducting the research I was extremely fortunate to meet (albeit often via internet) many leaders in developing CFT and felt inspired by whatever they presented with, whether it was humour, clarity of thought, care or tolerance of uncertainty. After each interview, I had learnt more about being a CFT therapist and felt a growing affinity with the model.

3 Final reflections

The research project provided the opportunity to experience and learn about: the research process from developing a research question through to writing up; specific research methods; and engaging in research supervision. Throughout the research process there was a repeated theme about learning to recognise ambitious plans, consider what was realistic and accept 'good enough'. At times there were challenges in maintaining momentum and motivation. However, developments in understanding compassion arising from the research project were instrumental in its completion.

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Appendices

Appendix A

Search terms

Field	Search terms
TITLE	({self-compassion} OR {loving-kindness} OR "loving kindness meditation" OR compassion*)
TITLE/ABSTRACT	AND (RCT OR randomized OR trial OR pilot OR feasibility OR efficacy OR effective* OR outcome OR evaluat*)
TITLE/ABSTRACT	AND (Intervention OR therapy OR treatment OR training OR therapeutic OR psychological OR group)
ALL FIELDS	NOT (Cancer OR oncology)

Appendix B

Flow of studies for inclusion in the review
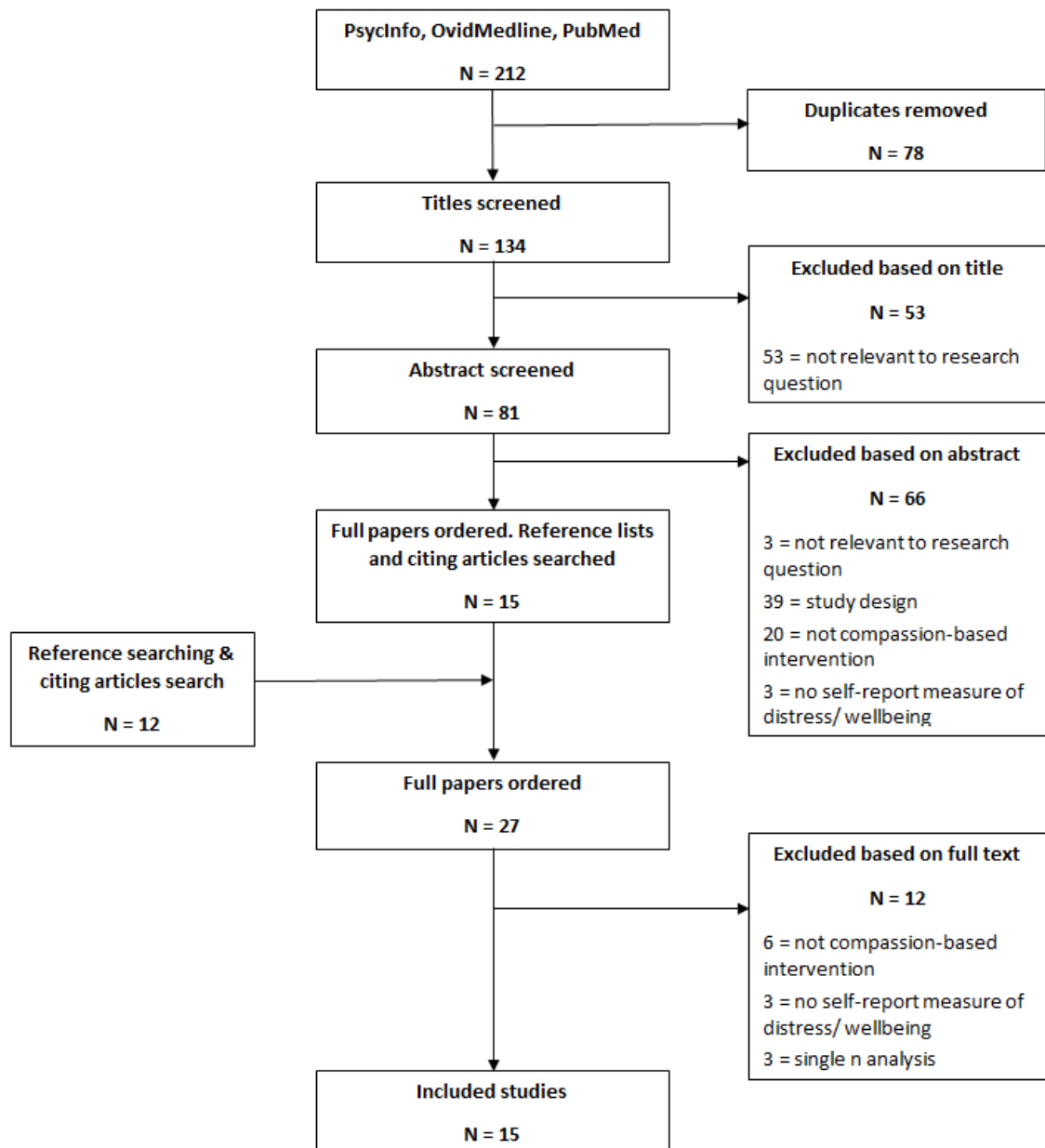
Appendix C

Data extraction headings

General	Ref ID
	Reference
	Year of publication
	Journal title
	Country
Design	Aim/ objective
	Study design
	Randomization described?
	Recruitment strategy
Sample	Participant characteristics
	Number allocated to conditions
	Number with data analysed
	Mean age (range/standard deviation)
	Percentage female
	Ethnicity
	Inclusion criteria
	Exclusion criteria
	Prior meditation experience?
	Characteristics compared across conditions?
	Participation remuneration
Conditions	Intervention
	Duration & frequency
	Control
	Duration & frequency
	Comparison intervention
	Duration & frequency
	Total no. of conditions
Measures	Outcome measure wellbeing
	Outcome measure distress/psychopathology/ negative affect
	Outcome other psychological construct
	Other measures
	Time points of measures
	Follow-up duration
Results	Results - within groups
	Results - between groups
	Statistics used
	Intention-to-treat or completers?

Appendix D

Quality Appraisal Tool

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

EPHPP

Effective Public Health Practice Project
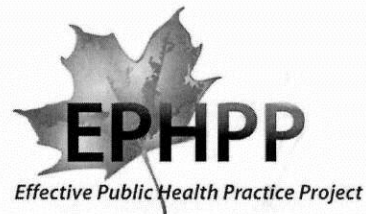
COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?
1   Very likely
2   Somewhat likely
3   Not likely
4   Can't tell

(Q2) What percentage of selected individuals agreed to participate?
1   80 - 100% agreement
2   60 – 79% agreement
3   less than 60% agreement
4   Not applicable
5   Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design
1   Randomized controlled trial
2   Controlled clinical trial
3   Cohort analytic (two group pre + post)
4   Case-control
5   Cohort (one group pre + post (before and after))
6   Interrupted time series
7   Other specify _____
8   Can't tell

Was the study described as randomized? If NO, go to Component C.
      No   Yes

If Yes, was the method of randomization described? (See dictionary)
      No   Yes

If Yes, was the method appropriate? (See dictionary)
      No   Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

1

C) CONFOUNDERS

(Q1)   Were there important differences between groups prior to the intervention?
        1 Yes
        2 No
        3 Can't tell

The following are examples of confounders:
        1 Race
        2 Sex
        3 Marital status/family
        4 Age
        5 SES (income or class)
        6 Education
        7 Health status
        8 Pre-intervention score on outcome measure

(Q2)   If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?
        1 80 – 100% (most)
        2 60 – 79% (some)
        3 Less than 60% (few or none)
        4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1)   Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?
        1 Yes
        2 No
        3 Can't tell

(Q2)   Were the study participants aware of the research question?
        1 Yes
        2 No
        3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1)   Were data collection tools shown to be valid?
        1 Yes
        2 No
        3 Can't tell

(Q2)   Were data collection tools shown to be reliable?
        1 Yes
        2 No
        3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

2

F)   WITHDRAWALS AND DROP-OUTS

(Q1)   **Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**
    1 Yes
    2 No
    3 Can't tell
    4 Not Applicable (i.e. one time surveys or interviews)

(Q2)   **Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).**
    1 80 -100%
    2 60 - 79%
    3 less than 60%
    4 Can't tell
    5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G)   INTERVENTION INTEGRITY

(Q1)   **What percentage of participants received the allocated intervention or exposure of interest?**
    1 80 -100%
    2 60 - 79%
    3 less than 60%
    4 Can't tell

(Q2)   **Was the consistency of the intervention measured?**
    1 Yes
    2 No
    3 Can't tell

(Q3)   **Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?**
    4 Yes
    5 No
    6 Can't tell

H)   ANALYSES

(Q1)   **Indicate the unit of allocation (circle one)**
community   organization/institution   practice/office   individual

(Q2)   **Indicate the unit of analysis (circle one)**
community   organization/institution   practice/office   individual

(Q3)   **Are the statistical methods appropriate for the study design?**
    1 Yes
    2 No
    3 Can't tell

(Q4)   **Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?**
    1 Yes
    2 No
    3 Can't tell

3

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	SELECTION BIAS	STRONG	MODERATE	WEAK	
		1	2	3	
B	STUDY DESIGN	STRONG	MODERATE	WEAK	
		1	2	3	
C	CONFOUNDERS	STRONG	MODERATE	WEAK	
		1	2	3	
D	BLINDING	STRONG	MODERATE	WEAK	
		1	2	3	
E	DATA COLLECTION METHOD	STRONG	MODERATE	WEAK	
		1	2	3	
F	WITHDRAWALS AND DROPOUTS	STRONG	MODERATE	WEAK	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

    No   Yes

If yes, indicate the reason for the discrepancy

1	Oversight
2	Differences in interpretation of criteria
3	Differences in interpretation of study

Final decision of both reviewers (circle one):   1   **STRONG**
       2   **MODERATE**
       3   **WEAK**

4

Appendix E

Study Quality Characteristics

Reference	Study design	Random-ization described	Part-icipant Remu-neration	Drop-out rate* (%)	Characteristics compared across conditions	Selection bias	Study design	Confounders	Blinding	Data Collection method	Withdrawals and dropouts	No. of domains assessed as weak
Albertson *et al.* (2014)	RCT	no	yes	52.4	yes – age, meditation experience and DVs	weak	strong	strong	weak	strong	weak	3
Beaumont *et al.* (2012)	controlled trial	no - stratified by trauma	NR	0	post-hoc comparisons in DVs	weak	moderate	moderate	weak	strong	strong	2
Desbordes *et al.* (2012)	RCT	no	NR	19.6	NR	weak	strong	weak	weak	strong	weak	4
Gale *et al.* (2014)	uncontrolled trial	n/a	NR	44.1	n/a	weak	weak	weak	weak	strong	weak	5
Gilbert & Proctor (2006)	uncontrolled trial	n/a	NR	33.3	n/a	weak	weak	weak	weak	strong	moderate	4
Jazaieri *et al.* (2014)	RCT	yes - weighted 60% to receive intervention	no	20	yes - age, ethnicity, gender	weak	strong	strong	weak	strong	moderate	2
Judge *et al.* (2012)	uncontrolled trial	n/a	NR	35.7	n/a	weak	weak	weak	weak	strong	moderate	4
Kelly *et al.* (2009)	controlled trial	no	yes	2.7	yes	weak	moderate	strong	weak	strong	weak	3

Reference	Study design	Random-ization described	Part-icipant Remu-neration	Drop-out rate* (%)	Characteristics compared across conditions	Selection bias	Study design	Confounders	Blinding	Data Collection method	Withdrawals and dropouts	No. of domains assessed as weak
Koopmann-Holm *et al.* (2013)	controlled trial	no	NR	22.9	NR	weak	moderate	weak	weak	strong	moderate	3
Laithwaite *et al.* (2009)	uncontrolled trial	n/a	NR	5.3	n/a	weak	weak	weak	weak	strong	strong	4
Lucre & Corten (2013)	uncontrolled trial	n/a	NR	20	n/a	weak	weak	weak	weak	strong	strong	4
Neff & Germer (2013)	RCT	no	yes	5.6	yes - no statistics reported	weak	strong	strong	weak	strong	strong	2
Shapira & Mongrain (2010)	controlled trial	yes	yes	80.3	yes - age, income, outcome measures	weak	moderate	strong	weak	strong	weak	3
Smeets *et al.* (2014)	controlled trial	yes	yes	5.8	yes - age, outcome measures	weak	moderate	strong	weak	strong	strong	2
Wallmark *et al.* (2013)	randomized controlled - stratified by gender	yes	NR	51.2	yes - age, gender, education, outcome measures	weak	strong	strong	weak	strong	moderate	2

DV= dependent variable; NR = not reported; n/a = not applicable *Drop-out rate calculated reflects pre-post comparisons not follow-up. For controlled trials, drop-out based on N allocated to conditions and reflects drop-out overall across all conditions. For uncontrolled trials, drop-out calculated based on N starting the intervention

Summary of included studies

Reference	Sample size (n)	Mean age (years)	Percentage female (%)	Participant characteristics	Compassion-based Intervention
Albertson *et al.* (2014)	479	37.56	100	women wanting to feel better about their bodies	Internet-based Mindful self-compassion
Beaumont *et al.* (2012)	32	NR	NR	referrals for therapy following traumatic incident	CBT plus CMT
Desbordes *et al.* (2012)	51	34.10	61	healthy adults with no prior meditation experience	Cognitively-based Compassion Training
Gale *et al.* (2014)	177	28.01	96	eating disorder service users	CFT for Eating Disorders
Gilbert & Proctor (2006)	9	45.20	67	long term mental health day hospital users	CMT group
Jazaieri *et al.* (2014)	158	43.08	72	community	Compassion Cultivation Training
Judge *et al.* (2012)	42	40.85	59	outpatient mental health service users	CFT-based group
Kelly *et al.* 2009	75	22.00	77	acne sufferers experiencing acne-related distress	CMT-based Self-Help exercises
Koopmann-Holm *et al.* (2013)	96	21.13	100	female students	Cognitively-based Compassion Training
Laithwaite *et al.* (2009)	19	36.90	NR	high security patients with psychosis	CMT-based recovery for psychosis programme
Lucre & Corten (2013)	10	NR	78	outpatients meeting criteria for personality disorders	CFT group
Neff & Germer (2013)	54	50.10	80	community	Mindful Self-Compassion program
Shapira & Mongrain (2010)	1002	34.00	82	community	Self-compassion visualisation & letter writing exercises
Smeets *et al.* (2014)	52	19.96	100	female psychology students	Self-compassion group meetings
Wallmark *et al.* (2013)	105	33.60	86	community	Buddhist meditation group programme (four immeasurables)

NR = not reported; CBT = Cognitive Behavioural Therapy; CMT = Compassionate Mind Training; CFT = Compassion Focused Therapy

Compassion Meditation Interventions – Results Table

Reference	Compassion-based Intervention	Control Conditions	Outcome measure - Wellbeing	Outcome measure - Depression, Anxiety, Other	Results
Albertson *et al.* (2014)	Mindful Self-Compassion. Web-based resources for daily practice (individual); 3 weeks	Waitlist	-	Other (Body dissatisfaction) Body Shape Questionnaire 16-item	Greater reductions in body dissatisfaction in SC group (medium effect size) SC group significant decrease in body satisfaction, maintained over follow-up.
Desbordes *et al.* (2012)	Cognitively-based compassion training (group); 8 weeks	(A) Mindful attention training (group) 8 weeks; (B) Health discussion (group) 8 weeks	-	BDI-II; BAI	No significant effects of group. Significant effect of time on BDI and BAI. Significant reduction of BDI in SC group but not other groups.
Jazaieri *et al.* (2014)	Compassion Cultivation Training (group); 9 weeks	Waitlist	Subjective Happiness Scale	Penn State Worry Questionnaire; Perceived Stress Scale 4-item	Significant interaction of group and time on Subjective Happiness Scale but significant main effects; Significant interaction of group and time on PSWQ but no main effect of group; No significant interaction of group by time on PSS.
Koopmann-Holm *et al.* (2013)	Compassion meditation (group); 8 weeks	(A) Mindfulness meditation (group) 8 weeks; (B) Improvisational theatre class (group) 8 weeks; (C) Waitlist	Satisfaction with Life Scale	Affect Valuation Index	No significant differences between groups on SWLS. No significant differences between two controls or between two meditation groups. Pooled data for both meditation groups vs. two controls - meditation groups significantly valued Low Arousal Positive Affect more than controls. No significant differences for High Arousal Positive Affect.

Reference	Compassion-based Intervention	Control Conditions	Outcome measure - Wellbeing	Outcome measure - Depression, Anxiety, Other	Results
Neff & Germer (2013)	Mindful Self-Compassion (group); 8 weeks	Waitlist	Subjective Happiness Scale; Satisfaction with Life Scale	BDI; State-Trait Anxiety Inventory - Trait form; Perceived Stress Scale	CBI group had significant improvements in SWLS (medium effect size), but not for Subjective Happiness Scale. CBI group had significantly greater reductions in depression (large effect size), anxiety (medium effect size) and stress (small effect size). Gains maintained at 6 and 12 month follow-up, with increases in SWLS at 12 months. Within group comparisons showed significant improvements in SWLS, depression, stress not SHS or anxiety. Waitlist also showed significant increases on SHS.
Smeets *et al.* (2014)	Self-compassion class (group); 3 weeks	Time management class (group) 3 weeks	Satisfaction with Life Scale	Penn State Worry Questionnaire 11-item; Positive and Negative Affect Schedule	No significant differences between groups for SWLS, PSWQ or PANAS. Within group differences showed significant increases in SWLS in both CBI and control groups. No significant within group differences for PSWQ or PANAS in either group.
Wallmark *et al.* (2013)	Buddhist meditation programme (group); 9 weeks	Waitlist	-	Perceived Stress Scale (Swedish version)	Significant decreases in CBI group compared to control on PSS (large effect size).

CBI = Compassion-based intervention; PSWQ = Penn State Worry Questionnaire; PANAS = Positive and Negative Affect Schedule; PSS = Perceived Stress Scale; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; SWLS = Satisfaction with Life Scale; SHS = Subjective Happiness Scale

Appendix H

CFT/ CMT Interventions – Results Table

Reference	Compassion-based Intervention	Control condition	Outcome measure - Depression, Anxiety, Other	Results
Beaumont *et al.* (2012)	CBT plus CMT (individual); up to 12 weeks	CBT only; up to 12 weeks	HADS; Impact of Events Scale – Revised	No significant between groups on HADS or Trauma. CBI group significantly greater reduction on the Avoidance subscale of the IES-R. CBI group had greater amount of change on depression score than control alone. Within group significant differences for CBI group on depression, anxiety, all three trauma symptom subscales.
Gale *et al.* (2014)	CFT for ED group; 20 sessions over 16 weeks	-	CORE-OM; Eating Disorder Examination Questionnaire; The Stirling Eating Disorder Scale	Significant improvements on the CORE-OM, EDE-Q and SEDS.
Gilbert & Proctor (2006)	CMT group; 12 weeks	-	HADS	Significant reductions in depression and anxiety.
Judge *et al.* (2012)	CFT group; 12-14 weeks	-	BDI; BAI	Significant reductions in depression and anxiety.
Laithwaite *et al.* (2009)	Recovery group with CMT; 20 sessions over 10 weeks	-	BDI-II; Positive and Negative Syndrome Scale	Significant reductions in depression and general psychopathology score of PANSS but not other subscales.
Lucre & Corten (2013)	CFT group; 16 weeks	-	Depression Anxiety and Stress Scale-21; CORE-OM	Significant reductions in depression and stress, but not anxiety. Significant improvements on the CORE-OM subscales (except risk – all low due to exclusion criteria)

HADS = Hospital Anxiety and Depression Scale; CORE-OM = Core Outcomes in Routine Evaluation – Outcome Measure; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; IES-R = Impact of Events Scale – Revised; CBI = Compassion-based intervention

<u>Appendix I</u>

<u>Compassion Exercises – Results Table</u>

Reference	Compassion-based Intervention	Alternative Intervention/ Control Conditions	Outcome measure - Wellbeing	Outcome measure - Depression, Anxiety, Other	Results
Kelly *et al.* (2009)	'Self-soothing' lab-based instructions, brief daily exercises (individual) 2 weeks	(A) 'Attack-resisting' lab-based instructions, brief daily exercises (individual) 2 weeks; (B) Waitlist	-	Depressive Experiences Questionnaire; BDI	No significant effect of group on depression. Alternative intervention condition showed reduced depression significantly more than waitlist. Significant reduction in emotional distress related to acne for both interventions compared to controls. No significant differences between intervention conditions.
Shapira & Mongrain (2010)	'Self-compassion' letter-writing exercises completed online daily (individual) 1 week	(A) 'Optimism' letter-writing exercises completed online daily (individual) 1 week; (B) 'Early memories' letter-writing exercises completed online daily (individual) 1 week	Steen Happiness Index	Depressive Experiences Questionnaire; Center for Epidemiological Studies Depression Scale	Significant interaction of group and time on happiness index. CBI group showed significantly greater gains on the happiness index compared to control at 3- and 6- month follow-up, but not post or 1 month follow-up. Alternative intervention made significant gains on happiness index at post, 3- and 6- month but not 1 month follow-up. Significant interaction of group and time on CES-D. CBI group had significant reductions in depression at 3 months compared to control, but not post-intervention, 1- or 6-months follow-up. Alternative condition showed significant reductions in depression compared to control at 1- and 3-month follow-up.

BDI = Beck Depression Inventory; CBI = Compassion-based intervention

Semi-structured Interview Schedule

Standard introductory instructions

This interview is about collating expert opinion on therapist competencies necessary for CFT. It's possible you may also think of desirable competencies, but it would help if that were made clear. It is anticipated that there will be overlaps with other therapies as well as aspects unique to CFT and we are interested in both. Competencies are considered within a knowledge, skills and attitudes framework with a couple of further areas of interest. I may ask questions along the way to clarify for me as someone new to the area and to cover the range of aspects of competence. I might take a few notes as reminders for me as we go along, is that ok? Do you have any questions before we start recording?

- In your experience, what are the therapist competencies necessary to deliver Compassion Focused Therapy?

Use prompts to gain clarification or detail, for example
- Can you tell me what you mean by that?
- What would that look like?

Answers are likely to fall into the following domains: skills, knowledge and attitudes. Use prompts as appropriate such as:
- You've told me X, Y and Z, are there any other skills that are necessary?
- Are there other aspects of competence required for CFT, perhaps in terms of knowledge or attitudes?

If these areas are not raised or clarification is required
- In your opinion, are there any therapist qualities that are necessary for competence in CFT?
- How do you see the role of self-practice of compassion in relation to therapist competencies?

End by summarising and providing the opportunity for any further comments or questions. Thank the interviewee for participating.

Appendix K

Round Two Survey

<u>Instructions</u>

The purpose of this is to gather opinions on a draft CFT competency framework to inform its development. I have included the draft competency framework and a survey. The survey items are draft competencies from the framework.

Please complete the following steps:

1. Complete the participant background information box below
2. Familiarise yourself with the draft competency framework (overleaf, two pages designed to sit side by side)
3. Suggest amendments to the overall structure in the box below. If possible, identify if necessary competencies are missing. It may help to draw on existing competency frameworks, for example see: http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm
4. Indicate your opinion on the necessity of each competency, using the tick boxes in the survey
5. Comment on each competency and its components, using the free text boxes in the survey
   - Consider if the components listed fit together or not, if some are more important than others, or if something should be added, removed or re-worded.

Please complete and return this document by **5th December** with a signed consent form, if you have not already completed one.

Please send these documents either by email to ael19@le.ac.uk or post to Alice Liddell, Trainee Clinical Psychologist, Department of Clinical Psychology, University of Leicester, 104 Regent Road, Leicester, LE1 7LT.

If you have any questions please do not hesitate to contact me by email ael19@le.ac.uk or telephone on 07583 381988.

Participant Background Information	Participant identifier:

<u>Participant Background Information</u>
Please delete as appropriate:

I participated in an interview for this research   yes / no

I forwarded the information on to other potential participants   yes / no   please state how many ....

I have been trained in CFT and have at least one year's focused, supervised practice in CFT   yes / no

---

Comments on the overall structure of framework, including anything missing:

CFT Therapist Competencies – draft framework

Note regarding relationships between groups of competencies:

Competencies specific to 'phases' of the therapy have been separated and relevant therapy content briefly outlined, for clarification. 'Implementation Skills' relate to all phases of therapy, which is represented by the blue box. 'Creating safeness' characterises the context within which all therapeutic skills are delivered, represented by the green box.

Knowledge/ understanding informs competencies in the green box. Supervision is used for ongoing development of competencies within the green box. Additional generic competencies have been included but not elaborated.

Knowledge/ Understanding
- Difficulties/ disorders
  - How they affect emotions
  - How they affect therapy process
  - How they relate to the model
- CFT (theoretical and personal understanding of concepts in relation to the therapist)
  - Common humanity philosophy
  - Definition of compassion
  - Fears of compassion
    - Blocks to the word
    - Obstacles to techniques
    - Emotional conditioning
    - Perceptions of Buddhism
  - Difference between shame & guilt
  - Emotional avoidance
  - Evolutionary model – old brain, new brain
  - Three circles model
  - CFT formulation
  - CMT Techniques
  - CFT theoretical integration
  - Theoretical underpinnings
    - Evolutionary neuropsychology
    - Social mentalities
    - Social & relational processes
    - Jungian
    - Cognitive-behavioural
    - Attachment
    - Transference & counter-transference

Generic Skills

Assessment skills
Group skills

Creates Safeness
(provides an experience of a compassionate other in a safe way, through the therapeutic relationship)
- Room set-up
- Maintains professional therapeutic boundaries
- **Core Skills**
  - Active listening skills
  - Pacing
  - Voice tone & pitch
- **Builds therapeutic alliance**
  - Attuned to client
  - Matches where the person's at
  - Encourages reflections on the therapeutic relationship
  - Repairs ruptures
  - Present with client, whilst balancing hypothesizing
- **Collaborative Engagement** (thinks with not for the client)
  - Non-expert position balanced with background knowledge
  - Adapts therapy to the individual
  - Appropriate use of power
  - Gives clients choice & opportunities to make decisions
- **De-shames**
  - Conveys a sense of common humanity 'we're all in the same boat'
    - Normalises
    - Uses carefully considered personal examples
    - Inclusive language e.g. 'we', 'our tricky brains'
    - Engages in practice alongside clients & shares reflections
  - Conveys the 'not your fault' message
    - Conveys idea of different 'versions'
    - Uses de-pathologising language
    - Validates
    - Does not expect certain results
- **Modelling the Compassionate Self**
  - Therapist Qualities
    - Key attributes of the compassionate mind (empathy, sympathy, care, kindness, distress tolerance, non-judgemental)
    - Warmth (moderated)
    - Strength & courage
    - Wisdom
    - Openness
    - Curiosity
    - Flexibility
    - Grounded
    - Lightness of touch (playful, creative, humour)
    - Confident
    - Honest & transparent
    - Assertive/ challenging if needed
    - Imperfect
  - Personal motivation & commitment to the model
    - Sensitivity to suffering
      - Splits attention between client and therapist's affect & responses
      - Notices & tracks own affect in response to client
      - Recognises & stays with therapist's own difficult/ avoided emotions/ 'Shadow' side
    - Alleviating suffering
      - Has regular self-practice to develop the compassionate self
      - Regulates own affect in response to client and day to day life (in order to hold to compassionate intention)

Implementation Skills		Phase of Therapy		

• **Works flexibility within the framework**
  o Grounds the client in the understanding/ first psychology of compassion before moving into CMT
  o Conceptual clarity guides use of techniques
  o Ensures client has capacity to ground/ soothe before doing trauma work
  o Appropriately timed
• **Focuses on affect**
  o Slows down & gives space
  o Uses empathic bridging
  o Uses skills in mentalizing
  o Notices & tracks shifting affect
  o Recognises & stays with client's difficult/ avoided emotions
  o Maintains a manageable connection with strong affect
• **Facilitates experiential learning**
  o Coaching skills
    ▪ Uses Socratic dialogue
    ▪ Uses inference chaining
    ▪ Uses circular questions
    ▪ Appropriate use of closed questions
    ▪ Delivers clear, simple, understandable explanations
    ▪ Checks out that the client understands
    ▪ Sets up learning through behavioural experiments
    ▪ Sets up homework/ practices
    ▪ Checks in about homework/ practices
    ▪ Utilises role plays
  o Explores & elicits with the client:
    ▪ Affective experiences
      • Body sensations/ physiology
      • Sensory experience
      • Emotional memories
      • Identifying & naming emotions
      • Avoided affect
      • Shame
    ▪ Fears/ blocks to compassion
    ▪ Key interactions in the therapeutic relationship
    ▪ Motivation & personal responsibility for change
    ▪ Links between emotion, thought & experience
    ▪ Links between client experience & model
	Content	**Sharing the Model**
		(accessibly introduces understanding of the model as it relates to the client)
		
		▪ Physiology of emotions
		▪ Old brain, new brain
		▪ Emotional conditioning
		▪ Common humanity philosophy
		▪ Definition of compassion
		▪ Fears and blocks to compassion
		▪ Evolutionary functional analysis
		▪ Three circles model
		▪ CFT formulation with relational aspects
		▪ Difference between shame & guilt
		▪ Role of shame & self-criticism
		▪ Compassion as 'trainable'
		▪ Rationale for using compassion to regulate emotions & engage with & alleviate difficulties
			Compassionate Mind Training
			(facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance)
			
			▪ Noticing & tracking affect
			▪ Short-term crisis management skills e.g. distraction
			▪ Soothing rhythm breathing
			▪ Safe place imagery
			▪ Mindfulness
			▪ Compassionate Self
			▪ Compassionate Other
				Putting the compassion to work
				(facilitates clients in using compassion to engage with difficulties & promote change)
				
				▪ Processing trauma & shame-based memories
				▪ Graded exposure
				▪ Re-scripting
				▪ Confronting/ facing fears in real world
				▪ Increasing drive system
				▪ Action-based methods
				▪ Compassionate letter writing
				▪ Chair work
				▪ Using soothing system in relationships
				▪ Developing a compassionate identity

	Skills	▪ Draws it out, side by side ▪ Integrates stories, examples & metaphors ▪ Pitches appropriately ▪ Uses limited didactic information giving ▪ Selects relevant part of model ▪ Provides appropriate materials (hand-outs)	▪ Appreciates full range ▪ Selects appropriate to purpose ▪ Encourages & supports practice ▪ Develops own style ▪ Delivers in a natural/fluid way ▪ Focuses on intention & motivation (not result) ▪ Rolls with resistance	▪ Chair work - isolates different emotions ▪ Trauma work - gradual & systematic ▪ Uses self-concepts vocabulary in dialogue

What are the therapist competencies necessary to deliver Compassion Focused Therapy (CFT)?

Round Two Survey

Knowledge and Understanding

1. Knowledge and understanding of the difficulties and disorders being worked with is necessary to deliver CFT.

As you can see from the draft framework, this competency encompasses: how difficulties and disorders affect emotions, how they affect the therapy process and how they relate to the model.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

2. Knowledge and a personal understanding of CFT theory, concepts and model are necessary to deliver CFT.

This competency encompasses: common humanity philosophy; definition of compassion; fears of compassion; difference between shame and guilt; emotional avoidance; evolutionary model 'old brain, new brain'; three circles model; CFT formulation; Compassionate Mind Training techniques; CFT theoretical integration; and theoretical underpinnings.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Creates Safeness

Provides an experience of a compassionate other in a safe way, through the therapeutic relationship.

3. Setting the room up to reflect safety is necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

4. Maintaining professional therapeutic boundaries is necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

5. Core skills in active listening, pacing, voice tone and pitch are necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

6. Building a therapeutic alliance is necessary to deliver CFT.

This competency encompasses: attunement; matching; reflecting on the therapeutic relationship; repairing ruptures; and being present with the client whilst balancing hypothesizing.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

7. Collaborative engagement 'thinking with not for the client' is necessary to deliver CFT.

This competency encompasses: taking a non-expert position balanced with background knowledge; adapting therapy to the individual; appropriate use of power; and giving clients choice and opportunities to make decisions.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

8. De-shaming by conveying a sense of common humanity 'we're all in the same boat' is necessary to deliver CFT.

This competency encompasses: normalising; using carefully considered personal examples; inclusive language (e.g. 'we'); engaging in practice alongside clients; and sharing reflections on practices.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

9. De-shaming by conveying the 'not your fault' message.

This competency encompasses: conveying the idea of different 'versions'; using de-pathologising language (e.g. 'protective' instead of maladaptive strategies); validating; and not expecting certain results.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

10. Modelling the Compassionate Self through therapist qualities is necessary to deliver CFT.

This competency encompasses the following qualities: key attributes of the compassionate mind (sympathy, empathy; distress tolerance, non-judgemental, care, kindness); warmth; strength; courage; wisdom; openness; curiosity; flexibility; being 'grounded'; 'lightness of touch'; humour; confidence; honesty; transparency; able to be assertive/challenging if needed; and imperfect.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

11. Modelling the Compassionate Self through personal motivation and commitment to the model is necessary to deliver CFT.

This competency encompasses both psychologies of compassion. (1) Sensitivity to suffering. This involves: splitting attention to track affect in client and therapist's affect in response to the client; and recognising and staying with therapist's own avoided emotions or 'Shadow' side. (2) Alleviating suffering. This involves: therapists having their own regular practice to develop the compassionate self; and therapists regulating their own affect in response to the client and to day to day life, in order to hold to their compassionate intention.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Implementation Skills

12. Working flexibly within the framework is necessary to deliver CFT.

This competency encompasses: grounding the client in the first psychology of compassion before moving into CMT; with conceptual clarity guiding the use of techniques; ensuring the client has the capacity to ground/ soothe before doing trauma work; and appropriate timing of therapy components.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

13. Focusing on affect is necessary to deliver CFT.

This competency encompasses: slowing down; giving space; empathic bridging; mentalizing; noticing and tracking shifting affect; recognising and staying with client's difficult or avoided emotions; and maintaining a manageable connection with strong affect.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

14. Facilitating experiential learning by using coaching skills is necessary to deliver CFT.

This competency encompasses: Socratic dialogue; inference chaining; circular questions; appropriate use of closed questions; delivering clear, simple understandable explanations; checking out that the client understands; setting up learning through behavioural experiments; setting up homework/ practices; and utilising role plays.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

15. Facilitating experiential learning by exploring and eliciting experiences and reflections with the client is necessary to deliver CFT.

This competency encompasses attention to: multiple facets of affective experience; fears and blocks to compassion; key interactions in the therapeutic relationship; motivation and personal responsibility for change; links between emotion, thought and experience; and links between client experience and the model.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Therapy phase-specific skills

16. Accessibly sharing an understanding of the model as it relates to the client is necessary to deliver CFT.

This competency encompasses: drawing it out side by side; integrating stories, examples and metaphors; appropriate pitching; limited use of didactic information giving; selecting relevant parts of the model; and providing appropriate materials.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

17. Facilitating the client in using techniques to regulate affect by building up the soothing system and bringing all three systems into balance is necessary to deliver CFT.

This competency encompasses: appreciating the full range of techniques and selecting appropriate to purpose; encouraging and supporting practice; developing the therapist's own style; delivering in a natural/ fluid way; focusing on intention and motivation (not result); and rolling with resistance.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

18. Facilitating the client in using compassion to engage with difficulties and promote change is necessary to deliver CFT.

This competency encompasses: chair work isolating different emotions; doing trauma work gradually and systematically; and using self-concepts vocabulary in dialogue.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Supervision

19. Using supervision to develop skills, utilising feedback from observations, is necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

20. Using supervision to develop the compassionate self is necessary to delivery CFT.

This competency encompasses: self-reflection in relation to the model; tolerating skill development; developing helpful critical evaluation during and after the session; and imagery practice.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

21. Using supervision to reflect on difficulties in the therapy, particularly process issues, transference and counter-transference, is necessary to deliver CFT.

This competency encompasses: reflecting on and engaging with therapist's own avoided affect and 'shadow' side.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Generic Skills

22. Assessment skills are necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

23. Group therapy skills are necessary to deliver CFT in groups.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Thank you for completing this survey.

Please return a consent form with your response, if you have not already done so.

Please send these documents either by email to ael19@le.ac.uk *or post to: Alice Liddell, Trainee Clinical Psychologist, Department of Clinical Psychology, University of Leicester, 104 Regent Road, Leicester, LE1 7LT*
by 5th December 2014.

I look forward to sharing the responses and developments with you.

If you have any questions please do not hesitate to contact me by email ael19@le.ac.uk *or telephone on 07583 381988.*

Appendix L

Round Three Survey (blank version)

Therapist Competencies necessary to deliver Compassion Focused Therapy: A Delphi Study

Round Three

The purpose of this is to reflect opinions on a draft CFT competency framework and to inform its development. This is the final stage of data collection for this research project.

Sections in this document

This document contains a number of sections, some for information and clarification, some require responses.

- Instructions are on page one, highlighting the responses needed.
- On page two there is a box labelled 'Remit Assumptions'. This clarifies the remit of the competency framework – what it covers and what is beyond it. This is important to guide you in how to answer the survey and ensure that all respondents are addressing the same question.
- Also on page two is a box labelled 'Main Amendments'. This highlights the major revisions made based on feedback from the last survey. It is important to be aware of these developments as they inform the survey.
- On page three is an outline of the competency framework and an explanation of how the competencies relate to one another. This provides an overview of the framework, but with the details removed. This will help orientate you to the structure of the framework, key competencies and survey items.
- On pages four and five is the detailed competency framework. This has all the competency headings in the outline and new suggestions that will appear as survey items. It also lists specific competencies within them. Page four covers Knowledge and Understanding; Supervision; and 'Creates Safeness'. Page five covers skills, divided into 'meta-skills', 'non phase-specific' and 'phase-specific'. Page five also covers therapy content, as a guide. However, therapy content relates to adherence (what is done), rather than competence (how it's done). Therefore the content sections do not appear in the outline of the competency framework or the survey.
- The survey starts on page six. There are two parts to the survey.
  - Part one of the survey is about competencies that have been added or suggested (did not appear in the round two survey). There is also an important question about the structure. Items are numbered I-VI. Similarly to round two, I will be asking for ratings about these. There are also specific questions about them with texts boxes to complete.
  - Part two of the survey is about competencies that were included in the round two survey. This starts on page eight and items are numbered 1-23. You will see amendments to the competencies based on your suggestions. Bold typeface indicates something has been added. Where words have been struck through, they have been removed. You will see the same rating scale as previously and be asked to rate your agreement with the amended item. You will be presented with the collated group response to the item as it was in round two, which is indicated as a percentage. You will also see your response to the item as it was in round two. This information may help to guide your decision about the necessity of each competency. Where queries were raised from the previous survey or there have been considerable changes, specific questions are posed about these items and a text box is provided.
  - At the end of the survey there is a free text box for any further comments you may have.

If you have any questions or if you would find it helpful to talk through any part of this document, please do not hesitate to contact me by email ael19@le.ac.uk or telephone on 07583 381988. I would be more than happy to discuss this over the phone with you. If you want to text or email me, I can give you a ring back a convenient time.

Instructions

Please complete the following steps:

1. Read the 'Remit Assumptions', 'Amendments' sections.
2. Review structure of the framework
3. Complete the survey
4. Return the survey by **30th January** to ael19@le.ac.uk or post to Alice Liddell, Trainee Clinical Psychologist, Department of Clinical Psychology, University of Leicester, 104 Regent Road, Leicester, LE1 7LT.

Remit Assumptions

Competence versus adherence

- The framework is about competence – the knowledge, skills and attributes that the therapist needs to deliver the therapy. It is not about adherence – what the model or therapy content is. However, some therapy content is included in the detailed framework as guidance to orientate the reader. The content sections will not appear in the final competency framework.

Competencies *necessary* to delivery CFT

- Questions were raised about: conducting assessments; working with couples or families; groups; and interventions under 'Putting the Compassion to work'.
- Based on the remit of the research question and participant feedback the following assumptions have been clarified:
  1. The framework covers competencies *necessary* to deliver CFT as a therapeutic intervention. As there are a variety of ways CFT can be delivered, **the framework focuses on the competencies that are shared across modalities**. Competencies specific to different modalities, client groups or interventions are acknowledged but not elaborated upon as this is beyond the remit of the current framework.
  2. Assessment of psychological need has been conducted, identifying that CFT would be helpful. Assessment skills are acknowledged but not elaborated.
  3. If delivering CFT with more than one person e.g. couples, families or in groups, the competencies in the framework should remain *necessary*. However there may be additional competencies for working in these specific modalities. These can be acknowledged but would not be elaborated upon.
  4. 'Putting the compassion to work' can be delivered using a range of therapeutic interventions, which is likely to vary with the specifics of the client e.g. age, cognitive abilities, difficulties. Competencies in the framework are *necessary* in the way these interventions are used. However there may be additional competencies specific to that intervention e.g. exposure or action-based methods. The details of competencies specific to these interventions are beyond the remit of the current framework. The framework gives examples of interventions concordant with CFT but does not aim to elaborate on which is used.

CFT-specific and 'generic' competencies

- The framework aims to cover what is necessary for CFT. It is acknowledged that some competencies will be considered generic therapeutic competencies or draw from other models. However, to highlight only 'CFT-specific' competencies would not accurately represent CFT. Therefore the framework aims to cover both.
- The differences can be discussed but ratings of importance should reflect both aspects.

Main Amendments

- Under 'Creates Safeness' (page four, second column). 'Room set-up' changed to 'Creates a safe environment'.
- 'Meta-skills' (top of page five) has been added as a label to cover three competencies that apply to the way that other skills are implemented:
  1. 'Works flexibly within the framework'
  2. 'Splits attention between client and therapist's affect and responses' – previously under 'Modelling the Compassionate Self - personal motivation and commitment to the model'.
  3. 'Aware of and reflects (in session) on what is happening in therapist's own three circles and the impact this may have on therapeutic interactions' – previously implied under other competencies.
- 'Non phase-specific aspects of CFT' (page five, first column) replaces the title 'Implementation skills'. This is divided into content and skills, similarly to the phase-specific items.
- 'Facilitates experiential learning by exploring and eliciting experiences and reflections with the client' (page five, bottom left corner) captures all the skills previously labelled 'Facilitates experiential learning by using coaching skills.' The aspects of therapy that are attended to have been moved to the 'content' section, this was previously labelled 'explores and elicits with the client'.

Suggested additions are shown on the competency framework in bold italics. Newly suggested items do not appear in the framework outline. Part one of the survey addresses competencies that were not in the previous version.

> **CFT Therapist Competencies – Framework outline**
>
> The framework can be simplified by removing therapy 'content' and the detailed description of each competency, listing only the headings and sub-headings of the competencies .
>
> The relationships between the groups of competencies are important. They are nested within one another, indicating that super-ordinate competencies apply to the way the competencies within them are demonstrated.
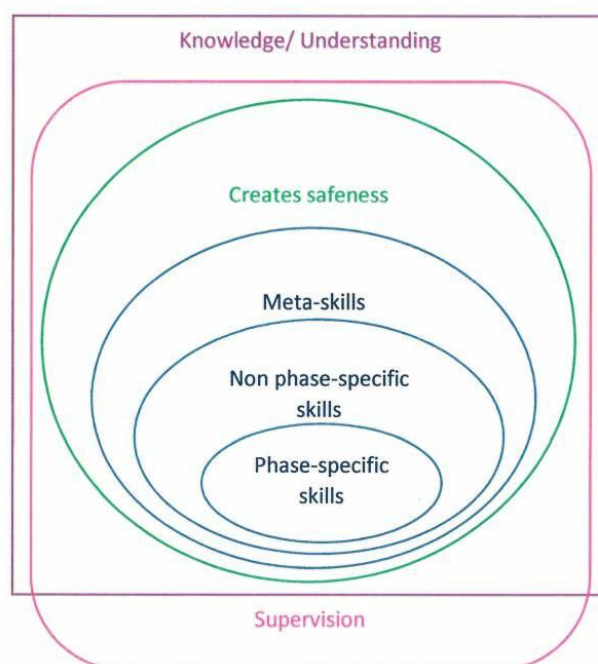>
> 'Knowledge/understanding' informs other competencies. 'Creates Safeness' is a required context for the other skills to take place within. Meta-skills applies to the way that the skills below it are used. Non phase-specific skills are required across all therapy phases. Supervision supports the development of all of the above.

Knowledge/ Understanding
- o Difficulties/ disorders
- o CFT (theoretical and personal understanding of concepts in relation to the therapist)

Creates Safeness - provides an experience of a compassionate other in a safe way, through the therapeutic relationship.
- o Creates a safe environment
- o Maintains appropriate professional therapeutic boundaries
- o Core Skills
- o Builds therapeutic alliance
- o Collaborative Engagement
- o De-shames
    - o Conveys a sense of common humanity 'we're all in the same boat'
    - o Conveys the 'not your fault' message
- o Modelling the Compassionate Self
    - o Authentically demonstrates qualities conveying the compassionate self
    - o Personal motivation & commitment to the model

Meta-skills
- o Works flexibility within the framework
- o Splits attention between client & therapist's affect & responses
- o Aware of and reflects (in session) on what is happening in therapist's own three circles and the impact this may have on therapeutic interactions

Non phase-specific skills
- o Focuses on affect
- o Facilitates experiential learning by exploring and eliciting experiences and reflections with the client

Phase specific-skills
- o Accessibly introduces understanding of the model as it relates to the client
- o Facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance
- o Facilitates clients in using compassion to engage with difficulties & promote change

Uses supervision to:
- o Develop skills
- o Develop the compassionate self
- o Reflect on difficulties in the therapeutic relationship

Knowledge/ Understanding
- ▪ **Difficulties/ disorders**
  - ○ How they affect emotions
  - ○ How they affect therapy process
  - ○ How they relate to the model
- ▪ **CFT (theoretical and personal understanding of concepts in relation to the therapist)**
  - ○ Common humanity philosophy
  - ○ Definition of compassion
  - ○ Fears and blocks to compassion
    - ▪ Blocks to the word
    - ▪ Obstacles to techniques
    - ▪ Emotional conditioning
    - ▪ Perceptions of the contemplative tradition
  - ○ Difference between shame & guilt
  - ○ Difference between shame self-criticism and compassionate self-correction
  - ○ Emotional avoidance
  - ○ Evolutionary model – old brain, new brain functions
  - ○ Three circles model of emotion regulation
  - ○ CFT formulation
  - ○ CMT Techniques
  - ○ Imagery practices (theory and from experience of self-practice)
  - ○ CFT theoretical integration
  - ○ Theoretical underpinnings
    - ▪ Evolutionary neuropsychology
    - ▪ Social mentalities
    - ▪ Social rank theory
    - ▪ Social & relational processes
    - ▪ Evolved motives/ archetypes
    - ▪ Cognitive-behavioural
    - ▪ Attachment
    - ▪ Transference & counter-transference

Uses supervision to:
- ▪ **Develop skills**
  - ○ Uses observation/ video feedback
  - ○ *Practising leading imagery practices*
- ▪ **Develop the compassionate self**
  - ○ Self-reflection in relation to the model
  - ○ Tolerating skill development (conscious competence growth)
  - ○ Develop compassionate self-correction during and after session
  - ○ Relating to clients' experiences of exercises
- ▪ **Reflect on difficulties in the therapeutic relationship, including:**
  - ○ Process issues, transference & counter-transference
  - ○ Interactions between therapist's and client's three circles and the impact this may have on therapeutic interactions
  - ○ Therapist's avoided affect/ 'shadow' side

Creates Safeness
(provides an experience of a compassionate other in a safe way, through the therapeutic relationship)
- ● **Creates a safe environment**
  - ○ Collaborating on length of sessions
  - ○ Offering ways for clients to indicate distress
  - ○ Room set-up (within limits of what is available)
- ● **Maintains appropriate professional therapeutic boundaries**
- ● **Core Skills**
  - ○ Active listening skills
  - ○ Pacing
  - ○ Voice tone & pitch
- ● **Builds therapeutic alliance**
  - ○ Attuned to client
  - ○ Matches where the person's at
  - ○ Encourages reflections on the therapeutic relationship
  - ○ Repairs ruptures
  - ○ Present with client, whilst balancing hypothesizing
- ● **Collaborative Engagement** (thinks with not for the client)
  - ○ Adapts therapy to the individual
  - ○ Appropriate use of power
  - ○ Gives clients choice & opportunities to make decisions
  - ○ Collaborative therapeutic goal-setting
  - ○ Non-expert position balanced with background knowledge
- ● **De-shames**
  - ○ **Conveys a sense of common humanity 'we're all in the same boat'**
    - ▪ Normalises
    - ▪ Uses carefully considered personal examples
    - ▪ Inclusive language e.g. 'we', 'our tricky brains'
    - ▪ Engages in practice alongside clients & shares reflections
  - ○ **Conveys the 'not your fault' message**
    - ▪ Conveys idea of different 'versions'
    - ▪ Uses de-pathologising language
    - ▪ Validates
    - ▪ Relates client experiences to the evolutionary model
- ● **Modelling the Compassionate Self**
  - ○ **Authentically demonstrates qualities conveying the compassionate self**
    - ▪ Key attributes of the compassionate mind (empathy, sympathy, care for wellbeing, kindness, distress tolerance, non-judgemental)
    - ▪ Warmth (moderated)
    - ▪ Strength & courage
    - ▪ Wisdom
    - ▪ Openness
    - ▪ Curiosity
    - ▪ Flexibility
    - ▪ Grounded
    - ▪ Lightness of touch (playful, creative, humour)
    - ▪ Confident
    - ▪ Honest & transparent
    - ▪ Assertive/ challenging if needed
    - ▪ Imperfect
  - ○ **Personal motivation & commitment to the model**
    - ▪ Sensitivity to suffering
      - ● Notices & tracks own affect
      - ● Recognises & stays with therapist's own difficult/ avoided emotions/ 'Shadow' side
    - ▪ Alleviating suffering
      - ● Has regular self-practice to develop the compassionate self
      - ● Regulates own affect in response to client and day to day life (in order to hold to compassionate intention)

Meta-skills

- **Works flexibility within the framework**
  - Moves between phases in response to client need
  - Attempts to ground the client in the understanding/ first psychology of compassion before moving into CMT
  - Uses conceptual clarity to guide use of techniques
  - Appropriately times delivery of messages and techniques
- **Splits attention between client's & therapist's affect & responses**
- **Aware of and reflects (in session) on what is happening in therapist's own three circles and the impact this may have on therapeutic interactions**

	Non phase-specific aspects of CFT	Phase-specific aspects of CFT		
		Sharing the Model	**Compassionate Mind Training (CMT)**	**Putting the compassion to work** *Examples of therapeutic techniques/ interventions include:*

Content	• Links between emotion, thought & experience
	• Links between client experience & model
	• Fears/ blocks to compassion
	• Key interactions in the therapeutic relationship
	• Motivation & personal responsibility for change
	• Affective experiences
	  ○ Body sensations/ physiology
	  ○ Sensory experience
	  ○ Emotional memories
	  ○ Identifying & naming emotions
	  ○ Avoided affect
	  ○ Shame
		▪ Physiology of emotions
		▪ Old brain, new brain
		▪ Emotional conditioning
		▪ Common humanity philosophy
		▪ Definition of compassion
		▪ Fears and blocks to compassion
		▪ Evolutionary functional analysis
		▪ Three circles model
		▪ Difference between shame & guilt
		▪ Role of shame & self-criticism
		▪ Compassion as 'trainable'
		▪ Rationale for using compassion to regulate emotions & engage with & alleviate difficulties
		▪ ***CFT formulation with relational aspects***
			▪ Attention training
			▪ Noticing & tracking affect
			▪ Short-term crisis management skills e.g. distraction
			▪ Soothing rhythm breathing
			▪ Safe place imagery
			▪ Mindfulness
			▪ Compassionate Self
			▪ Compassionate Other
			▪ *Developing a compassionate identity*
				▪ Processing trauma & shame-based memories
				▪ Graded exposure
				▪ Behavioural activation
				▪ Re-scripting
				▪ Confronting/ facing fears in real world
				▪ Practising receiving compassion outside of relationships
				▪ Increasing drive system
				▪ Action-based methods
				▪ Activing techniques
				▪ Compassionate letter writing
				▪ Chair work
				▪ Multi-self work
				▪ Cognitive re-structuring

Skills	• **Focuses on affect**
	  ○ Slows down & gives space
	  ○ Uses empathic bridging
	  ○ Uses skills in mentalizing
	  ○ Notices & tracks shifting affect
	  ○ Recognises & stays with client's difficult/ avoided emotions
	  ○ Maintains a manageable connection with strong affect
	• **Facilitates experiential learning by exploring and eliciting experiences and reflections with the client**
	  ○ Uses Socratic dialogue
	  ○ Uses inference chaining
	  ○ Uses circular questions
	  ○ Motivational Interviewing techniques
	  ○ Appropriate use of closed questions
	  ○ Delivers clear, simple, understandable explanations
	  ○ Checks out that the client understands
	  ○ Sets up learning through behavioural experiments
	  ○ Sets up homework/ practices
	  ○ Checks in about homework/ practices
	  ○ Utilises role plays
	• *Distinguishes between shame-based self-criticism and compassionate self-correction?*
		Accessibly introduces understanding of the model as it relates to the client
		▪ Draws it out, side by side
		▪ Integrates stories, examples & metaphors
		▪ Pitches appropriately
		▪ Uses limited didactic information giving
		▪ Selects relevant part of model
		▪ Provides appropriate materials (hand-outs)
			Facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance
			▪ Appreciates full range
			▪ Selects appropriate to purpose
			▪ Encourages & supports practice
			▪ Delivers in an natural/fluid way (rather than from a script)
			▪ Focuses on intention & motivation (not result)
			▪ Rolls with resistance
				Facilitates clients in using compassion to engage with difficulties & promote change
				
				Implements therapeutic interventions as appropriate to the client, utilising the client's compassionate self.
				
				Examples of technique/intervention specific competencies:
				▪ Chair work - isolates different emotions
				▪ Trauma work - gradual & systematic
				▪ Uses self-concepts vocabulary in dialogue
				
				Follow-up/ relapse prevention?

What are the therapist competencies necessary to deliver Compassion Focused Therapy (CFT)?
Round Three Survey

Part 1: New Competencies developed from Round Two

- Please answer the question below
- Please rate each item in this section and address the specific questions in the spaces provided

---

Key question about structure

Three 'phases' of therapy have been identified, with specific content and skills. These are 'Sharing the Model', 'Compassionate Mind Training' and 'Putting the Compassion to Work'. It has been suggested that two further 'phases' could be separated out: **'formulation'** and **'building a compassionate identity'**.

Would the framework benefit from having these five phases identified separately, instead of just three?
Please comment.

I. **Competencies in developing an individualised formulation with the client** are necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Are there competencies specific to formulation that are not covered elsewhere in the framework? If so, please can you identify them?

II. **Competencies in facilitating the client to develop a compassionate identity** are necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Are there competencies specific to facilitating a compassionate identity that are not covered elsewhere in the framework? If so, please can you identify them?

III. **Competencies in follow-up/ relapse prevention** are necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

How would you describe how the competent CFT therapist does follow-up/ relapse prevention within CFT?

Are there _competencies_ specific to follow-up/ relapse prevention that are not covered elsewhere in the framework? If so, what are they?

IV. **Distinguishing between shame-based self-criticism and compassionate self-correction is** necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Is this a competency in its own right?

Can you identify any other related skills or abilities not already covered?

Does this fit under the 'non phase-specific skills'? If not, where would be better?

V. **Splitting attention between client's and therapist's affect and responses** is necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Does this fit as a meta-skill? If not, where would be better?

VI. **Being aware of and reflecting (in session) on what is happening in therapist's own three circles and the impact this may have on the therapeutic interaction** is necessary to deliver CFT.

No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT

Does this fit as a meta-skill? If not, where would be better?

Part 2: Amended Competencies from Round Two

Based on comments in round two, additions are shown in **bold**, removed items shown with a ~~strike through~~.

- Please consider the amendments indicated, the group response and your previous response.
- For each item, please indicate your opinion on the necessity of each competency, using the tick boxes.
- Please answer the specific questions in text boxes.
- If you have any additional comments, please use the free text box at the end of the survey.

Knowledge and Understanding

1. Knowledge and understanding of the difficulties and disorders being worked with is necessary to deliver CFT.

As you can see from the draft framework, this competency includes: how difficulties and disorders affect emotions, how they affect the therapy process and how they relate to the model.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	14%	86%
Your previous response					
Round three (please tick)					

2. Knowledge and a personal understanding of CFT theory, concepts and model are necessary to deliver CFT.

*This competency includes: common humanity philosophy; definition of compassion; fears of compassion; difference between shame and guilt; **difference between shame self-criticism and compassionate self-correction**; emotional avoidance; evolutionary model old brain, new brain functions; three circles model; CFT formulation; Compassionate Mind Training techniques; CFT theoretical integration; and theoretical underpinnings.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	0%	100%
Your previous response					
Round three (please tick)					

Creates Safeness

Provides an experience of a compassionate other in a safe way, through the therapeutic relationship.

3. ~~Setting the room up to reflect safety~~ **Creating a safe environment** is necessary to deliver CFT.

This competency includes: collaborating on length of sessions; offering ways for clients to indicate distress; and room set-up (within limits of what is available).

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	21%	36%	43%
Your previous response					
Round three (please tick)					

Are there other ways a therapist can create a safe <u>environment</u> (other than the therapeutic relationship)?

4. Maintaining **appropriate** professional therapeutic boundaries is necessary to deliver CFT.

Boundaries should be within the ethical framework but not 'neutral analytic stance' - see item 8 on common humanity regarding personal disclosures.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	29%	71%
Your previous response					
Round three (please tick)					

Please add your thoughts on what is meant by boundaries in CFT.

5. Core skills in active listening, pacing, voice tone and pitch are necessary to deliver CFT.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	7%	93%
Your previous response					
Round three (please tick)					

6. Building a therapeutic alliance is necessary to deliver CFT.

This competency includes: attunement; matching; reflecting on the therapeutic relationship; repairing ruptures; and being present with the client whilst balancing hypothesizing.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	14%	86%
Your previous response					
Round three (please tick)					

7. Collaborative engagement 'thinking with not for the client' is necessary to deliver CFT.

*This competency includes: taking a non-expert position balanced with background knowledge; adapting therapy to the individual; appropriate use of power; **collaborative therapeutic goal-setting**; and giving clients choice and opportunities to make decisions.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	7%	86%
Your previous response					
Round three (please tick)					

8. De-shaming by conveying a sense of common humanity 'we're all in the same boat' is necessary to deliver CFT.

*This competency includes: normalising; using carefully considered personal examples; inclusive language (e.g. 'we'); **engaging in practice alongside clients; and sharing reflections on practices.***

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	0%	93%
Your previous response					
Round three (please tick)					

Do you think 'engages in practice alongside clients & shares reflections' is a necessary competency for CFT?

9. De-shaming by conveying the 'not your fault' message.

*This competency includes: conveying the idea of different 'versions'; using de-pathologising language (e.g. 'protective' instead of maladaptive strategies); validating; and ~~not expecting certain results~~ **relates client experiences to the evolutionary model.***

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	0%	100%
Your previous response					
Round three (please tick)					

10. Modelling the Compassionate Self through '**authentically demonstrating qualities conveying the compassionate self**' is necessary to deliver CFT.

*This competency includes the following qualities: key attributes of the compassionate mind (sympathy, empathy; distress tolerance, non-judgemental, care **for wellbeing**, kindness); warmth; strength; courage; wisdom; openness; curiosity; flexibility; being 'grounded'; 'lightness of touch'; humour; confidence; honesty; transparency; able to be assertive/challenging if needed; and imperfect.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	7%	93%
Your previous response					
Round three (please tick)					

11. Modelling the Compassionate Self through personal motivation and commitment to the model is necessary to deliver CFT.

*This competency includes both psychologies of compassion. (1) Sensitivity to suffering. This involves: ~~splitting attention to track affect in client and therapist's affect in response to the client;~~ **noticing and tracking own affect**; and recognising and staying with therapist's own avoided emotions or 'Shadow' side. (2) Alleviating suffering. This involves: therapists having their own regular practice to develop the compassionate self; and therapists regulating their own affect in response to the client and to day to day life, in order to hold to their compassionate intention.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	29%	71%
Your previous response					
Round three (please tick)					

Meta-Skills

12. Working flexibly within the framework is necessary to deliver CFT.

*This competency includes: **moving between phases in response to client need; attempting** to ground the client in the first psychology of compassion before moving into CMT; using conceptual clarity to guide use of techniques; ~~ensuring the client has the capacity to ground/soothe before doing trauma work~~ and appropriately times delivery of **messages and techniques**.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	29%	71%
Your previous response					
Round three (please tick)					

Non phase-specific skills

13. Focusing on affect is necessary to deliver CFT.

This competency includes: slowing down; giving space; empathic bridging; mentalizing; noticing and tracking shifting affect; recognising and staying with client's difficult or avoided emotions; and maintaining a manageable connection with strong affect.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	0%	93%
Your previous response					
Round three (please tick)					

14. Facilitating experiential learning by ~~using coaching skills~~ **exploring and eliciting experiences and reflections with the client** is necessary to deliver CFT.

This competency includes: Socratic dialogue; inference chaining; circular questions; **Motivational Interviewing techniques;** *appropriate use of closed questions; delivering clear, simple understandable explanations; checking out that the client understands; setting up learning through behavioural experiments; setting up homework/ practices; and utilising role plays.*

This competency has been integrated with the one below.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	14%	79%
Your previous response					
Round three (please tick)					

Are the elements in the list of competencies this includes that are NOT necessary? Please identify which ones and if they are a 'helpful addition' or 'important but not essential'.

15. ~~Facilitating experiential learning by exploring and eliciting experiences and reflections with the client is necessary to deliver CFT.~~

~~*This competency includes attention to: multiple facets of affective experience; fears and blocks to compassion; key interactions in the therapeutic relationship; motivation and personal responsibility for change; links between emotion, thought and experience; and links between client experience and the model.*~~

This competency has been integrated with the above, therefore now represents a duplication. The aspects that therapists attend to have been re-labelled as therapy content **(relates to adherence to the model rather than competence at delivering the therapy). No rating required.**

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	0%	100%

Therapy phase-specific skills

16. Accessibly sharing an understanding of the model as it relates to the client is necessary to deliver CFT.

This competency includes: drawing it out side by side; integrating stories, examples and metaphors; appropriate pitching; limited use of didactic information giving; selecting relevant parts of the model; and providing appropriate materials.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	29%	64%
Your previous response					
Round three (please tick)					

17. Facilitating the client in using techniques to regulate affect by building up the soothing system and bringing all three systems into balance is necessary to deliver CFT.

*This competency includes: appreciating the full range of techniques and selecting appropriate to purpose; encouraging and supporting practice; ~~developing the therapist's own style~~; delivering/ **teaching practices** in a natural/ fluid way (rather than from a script); focusing on intention and motivation (not result); and rolling with resistance.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	14%	86%
Your previous response					
Round three (please tick)					

18. Facilitating the client in using compassion to engage with difficulties and promote change is necessary to deliver CFT.

*This competency involves: **implementing therapeutic interventions e.g. exposure, multi-self, chair work, as appropriate to the client, utilising the client's compassionate self.***

This competency does not cover the specifics of how to do each 'intervention' and additional skills in these areas may be needed.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	21%	71%
Your previous response					
Round three (please tick)					

Supervision

This relates to the way that the CFT therapist uses supervision as a supervisee in ongoing practice, in order to support competent delivery of CFT.

19. Using supervision to develop skills, utilising feedback from observations, is necessary for delivering CFT.

*This competency includes **practising leading imagery practices.***

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	21%	79%
Your previous response					
Round three (please tick)					

Is 'practising leading imagery practices' necessary for <u>delivering</u> CFT or for <u>learning</u> CFT (or both)?

20. Using supervision to develop the compassionate self is necessary for delivering CFT.

*This competency includes: self-reflection in relation to the model; tolerating skill development; developing compassionate self-correction ~~helpful critical evaluation~~ during and after the session; and **being able to relate to clients' experiences of exercises** ~~imagery practice~~.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	43%	50%
Your previous response					
Round three (please tick)					

Is this competency overall necessary for <u>delivering</u> CFT or for <u>learning</u> CFT (or both)?
Is engaging in imagery practice with the supervisor necessary for delivering or learning CFT (or both)?

21. Using supervision to reflect on difficulties in the therapeutic relationship is necessary to deliver CFT.

*This competency includes reflecting on: process issues, transference and counter-transference; **interactions between therapist's and client's three circles and the impact this may have on therapeutic interactions**; and engaging with therapist's own avoided affect or 'shadow' side.*

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	0%	21%	79%
Your previous response					
Round three (please tick)					

Additional Skills

Please see 'Remit Assumptions' box on page 2. Please rate the importance of the competency for the main purpose of the framework – <u>to deliver CFT as a therapeutic intervention, regardless of individual or group working.</u>

22. Assessment skills are necessary to deliver CFT.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	14%	79%
Your previous response					
Round three (please tick)					

23. **Skills in running groups** are necessary to deliver CFT.

	No, this would be counter-CFT	No this is not needed/ required	Can be a helpful addition	Important but not essential	Yes absolutely essential to CFT
Group response	0%	0%	7%	43%	50%
Your previous response					
Round three (please tick)					

Please feel free to make additional comments

Thank you for completing this survey.

Please return this survey by email to ael19@le.ac.uk or post to Alice Liddell, Trainee Clinical Psychologist, Department of Clinical Psychology, University of Leicester, 104 Regent Road, Leicester, LE1 7LT.

I would be more than happy to discuss anything in this document with you. If you have any questions please do not hesitate to contact me by email ael19@le.ac.uk or telephone on 07583 381988.

I look forward to feeding back the results to you.

Appendix M

Audit Trail of Template Analysis

Interview data for round one of the Delphi method was analysed using Template Analysis. This method involved several stages and the process of analysis is detailed in line with these stages.

A priori themes

A priori themes were identified from the CFT literature and existing work on competencies.

- Guided discovery/ Socratic questioning
- Building a therapeutic relationship
- Delivering psycho-education
- Evolutionary functional analysis
- Facilitating use of compassion to engage with difficulties
- Working with shame, self-criticism and self-blame
- Knowledge of the evolutionary model
- Warmth
- Empathy

Initial coding - use of a priori and new themes

Four transcripts were selected to inform the Initial Template. Data were coded and grouped into early initial theme ideas. Some codes were about what CFT is 'not'. They were not directly used as it was considered more useful to frame competencies in terms of what they were.

Reflections

This process was predominantly grounded in the data, with *a priori* themes temporarily put to one side. However, the definition of competencies covering knowledge, skills and attributes was present in the mind of the researcher at this stage and may have influenced the early imposition of knowledge and qualities at this stage. The researcher was also aware that imposing this framework would reflect the interview questions more than the content of the data, therefore analysis moved away from this framework and the data was reviewed more closely.

Initial Themes

- Knowledge
- Focusing on emotions
- Sharing the model
- Core skills
- Self-reflection
- Cultivating self-compassion in therapists
- Qualities
- Common humanity
- Meta-competencies
- Interventions
- Using supervision
- Miscellaneous

Development of the Initial Template

The revision of initial themes through to the initial template passed through various iterations. The first and second versions reflected processes. This was relatively top-down as a first attempt to make sense of the data as a whole and how different aspects might relate to one another. These versions struggled to accommodate meta-competencies and core skills. Initial themes were reviewed for heterogeneity and homogeneity. Codes were re-grouped and re-named. The relationship between the themes was also considered, with most competencies (themes) relevant to the way that others were implemented. Version three resulted in nine themes.
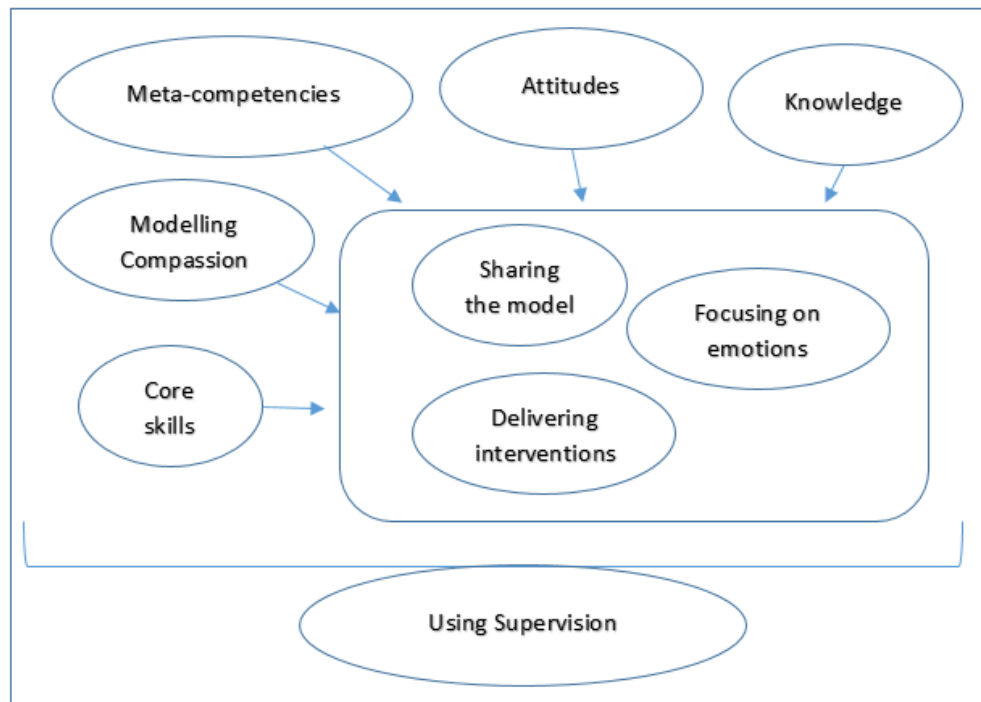
Initial Template Version 3.

Two further revisions of the template involved changes to the structure and clarification of sub-themes. Attention was drawn to 'what' and 'how' components of 'sharing the model' and 'delivering interventions'. Version five was discussed in supervision. Assumptions about the remit of the framework were re-considered. Data was re-organised leading to changes in the hierarchy of themes and re-naming. A further two versions resulted in an Initial Template (version seven) that sufficiently captured the data from the subset of transcripts.
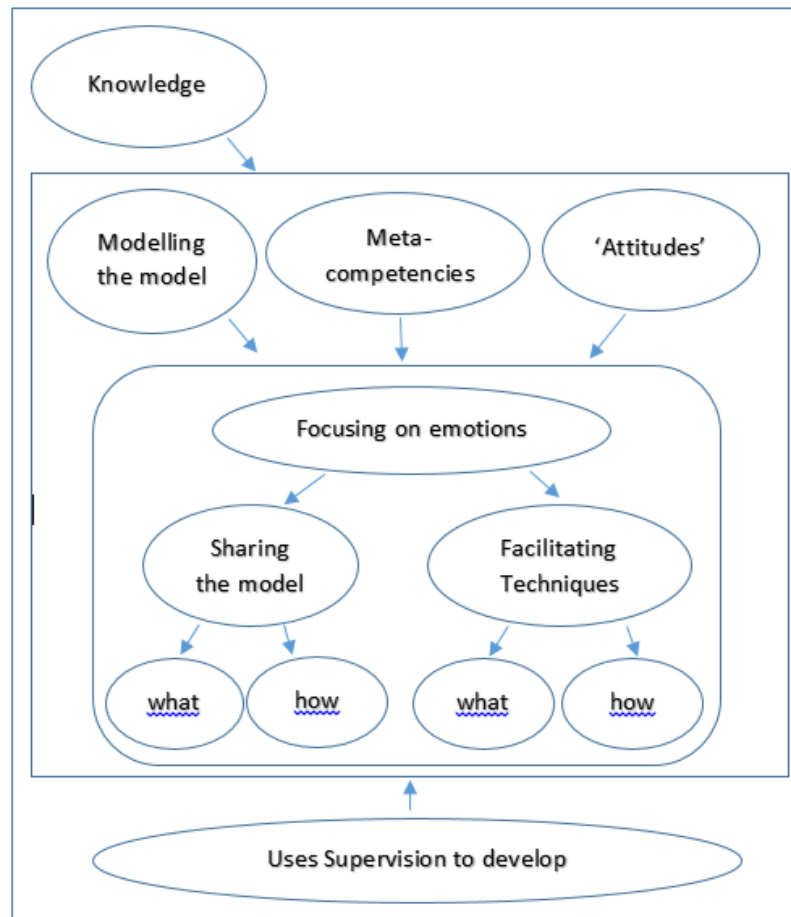
Initial Template Version five.

Application of the template

The remaining eight transcripts were coded on the basis of the initial template. Any remaining codes were collated, iteratively incorporated into the template and the template amended accordingly. The remaining data helped to clarify aspects of the subset that had not cohered well initially.

Final Template

The final template of main competencies is listed in Appendix N 'Round One'. All main and sub-competencies appear in the Round Two Survey (Appendix B).

Initial Template

Knowledge/ Understanding

- Difficulties/ disorders
- CFT

Creates Safeness

- Balances non-expert position with background knwoledge
- Balances being present with the client and hypothesizing
- Room set-up
- Core skill
- Modelling Compassion
  - Qualities
  - Common humanity philosophy
  - Appropriate use of power
  - Sensitivity to suffering
  - Willingness & commitment to alleviate suffering

Implementation Skills (Generic)

- Socratically explores and elicits client's lived experiences
- Socratically explores & elicits client's affective expereince
- Facitiliates the client to make links & learn to notice & track own affect

Implementation Skills Specific to Phase of Therapy

- Sharing the model
- Facilitating Techniques
- Putting the Compassion to work

Uses Supervision to:

- Develop skills
- Develop the compassionate self
- Reflect on difficulties in the therapy
- Reflect on issues of power in the therapeutic relationship

Generic Skills

- Assessment skills
- Group skills

Initial Template Version 7

Appendix N

Main Competencies at End of Each Round

Round One (following Template Analysis of Interviews (*N*=12), sent to round two participants)	**Round Two** (developed from percentage endorsement and comments from survey (*N*=14), sent to round three participants)	**Round Three** (refinements from revised percentage endorsement and comments from final survey (*N*=7), not reviewed by participants)
Creates Safeness • Room set-up • Maintains professional therapeutic boundaries • Core skills • Builds therapeutic alliance • Collaborative Engagement • De-shames – conveys a sense of common humanity 'we're all in the same boat' • De-shames – convey the 'not your fault message' • Modelling the Compassionate Self – therapist qualities • Modelling the Compassionate Self – personal motivation & commitment to the model (includes 'splits attention between client & therapist's affect & responses, notices & tracks own affect & response to the client)	Creates Safeness • Creates a safe environment • Maintains appropriate professional therapeutic boundaries • Core skills • Builds therapeutic alliance • Collaborative Engagement • De-shames – conveys a sense of common humanity 'we're all in the same boat' • De-shames – convey the 'not your fault message' • Modelling the Compassionate Self – Authentically demonstrates qualities conveying the compassionate self • Modelling the Compassionate Self – personal motivation & commitment to the model	Competencies in Creating Safeness • Provides a safe context • Maintains appropriate professional therapeutic boundaries • Core skills • Builds and maintains the therapeutic alliance • Fosters collaborative Engagement • De-shames – conveys a sense of common humanity 'we're all in the same boat' • De-shames – convey the 'not your fault message' • Modelling the Compassionate Self – Authentically demonstrates qualities conveying the compassionate self • Modelling the Compassionate Self – demonstrates a personal motivation & commitment to the model

	Meta-skills	Meta-skills
	• Works flexibly within the framework	• Works flexibly within the framework
	• Splits attention between client's & therapist's affect & responses • Aware of and reflects (in session) on what is happening in the therapist's own three circles and the impact this may have on therapeutic interactions	• Notices affects and responses as they arise in the client and therapist
Implementation Skills • Works flexibly within the framework • Focuses on affect • Facilitates experiential learning – coaching skills • Facilitates experiential learning – explores and elicits with the client	Non phase-specific Skills • Focuses on affect • Facilitates experiential learning by exploring and eliciting experiences and reflections with the client • *Distinguishes between shame-based self-criticism and compassionate self-correction*	Non phase-specific Skills • Focuses on affect • Facilitates experiential learning by exploring and eliciting experiences and reflections with the client • Distinguishes between shame-based self-criticism and compassionate self-correction
Skills linked to Phase of Therapy • Sharing the Model • Compassionate Mind Training • Putting the Compassion to work	Phase-specific skills • Accessibly introduces understanding of the model as it relates to the client • *CFT formulation with relational aspects* • Facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance • *Developing a compassionate identity* • Facilitates clients in using compassion to engage with difficulties and promote change	Phase-specific skills • Accessibly introduces understanding of the model as it relates to the client • Develops an individualised CFT formulation with the client • Facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance • Facilitates the client in cultivating a compassionate identity • Facilitates clients in using

	• *Follow up/ relapse prevention*	compassion to engage with difficulties and promote change • *Facilitates the use of compassion beyond therapy*
Knowledge/ Understanding • Difficulties/ disorders • Compassion Focused Therapy	Knowledge/ Understanding • Difficulties/ disorders • Compassion Focused Therapy	Knowledge/ Understanding • Difficulties/ problems specific to client group • Compassion Focused Therapy
Uses Supervision to: • Develop skills • Develop the compassionate self • Reflect on difficulties in the therapy process (process issues, transference & counter-transference)	Uses Supervision to: • Develop skills • Develop the compassionate self • Reflect on difficulties in the therapeutic relationship	Uses Supervision to: • Develop skills • Develop a personal understanding of the model as it relates to the therapist • Reflect on difficulties in the therapeutic relationship
Generic Skills • Assessment skills • Group skills		

Italics indicate substantial revision or introduction of new ideas

Appendix O

<u>List of all Main and Sub-Competencies</u>

Competencies in Creating Safeness
Provides an experience of a compassionate other in a safe way, through the therapeutic relationship.

Builds and maintains the therapeutic alliance
- Attuned to client
- Matches where the person's at
- Encourages reflections on the therapeutic relationship
- Repairs ruptures
- Present with client, whilst balancing hypothesizing

Maintains appropriate professional therapeutic boundaries

Fosters collaborative engagement (thinks with not for the client)
- Adapts therapy to the individual
- Appropriate use of power
- Gives clients choice & opportunities to make decisions
- Collaborative therapeutic goal-setting
- Non-expert position balanced with background knowledge

Demonstrates core skills
- Active listening skills
- Pacing
- Voice tone & pitch

Provides a safe context
- Discusses confidentiality and its limits
- Contracts with the client
- Collaborates on length of sessions
- Uses appropriate facilities to engage in therapy (within limits of what is available) i.e. private, quiet room with appropriate set-up, free from intrusions.
- Offers ways for clients to indicate distress
- Works with the client's care network (if appropriate)
- Ensures risk management plans are in place and shared with wider therapeutic team (if appropriate)
- Helps clients access other services if necessary by providing information / referrals (e.g. crisis services)
- Helps clients be aware of complaints procedures/policies
- Offers flexibility over choice of therapist (where possible)

Models the Compassionate Self
- o Authentically demonstrates qualities conveying the compassionate self
  - Key attributes of the compassionate mind (empathy, sympathy, care for wellbeing, kindness, distress tolerance, non-judgemental)
  - Warmth (moderated)
  - Strength & courage
  - Wisdom
  - Openness
  - Curiosity
  - Flexibility
  - Grounded
  - Lightness of touch (playful, creative, humour)
  - Confident
  - Honest & transparent
  - Assertive/ challenging if needed
  - Imperfect

- o Personal motivation & commitment to the model
  - Recognises & stays with therapist's own difficult/ avoided emotions/ 'Shadow' side
  - Regulates own affect in response to client and day to day life (in order to hold to compassionate intention)
  - Commitment to developing the compassionate self through actions and self-practice

De-shames
- o Conveys a sense of common humanity 'we're all in the same boat'
  - Normalises
  - Uses carefully considered personal examples
  - Inclusive language e.g. 'we', 'our tricky brains'
  - Engages in practice alongside clients & shares reflections
- o Conveys the 'not your fault' message
  - Conveys idea of different 'versions'
  - Uses de-pathologising language
  - Validates
  - Relates client experiences to the evolutionary model

Meta-skills

Works flexibly within the framework
- o Moves between phases in response to client need
- o Attempts to ground the client in the understanding/ first psychology of compassion before moving into CMT
- o Uses conceptual clarity to guide use of techniques
- o Appropriately times delivery of messages and techniques

Notices affects and responses as they arise in client and therapist
- o Links this to therapist's own three circles
- o Aware of the potential impact on therapeutic interactions

Non phase-specific skills

Focuses on affect
- o Slows down & gives space
- o Uses empathic bridging
- o Uses skills in mentalizing
- o Notices & tracks shifting affect
- o Recognises & stays with client's difficult/ avoided emotions
- o Maintains a manageable connection with strong affect

Facilitates experiential learning by exploring and eliciting experiences and reflections with the client
- o Uses Socratic dialogue
- o Uses inference chaining
- o Uses circular questions
- o Appropriate use of closed questions
- o Delivers clear, simple, understandable explanations
- o Checks out that the client understands
- o Sets up learning through behavioural experiments
- o Sets up homework/ practices
- o Checks in about homework/ practices

Distinguishes between shame-based self-criticism and compassionate self-correction
- o Recognises, identifies and addresses this with the client

Phase-specific skills

Accessibly introduces understanding of the model as it relates to the client
- Draws it out, side by side
- Integrates stories, examples & metaphors
- Pitches appropriately
- Uses didactic information-giving as appropriate
- Selects relevant part of model
- Provides appropriate materials (hand-outs)

Develops an individualised CFT formulation with the client
- Facilitates understanding of the three affect regulation systems (three circles model) in the 'here and now' with the client
- Facilitates understanding of an individualised longitudinal formulation of the client's difficulties
  - o Builds an understanding with the client of how their three affect regulation systems have developed over time
  - o Identifies with the client the relevant early life experiences, key fears, protective/ safety strategies and unintended consequences, and links between these.
  - o Helps the client to clarify between the internal and external in relation to fears and protective strategies

Facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance

- Appreciates full range
- Selects appropriate to purpose
- Encourages and supports practice
- Delivers in a natural/ fluid way (rather than from a script)
- Focuses on intention and motivation (not result)
- Rolls with resistance

Facilitates cultivation of a compassionate identity

- Attends to developing a compassionate motivation
- Sets up practising "small acts of compassion" on a daily basis
- Facilitates recording and reflecting on practices of giving and receiving compassion and self-compassion
- Encourages clients to practice between sessions
- Identifies when and what pace a compassionate identity can be accepted/ tolerated

Facilitates clients in using compassion to engage with difficulties and promote change

Implements therapeutic interventions as appropriate to the client, utilising the client's compassionate self – intervention-specific techniques are additional

Facilitates the use of compassion beyond therapy

(Includes continuing to use compassion in day to day life and using compassion to address clinical problems.)

- Reflects with the client on the impact of CMT in order to enhance motivation to continue compassion focused practice /work
- Shares a normalising understanding of relapse
  - o Emphasising "stages of change" model for recovery
  - o Not always predictable
  - o Can be considered within the 'flow of life'
- Identifies potential risk/ relapse triggers
- Facilitates the client in developing awareness of potential risk/ relapse triggers e.g. re-emergence of safety strategies
- Makes plans (specific or loose) regarding steps needed if difficulties are encountered in the future
  - o Identifies compassion based self correctional responses
  - o Identifies compassionate behavioural strategies
- Encourages balance between independent skill use and knowing when support might be needed- including support from services if necessary
- Gradually reducing therapeutic contact prior to discharge to facilitate the time for the client to experience, recognise and recover from lapses
- If the client is also working with other services: to share this model and management plan with them

<u>Knowledge/ Understanding of:</u>

Difficulties/ problems specific to the client group
- How they affect emotions
- How they affect therapy process
- How they relate to the model

CFT (theoretical and personal understanding of concepts in relation to the therapist)
- Common humanity philosophy
- Definition of compassion
- Fears and blocks to compassion
    - Blocks to the word
    - Obstacles to techniques
    - Emotional conditioning
    - Preconceptions of Buddhism/ meditation/ the contemplative tradition
- Difference between shame & guilt
- Difference between shame-based self-criticism and compassionate self-correction
- Emotional avoidance
- Evolutionary model – old brain, new brain functions
- Three circles model of emotion regulation
- CFT formulation
- CMT Techniques
- Imagery practices (theory and from experience of self-practice)
- CFT theoretical integration
- Theoretical underpinnings
    - Evolutionary neuropsychology
    - Social mentalities
    - Social rank theory
    - Social & relational processes
    - Evolved motives/ archetypes
    - Cognitive-behavioural
    - Attachment
    - Transference & counter-transference

<u>Uses supervision to:</u>

Develop skills
- Uses observation/ video feedback

Reflect on difficulties in the therapeutic relationship, including:
- Process issues, transference & counter-transference
- Interactions between therapist's and client's three circles and the impact this may have on therapeutic interactions
- Therapist's avoided affect/ 'shadow' side

Develop a personal understanding of the model as it applies to themselves
- Self-reflection in relation to the model
- Tolerating skill development (conscious competence growth)
- Develop compassionate self-correction during and after session
- Relate to clients' experiences of exercises

Appendix P

Data Excluded from Final Analysis

Competency rated in the survey	Participant ratings of necessity of competencies (percentage of participants per round)					
	Round Two (*N*=14)			Round Three (*N*=7)		
	Can be a helpful addition	Important but not essential	Essential to CFT	Can be a helpful addition	Important but not essential	Essential to CFT
Generic Skills						
Assessment Skills	7	14	76	0	14	86
Group skills	7	43	50	14	43	43

Phase-specific competencies and Therapy content

Main Phase-specific Competency	Phase of Therapy	Therapy Content suggested by participants
Accessibly introduces understanding of the model as it relates to the client	Sharing the Model	▪ Physiology of emotions ▪ Old brain, new brain ▪ Emotional conditioning ▪ Common humanity philosophy ▪ Definition of compassion ▪ Fears and blocks to compassion ▪ Evolutionary functional analysis ▪ Three circles model ▪ Difference between shame & guilt ▪ Role of shame & self-criticism ▪ Compassion as 'trainable' ▪ Rationale for using compassion to regulate emotions & engage with & alleviate difficulties
Develops an individualised CFT formulation with the client	Formulation	CFT threat-based formulation identifying early life experiences, key fears, protective strategies and unintended consequences, including internal and external relational aspects.
Facilitates client to use techniques to regulate affect by building up soothing system & bringing three systems into balance	Compassionate Mind Training (CMT)	▪ Attention training ▪ Noticing & tracking affect ▪ Short-term crisis management skills e.g. distraction ▪ Soothing rhythm breathing ▪ Safe place imagery ▪ Mindfulness ▪ Compassionate Self ▪ Compassionate Other
Facilitates cultivation of a compassionate identity	Building a compassionate identity	▪ Compassionate self role plays ▪ Acting techniques
Facilitates clients in using compassion to engage with difficulties & promote change	Putting the compassion to work	*Examples of therapeutic techniques/ interventions include:* ▪ Processing trauma & shame-based memories ▪ Graded exposure ▪ Behavioural activation ▪ Re-scripting ▪ Confronting/ facing fears in real world ▪ Practising receiving compassion outside of

		relationships ▪ Increasing drive system ▪ Action-based methods ▪ Activing techniques ▪ Compassionate letter writing ▪ Chair work ▪ Multi-self work ▪ Cognitive re-structuring
Facilitates the use of compassion beyond therapy	Compassion beyond therapy	▪ Continuing to use compassion in day to day life ▪ Relapse prevention – using compassion to address potential future re-emergence of clinical problems

Appendix R

<u>Statement of Epistemological Position</u>

The researcher adopted a 'critical realist' position as a pragmatic mid-point between positivism and constructivism. The critical realist approach acknowledges post-positivist critiques of positivism, the complexity of the world and multiple perspectives. It is concerned with mechanisms through which actions produce outcomes within a certain context.

Appendix S

Chronology of Research Process

Research Proposal submitted to peer review	September 2013
Submitted to University Ethics Committee	December 2013
Ethical Approval Granted	December 2013
Amendments to application for Ethical Approval submitted and granted	March 2014
Recruitment for 'expert' participants and scheduling of interviews	May – August 2014
Data Collection - Round One Interviews	June – August 2014
Qualitative Analysis of Round One	September – October 2014
Recruitment for 'practitioner' participants	September – October 2014
Data Collection - Round 2 Survey	October – December 2014
Analysis of Round Two data	December 2014
Data Collection - Round Three Survey	January – February 2015
Analysis of Round Three data	February 2015
Write-up	January – April 2015

Appendix T

Guidelines to authors for literature review

Target Journal: Clinical Psychology Review.

Excerpt from 'Guide for Authors' retrieved 17 April 2015 from
www.elsevier.com/journals/clinical-psychology-review/0272-7358/ guide-for-authors#4000

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.

Participant Consent Form (A)

BACKGROUND INFORMATION

Title: Therapist Competencies necessary for the delivery of Compassion Focused Therapy: A Delphi Study

Researchers: Our names are Alice Liddell and Dr Steve Allan from the University of Leicester, School of Psychology.

Purpose of data collection: Doctoral research

This research study is interested in exploring and clarifying expert opinion of therapist competencies necessary for the delivery of Compassion Focused Therapy (CFT) in order to develop a competency framework. The research aims to analyse this information systematically and provide an opportunity for experts and experienced practitioners to communicate and give feedback. It is hoped that the resulting competency framework will contribute towards greater clarity in future clinical research, supervision, training and evaluation of routine clinical practice.

Details of Participation:
The procedure has three rounds of involvement.

Round One
The first round will involve a one to one interview of up to one hour with the lead researcher. Interviews will be conducted in person at an appropriate non-NHS site convenient to the you, unless travelling distances are impractical. Where more appropriate, interviews will be conducted via video-conferencing facilities. Interviews conducted in person will be audio recorded. Interviews conducted through video-conferencing will initially include both audio and visual recordings, however only audio will be analysed. The researcher will use a semi-structured interview schedule to explore your opinion of therapist competencies necessary for the delivery of CFT. You will be contacted by email prior to the interview to confirm the arrangements and afterwards to thank you for your participation and confirm the next steps in the procedure.

Interviews will be transcribed and anonymised. We may use quotations as examples in the documentation sent to participants and in documents disseminated more widely. Quotations will not be personally identifiable. If you are not willing to consent to the use of verbatim quotations, please indicate this below. Collecting and analysing data from the interviews in round one may take up to six months. Therefore you may not be contacted for the second round for up to about six months.

Round Two
The second round will involve email contact. The researcher will send you the findings from the qualitative analysis of the interviews conducted in round one. This will be presented as a preliminary competency framework, which you will be invited to comment on or suggest amendments. You will also be sent a survey, asking you to rate your agreement with the each competency identified, on a scale of one to five. It is anticipated that this will take approximately 15-30 minutes to complete. The researcher will ask you to complete this and reply via email within two weeks. On receipt of completed surveys, the researcher will email you to thank you and advise you of the next stages in the procedure. If you have been unable to respond within this time, a polite reminder email will be sent asking for a response within one week. If you do not respond in this time, you will not be contacted to participate in

round three. You will still receive a summary of the preliminary findings at the end of the procedure, if requested.

The researcher will collate responses to the survey and start round three within approximately three weeks of round two ending.

Round Three
Round three will involve email contact similar to above. You will be emailed the preliminary competency framework with any amendments. You will also be sent the survey as before, this time with group level data collected from round two. This will be in the form of percentages of participants that endorsed each level of agreement e.g. for competency 'A' 10% said 5 - strongly agree; 57% said 4 – agree etc. You will also be sent your individual response to round two and asked to re-complete the survey, in light of the group level data. You can choose not to change your answers. It is anticipated that this will take 20-30 minutes to complete. Only you and the researcher will know your individual responses, but all participants in round three will see group data. You will be asked to send your response via email to the researcher within two weeks. On receipt of completed surveys, the researcher will email you to thank you for participating. If you have not responded in this time, a polite reminder email will be sent by the researcher, asking you to send your response within the next week. Responses will be collated by the researcher and a summary of the preliminary findings will be sent to you, if requested.

CONSENT STATEMENT

1. I understand that my participation is voluntary and that I may withdraw from the research at any time without giving any reason.

2. I am aware of what my participation will involve.

3. My data are to be held confidentially and only Alice Liddell and Dr Steve Allan will have access to them.

4. My data will be kept in a locked filing cabinet for a period of at least five years after the appearance of any associated publications. Any aggregate data (e.g. spreadsheets) will be kept in electronic form for up to one year, after which time they will be deleted.

5. In accordance with the requirements of some scientific journals and organisations, my coded data may be shared with other competent researchers. My coded data may also be used in other related studies. My name and other identifying details will not be shared with anyone.

6. The overall findings may be submitted for publication in a scientific journal, or presented at scientific conferences.

7. This study will take approximately 4 to 10 months to complete, this is dependent upon when my interview is and how long it takes for other interviews in round one to be completed. Contact for rounds two and three will be more frequent and occur over a 4 month period.

8. I will be able to obtain general information about the results of this research by consenting to participate, providing my email address and indicating this on the form below. This will be emailed to me by the researcher on completion of data collation from round three.

9. I am willing to provide an email address that you can use to contact me with for the purposes of the research as described above.

10. Anonymised verbatim quotations <u>may / may not*</u> be used as part of the procedure and dissemination. (*delete as appropriate)

I am giving my consent for data to be used for the outlined purposes of the present study.

All questions that I have about the research have been satisfactorily answered.

I agree to participate.

Participant's signature: _____

Participant's name (please print): _____

Date: _____

If you would like to receive a summary of the results when the study is complete

please provide your email address: _____

If you have further questions about this study, you may contact Alice Liddell, Trainee Clinical Psychologist, University of Leicester by telephone on 07583 381988 or email ael19@le.ac.uk. This study was reviewed by the University of Leicester Psychology Research Ethics Committee (PREC). You may contact the Chair of PREC Dr. Heather Flowe at hf49@le.ac.uk if you have any questions or concerns regarding the ethics of this project.

Please note that this form will be kept separately from your data

Participant Information sheet and Consent form – Rounds 2 and 3 only

Participant Consent Form (B)

BACKGROUND INFORMATION

Title: Therapist Competencies necessary for the delivery of Compassion Focused Therapy: A Delphi Study

Researchers: Our names are Alice Liddell and Dr Steve Allan from the University of Leicester, School of Psychology.

Purpose of data collection: doctoral research

This research study is interested in exploring and clarifying expert opinion of therapist competencies necessary for the delivery of Compassion Focused Therapy (CFT) to develop a competency framework. The research aims to analyse this information systematically and provide an opportunity for experts and experienced practitioners to communicate and give feedback. It is hoped that the resulting competency framework will contribute towards greater clarity in future clinical research, supervision, training and evaluation of routine clinical practice.

Details of Participation:
The procedure for the study overall has three rounds of involvement. Round one will involve the generation of a preliminary competency framework for CFT with another group of participants. You have been invited to participate in rounds two and three to provide your feedback on this.

Round Two
This will involve email contact. The researcher will send you the preliminary competency framework developed in round one, which you will be invited to comment on or suggest amendments. You will also be sent a survey, asking you to rate your agreement with the each competency identified, on a scale of one to five. It is anticipated that this will take approximately 15-30 minutes to complete. The researcher will ask you to complete this and reply via email within two weeks. On receipt of completed surveys, the researcher will email you to thank you and advise you of the next stages in the procedure. If you have been unable to respond within this time, a polite reminder email will be sent asking for a response within one week. If you do not respond in this time, you will not be contacted to participate in round three. You will still receive a summary of the preliminary findings at the end of the procedure, if requested.

The researcher will collate responses to the survey and start round three within three weeks of round two ending.

Round Three
Round three will involve email contact similar to above. You will be emailed the preliminary competency framework with any amendments. You will also be sent the survey as before, this time with group level data collected from round two. This will be in the form of percentages of participants that endorsed each level of agreement e.g. for competency 'A' 10% said 5 - strongly agree; 57% said 4 – agree etc. You will also be sent your individual response to round two and asked to re-complete the survey, in light of the group level data. You can choose not to change your answers. It is anticipated that this will take 20-30 minutes to complete. Only you and the researcher will know your individual responses, but all participants in round three will see group data. You will be asked to send your response via email to the researcher within two weeks. On receipt of completed surveys, the

researcher will email you to thank you for participating. If you have not responded in this time, a polite reminder email will be sent by the researcher, asking you to send your response within the next week. Responses will be collated by the researcher and a summary of the preliminary findings will be sent to you, if requested.

CONSENT STATEMENT

1. I understand that my participation is voluntary and that I may withdraw from the research at any time without giving any reason.

2. I am aware of what my participation will involve.

3. My data are to be held confidentially and only Alice Liddell and Dr Steve Allan will have access to them.

4. My data will be kept in a locked filing cabinet for a period of at least five years after the appearance of any associated publications. Any aggregate data (e.g. spreadsheets) will be kept in electronic form for up to one year, after which time they will be deleted.

5. In accordance with the requirements of some scientific journals and organisations, my coded data may be shared with other competent researchers. My coded data may also be used in other related studies. My name and other identifying details will not be shared with anyone.

6. The overall findings may be submitted for publication in a scientific journal, or presented at scientific conferences.

7. This study will take approximately 4 months to complete. There may be a wait of up to six months from hearing about the study to being contacted to participate, based on it taking up to six months for interviews to be conducted for round one.

8. I will be able to obtain general information about the results of this research by consenting to participate, providing my email address and indicating this on the form below. This will be emailed to me by the researcher on completion of data collation from round three.

9. I am willing to provide an email address that you can use to contact me with for the purposes of the research as described above.

10. Anonymised verbatim quotations may / may not* be used as part of the procedure and dissemination. (*delete as appropriate)

I am giving my consent for data to be used for the outlined purposes of the present study.

All questions that I have about the research have been satisfactorily answered.

I agree to participate.

Participant's signature: _____

Participant's name (please print): _____

Date: _____

If you would like to receive a summary of the results when the study is complete
please provide your email address: _____

If you have further questions about this study, you may contact Alice Liddell, Trainee Clinical
Psychologist, University of Leicester by telephone on 07583 381988 or email
ael19@le.ac.uk. This study was reviewed by the University of Leicester Psychology
Research Ethics Committee (PREC). You may contact the Chair of PREC Dr. Heather Flowe
at hf49@le.ac.uk if you have any questions or concerns regarding the ethics of this project.

Please note that this form will be kept separately from your data

Appendix W

Letters to and from Ethics

University of Leicester Ethics Review Sign Off Document

University of Leicester

To: ~~ALICE LIDDELL~~

Subject: Ethical Application Ref: ~~ref19-3844~~

(Please quote this ref on all correspondence)

05/12/2013 14:13:11

Psychology

Project Title: **Therapist Competencies necessary for the delivery of Compassion Focused Therapy: A Delphi Study**

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

- http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice

- http://www.le.ac.uk/safety/

Page 1 of 2

The following is a record of correspondence notes from your application ████████ Please ensure that any proviso notes have been adhered to:-

Nov 17 2013 2:46PM   With regards to ethical approval that may be needed from the NHS Research and Development department, ████████, has been consulted and it has been agreed that this research does not require NHS permission. This is because the participants being recruited are NOT being recruited through their roles within an NHS organisation or on the basis that they are NHS staff. Participants are being recruited through a charitable organisation - the Compassionate Mind Foundation - on the basis of their affiliation with this model. Although some participants may work in the NHS many will not be NHS staff. It was agreed that NHS permission was therefore not appropriate, hence the application to the University. This is currently being confirmed in writing with ████████ and evidence of this can be forwarded to the University Research Ethics Officer when available, in support of this application.

Nov 18 2013 3:56PM   Two consent forms have been submitted with this application. Consent Form A is intended for participants meeting the 'expert' sample criteria and outlines the procedure from rounds one to three accordingly. Consent Form B is intended for participants meeting the 'practitioner' sample criteria who would only be involved in rounds two and three, which is reflected in the content of the Information Sheet.

--- END OF NOTES ---

From:	Prados, Jose (Dr)
Sent:	17 March 2014 11:54
To:	Liddell, Alice E
Subject:	RE: Amendment request for ael19-7384*

Dear Alice

Thank you very much for your e-mail. The changes to the research protocol are clear and have been well described and justified and do not raise any ethical issues. I am happy to approve these changes to the protocol.

Regards,

Jose Prados

From: Liddell, Alice E
Sent: 14 March 2014 10:19
To: Prados, Jose (Dr)
Cc: Hatcher, Ruth M. (Dr.); Kocik, Joy; Allan, Steven (Dr.)
Subject: Amendment request for ael19-7384

Dear. Dr. Prados
I would be most grateful if you could review the minor amendments to my research, as described below.
I hope this provides all the information that you need, if you require any further information, please do not hesitate to contact me.

Kind regards
Alice Liddell

Reference number: ael19-7384a

Title: Therapist Competencies necessary for the delivery of Compassion Focused Therapy: A Delphi Study

Researchers: Alice E. Liddell; Dr. Steve Allan (supervisor)

Date of original approval: 5th December 2013

<u>Summary of Original Proposal</u>

Introduction
Compassion Focused Therapy (CFT) (Gilbert, 2010) is a relatively new therapy. It would be helpful to have greater clarification of the competencies thought to be important in CFT in order to further develop effectiveness and improve outcomes.

Research Questions
1. What are the therapist competencies necessary to deliver Compassion Focused Therapy?
2. How can these competencies be organised into a useful conceptual framework?

Method

1

The proposed project will use the Delphi method (Linstone & Turoff, 2002), to collate expert opinion and provide a method of anonymous communication between experts and practitioners. Participants will be recruited through the Compassionate Mind Foundation (CMF) which is the sole organisation for researching CFT in the UK. There will be three rounds.

Firstly, approximately 10-15 experts will be interviewed for an hour each, face to face or via video conferencing. The researcher will record, transcribe and analyse the content of the interview data using Template Analysis (King, 2007). This organises the data into themes, which will form the basis of the competency framework. Rounds two and three involve email communication with a wider range of participants who are asked to comment on and numerically rate agreement with the competency framework produced from round one.

References

Gilbert, P. (2010). *The Compassionate Mind: A new approach to life's challenges.* Constable & Robinson Limited.

King, N. (2007). *Template Analysis, The Technique.* Retrieved 8 September 2013 from http://hhs.hud.ac.uk/w2/research/template_analysis/technique/technique.htm

Linstone, H.A. & Turoff, M. (Eds.) (2002). *The Delphi method: Techniques and applications.* Retrieved 8 September 2013 from http://is.njit.edu/pubs/delphibook/delphibook.pdf

Summary of Proposed Changes

1. Interviews will <u>not</u> be conducted on NHS premises. Alternative appropriate locations may be considered however it is likely that a greater proportion of interviews will be conducted via video-conferencing technology.
2. Inclusion criteria for expert sample missing from original submission, should include:
   - "is involved in the development of CFT treatment protocols
   - is either a member of the CMF board or directly trained and supervised in the practice of CFT by a member of the CMF board
   - supervised, focused practice in CFT for a minimum of three years."
3. Estimated end date for the project to be changed to 30/09/15.
4. Additional possible participants have been identified outside of the UK. These are in Denmark, Iceland and France. Their participation would be via video conferencing and email.
5. Change to mobile number for main researcher (applicant Alice Liddell): 0758338198█
6. Changes to information and consent sheets to reflect the above (see attached).