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The development of the Compassion Focused Therapy Therapist Competence Rating Scale

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Objectives. Compassion-focused therapy (CFT) has shown promise as a treatment for a number of clinical presentations; however, existing studies have not adequately addressed issues of treatment fidelity. The aims of the present study were to identify initial candidate items that may be included in a CFT therapist competence rating scale and to develop the behavioural indicators to anchor these items.

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

Methods. Face-to-face meetings with two CFT experts were conducted in rounds one, two, and five, and these were used to define and operationalize the competencies. Nine other CFT experts were invited to complete online surveys in rounds two and four. An 80% consensus level was applied to the online surveys.

Results. The resulting Compassion Focused Therapy Therapist Competence Rating Scale (CFT-TCRS) consisted of 23 competencies which were separated into 14 'CFT unique competencies' and nine 'Microskills'. There was high agreement about the included 'CFT unique competencies' and 'Microskills'; however, there were some differences in opinion about the specific content of some items.

Conclusions. This is the first study that has attempted to reach consensus regarding the competencies and behavioural anchors for a CFT therapist competence rating scale. The next stage of development for the CFT-TCRS is to establish whether the scale can be reliably and validly used to evaluate CFT practice.

Practitioner points

- The Compassion Focused Therapy Therapist Competence Rating Scale (CFT-TCRS) is the first scale to operationalize the unique and generic competencies required to deliver compassion-focused therapy (CFT).
- The CFT-TCRS can be used as a learning guide for delivering CFT training and with further development could be used to assess therapist competence for CFT training courses, clinical practice, and treatment fidelity in research trials.

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Compassion-focused therapy (CFT) is a transdiagnostic psychological approach that draws on Buddhist philosophy and neuroscience, as well as social, developmental, and evolutionary psychology (Gilbert, 2009). It was initially developed for people with high levels of shame and self-criticism (Gilbert & Irons, 2005). There is emerging evidence for the effectiveness of CFT across range of clinical problems including depression and anxiety (Gilbert & Procter, 2006; Judge, Cleghorn, McEwan, & Gilbert, 2012), personality disorder (Lucre & Corten, 2012), eating disorders (Gale, Gilbert, Read, & Goss, 2012; Kelly & Carter, 2015; Williams, Tsivos, Brown, Whitelock, & Sampson, 2017), psychosis (Braehler *et al.*, 2013; Heriot-Maitland, Vidal, Ball, & Irons, 2014; Kennedy & Ellerby, 2016; Laithwaite *et al.*, 2009; Mayhew & Gilbert, 2008), acquired brain injury (Ashworth, Clarke, Jones, Jennings, & Longworth, 2015; Ashworth, Gracey, & Gilbert, 2011), and post-traumatic stress disorder (Au *et al.*, 2017; Beaumont, Durkin, McAndrew, & Martin, 2016; Beaumont, Galpin, & Jenkins, 2012). However, these studies are primarily pilot/feasibility studies or service evaluations, and hence, the conclusions that can be drawn are limited. Further studies involving randomized control trials are required; these will need to include measures of treatment fidelity and therapist competency. This reflects the current state of research not just for CFT, but also for other compassion-based interventions. For a review of these issues, see Kirby, Tellegan, and Steindl (2017).

Treatment fidelity

Treatment fidelity is described as the degree to which an intervention is implemented as intended and includes therapist competence, therapist adherence to protocols, and treatment differentiation (Perepletchikova, Treat, & Kazdin, 2007). Monitoring and assessing treatment fidelity in research trials is required to ensure treatment has been delivered as intended, to increase the internal and external validity and validate the conclusions drawn (Nezu & Nezu, 2008, pp. 263–284). Therapist competence addresses 'the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects' (Fairburn & Cooper, 2011).

In a detailed review of the importance of treatment fidelity, Moncher and Prinz (1991) noted that the majority of studies ignored issues of treatment fidelity. Studies that have evaluated CFT have also been limited by this omission (Leaviss & Uttley, 2015). This has led to major limitations in the conclusions that can be drawn about the effectiveness of CFT and the replicability of studies published thus far. Moncher and Prinz (1991) noted that treatment fidelity requires clear specification of both the content and procedures of treatment and verification that treatment is being delivered as intended.

Treatment fidelity and CFT competencies

A study by Liddell, Allan, and Goss (2016) attempted to address one element of fidelity by surveying CFT practitioners to develop agreement about the therapist competencies required to deliver CFT. They developed a CFT competency framework outlining the necessary therapist competencies required to effectively deliver CFT. The framework comprised six key areas of competence and 25 main competencies. However, this framework is not a therapist competency rating scale.

Therapist competence scales have been developed to translate the complexity of the skills practised by therapists into robust evidence-based measures. Therapist competence scales can be used to specify best practice, increase a study's reliability and validity, and evaluate training and supervision practices (Kohrt *et al.*, 2015; Roth & Pilling, 2008; Slade,

Thornicroft, & Glover, 1999). Their overall purpose has been to improve treatment fidelity, to understand change factors, and to differentiate treatments (Bennett & Parry, 2004; Blackburn *et al.*, 2001).

Therapist competence has been measured in studies that have investigated a range of therapies including cognitive behavioural therapy (CBT; Keen & Freeston, 2008; Roth, 2016), dynamic therapy (Barber & Critis-Christoph, 1996), cognitive analytic therapy (CAT; Bennett & Parry, 2004), family therapy (Hogue *et al.*, 2008), interpersonal therapy (Chevron & Rounsaville, 1983), emotion-focused trauma therapy (Paivio, Holoway, & Hall, 2004), acceptance and commitment therapy (Strosahl, Hayes, Wilson, & Gifford, 2004; Walser, Karlin, Trockel, Mazina, & Taylor, 2013), mentalization-based therapy (Karterud *et al.*, 2013), and drug counselling (Barber, Mercer, Krakauer, & Calvo, 1996). They have been developed to evaluate the level of competence for psychological training courses (Muse, McManus, Rakovshik, & Thwaites, 2016; Tweed, Graber, & Wang, 2010). However, scales have differed in their structure, number of items, and how they were developed, and some scales have measured competence and adherence as a joint construct.

Currently, there are no agreed guidelines about how to develop therapist competency scales; however, methods have tended to rely on eliciting competencies from therapy manuals and expert opinion (Barber & Critis-Christoph, 1996; Ogrodniczuk & Piper, 1999). The Delphi method has been applied to develop competencies for specific therapies and clinical populations, such as CFT (Liddell *et al.*, 2016), CBT for anxiety and depression (Roth & Pilling, 2008), CBT for psychosis (Morrison & Barratt, 2010), CBT for children and adolescence (Sburlati, Schniering, Lyneham, & Rapee, 2011), suicide risk (Kotowski & Roye, 2017), and eating disorders (Williams & Haverkamp, 2010). Modified Delphi methods have been used in studies to develop therapist competence scales for CAT (Bennett & Parry, 2004), online CBT (Cooper *et al.*, 2015), and motivational interviewing (Barsky & Coleman, 2001). Overall modified Delphi techniques seem an appropriate and useful measure for developing therapist competence scales.

There is currently no validated scale to measure CFT therapist competencies. Gilbert and Wood developed an unpublished scale called the 'CFT Therapy Assessment Guide' to assess therapist competence in CFT training programmes. This 45-item scale aimed to assess therapists' microskills, formulation skills, skills in explaining CFT, developing and maintaining therapeutic contracts, and use of CFT techniques. However, this scale did not follow any formal procedure for item selection or for the development of the behavioural anchors required to rate specific competencies. As far as we are aware, no published studies have used this scale to assess therapist competency.

The aims of the present study were to identify initial candidate items that may be included in a CFT therapist competence rating scale and to develop the behavioural indicators to anchor these items. A Delphi methodology (Linstone & Turoff, 1975) was used to develop a consensus for each of the candidate items and their behavioural anchors to ensure that the scale represented the views of a range of experts in CFT.

Method

The Delphi method

The Delphi method is a way of structuring communication between experts to explore opinions and promote agreement about a complex problem (Linstone & Turoff, 1975). The Delphi method is widely used to achieve a convergence of opinion amongst experts

(Boulkedid, Abdoul, Loustau, Sibony, & Alberti, 2011). Delphi studies typically have carefully selected expert participants and are conducted in a series of two or more sequential rounds (Iqbal & Pipon-Young, 2009). The first round involves the main researcher asking all the participants questions to generate initial ideas. These ideas are collected and analysed, and the data are fed back in a questionnaire in round two. Participants are required to complete their questionnaires anonymously. They are provided with the comments of others and asked to re-evaluate their earlier responses. This process of controlled feedback is ongoing until consensus is obtained or the desired outcome is reached (Hasson, Keeney, & McKenna, 2000).

The advantages of this method include anonymity for group members and greater creativity and honesty (De Meyrick, 2003; Iqbal & Pipon-Young, 2009). It is also a practical method when geography, time, or other constraints may limit other forms of communication (Landetta, 2006). The Delphi method has been used to identify professional competencies in a range of clinical settings and across a range of therapeutic models (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008; Green & Gledhill, 1993; Morrison & Barratt, 2010). This method was also used to develop the competency framework for CFT (Liddell *et al.*, 2016).

Participants

CFT is a relatively new therapeutic approach and so the sample of experts was drawn from a small pool of 20 clinicians, of whom eleven consented to participate. The participants consisted of two groups of CFT experts. Two experts in CFT were recruited to the independent expert panel (IEP). They were founder members of the Compassionate Mind Foundation. They were involved in the initial development and subsequent editing of items and behavioural anchors.

Nine participants were recruited to the second group. This was called the survey expert panel (SEP). The SEP participated in the online surveys that were used in the study. Members of the SEP were required to have both extensive knowledge and competency in delivering CFT. The SEP were experienced CFT therapists who had previously been a member of the Compassionate Mind Foundation board or were trained and supervised by a member of the board. They had also been involved in devising CFT treatment protocols or training and supervising others in CFT.

Design and procedure

The study was conducted using a modified Delphi method (Avella, 2016; Hsu & Sandford, 2007; Linstone & Turoff, 1975). A modification was made to the first round by using initial interviews with the IEP in order to review and condense previous work conducted in relation to CFT competencies.

The study took place over five rounds. Round one focused on identifying the initial candidate items for inclusion in a meeting with the IEP. Items were included in the scale if the IEP agreed that they were necessary for inclusion. This round identified 30 candidate items. In round two, these items were sent to the nine members of the SEP in the form of an online survey. Participants were asked to rate how important they thought each competency was for inclusion in a CFT therapist competence rating scale. This was rated using a five-point Likert scale ranging from 'not important' to 'very important'. The participants were asked to comment on the score they had provided and to suggest

changes that might be required. They were also asked to comment on how each item might be observed and measured in practice.

Content analysis was used to analyse the qualitative data in order to summarize the common themes reported by the SEP for each competence (Graneheim & Lundman, 2004; Vaismoradi, Turunen, & Bondas, 2013). This information was used to provide summaries of the comments to guide the round three meeting with the IEP.

In round three, the IEP met to finalize the items for inclusion in a draft scale and to develop the initial behavioural indicators that could be used to anchor each item. At the end of this round, 23 candidate items and their behavioural anchors were drafted. The candidate items used a five-point Likert scale, with zero indicating an inappropriate or absent level of competency and four representing skilful enactment of a competency.

In round four, a second online survey was conducted with the SEP using the items and rating scales developed in round three. In this survey, the SEP were asked to rate on a five-point Likert scale whether the item accurately described and operationalized each competence using the same five-point Likert scale used in round two. An open-ended question offered the SEP an opportunity to suggest changes to the draft scale. In round five, the survey data from round four were reviewed by the IEP to finalize the scale.

Analysis

All discussions with the IEP (rounds one, three, and five) were recorded on a digital recorder, and contemporaneous notes were taken for later review. The quantitative survey data from round two were analysed to establish consensus for each item. For the item to be included in the scale, 80% of the SEP had to rate four or higher on the five-point Likert scale. A high level of consensus was chosen as the group was assumed to be relatively homogeneous, and all participants were required to have an expert level of knowledge of CFT. In round four, the data were analysed using a similar method to round two. However, a stricter consensus threshold was applied given that the aim was to edit and revise the scale items. This required 80% of the SEP to give a rating of five out of five on the Likert scale. The items that did not reach this level of consensus were re-evaluated and edited based on the comments generated. Content analysis was applied to the qualitative data obtained in rounds two and four to summarize the views of the SEP and to identify possible refinements to the scale.

Results

Generation of the competency items

CFT unique competencies

The candidate items for the 'CFT unique competencies' developed in round one, the consensus levels in round two. and the nature of the subsequent amendments of the candidate items in round three are presented in Table 1.

Four of the 'CFT unique competencies' from round one did not reach the standard of consensus required in round two. Three of these competencies were rated as either 'important' or 'very important' with a consensus level of 77.8%. These were *understanding the human motivation system, theory of mind*, and *inference chains and cognitions*. One competence was rated as either 'important' or 'very important' with a consensus level of 55.5% (*distinguish between motives and emotions*). These five items were excluded from the next round. The competencies of *cultivate and tolerate*

Table 1. Candidate items for 'CFT unique competencies' developed in round one: consensus levels in round two and amendments made to candidate items in round three

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

emotions and *breathing, training, tone of voice and facial expression* were also excluded by the IEP in round three based on comments from the SEP regarding item overlap. Ten of the 'CFT unique competencies' were reworded in round three based on SEP comments in round two. The description for the competence *unconscious emotions* was the only item not amended in round three. An additional item, labelled *multiple selves*, was constructed by the IEP based on recommendations by three of the SEP.

Microskills

The candidate items for the CFT 'Microskills' developed in round one, the consensus levels in round two and the nature of the subsequent amendments of the candidate items in round three are presented in Table 2.

The 'Microskill' item *agenda 1* did not reach the standard of consensus required in round two, and this item was excluded. However, in round three the IEP agreed that some aspects of this item should be merged with the *agenda 2* item to make this more concise. The IEP excluded two additional 'Microskills' in round three. *Attuned and connected to client's whole being* was excluded as it proved too difficult to formulate behavioural anchors for this item. *Notices and reflects on the process of therapy* was excluded as these skills were covered by other items.

The item *non-verbal communication* was rated as 'very important' by all participants in round two; however, the SEP suggested that this item needed to be more specific and CFT focused. Therefore, in round three the IEP divided *non-verbal communication* into two separate items. One of these items focused on non-verbal communication as a generic therapy skill, and the other item focused on CFT-specific non-verbal skills. SEP comments suggested that several 'Microskills' should be combined, and in round three, the IEP merged *paraphrases* and *summarising* into a single item. The descriptions for the items *verbal communication, agenda 2,* and *mentalisation* were edited and reworded to increase clarity and specificity. Four item descriptions were not amended. These were *pacing, Socratic questioning, validates,* and *normalisation*.

Finalizing items and developing behavioural anchors

CFT unique competencies and behavioural anchors

In round three, the IEP met to finalize the items for inclusion in the second version of the scale and to develop the initial behavioural indicators that might be used to anchor each item. The resulting 23 candidate items and their behavioural anchors were assessed by the SEP in a second online survey in round four. Table 3 presents the items for the 'CFT unique competencies' developed in round three, the consensus levels in round four, and the nature of the subsequent amendments of the candidate items in round five.

A number of changes were made to these candidate items. The SEP comments in round four suggested *building courage and motivation* could be divided into two items with an item focused on building courage to tolerate distress. In round five, this competence was divided into two competencies which were *building courage* and *building motivation*. The items *formulation links* and *developing individualised formulation* were combined in round five into a single *formulation* item. An additional item was added in round five called *cultivating and tolerating positive feelings in the drive system*.

The *fear, blocks and resistance* item was amended in the round five IEP meeting. Changes included adding content about the therapist recognizing and addressing the

Table 2. Candidate items for CFT 'Microskills' developed in round one: consensus levels in round two and amendments made to candidate items in round three

Candidate items for CFT Microskills generated in round one	Participant ratings of necessity of competencies and consensus levels in round two							Amendments made in round three
	Very important	Important	Moderately important	Somewhat important	Not important	Consensus >80%	Mean (*SD*)	
18. Non-verbal communication	100	0	0	0	0	100	5.00 (0)	Two items
19. Verbal communication	100	0	0	0	0	100	5.00 (0)	Reworded
20. Pacing	100	0	0	0	0	100	5.00 (0)	No changes
21. Socratic questioning	88.9	11.1	0	0	0	100	4.78 (0.46)	No changes
22. Agenda 1	33.3	44.4	11.1	11.1	0	77.7	4.11 (1.07)	Excluded
23. Agenda 2	55.6	44.4	0	0	0	100	4.44 (0.52)	Reworded
24. Paraphrases	88.9	11.1	0	0	0	100	4.89 (0.35)	Combined with t25
25. Summarising	66.7	33.3	0	0	0	100	4.67 (0.52)	Combined with item 24
26. Validates	100	0	0	0	0	100	5.00 (0)	No changes
27. Normalisation	88.9	11.1	0	0	0	100	4.89 (0.35)	No changes
28. Mentalisation	77.8	22.2	0	0	0	100	4.78 (0.46)	Reworded
29. Attuned and connected to client's whole being	77.8	11.1	0	0	11	89	4.33 (1.75)	Excluded
30. Notices and reflects on the process of therapy	66.7	33.3	0	0	0	100	4.67 (0.51)	Excluded

Table 3. Candidate items for 'CFT unique competencies' developed in round three: consensus levels in round four and amendments made to candidate items in round five

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

client's fears, blocks, and resistances to aid their recovery and to notice these fears as they arise in therapy. The IEP also changed the content and language used in the *functional analysis* item. This involved changing the word 'behaviour' to 'strategies' and adding the need to link safety strategies back to a wider formulation.

Several items were reworded in round five. The item label *CFT techniques* was changed to *compassionate mind training*. SEP feedback was used to clarify the language used in the *multiple selves* item. The SEP noted that the 'Three Systems' model was included in three items (*motives and emotions, recognising the three systems*, and *understanding the relationship between three systems*); therefore, in round five the IEP refined the item labels and behavioural anchors to *recognising motives and emotions, actively working with the three systems*, and *understanding the relationship between three systems*. The SEP suggested that the item *unconscious emotions and processes* needed to be more clearly defined, and this was also done in round five.

Microskills and behavioural anchors

Table 4 presents the candidate items for 'Microskills' that were developed in round three, the consensus levels in round four, and the subsequent amendments made to candidate items in round five.

There were fewer qualitative comments and greater agreement about the 'Microskills' items compared to the 'CFT unique competency' items. However, the SEP noted that *paraphrasing and summaries* might be linked to the CFT model and formulation and so amendments were made to this item in the round five. The *Socratic questioning* item reached a 75% consensus level in round four. Here, the SEP noted that the use of open and closed questions should be added to the item, and this was done in round five.

The SEP suggested that *non-verbal communication* and *CFT principles and non-verbal communication* items overlapped and could be merged. The IEP changed the labels of these items to 'non-verbal communication to build rapport' and 'non-verbal communication and motivational/emotional systems' to increase clarity. The SEP also suggested that the *mentalisation* item required a clearer description of 'mentalisation' and 'perspective taking', and therefore, examples were included in round five. Only 37.5% of the SEP in round four 'strongly agreed' that *agenda setting* was accurately defined. As there was only one SEP comment about this item, it was difficult to interpret this low score and so this item was not amended.

Outcome of round five

At the end of round five, 23 items reached the standard of consensus required for inclusion in the final version of the Compassion Focused Therapy Therapist Competence Rating Scale (CFT-TCRS). This version consisted of 14 'CFT unique competencies' and nine 'Microskills'. The list of 'CFT unique competencies' and 'Microskills' are presented in the Appendix. An example of a 'CFT unique competency' item is presented in Figure 1, and an example of a 'Microskill' *item* is presented in Figure 2.

Discussion

This is the first study that has attempted to reach consensus regarding the competencies and behavioural anchors for a CFT therapist competence rating scale. It focused on generating and operationalizing the competencies in preparation for assessing the scale's

Table 4. Candidate items for CFT 'Microskills' developed in round three: consensus levels in round four and amendments made to candidate items in round five

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

ITEM 2: Recognizing motives and emotions

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

These points should be considered when scoring:

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

Unable to rate: X

Absent or inappropriate				**Skilful enactment**
0	**1**	**2**	**3**	**4**

Less competent	**More competent**
The therapist does not make reference to the three-circle model, uses inappropriate feedback, and makes no links between theory and client's experience	The therapist appropriately explores the three-circle model and uses this to help the client understand their experience and move the client forward in therapy. The therapist relates the three-circles model to examples in the client's life

Figure 1. An example of a CFT 'unique competency'.

psychometric properties in a future study. This contrasts with some previous therapist competency rating scale studies that have focused on testing the scales' psychometric properties rather than developing an initial expert consensus about the scale items (Blackburn *et al.*, 2001; Ogrodniczuk & Piper, 1999; Paivio *et al.*, 2004; Vallis, Shaw, & Dobson, 1986; Young & Beck, 1980).

The 'Microskills' items generated less qualitative feedback and less disagreement compared to the 'CFT unique competencies' items. This was not surprising as experts often have higher levels of agreement on generic therapeutic competencies that are applicable to all psychotherapies (Morrison & Barratt, 2010).

Overall, there were high levels of agreement on the 'CFT unique competencies' that could be included in the scale; however, there were different opinions regarding the content of some of these items, mainly in relation to item overlap. For example, some experts reported that the three items describing the affect regulation systems overlapped, that *functional analysis* seemed to overlap with *formulation*, and that the two non-verbal communication items also overlapped.

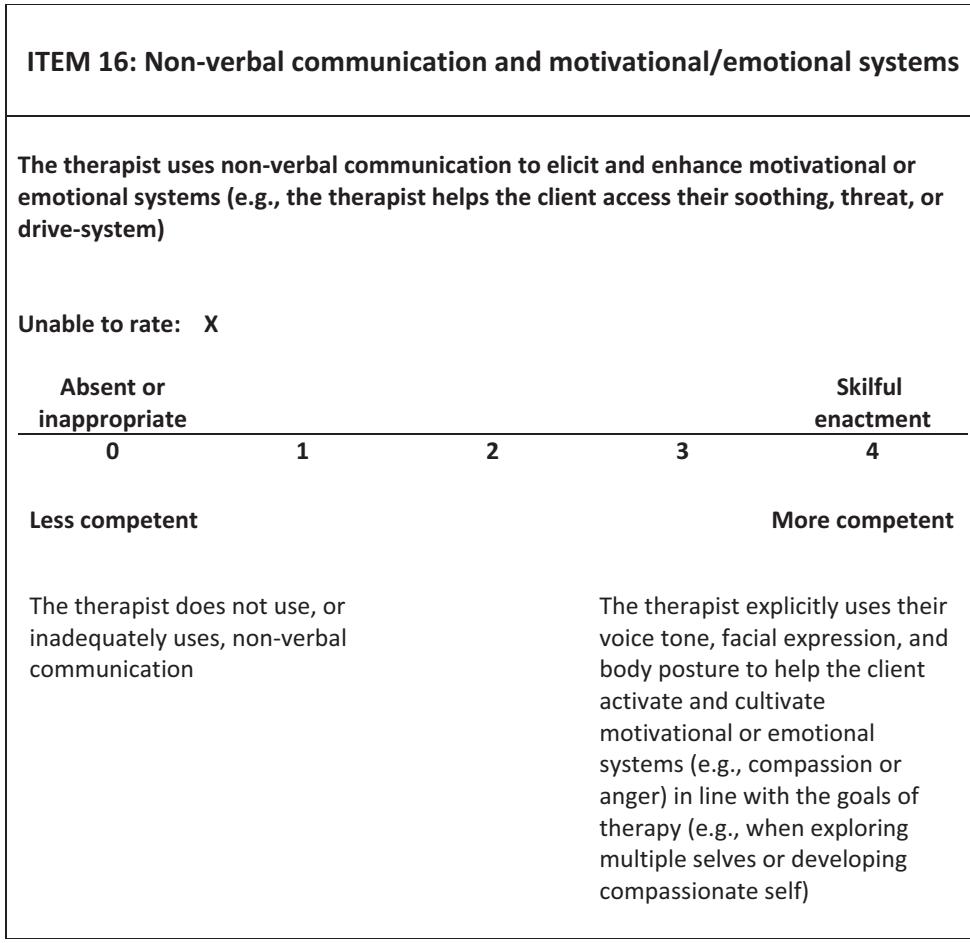

Figure 2. An example of a CFT 'Microskill'.

There were differences in opinion about whether 'agenda setting' was a standard part of a CFT. Despite the potential overlap with rating scales for other therapies, these skills were agreed to be essential for a CFT session as part of building a therapeutic relationship. This is in line with the literature regarding the therapeutic relationship as being a key ingredient for change and positive therapy outcomes (Ackerman & Hilsenroth, 2003).

The current CFT evidence base has been a criticized for the lack of assessment of treatment fidelity (Leaviss & Uttley, 2015). This, at least in part, is due to the lack of an agreed measure of the competencies required to deliver CFT. The CFT-TCRS has the potential to be an appropriate scale to assess treatment fidelity.

Strengths and limitations

This is the first study to define and operationalize the competencies required to deliver CFT. Data were gathered over five rounds that involved approximately 16 hr of face-to-face meetings with the IEP and two survey rounds with the SEP which generated quantitative and qualitative data. These surveys enabled a geographically dispersed group of international experts to participate in the study.

The 'CFT unique competencies' included in the final version of the CFT-TCRS were consistent with the CFT literature (Gilbert, 2009, 2014). The CFT-TCRS included the views of expert clinicians working in a range of clinical settings, and it is hoped the competencies measured will be generally applicable.

Given the relatively recent development of CFT, the number of experts meeting the threshold for inclusion was small. However, similar participant numbers have been used in Delphi studies when experts have a similar training and an in-depth understanding in the field of interest (Akins, Tolson, & Cole, 2005). The online surveys method may have lacked the richness and depth that could be obtained using another methodology, such as a focus group (Iqbal & Pipon-Young, 2009); however, this was not practical.

The content of the scale reflects a current consensus regarding the therapeutic competencies required to deliver CFT. Given that CFT is a relatively new therapy and has changed substantially over time (see Gilbert, 2014), the scale may need to be updated in future to reflect new developments in the model and its therapeutic applications. The scale does not address specific treatment protocols, and further measures/checklists may need to be added to the scale when evaluating the use of CFT in specific populations (e.g., eating disorders, Goss & Allan, 2014) or settings (e.g., inpatient acute wards, Heriot-Maitland *et al.*, 2014).

Future research

The next stage of development for the CFT-TCRS is to establish whether the scale can be reliably used to evaluate CFT practice (Barber, Sharpless, Klostermann, & McCarthy, 2007). This would be consistent with previous studies that have assessed the psychometric properties of competency scales for other psychological therapies (Bennett & Parry, 2004; Blackburn *et al.*, 2001; Chevron & Rounsaville, 1983; Ogrodniczuk & Piper, 1999).

Conclusions

The current study identified the therapist competencies and the behavioural anchors considered by experts to be essential for the effective delivery of CFT. A scale was developed to measure these competencies. The CFT-TCRS comprises 14 'CFT unique competencies' and nine 'Microskills'. It is not expected that all of the 'CFT unique competencies' will be observed in every CFT session, as this will depend on the client's needs. However, it is likely that each of the 'Microskills' will be demonstrated in every CFT session.

Research is currently underway to evaluate the psychometric properties of the scale. This includes establishing inter-rater reliability, usability, and finalizing the items and behavioural anchors so it can be used to assess CFT therapist competence. However, the key themes of the scale (see Appendix) may provide useful guidance for trainers and supervisors whilst the psychometric properties of the scale are being established.

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Appendix : Final set of CFT unique competencies and CFT Microskills

CFT unique competencies

Psychoeducation

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

Recognising motives and emotions

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

Actively working with the three systems

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

Understanding the relationship between three systems

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

Compassionate mind training

The therapist is able to use techniques to help the client train their soothing system (e.g., using practices such as soothing rhythm breathing, body posture exercises, voice tone, facial expressions, and imagery).

Building motivation

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

Building courage

The therapist helps to build courage to tolerate and work with suffering (e.g., the therapist supports the client to develop techniques to regulate affect by building their soothing system).

Cultivating and tolerating affiliative emotions

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

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

Functional analysis
The therapist is able to help the client functionally analyse the forms and functions of safety strategies (e.g., the forms and functions of self-criticism or shame and how these link to safety strategies).

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

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

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

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

CFT Microskills

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

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

Verbal communication

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

Pacing

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

Socratic questioning

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

Paraphrasing and Summaries

The therapist appropriately uses paraphrasing and summarizing.

Agenda setting

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

Validation and normalisation

The therapist uses validation and normalization to help the client use the CFT model to understand and work with their issues (e.g., the evolutionary model, how our emotional/motivational systems work). The therapist uses validation and normalization to help the client understand and address shame and self-criticism as it arises in the session.

Mentalisation

The therapist helps the client to develop mentalization skills (e.g., the therapist helps the person consider the reasons for their own and other people's behaviours within an attachment framework).