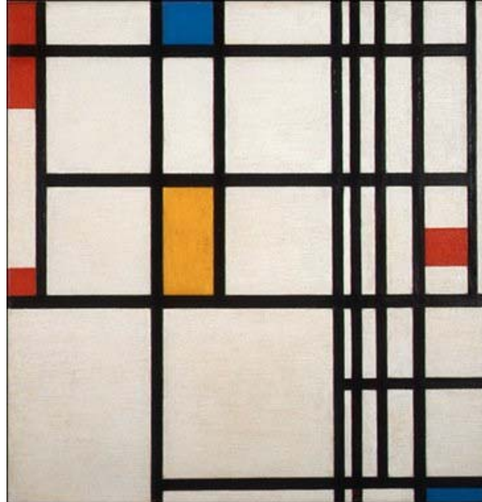

The competences required to deliver effective Humanistic Psychological Therapies

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The full listing of competences in humanistic psychological therapies described in this report is available online at www.ucl.ac.uk/CORE

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Short summary (reader box)
This document identifies the activities associated with the delivery of high-quality humanistic psychological therapies and the competences required to achieve these. It describes a model of the relevant competences, and discusses how this should be applied by practitioners, its advantages for clinicians, trainers and commissioners, and the uses to which it can be put.

Acknowledgements

This work described in this report was commissioned by Skills for Health.

The project team was headed by Anthony Roth and Stephen Pilling. Andrew Hill took the lead role in identifying source materials, extracting competences and producing drafts for discussion.

The work was overseen by Expert Reference Group (ERG)[1] whose invaluable advice and collegial approach contributed enormously to the development of the work. The ERG comprised Sally Aldridge, Angela Cotter, Catherine Clarke, Professor Mick Cooper, Professor Robert Elliot, Andrew Hill, Professor Germain Lietaer, Professor Vanja Orlans, Nancy Rowland and Janet Tolan.

Alison Brettle (University of Salford) contributed to the identification of source materials. Elizabeth Freire (University of Strathclyde) contributed specific advice on client-centred competences.

Additional comment was offered at several stages of the work by members of the HIPS/UKCP Skills for Health Working Group: Tricia Scott (Chair), Angela Cotter, Ken Evans, Barbara Monk-Steel, Vanja Orlans, Jocelyne Quennel and Heward Wilkinson.

We are also grateful to Professor Les Greenberg for his peer-review of the competences associated with Process-Experiential/ Emotion Focused Therapy.

[1] Appendix A shows the professional affiliations of members of the ERG

A note on terminology – Humanistic Psychological Therapies

The term "humanistic psychological therapies" has been chosen to encompass the wide range of approaches to counselling and psychotherapy that can belong to the humanistic tradition. As discussed in this report, the framework is intended to be inclusive of a breadth of approaches whose affiliations are 'humanistic'. This includes, for example, the Rogerian person-centred position, therapies which reflect, but are not necessarily grounded in this tradition (such as Process-Experiential/Emotion Focused, Existential, or Focusing-oriented therapies), as well as the integrative-humanistic position.

Who can apply the competence framework?

All the modality competence frameworks describe *what* a therapist might do; they do not identify *who* can implement them. The standards set by the framework can be met by therapists with a range of professional backgrounds, on the basis that they have received a training which equips them to carry out the therapy competently.

The issue of competence and of relevant training is the critical factor, rather than the title of the person offering the therapy. Some therapists will use the professional title of 'psychotherapist' while others will be denoted as 'counsellors'. The distinction in title reflects a mix of factors, such as the type and the length of training and the training institution offering the training. It needs to be emphasised that both counsellors and psychotherapists could offer the competences embodied in this framework, so long as they have had an appropriate level of training.

Relationship between the competence frameworks and the development of National Occupational Standards

The competence frameworks and National Occupational Standards are constituent parts of a programme overseen by the Department of Health. This has the objective of specifying occupational standards for the practice and training of psychological therapists, initially in four modalities (CBT, psychoanalytic/psychodynamic, systemic and humanistic).

The two pieces of work are closely linked, but are intended to have somewhat different applications, and are published independently.

How competence frameworks/NOS are developed

Competence frameworks: The competence frameworks for each modality are commissioned by Skills for Health (and, in the case of the supervision competence framework, also by Care Services Improvement Partnership and NHS Education for Scotland). For the purposes of the National Occupational Standards project these competences are referred to as Statements of Evidence. They are developed by a team at UCL, a process which is overseen by an Expert Reference Group constituted of researchers and trainers selected for their expertise in the relevant therapy modality. Competences are identified using an evidence-based methodology (described in detail in the documentation which accompanies each framework). These are clustered according to a 'map' of the activities through which therapists carry out the therapy. This process is subject to careful review from the Expert Reference Group. When completed, this work is published by the Department of Health, and made available through the UCL website (www.ucl.ac.uk/CORE/).

This work also constitutes the first phase of the Psychological Therapies National Occupational Standards development project undertaken by Skills for Health.

National Occupational Standards: Skills for Health convene a Modality Working Group to review and develop the UCL competence frameworks into National Occupational Standards for the psychological therapies. This group comprises senior clinicians with expertise in the relevant modality. These individuals are nominated by professional organisations with an interest in the standard of professional practice.

Consultants contracted by Skills for Health work with the Modality Working Group to translate the UCL competence framework into the formats used for National Occupational Standards and to ensure that the realities of day to day practice are taken account of in the standards. Expert readers are asked to review the drafts and they subsequently go to wider consultation and testing in practice. A National Reference Group, consisting of representatives from the professional organisations, is responsible for the quality of the draft standards that are submitted for accreditation as National Occupational Standards and publication on the Skills for Health website.

More information regarding this project can be found at:
www.skillsforhealth.org.uk/page/competences/competences-in-development/psychological-therapies

What are the similarities and differences between the competence frameworks and the NOS, and how can they each be used?

The competence frameworks are stand-alone, detailed representations of the competences needed to deliver and supervise the various modalities of therapy, and the ways in which these modalities can be applied in relation to specific psychological disorders, or how these modalities are adapted to form distinctive therapeutic interventions. They are already being used, for example, to develop training curricula and training materials, are being applied in research, and are being used as a basis for quality assuring courses.

The draft NOS are a broader description of the way in which each therapy modality is implemented. They focus on the generic, basic and specific competences identified in the competence framework. They do not provide the detail of disorder or problem specific practice found in the competence framework. Nevertheless they are also being used to review and refine training curricula. Instead of the finer detail, NOS have the benefit of being linked to the range of competence standards that Skills for Health have developed for interventions across the field of mental health care. National Occupational Standards are recognised across the UK and therefore support the transparency and transferability of qualifications. They are also mapped to the NHS Knowledge and Skills Framework. This enables them to be used as well in workforce planning and service specification, where they help to identify the standards expected of workers at each level of a multi-disciplinary team, from the generic skills required by all workers through to the more specialised skills needed by workers who are specialising in the delivery of psychological therapies. They are also used to develop job descriptions that in turn can build a career framework; this work is being undertaken through the New Ways of Working for Psychological Therapies programme of work. Lastly, they will provide one of the inputs to the content of the Standards of Proficiency which are being developed by the Health Professions Council for the regulation of Psychotherapists and Counsellors.

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The competences required to deliver effective Humanistic Psychological Therapies

Executive summary

The report begins by briefly describing the background to the work on competences for psychological therapies.

It then outlines an evidence-based method for identifying competences, and presents a competence model for humanistic psychological therapies. This organises the competences into five domains:

1. **Generic competences** - used in all psychological therapies
2. **Basic competences for humanistic psychological therapies**
3. **Specific humanistic psychological therapies competences** – "technical" interventions employed by some (though not all) forms of humanistic psychological therapies
4. **Specific adaptations of humanistic psychological therapies** – adaptations of humanistic interventions into discrete evidence-based approaches
5. **Metacompetences** – overarching, higher-order competences which practitioners need to use to guide the implementation of humanistic psychological therapies

The report then describes and comments on the type of competences found in each domain, before presenting a 'map' which shows how all the competences fit together and inter-relate.

Finally the report comments on issues which are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

How to use this report

This report describes the model of competences for humanistic psychological therapies and (based broadly on empirical evidence of efficacy) indicates the various areas of activity that, taken together, represent good clinical practice. This report does not include the detailed descriptions of the competences associated with each of these activities: these can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE). They are available as pdf files, accessed directly or by navigating the map of competences (as represented by Figure 2 in this report).

Background

The Improving Access to Psychological Therapies (IAPT) programme, which was launched in May 2007, provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies[2]. The IAPT programme has focused to date on delivering CBT for adults with common mental health problems because CBT has the most substantial evidence base supporting its effectiveness in the treatment of depression and anxiety in particular (e.g. NICE, 2004a, 2004b, 2005a, 2005b). Consequently, the first wave of work was concerned to identify the competences needed to deliver good quality CBT. The CBT competence model was specifically developed to be a “prototype” for developing the competences associated with other psychological therapies. The work reported here is based on this model.

National Occupational Standards (NOS): The work undertaken in this report also needs to be seen in the context of the development of National Occupational Standards (NOS), which apply to all staff working in health and social care. There are a number of NOS which describe standards relevant to mental health workers, downloadable at the Skills for Health website (www.skillsforhealth.org.uk), and the work described in this report will be used to inform the development of standards for humanistic psychological therapies.

How the competences were identified

Oversight and peer-review: The work described in this project was overseen by an Expert Reference Group (ERG). Members of the group were identified on the basis of their expertise in humanistic therapies – for example, their involvement in the development of humanistic treatments, the evaluation of humanistic psychological therapy in formal trials, and the development and delivery of supervision and training models in humanistic psychological therapy. Membership of professional organisations

[2] When the work is complete there will be competence frameworks for CBT, psychoanalytic/psychodynamic, systemic and humanistic therapies, along with a description of the competences required for supervision of these therapies.

was secondary to these considerations, since the frameworks aim to set out clinical practice rather than to describe professional affiliation. Nonetheless, the composition of the ERG ensured the representation of the United Kingdom Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP) and the British Association for the Person Centred Approach (BAPCA).

The ERG ensured that the trials, manuals and basic texts most relevant to the modality were identified and that the process of extracting competences was appropriate and systematic. Additional peer review was provided by the researchers and clinicians who had developed the therapies contained in the framework. All this was designed to assure the fidelity of the framework in relation to the therapy it claimed to represent. Overall, this process of open peer-review ensured that the competence lists were subject to a very high level of scrutiny.

Identifying competences by looking at evidence of what works[3]: The approach taken across the suite of competence frameworks is to start by identifying clinical approaches with the strongest claims for evidence of efficacy, based on the outcome in clinical controlled trials. Almost invariably the therapy delivered in these trials is based on a manual which describes the treatment model and associated treatment techniques. Treatment manuals are developed by research teams to improve the internal validity of research studies: they explicate the technical principles, strategies and techniques of particular models of therapy. In this sense the manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Because research trials monitor therapist performance (usually by inspecting audio or video recordings) we know that therapists adhered to the manual. This makes it possible to be reasonably confident that if the procedures set out in the manual are followed there should be better outcomes for clients.

Once the decision is taken to focus on the evidence base of clinical trials and their associated manuals, the procedure for identifying competences falls out logically. The first step is to review the outcome literature, which identifies effective therapeutic approaches. Secondly, the manuals associated with these successful approaches are identified. Finally the manuals are examined in order to extract and to collate therapist

[3] An alternative strategy for identifying competences could be to examine what therapists actually do when they carry out a particular therapy, complementing observation with some form of commentary from the therapists in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological therapies set out a theoretical framework which purports to explain human distress, and this framework usually links to a specific set of therapist actions aimed at alleviating the client's problems. In practice these 'pure' forms of therapy are often modified as therapists exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which does not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice.

competences[4]. A major advantage of using the manuals to extract competences is that by using the evidence base to narrow the focus it sets clear limits on debates about what competences should or should not be included.

While the foregoing sets out the basic methodological 'template' we have tried to follow, it is worth making some observations relevant to work in this modality.

Humanistic psychological therapies and the evidence-base

The method we have adopted presupposes that the nature of "evidence" is something over which there is wide agreement. However, some practitioners have expressed fundamental concerns about the quantitative empirical methods conventionally used to assess the efficacy of psychological therapies. Although these concerns take many forms, there are at least two significant objections to the approach we have taken:

> a) The evidence-base places an inappropriate focus on specific techniques of therapy, to the neglect of 'relationship' factors (such as the interpersonal contribution made by the therapist and the client) and the importance of the therapeutic alliance.
>
> b) The standard of evidence we have adopted is almost invariably the randomised controlled trial, or (more rarely) a controlled trial, consonant with current NICE standards of evidence. The concern is that this inappropriately narrows the evidence on which we can draw, partly because trials such as this may be hard to conduct (for example, research funding may not be forthcoming). More fundamentally however, there is a view that such trials need to be supplemented by qualitative approaches, or trials which are more process-oriented, and that both these methods can validate the efficacy of an approach as conclusively as the RCT.

It is important to acknowledge these points, and to note that in the early stages of this work they were debated actively within the Expert Reference Group. Out of this emerged a consensus that applying different standards of evidence in relation to different modalities of therapy would be unhelpful. A particular risk is that this could lead to a perception that the humanistic framework was based on less rigorous standards than applied to the other frameworks.

Having agreed to maintain the broadly quantitative empirical standards described above, the ERG recognised the need to ensure that all available evidence was taken into account. The group therefore drew on three sources of evidence:

> a) The Cochrane review of counselling conducted by Bower and Rowland (2006)
>
> b) A database of humanistic psychological therapy trials collated by Robert Elliott and colleagues at Strathclyde University. This comprehensive and continuously

[4] A detailed account of the methodology and procedures used in this project can be found in Roth and Pilling (2008). Although this paper focuses on the development of the CBT framework the methodological issues it raises are relevant to the present framework).

updated database maintains a record of all humanistic trials, and is not restricted to RCTs.

c) A search of databases held by CORE (originally as part of NICE guideline development), identifying any additional humanistic trials not identified by the foregoing sources of information

In order to decide which of the trials in these databases met appropriate criteria for robustness the databases were reviewed by a subgroup of the ERG (Tony Roth, Stephen Pilling and Robert Elliott) and a "longlist" of trials presented to the full ERG. Discussion within the full ERG resulted in a final list of trials which met, or came close to meeting, NICE standards of evidence.

In relation to the criteria we applied, it seems that the evidence base for the efficacy of humanistic psychological therapies is not especially extensive, though there are indications that the volume of research in this area is increasing. Although there is some support for the benefits of humanistic approaches in general, there is only one specific approach for which there is substantive evidence of efficacy: Process-Experiential /Emotion-Focused Therapy. This should not be taken to indicate that other specific humanistic approaches are ineffective, since this conclusion may reflect the absence of current evidence rather than evidence of non-effectiveness.

Selection of manuals

A narrow interpretation of the evidence base would have restricted us exclusively to manuals for Process Experiential/Emotion Focused Therapy. This would have had the unfortunate effect of skewing the framework towards a single model, and one which may not be representative of practice in this modality (as noted above).

A second (and major) constraint is that, we were able to identify few therapy manuals from which to work (the exceptions being manuals developed for Process-Experiential/Emotion-Focused Therapy and a manual used in the counselling study undertaken by King et al. (2002), However, descriptions of humanistic therapy are available in textbooks which combine statements of theory with indications of specific practice. The ERG identified a series of core texts which were considered to be representative of person-centred and humanistic practice, in that many training programmes in the field make use of them (listed in Appendix B).

The competences which emerged were therefore based on an amalgamation of these overlapping texts, along with manuals for Process-Experiential/Emotion-Focused Therapy.

Scope of the work

Representation of different approaches within the field of humanistic therapies

All modalities of therapy contain within them specific models of practice. Though these can differ in matters of theory and emphasis, most can be contained fairly comfortably

under a single modality title because practitioners are able to agree on a common ‘core’ of philosophy and practice. In the case of the humanistic framework locating this common ‘core’ has been more challenging, since there are significant variations in the basic assumptions of the different ‘schools’ usually subsumed under the heading of humanistic psychological therapies.

Perhaps one core theme is that humanistic therapists eschew intellectual solutions in favour of interventions which reinforce and validate spontaneous and immediate experience, actions which are seen as facilitating the integrity of the self and a sense of personal authenticity. The assumption is that emotional problems arise when circumstances prevent an individual from fulfilling his or her potential and force the individual to inhibit essential aspects of his or her personality. Humanistic approaches do encourage self-awareness, including awareness of experience itself, of emotional reactions and the experience of interactions with others. Traditionally at least, the therapist's role is one of a facilitating participant, who will aid clients in extending their awareness of their subjective world. Insight and symptomatic improvement are not seen as the immediate goals for therapy; instead, clients are offered support in their natural striving toward self-determination, personal meaning, and self-awareness.

Because of its non-mechanistic philosophy, humanistic approaches tend to place less emphasis on “technique” compared to therapies in other modalities. Rather the key elements that are assumed to facilitate change are therapist qualities such as a capacity for sustained empathic enquiry, openness, receptiveness, and the maintenance of a fundamentally accepting attitude towards the client.

Despite some shared assumptions, significant variations in the philosophy - and hence the practice - of humanistic therapies have been evident from the outset. For example, the ‘person-centred’ approach, originated by Carl Rogers in the 1940s, emphasises the human capacity for self-direction and development (embodied in the notion of the “actualising tendency”). As a consequence its methods are sometimes characterised as ‘non-directive’ because the role of the therapist is to support this process, rather than directing the client. This is not a passive process (since it involves active listening and empathic responding), but from this perspective practitioners eschew more active therapeutic interventions (as well as activities, such as assessment and formulation) because they risk imposing the therapist’s assumptions and values. Other traditions have taken a rather different position; for example the Gestalt school originated by Fritz Perls is characterised by a range of active methods for the exploration of feelings which involve quite decisive interventions on the part of the therapist. Other examples of specific humanistic models could be adduced to illustrate the basic point - an important dimension of difference within this modality is the extent to which therapist directedness is construed as a legitimate part of therapy technique. These differences are a direct consequence of the model of the mind that characterises each specific approach. For example, the model of emotions underpinning Process-Experiential/Emotion Focused Therapy creates the context for a central therapeutic aim - to help clients to access and to give meaning to feeling states of which they were previously unaware or which they find it difficult to give voice to. This requires the therapist to identify areas where emotional expression might be inhibited and

to help clients to reappraise and if necessary change the meanings they give their emotions. These are active therapeutic interventions, and ones which imply that there may be disadvantages to over-reliance on the client's spontaneous capacity to recognise and to explore feeling states. Clearly a client-centred therapist may take a different view; but acknowledging that such differences exist is critical, and has led to considerable debate among the Expert Reference Group as to the best way to accommodate potentially disparate viewpoints.

Over and above the issue of therapist directedness, it is important to recognise the emergence of a particular "integrative-humanistic" tradition in the UK and Europe. This maintains a humanistic stance but includes concepts from the different humanistic suborientations, and integrates within it concepts of unconscious process,- specifically, the role of unconscious communication in the therapeutic encounter. This tradition emphasises the process of therapy as much as its content, using notions of counter-transference to help the therapist focus on what is unspoken (but nonetheless felt) within the therapeutic relationship. However, in distinction to analytic technique, the therapist does not interpret or actively seek to foster transference in the therapeutic relationship (indeed transferences are understood to be ubiquitous and part of the intersubjective field in all relationships, as well as in the therapeutic encounter). Rather, the therapist comments on their experience (for example, drawing attention to their experience of being with the client) and intend their observations to be an invitation for further joint exploration.

This brief sketch of difference between humanistic models is illustrative rather than comprehensive – it leaves out a large number of approaches and traditions, However, it is intended to make an important point: the diversity of approach within this field is such that any humanistic competence framework will contain within it elements that therapists of different persuasions may not see as part of their routine practice. This makes it critical that readers understand the structure of the framework, and in particular the fact that while 'basic' competences are (broadly speaking) shared across all variants of humanistic therapy, there is no expectation that all practitioners will make use of the full range of 'specific' competences. Indeed, it is within this domain that major differences of practice are accommodated.

The competence model for Humanistic Psychological Therapies

Organising the competence lists

Competence lists need to be of practical use. The danger is that they either provide too much structure and hence risk being too rigid or they are too vague to be of use. The aim

has been to develop competence lists structured in a way which reflects the practice they describe, set out in a framework that is both understandable (in other words, is easily grasped) and valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into five domains: the components are as follows:

Generic competences

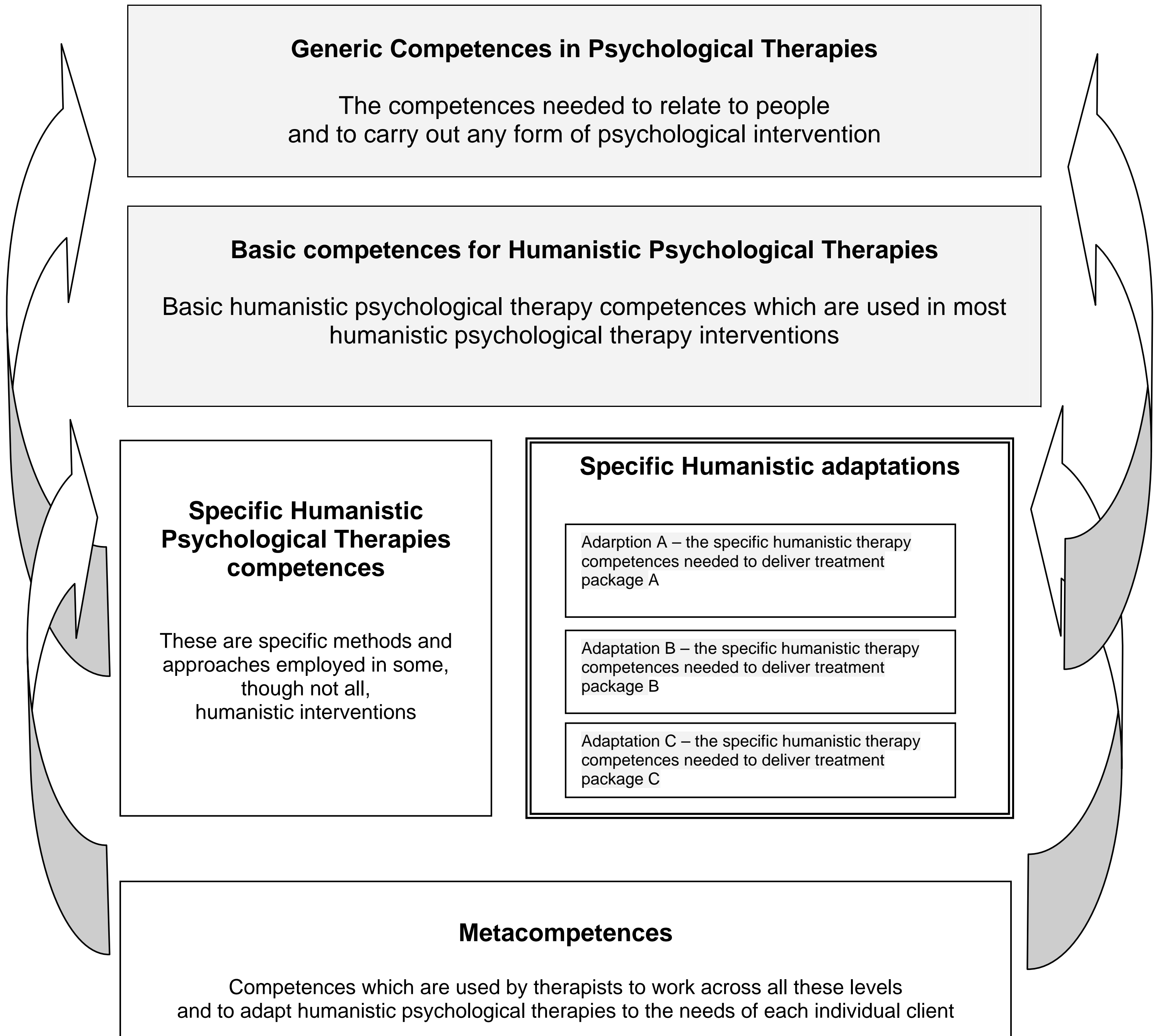
Generic competences are those employed in any psychological therapy, reflecting the fact that all psychological therapies, including humanistic therapy, share some common features. For example, therapists using any accepted theoretical model would be expected to demonstrate an ability to build a trusting relationship with their clients, relating to them in a manner which is warm, encouraging and accepting. Without building a good therapist-client relationship technical interventions are unlikely to succeed. Often referred to as ‘common factors’ in therapy, it is important that the competences in this domain are not overlooked or treated as an afterthought.

Basic competences for humanistic psychological therapies

Basic competences establish the underpinning structure for humanistic therapies interventions, and form the context for the implementation of a range of more specific humanistic approaches and methods. Although (as noted above) there are distinct variations in practice across the field of humanistic therapies, the basic competences set out a range of activities that almost all humanistically-oriented therapists should be able to acknowledge as fundamental to their practice. Humanistic approaches privilege a focus on the therapeutic relationship, based on the proposition that this relationship is the primary vehicle for change. While there may be differences of view about how this is taken forward, this is a common feature of this modality. As a consequence it makes sense for competences in this domain to detail the activities which contribute to the cycle of developing, maintaining and concluding the therapeutic relationship.

Figure 1

Outline model for competences in Humanistic Psychological Therapies



Distinguishing "Basic competences for humanistic psychological therapies" from "Specific humanistic psychological therapies competences"

As should be clear from the foregoing discussion, the framework needs to accommodate traditions that are somewhat distinct in their approach to clinical work. This is reflected in the structure of the framework. While the competences listed in the basic domain are assumed to be ubiquitous, it is also assumed that practitioners will select only those techniques from the specific competences domain that mirror their orientation. This is a critical point; the framework assumes that some specific interventions will be inimical to some, while being privileged by others.

Specific humanistic psychological therapies competences

These are the specific approaches and methods employed by the various suborientations of humanistic therapies.

Specific adaptations of humanistic psychological therapies

In common with the frameworks for other modalities, this domain is restricted to specific adaptations for which there is evidence of benefit. At present only one approach (Process-Experiential /Emotion-Focused Therapy) has an evidence-base of a kind which justifies inclusion in this domain. Over time this may change, since other adaptations can be included if and when evidence of their efficacy becomes available. The absence of other approaches should not be taken to imply that Process-Experiential/Emotion-Focused Therapy is the only approach to humanistic therapy which should be practiced.

Metacompetences

A common observation is that carrying out a skilled task requires the person to be aware of why and when to do something (and just as important, when not to do it!). This is a critical skill which needs to be recognised in any competence model. Reducing psychological therapy to a series of rote operations would make little sense, because competent practitioners need to be able to implement higher-order links between theory and practice in order to plan and where necessary to adapt therapy to the needs of individual clients. These are referred to as metacompetences in this framework: the procedures used by therapists to guide practice, and operate across all levels of the model. These competences are more abstract than those in other domains because they usually reflect the intentions of the therapist. These can be difficult to observe directly but can be inferred from therapists' actions, and may form an important part of discussions in supervision.

Specifying the competences needed to deliver Humanistic Psychological Therapies

Integrating knowledge, skills and attitudes

A competent clinician brings together knowledge, skills and attitudes. It is this combination which defines competence; without the ability to integrate these areas practice is likely to be poor.

Clinicians need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about *how* to implement their skills, but also *why* they are implementing them.

Beyond knowledge and skills, the therapist's attitude and stance to therapy is also critical – not just their attitude to the relationship with the client, but also to the organisation in which therapy is offered, and the many cultural contexts within which the organisation is located (which includes a professional and ethical context, as well as a societal one). All of these need to be held in mind by the therapist, since all have bearing on the capacity to deliver a therapy that is ethical, conforms to professional standards, and which is appropriately adapted to the client's needs and cultural contexts.

The map of competences in Humanistic Psychological Therapies

Using the map

The map of competences in humanistic psychological therapies is shown in Figure 2. It organises the competences into the five domains outlined above and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of more detailed competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

The map shows the ways in which the activities fit together and need to be 'assembled' in order for practice to be proficient. A commentary on these competences follows.

Figure 2
The map of competences in humanistic psychological therapies

Ability to offer a therapeutic relationship that facilitates experiential exploration within a relational context

Generic therapeutic competences

- Knowledge and understanding of mental health problems
- Knowledge of, and ability to operate within, professional and ethical guidelines
- Knowledge of a model of therapy, and the ability to understand and employ the model in practice
- Ability to engage client
- Ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'
- Ability to work with the emotional content of sessions
- Ability to manage endings
- Ability to undertake generic assessment (relevant history and identifying suitability for intervention)
- Ability to make use of supervision

Basic humanistic psychological therapy competences

- Knowledge of the basic assumptions and principles of humanistic psychological therapies
- Ability to initiate therapeutic relationships
  - Ability to explain and demonstrate the rationale for humanistic approach es to therapy
  - Ability to work with the client to establish a therapeutic aim
- Ability to maintain and develop therapeutic relationships
  - Ability to experience and communicate empathy
  - Ability to experience and to communicate a fundamentally accepting attitude to clients
  - Ability to maintain authenticity in the therapeutic relationship
- Ability to conclude the therapeutic relationship

Specific humanistic psychological therapy competences

- Approaches to work with emotions and emotional meaning
  - Ability to help clients access and express emotions
  - Ability to help clients articulate emotions
  - Ability to help clients reflect on and develop emotional meanings
- Ability to help clients make sense of experiences that are confusing and distressing
- Ability to make use of methods that encourage active expression
- Approaches to working relationally
  - Ability to maintain a client-centred stance
  - Ability to work with the immediate therapeutic relationship

Specific humanistic adaptations

- Process Experiential / Emotion Focused Therapy

Metacompetences

- Generic metacompetences
  - Capacity to use clinical judgment when implementing treatment models
  - Capacity to adapt interventions in response to client feedback
- Humanistic metacompetences
  - Metacompetences specific to humanistic psychological therapies

Generic therapeutic competences

Knowledge: Knowledge of mental health problems, of professional and ethical guidelines and of the model of therapy being employed forms a basic underpinning to any intervention, not just to humanistic psychological therapies. Being able to draw on and apply this knowledge is critical to the delivery of effective therapy.

The ability to operate within professional and ethical guidelines encompasses a large set of competences, many of which have already been identified and published elsewhere (for example, profession-specific standards, or national standards (such as the Shared Capabilities (Hope, 2004)) and the suites of National Occupational Standards relevant to mental health (available on the Skills for Health website (www.skillsforhealth.org.uk)). Embedded in these frameworks is the notion of "cultural competence", or the ability to work with individuals from a diverse range of backgrounds, a skill which is important to highlight because it can directly influence the perceived relevance (and hence the likely efficacy) of an intervention.

Building a therapeutic alliance: The next set of competences is concerned with the capacity to build and to maintain a therapeutic relationship. Successfully engaging the client and building a positive therapeutic alliance is associated with better outcomes across all therapies. Just as important is the capacity to manage the end of treatment; which can be difficult for clients and for therapists. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the 'management' of the therapeutic relationship.

Assessment: The ability to make a generic assessment is crucial if the therapist is to begin understanding the difficulties which concern the client. A generic assessment is intended to gain an overview of the client's history, their perspectives, their needs and their resources, their motivation for a psychological intervention and (based on the foregoing) a discussion of treatment options.

Assessment also includes an appraisal of any risk to the client or to others. This can be a challenging task, especially if the person undertaking the assessment is a junior or relatively inexperienced member of staff. Bearing this in mind, the ability for workers to know the limits of their competence and when to make use of support and supervision, will be crucial.

Supervision: Making use of supervision is a generic skill which is pertinent to all practitioners at all levels of seniority, because clinical work is demanding and usually requires complex decision making. Supervision allows practitioners to keep their work on track, and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

Basic competences for Humanistic Psychological Therapies

This domain contains a range of activities that are basic in the sense of being fundamental areas of skill and knowledge; they represent practices that underpin any humanistic psychological therapy intervention.

Knowledge of the basic assumptions and principles of humanistic psychological therapies falls into three areas: knowledge of humanistic philosophy and principles that inform this therapeutic approach; knowledge of humanistic theories of human growth and the origins of psychological distress; and knowledge of humanistic conditions for, and goals of, therapeutic change.

Two areas of activity constitute the **ability to initiate therapeutic relationships. The ability to explain and demonstrate the rationale for humanistic therapies** to the client involves offering the client a description of the humanistic approach being undertaken, the therapist's stance and particularly their belief in the client's capacity to make use of their own inner resources in order to achieve growth and to resolve problems. This is more than passing on information in an intellectual manner, since it takes place in the context of establishing the collaborative context of the therapeutic relationship. **The ability to work with the client to establish a therapeutic aim** involves working with the client to identify a therapeutic focus which is meaningful to them and which also identifies any goals which they wish to achieve. Therapists need to be able to renegotiate both areas as therapy progresses, and to balance the process of working towards goals with the maintenance of the therapeutic relationship.

Maintaining and developing therapeutic relationships involves three areas of activity. The **ability to experience and communicate empathy** rests on the therapist's capacity to be open to, and absorbed in, the client's frame of reference. This is a holistic activity which requires sensitivity both to what the client expresses explicitly and to what they convey implicitly by way of nonverbal and paralinguistic cues. Communicating an understanding of the client's experience is a part of this process, as is the capacity to create the conditions for the client to confirm – or indeed disconfirm – the accuracy of the therapist's perceptions and observations. **Experiencing and communicating a fundamentally accepting attitude to clients** is a matter of conveying a consistent attitude of respect for and unconditional valuing of the client, no matter that their behaviour, attitudes or beliefs may be at variance with the values held by the therapist. Various terms have been used to describe this attitude, such as unconditional positive regard, non-possessive warmth, prizing, respecting, affirming, and valuing the client's humanity. All these terms reflect an assumption that the attitude of the therapist can have significant therapeutic effects, such as helping the client feel secure enough to self-disclose, promoting higher levels of self-esteem, increasing autonomy, independence and assertiveness. It also needs to be recognised that these terms describe a potentially complex area and are not simply synonyms for therapists "liking" their clients. For example clients who have experienced rejection in significant relationships may at times induce negative and rejecting feelings in the therapist. Where this is the case it is important that such feelings are experienced and reflected upon, rather than acted on, and

do not undermine the therapist’s overall attitude of valuing the client and wishing to promote their wellbeing.

Maintaining authenticity in the therapeutic relationship refers to a capacity to maintain a spontaneous presence for the client that is not masked by a professional persona, aiming to be present “in the moment” so as to be able to respond to what is occurring in the client “in the moment”. The therapist is able to work in a non-defensive and (where appropriate) self-disclosing manner, using their own feelings and reactions to convey their experience of the client. Self disclosure requires some clinical judgment: since the primary purpose is to facilitate the client’s progress, the therapist needs to be sure that disclosure is congruent with this aim.

As important as building the therapeutic relationship is the **ability to conclude** it in a collaborative manner that helps the client to review their progress, and identify their capacity to manage issues which emerge in the future. While it is to be hoped that ending can be a positive process, most therapies are not open-ended and it can be part of the therapist’s role to initiate endings at points where the client may be uncertain or indeed unhappy about terminating therapeutic contact. This places some emphasis on the therapist’s ability to ensure that this phase of therapy is, in its own way, an opportunity for learning rather one which the client experiences as negative.

Specific Humanistic Psychological Therapies competences

This domain sets out specific interventions employed by humanistic therapists, but it is critical to bear in mind that it is here that very different approaches to work in this modality are contained. There is no expectation that all practitioners would subscribe (or indeed would be required to subscribe) to all the techniques described here. In this narrow sense this means that competences in this domain are elective.

The first section of the map describes **approaches to work with emotions and with emotional meanings,** under which header are a sequence of activities. The **ability to help clients access and express emotions** involves helping clients to begin focusing on and identifying emotions which they may be finding difficult to experience or to manage. A feature of this work is the ability to help clients to achieve an optimal level of contact with their feelings; little meaningful work can occur if there is only minimal contact, but equally it is important to ensure that clients are not overwhelmed by emotions. It cannot be assumed that clients can find a ‘language’ with which to discuss feelings, and the **ability to help clients articulate emotions** is sometimes a critical skill – for example, working with the client to elaborate the language they use to describe feelings, or suggesting appropriate imagery or metaphors. The **ability to help clients reflect on and develop emotional meanings** follows from this process of elaboration, since it involves the client exploring and evaluating the implications of emotional meanings that emerge.
The **ability to help clients make sense of experiences that are confusing and distressing** refers to a specific but fairly common experience in therapy, whereby clients

find themselves puzzled by their reactions to events. An ability to help clients explore further is important, because their experience of something being problematic can signal meaningful, and hence therapeutically significant, issues. Exploration does not simply mean taking the client back through the event, since there is also a focus on helping them to identify links between their reactions and their construal of the situation.

Where clients show clear difficulty in expressing and resolving conflicting feelings or unfinished business with significant others, therapists may **make use of methods that encourage active expression**. The introduction of these methods into therapy is cued by a 'marker' of an issue (for example, conflict between opposing wishes, or clear difficulty in allowing self-expression). The therapist then facilitates and structures a 'conversation' between differing aspects of the person, the aim of which is to help the client identify and work towards resolution of the issue causing distress. Many therapists will recognise these methods as core to gestalt approaches; they are also a major feature of Process-Experiential/Emotion-Focused Therapy.

Under the header of **approaches to working relationally** are two distinct – and distinctively different – stances on clinical work. The first refers to the **ability to maintain a client-centred stance.** This is underpinned by the notion of the actualising tendency, a concept which points to the essentially self-directed nature of human growth. It follows that the aim of the therapist's interventions would primarily be on the promotion of growth through a rigorous focus on the issues and perspectives brought by the client. It also implies that the therapist should take care not to introduce or to impose their own 'agenda' into the work.

An ability to work with the immediate therapeutic relationship rests on the philosophy associated with the integrative-humanistic approach. Although recognisably humanistic in orientation, this draws both on developmental theory (especially attachment theory) and on the assumption that interactions between client and therapist include explicit content as well as implicit, unconscious communications. It follows that therapists will need to be alert to the ways in which transactions in the therapy room echo the client's relationship history, and be aware of the ways in which they themselves become drawn into (and hence become a part of) this interactional process. On this basis there is a shift away from thinking about the client only in terms of their 'intrapsychic' presentation, and more towards to the notion of 'inter-subjectivity', seeing what emerges in therapy as a co-construction of ideas and meanings between both client and therapist. Importantly the therapist is expected to make use of this process by being sensitive to, and making use of, their emotional reactions to the client, particularly where their sense is that their reactions reflect elements in the client's presentation of which the client is unaware (or unconscious). Therapists may recognise the notion of 'countertransference' in this description, but whereas a psychodynamic psychotherapist might use this as the basis for interpretation, the integrative-humanistic therapist applies a very different intervention, including self-disclosure of their reactions to the client and offering this as the basis for further empathic exploration.

Specific adaptations of humanistic psychological therapies

This domain contains a description of the competences associated with Process-Experiential/Emotion Focused Therapy. This approach draws on a number of humanistic traditions, underpinned by a model of emotions and of emotional expression, and sets out active methods for the identification and integration of emotional experience.

Metacompetences

Therapy cannot be delivered in a 'cook-book' manner; by analogy, following a recipe is helpful, but it doesn't necessarily make for a good cook. This domain describes some of the procedural rules (e.g. Bennett-Levy, 2005) which enable therapists to implement therapy in a coherent and informed manner.

Therapeutic flexibility - the ability to respond to the individual needs of a client at a given moment in time - is an important hallmark of competent therapists. The interaction of a particular therapist and a particular client also produces dynamics unique to that therapeutic relationship, resulting in context-dependent challenges for the therapist. In other words, in psychological therapy the problems to be addressed can present differently at different times. The contextual meanings of the therapist and the client's actions change and the therapist is engaged in a highly charged relationship that needs to be managed. What is required therefore are a range of methods and approaches and complex interpersonal skills, under the guidance of very sophisticated mental activities.

On the whole these are more abstract competences than are described elsewhere, and as a result there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Most of the list has been extracted from manuals, with some based more on expert consensus[5] and some on research-based evidence (for example, "an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise", or "an ability to implement models flexibly, balancing adherence to a model against the need to attend to any relational issues which present themselves").

The lists are divided into two areas. Generic metacompetences are common to all therapies, and broadly reflect the ability to implement an intervention in a manner which is flexible and responsive. Humanistic metacompetences refer to the implementation of this therapy in a manner which is consonant with its philosophy, as well as the way in which specific techniques are applied. As is the case in other parts of the model, this division is pragmatically useful, but it is the case that many of the competences described as 'therapy-specific' could easily be adapted and apply to other interventions or techniques.

[5] Through discussion and review of metacompetences by the Expert Reference Group

Implementing the competence framework

A number of issues are relevant to the practical application of the competence framework.

Do clinicians need to do everything specified in a competence list? The competence lists are based on manuals or descriptions of humanistic techniques in therapy textbooks. Some of these techniques may be critical to outcome, but others may be less relevant, or on occasions irrelevant. Even where there is research evidence which suggests that specific "packages" of technique are associated with client improvement we cannot be certain about which components actually make for change, and exactly by what process.

It needs to be accepted that the competences in the framework could represent both "wheat and chaff": as a set of practices they stand a good chance of achieving their purpose, but at this stage there is not enough empirical evidence to sift effective from potentially ineffective strategies. This means that competence lists may include therapeutic *cul de sacs* as well as critical elements.

A final point (raised earlier in this document) relates to the fact that because the humanistic field contains some significant variations in practice, clinicians will necessarily be selecting only those areas of the specific competence domain that fit to their model of practice. Although this means that it is completely legitimate for therapists to be selective about which areas of the framework they adhere to, *within* each area the expectation is that all competences are probably relevant to practice.

Are some competences more critical than others? For many years researchers have tried to identify links between specific therapist actions and outcome. Broadly speaking better outcomes follow when therapists adhere to a model and deliver it competently (Roth and Pilling, in preparation), but this observation really applies to the model as a whole rather than its specific elements.

Given the relative paucity of research on humanistic therapies there is only very limited evidence on which to base judgments about the value of specific activities, and comment on the relative value of competences may well be premature.

The impact of treatment formats on clinical effectiveness: The competence lists in this report set out what a therapist should do, but do not comment on the way in which therapy is organised and delivered – for example, the duration of each session, how sessions are spaced or whether the therapy is time-limited or longer term. Although such considerations will undoubtedly shape the clinical work that can be undertaken, the consensus of the ERG was that these variations do not necessarily have implications for the skills that therapists deploy.

The contribution of training and supervision to clinical outcomes: Elkin (1999) highlighted the fact that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and

supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (in preparation) reviewed the training and ongoing supervision associated with the delivery of therapy in the exemplar trials which contributed to this report. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy - a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems which help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the competence framework

This section sets out the various uses to which the humanistic psychological therapies competence framework can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed.

Commissioning: The humanistic psychological therapy framework can contribute to the effective use of health care resources by enabling commissioners to specify the appropriate levels and range of humanistic psychological therapies for identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and development of psychological therapy services: The framework represents a set of evidence-based competences, and aims to describe best practice - the activities that individuals and teams should follow to deliver evidence-based treatments.

Although further work is required on the utility and associated method of measurement – they will enable:

- the identification of the key competences required by a practitioner to deliver humanistic psychological therapies interventions
- the identification of the range of competences that a service or team would need to meet the needs of an identified population

- the likely training and supervision competences of those managing the service

This level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of the research trials on which claims for efficacy rest. In this way it could help to ensure that evidence based interventions are likely to be provided in a competent and effective manner.

Clinical governance: Effective monitoring of the quality of services provided is essential if clients are to be assured optimum benefit. Monitoring the quality and outcomes of psychological therapies is a key clinical governance activity; the framework will allow providers to ensure that:

- Humanistic psychological therapies are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of therapist performance
- Clinical Governance systems in Trusts meet their requirement for service monitoring from the HCC and other similar bodies

Supervision: The humanistic psychological therapies competence framework potentially provides a useful tool to improve the quality of supervision by helping supervisors to focus on a set of competences which are known to be associated with the delivery of effective treatments. Used in conjunction with the supervision competence framework (available online at www.ucl.ac.uk/CORE/) it can:

- provide a structure which helps to identify the key components of effective practice in humanistic psychological therapies
- help in the process of identification and remediation of sub-optimal performance

Supervision commonly has two (linked) aims – to improve the performance of practitioners and to improve outcomes for clients. The humanistic psychological therapies framework could achieve these aims through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Training: Effective training is vital to ensuring increased access to well-delivered psychological therapies. The framework will support this by:

- providing a clear set of competences which can guide and refine the structure and curriculum of training programmes (including pre- and post-qualification professional trainings as well as the training offered by independent organisations)
- providing a system for the evaluation of the outcome of training programmes

Registration: The registration of psychotherapists and counsellors is a key objective for the Department of Health. Although a clear set of competences associated with the key activities of these professionals groups may well contribute to the process of establishing a register, one caution is that it represents only one aspect of a broad set of requirements for a formal registration system.

Research: The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the relationship between therapy process and outcome and the evaluation of training programmes and supervision systems.

Concluding comments

This report describes a model which identifies the activities which characterise effective interventions in the field of humanistic psychological therapies, and locates them in a "map" of competences.

The work has been guided by two overarching principles. Firstly, it stays as close to the evidence-base as possible, meaning that an intervention carried out in line with the competences described in the model should be close to best practice, and therefore likely to result in better outcomes for clients. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cook-book. Delivering effective therapy involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Therapists of all persuasions need to operate using clinical judgment in combination with their technical skills, interweaving technique with a consistent regard for the relationship between themselves and their clients.

Setting out competences in a way which clarifies the activities associated with a skilled and effective practitioner should prove useful for workers in all parts of the care system. The more stringent test is whether it results in more effective interventions and better outcomes for clients.

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Appendix A

Membership of the ERG

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Nancy Rowland	Director of Research, Policy and Professional Practice, British Association for Counselling and Psychotherapy
Janet Tolan	British Association for the Person-Centred Approach (BAPCA)

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