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Ten generic competences to improve outcomes of cognitive behaviour therapy: Evidence, postulated processes, and clinical implications

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ABSTRACT

In the 18 years since higher-order, generic competences (metacompetences) were first identified to guide the implementation of cognitive behaviour therapy (CBT) across anxiety and depression, much evidence has accrued supporting these generic competences and identifying others. We describe 10 generic competences that can support therapists to deliver the strongest possible outcomes in CBT across different forms of psychopathology. In each case, the robustness of the evidence-base is reviewed, the theoretical processes that link the generic competence with improved outcome for the patient are considered, and practical suggestions are offered to the therapist. The ten generic competences include: balance firmness and empathy to ensure an effective working alliance; manage therapist discomfort to use effective techniques; push for early behavioural change; focus on (and respond to) session-by-session progress in therapy; require your patient (and service) to invest in an intensive start to therapy; complex presentations should initially be met with routine therapy, changing only where guided by evidence; deliver therapy competently rather than with rigid adherence; encourage the patient to argue for behavioural change; homework completion is critical for therapy to be effective; and positive outcomes require therapists who are well-trained and well-supervised. We provide recommendations for clinical practice and future research, recognising that this list will change and grow as new evidence accumulates.

1. Definitions

Therapist competence has been described as 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). This involves both delivering the procedures required to be consistent with the therapeutic model (also confusingly termed competences by Roth & Pilling, 2007), as well as the skill involved in the delivery of those procedures.

Competence across disorders has been termed "metacompetences". Originally introduced in the framework guiding effective cognitive behaviour therapy (CBT) for people with depression and/or anxiety disorders, under the Improving Access to Psychological Therapies (IAPT) programme in the United Kingdom (Roth & Pilling, 2007), metacompetences are defined in various ways. First, as the "overarching, higher-order competences which practitioners need to use to guide the implementation of any intervention" (p. 1). Second, "Competences that are used by therapists to … adapt CBT to the needs of each individual patient" (p. 7). Third, "higher-order links between theory and practice to plan and, where necessary, to adapt therapy to the needs of individual patients" (p. 9).

Roth and Pilling (2007) then went on to differentiate between generic and CBT-specific metacompetences. The former are employed in all therapies while the latter are employed specifically in CBT to implement an intervention in a manner that is flexible and responsive to the individual. The five CBT-specific metacompetences identified by Roth and Pilling (2007) included capacity to: (1) implement CBT in a manner consonant with its underlying philosophy; (2) formulate and apply CBT models to the individual patient; (3) select and apply the most appropriate method; (4) structure sessions and maintain appropriate pacing; and (5) manage obstacles to therapy.

Some limitations of metacompetences can be identified. First, the definition is not clearly operationalised. Second, Roth and Pilling (2007, p. 18) did identify them as being somewhat abstract. Third, much evidence has accumulated since the original framework was published.

To address these problems, we suggest that use of the term "generic

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competence" may be better understood, where generic refers to "across disorders" and, utilising the terminology of Fairburn and Cooper (2011), competence refers to "knowledge and skill". In other words, a generic competence is the (1) knowledge of an evidence-based procedure that improves therapy outcomes across different psychopathologies and (2) skill to put these procedures into action in a way that is congruent with the disorder and the therapeutic model used.

Accordingly, we describe ten generic competences in the context of CBT (listed in Table 1) across an expanded range of disorders – not just depression and anxiety - offering a clear description of the procedure involved. Second, we summarise the body of evidence that has accumulated since 2007 that supports each of these generic competences and provide a rating of the nature (direct or indirect) and strength of that evidence. To do this, we use National Health and Medical Research Council (NHMRC, 2009) levels of evidence specific to prognosis (listed in Table 2), given that we are summarising evidence that the generic competence significantly improves treatment outcome. Third, we highlight what could be key theoretical processes that link the generic competence to an improved treatment outcome. Finally, we communicate those generic competences in a concrete manner, as procedures that therapists can understand and employ to make their clinical practice more effective through individualisation to the patient's needs.

2. Generic competence 1: firm empathy

2.1. Description

Firm empathy (Wilson et al., 1997) is the utilisation of protocol-based techniques in judicious combination with maintaining the therapeutic bond. In other words, the therapist does not wait until therapeutic alliance is established before commencing therapy or hold back on the effective elements of therapy until they feel that the patient likes and/or trusts them. This is best captured in the term 'working alliance' (Bordin, 1979), which consists of three components: (1) agreement on goals, (2) assignment of tasks, *and* (3) the development of bonds i.e., bond development alone is not sufficient for an alliance that can lead to change. The patient and therapist might like each other, but if that is at the cost of shared focus on the tasks and goals of CBT, then that means that the patient is unlikely to change and benefit from therapy, in the short or the long term.

2.2. Evidence

There is a reciprocal relationship between early behavioural change and alliance, where early symptom change strengthens the alliance and in turn the alliance increases subsequent behavioural change for the patient. A meta-analysis of twenty eating disorder treatment studies showed the relationship between early alliance and treatment outcome was partially accounted for by early symptom improvement (Graves et al., 2017). Omnibus analyses showed that greater early improvement in symptoms was associated with a stronger early alliance ($\beta = 0.19$) while greater early- and mid-treatment alliance predicted greater subsequent symptom change ($\beta = 0.13$). Early alliance showed weaker associations with outcome in therapies with a strong behavioural component (such as CBT) relative to nonbehavioral therapies (Graves et al., 2017). This may be attributed to the early utilisation of cognitive behavioural techniques driving greater change than alliance. A further meta-analysis, this time across treatment of depression, anxiety, post-traumatic stress disorder (PTSD) and eating disorders, and across various therapeutic modalities including CBT, identified significant reciprocal within-patient effects between alliance and symptoms within the first seven treatment sessions (Flückiger et al., 2020). Given two meta-analyses showing reciprocal direction of associations between early change and alliance over treatment across different psychological disorders are associated with better post-treatment outcome (Flückiger et al., 2020; Graves et al., 2017), we rate this evidence as direct and

Table 1
Evidence-based generic competences for effective cognitive behaviour therapy.

#	Generic Competence	What does it look like in clinical practice?
1	Firm empathy	The therapist does not wait until therapeutic alliance is established before commencing therapy – they immediately start working with the patient on change, understanding that early change builds alliance and vice versa simultaneously.
2	Don't overestimate the patient's fragility	The therapist understands that they tend to overestimate the fragility of a patient and that this therapist anxiety means that they are less likely to do exposure therapy. The therapist sits with their anxiety so they can help the patient *do* the evidence-based therapy.
3	Prioritise early change in therapy	The therapist is highly motivated to work on early change in therapy (first 4 to 10 sessions) as they know it is one of the best predictors of therapy outcome and the time when most of the change occurs.
4	Measure symptoms at each session and share outcomes with the patient	The therapist uses brief measurement tools each session to identify early change, sharing this with the patient, aware of the evidence that this reduces therapy drop-out, improves treatment outcomes, makes less effective therapists more effective, while reducing therapy duration.
5	Utilise weekly sessions initially to maximise change	The therapist advocates for weekly sessions initially, sharing evidence with the patient that more frequent therapy is associated linearly with steeper recovery curves, compared to therapy conducted every 2- or 3-weeks. Sessions once a month will see a gradual deterioration in the person's functioning.
6	Do not assume that more complex therapy is required where there is comorbidity	The therapist "holds their nerve" in the face of comorbidity and starts therapy by focusing on one disorder, knowing that this may benefit comorbid conditions. Changes to therapeutic protocol are guided by evidence of lack of early change, which if present due to the presence of comorbidity, may result in a move to more complex CBT which may improve longer-term outcomes.
7	Competence in adapting the protocol to the patient is better than rigid adherence	The therapist has a deep understanding of the therapeutic protocol and can adapt this to the patient's characteristics and avoids rote application of the manualised therapy.
8	Utilising cognitive dissonance to promote internalisation of challenging ideas	The therapist is familiar with cognitive dissonance theory, social psychological theory and motivational enhancement techniques, weaving frequent opportunities in each session for the patient to argue for change to promote behaviour change.
9	Collaborate with the patient to effectively set goals between each session	The therapist is proficient in effective goal setting – considering obstacles that prevent the patient from achieving valued goals.
10	Prioritise both training and supervision.	The therapist knows that just reading the manual won't change what they do in therapy. Both training and supervision are required to change therapist behaviour in the therapy room. Supervision may also improve patient outcomes.

Table 2
Strength of the evidence related to prognostic value of the generic competence.

Level of Evidence	Prognosis
I	A systematic review of level II studies
II	A prospective cohort study [a]
III-1	All or none [b]
III-2	Analysis of prognostic factors amongst persons in a single arm of a randomised controlled trial
III-3	A retrospective cohort study
IV	Case series, or cohort study of persons at different stages of disease

[a] At study inception the cohort is either non-diseased or all at the same stage of the disease. A randomised controlled trial with persons either non-diseased or at the same stage of the disease in both arms of the trial would also meet the criterion for this level of evidence.

[b] All or none of the people with the risk factor(s) experience the outcome; and the data arises from an unselected or representative case series which provides an unbiased representation of the prognostic effect.

Level I.

2.3. Postulated key theoretical process

One process that may link good working alliance with better outcome is the improvement of patient (and therapist) self-efficacy. Early introduction of CBT techniques in a supportive manner that help the patient to change quickly is likely to improve their sense of agency, and hence their self-efficacy. Low self-efficacy has been shown to result in depressive symptoms (Santos et al., 2018) and eating disorder symptomatology (Bardone-Cone et al., 2006). This process is consistent with Bandura's Self-Efficacy Theory of Motivation where self-efficacy mediates experience and behaviour/performance (Bandura, 1977).

2.4. Clinical implications

From the very first session of therapy the therapist works alongside the patient to help them utilise CBT techniques for change (e.g., exposure, monitoring, behavioural experiments), accompanied by a clear rationale and engaging summaries of the evidence that this approach produces better outcome. Socratic thinking can also be very helpful in avoiding conflict at this stage (e.g., "I don't know if this will help you to overcome your problems – but if we give it a try then we might be able to work it out. Does staying as you have been seem a better option?"). There is empathic recognition that change is always difficult and anxiety-provoking, while stressing that it will be worthwhile.

3. Generic competence 2: effectively manage personal discomfort so that you use effective CBT techniques

3.1. Description

The therapist needs to manage personal discomfort such that it does not provide an obstacle in applying CBT techniques. A common source of therapist anxiety in CBT is the use of exposure. The evidence suggests that therapists systematically avoid those therapy tasks that cause us anxiety, fearing an adverse impact on the patient or a negative impact on working alliance (Waller & Turner, 2016). Not overestimating the patient's fragility will allow the therapist to use more effective change techniques, which typically require the use of exposure in the early phase of treatment.

3.2. Evidence

Exposure is often underutilised in treatment, despite documented effectiveness e.g., Racz and colleagues (2024). For example, in the treatment for youth anxiety disorders, no randomised clinical trials uniquely evaluate exposure (Teunisse et al., 2022). Deacon and colleagues (2013) showed an association between negative beliefs about exposure therapy with negative reactions to a series of exposure therapy case vignettes, and the cautious delivery of exposure therapy in the treatment of a hypothetical patient with obsessive-compulsive disorder. A meta-analysis identifies therapist anxiety as one predictor of exposure being significantly less likely to be used in therapy (Langthorne et al., 2023). Given the substantial evidence on the efficacy of exposure and the existence of this meta-analysis linking therapist anxiety to the avoidance of using exposure, we rate this evidence as direct and Level I. We note, however, that further evidence directly linking therapist characteristics and beliefs and the use of specific CBT techniques is required.

3.3. Postulated key theoretical process

The process that links exposure and better outcomes has been explored previously by Craske and colleagues (2014), with the inhibitory learning model of extinction (Bouton et al., 2004) suggested to produce deeper, more generalised learning, above fear habituation and 'belief disconfirmation using behavioural testing' models. This model applies to both the therapist (exposure to using exposure in therapy) and to the patient. A further theoretical mechanism to consider is the *spun-glass theory of the mind* (Meehl, 1973, pp. 225–302). This term refers to the therapist's belief that the human organism is so fragile that minor negative events, such as criticism, rejection, or failure - or being encouraged to change – will lead to catastrophic consequences. This belief can prevent the use of exposure therapy by therapists, due to their anxious predictions about possible consequences.

3.4. Clinical implications

The therapist mantra to the patient and supervisee alike should echo Christopher Robin's message to Winnie the Pooh: "You are braver than you believe, stronger than you seem, and smarter than you think". Given the strong evidence supporting the efficacy of exposure across different psychological disorders, we recommend that the therapist employs exposure from the first session of treatment, setting up clear monitoring of consequences and benefits, and exploring with curiosity whether these match the patient's initial catastrophic predictions. Given the widespread reluctance to use exposure in the early phase of treatment, it is essential that we use supervision to ensure that our personal characteristics (Waller & Turner, 2016) or lack of experience (Öst et al., 2012) do not interfere with the delivery of evidence-based therapy, for fear of 'breaking' the patient who we see as fragile. The supervisor can enhance supervisee skills through using a combination of role-play in supervision, listening to and commenting on recorded sessions, and inviting the supervisee to attend treatment sessions where the supervisee is able to observe the skills in action. It is also valuable for the supervisee to have the opportunity to meet with or hear testimony from patients who have undertaken exposure therapy, to learn the benefits of this intervention. A useful tool to demonstrate the need for such learning opportunities and their benefits is the Therapist Beliefs about Exposure Scale (Deacon et al., 2013). In the absence of a supervisor skilled in exposure work, the tool could be used in conjunction with a readable summary of the evidence (e.g., Craske et al., 2014), associated with goal setting in the context of peer supervision to keep therapists accountable for developing new behaviours.

4. Generic competence 3: prioritise early change in therapy

4.1. Description

An immediate focus in therapy on utilising the working alliance to effectively help the patient engage in techniques that lead to change is required. Early change in therapy is a very potent predictor of good

outcome. The therapist should be highly motivated and supervised to focus on early change in therapy (first 4 to 10 sessions). To work collaboratively to achieve early change, we should share this knowledge and evidence with the patient. However, referring to the previous generic competence, we should not assume that the patient will be immediately willing to make early change, particularly if they have previously had therapy that did not push for such change. Engaging the patient will require psychoeducation about the nature of anxiety - that it will be high in these early stages, but that this is a sign that therapy is targeting the mechanisms keeping problematic behaviours in place, and that the anxiety will diminish over time as the new behaviours become habitual without negative consequences. In short, change to difficult behaviours will not occur in the absence of anxiety. While this generic competence clearly overlaps with the two described above, it demonstrates that there is an ethical imperative to provide active therapeutic components to patients from the first session of therapy, enabling those individuals who make early change to have a shorter duration of therapy (Niileksela et al., 2021) and shortening therapy without losing effectiveness.

4.2. Evidence

Evidence from two meta-analyses shows clearly that early change is one of the strongest and most replicable predictors of therapy outcome (Beard & Delgadillo, 2019; Vall & Wade, 2015). It is also the time when most of the overall change of therapy occurs (Klein et al., 2024; Rose & Waller, 2017; Saxon et al., 2017; Wade et al., 2021). The number of patients who show early change is at least partially a reflection of our performance as therapists. In their examination of IAPT therapists working with adult patients who were depressed or anxious, Saxon and colleagues (2017) divided therapists into three groups based on the percentage of patients achieving recovery, identifying 'below average', 'average' and 'above average' therapists. To determine statistically reliable and clinically significant improvement (i.e. 'recovery'), change scores for patients had to be greater than the reliable change index to take account of measurement error, and the end point score had to move from above the cut-off level to below this predetermined score. Regardless of the categorisation, recovery rates reached their maximum by session 8. However, while recovery rates began to level out around session 8 for 'average' and 'above average' therapists, the rate decreased again for the 'below average' therapists. Given the existence of two meta-analyses linking early change to better outcomes, we rate this evidence as direct and Level I. The evidence that the therapist can enhance this process of early change is thus far indirect. Future experimental work is required to test the degree to which individual patient's trajectories of early change can be enhanced by what the therapist does.

4.3. Postulated key theoretical process

It is likely that early change for the patient encourages a sense of agency for the patient. The lack of early change will leave the patient with an experience that reinforces previous learned helplessness, and this becomes the defining expectation of therapy moving forward. In comparison, armed with a sense of agency, they are more able to build on their success by engaging more fully in change between and within sessions. This process is consistent with the learned helplessness theory, where a patient exposed to repeated and situations perceived to be uncontrollable will stop trying to control the situation (Maier & Seligman, 1976).

4.4. Clinical implications

Further work is required to understand *how* we can increase the proportion of patients who experience early change (i.e., the active mechanisms). Given that the ability to produce early change in patients does vary across therapists (Saxon et al., 2017), this will clearly involve enhancing the skills of those therapists who do not generate early change in their patients. As well as providing psychoeducation about the prognostic value of early change and anxiety and using the CBT techniques that support early change from the first session, providing information about the adaptive brain and epigenetics can facilitate behavioural change (Schleider et al., 2022; Zhou et al., 2020). This psychoeducation material highlights a person's ability to change, that there is evidence relating to the neuroplasticity of the brain, that heritable traits are modifiable, that personality can change, and that consistently practising new behaviours embeds changes to brain and genetic functioning (Schleider et al., 2020).

5. Generic competence 4: meaningfully and regularly reflect progress (or otherwise) with the patient

5.1. Description

The therapist needs to utilise approaches to providing ongoing feedback to the patient about changes they are (or are not) making over the course of therapy. Many therapists will be familiar with measuring outcomes at the beginning and end of therapy, using a range of measures. However, that should only be part of our clinical practice. Knowing whether the patient has done well by the end of therapy tells us how helpful the therapy was, while measuring and sharing progress on a session-by-session basis can help us to *get better* at delivering effective therapy. Thus, the fourth generic competence involves measurement of, and response to, progress (or the lack of it) in therapy *in each session of therapy*. This skill involves use of brief measurement tools immediately before each session to identify whether the problematic symptoms that brought the patient to therapy are indeed changing. The results from these tools are shared in session with the patient, preferably in a graphical format, to communicate the message about progress, and to discuss ways in which the patient has worked to change, and how to do more to enhance progress going forward.

5.2. Evidence

While explicit progress monitoring is not utilised by many therapists and can be experienced as somewhat challenging (Persons et al., 2016), the evidence of its clinical utility is compelling. Various studies and meta-analyses have shown that measuring sessional symptom change and sharing it with the patient is associated with reduction in therapy drop-out, improved treatment outcomes, making less effective (or below average) therapists more effective, and reducing therapy duration (de Jong et al., 2021; Delgadillo et al., 2018, 2022; Janse et al., 2020). Acknowledging that effect sizes are small but significant, the data suggest the presence of several potential moderating factors that can enhance effectiveness of this metacompetency. One such moderator is the type of feedback (de Jong et al., 2021). Compared to the simple presentation of raw data about expected recovery trajectories, significantly better outcomes are attained when patients' progress was checked against a benchmark within the provision of clinical support, such as motivational enhancement (de Jong et al., 2021). Both responding to lack of early change (by focusing on it as a therapy-interfering factor) and highlighting positive early change (linking it to self-efficacy) require time within each therapy session. That means a temporary diversion from rigid adherence to protocol as time is dedicated to getting the patient back on track or stressing the value of their engagement with change (see generic competence 7). However, the benefits are substantial and clearly merit the flexibility of thinking and action that they require of the therapist. Given the existence of two meta-analyses (de Jong et al., 2021; Delgadillo, Deisenhofer, et al., 2022) linking sessional feedback to better outcomes, we rate this evidence as direct and as Level I.

5.3. Postulated key theoretical process

The field of ergonomics has long stressed the value of positive, effective feedback on performance, and this seems eminently applicable to the patient's ability to benefit from therapy. Goal setting theory suggests that performance appraisal and satisfaction with performance mediate the relationship between goal setting and willingness to commit to new challenges (Locke & Latham, 2002). de Jong et al. (2021) also notes these processes being of relevance to the therapist, as it draws the attention of the therapist to what works, changes their expectations, provides new information, enhances the alliance, and enhances communication with the patient. This is consistent with the finding that progress feedback reduces the variability between more and less effective therapists due to increased ability of therapists to support symptom improvements (Delgadillo, Deisenhofer, et al., 2022). Thus, evaluating with the patient whether the therapy is helpful can identify what is necessary to make it work better; information that can be used to adjust the treatment so that poor outcomes might be prevented (de Jong et al., 2021).

5.4. Clinical implications

In a multi-level meta-analysis conducted by De Jong and colleagues (2021), the most frequently used feedback tools were the Outcomes Questionnaire System (Lambert et al., 2010, p. 38 %) and the Partners for Change Outcome System (36 %). The former has short and long versions (10–40 items) for various age groups, and the latter employs two four-item scales, the Outcome Rating Scale and Session Rating Scale (Campbell & Hemsley, 2009). Alternatively, brief symptom-specific tools can be used (e.g., Zhou et al., 2024). Various apps are also able to provide this feedback. Of course, therapists should also highlight behavioural and biological feedback, where appropriate (e.g., fewer episodes of impulsive or compulsive behaviours than in previous weeks; change in weight in eating disorders), as the patient might or might not be aware of the change but is likely to benefit from seeing how it relates to their use of therapy over the past week (e.g., more use of urge surfing; challenging beliefs about others being uninterested; eating to planned targets). As mentioned earlier, this focus on the patient's ability to improve is critical for enhancing their self-efficacy. It can also contribute to the self-efficacy of the therapist.

6. Generic competence 5: require your patient (and service) to invest in an intensive start to therapy

6.1. Description

Utilise approaches to help people understand the benefits of prioritising therapy. Given the evidence suggests weekly therapy delivers the most rapid and steep change compared to less frequent sessions, this often requires patients and services to do what they are reluctant to do. There can be many reasons given by the patient for an inability to attend weekly sessions, including financial and work/life commitments. Some services offer less frequent sessions to deal with shortage of resources. The job of the therapist is to use the evidence to persuade both the patient and service managers to commit to weekly sessions initially, which dovetails nicely with the evidence showing early change is associated with better outcome at end of treatment and over follow-up. In other words, the therapist needs to work as a team with other providers and the patient to attempt to decrease the barriers that prevent access to care.

6.2. Evidence

Weekly therapy is associated with steeper recovery curves, compared to therapy conducted every two or three weeks (Erekson et al., 2015). Indeed, sessions once a month will see a gradual deterioration in the person's functioning. Given only one prospective cohort study (Erekson et al., 2015; N = 21,488 university counselling centre patients), we rate this evidence as Level II, and indirect when applied to CBT. It is worthy of note that there are some recommendations in the literature that twice-weekly sessions might be clinically justified (e.g., Fairburn, 2008). However, this is an area where there is insufficient evidence to date to support incorporating this particularly intensive approach.

6.3. Postulated key theoretical process

Provision of weekly sessions harnessing the generic competences explored above will result in rapid and noticeable change for the patient, thus potentially increasing self-efficacy, as outlined in the Self-Efficacy Theory of Motivation (Bandura, 1977). It may also increase hope. Effects of transdiagnostic CBT on changes in anxiety were found to be mediated by treatment effects on hope (Gallagher et al., 2020). The role of hope in therapeutic changes requires further investigation.

6.4. Clinical implications

We suggest that initial weekly sessions should be presented as a therapy non-negotiable. This relationship between frequency of sessions and improvement is graphically and convincingly portrayed in Figure 1 of Erekson and colleagues' paper, and we encourage therapists to have this visual depiction available to give to patients. A pre-therapy discussion about the rationale for weekly sessions, in terms of more rapid and enhanced improvement, and cost-benefit, may lead the patient to delay therapy until they can get most benefit from it, or to prioritise therapy to give it the best chance of success.

7. Generic competence 6: start simple and use evidence that the therapy is not working well to inform any changes

7.1. Description

Therapists need to appreciate the strengths and limits of evidence-based protocols and knowing when greater complexity of therapy is helpful to be introduced. Therapists often cite the complexity of cases as meaning that existing evidence-based protocols cannot be assumed to apply, and that therapists should engage in more complex therapy approaches. Of course, this is a classic example of what Meehl (1954) referred to as 'broken leg exceptions', where a relatively prominent but evidentially irrelevant aspect of the patient's presentation (in this case, comorbidity, but it could equally be gender, ethnicity, etc.) is used by the therapist to reach the conclusion that the evidence-based approach should be dropped and an alternative approach, not associated with evidence, should be employed. Given the limited evidence to support such a deviation from protocol, this use of therapist judgement can result in unnecessarily poorer outcomes for the patient (Grove et al., 2000; Meehl, 1954). Therefore, it is important that therapists can remain 'on protocol', focusing on one problem at a time (e.g., Macdonald, 2011), when there is limited or no evidence that deviating from that protocol might be a positive change. It requires the therapist to 'hold their nerve' in the face of comorbidity, and to agree with the patient that therapy will start by focusing on one disorder.

This generic competence is more nuanced than most, involving 'if … then … ' considerations on the part of the therapist. If, after a review of the data, early change is not evident or pronounced enough, then this should be reviewed with the patient, identifying key obstacles, and considering how this will impact the treatment offered (Wade et al., 2024).

7.2. Evidence

A strong body of evidence shows that the 'one target at a time' approach benefits comorbid conditions and improves general quality of

life (Cuijpers et al., 2023; Kindred et al., 2022; Linardon & Brennan, 2017; Liu et al., 2023). Some evidence suggests that a focus on one condition at a time may be of more benefit to the patient than simultaneous consideration of all conditions (Craske et al., 2007; Gibbons & DeRubeis, 2008; Shafran et al., 2018). In contrast, the evidence that complexity of a disorder indicates that the individual will not benefit from the empirically supported therapy is limited. For example, de Beurs et al. (2020) found that complexity had only a small impact on the prognostic value of routine therapy for outcome or treatment dose, and Kazdin and Whitley (2006) showed that complexity was associated with either no impact on therapy or with better outcomes than for less complex cases.

Considering that 'if … then' approach mentioned earlier, we also need to respond to the needs of the individual as they progress in therapy. While comorbidity (either diagnostic or due to a psychological trait) is not a strong predictor of treatment outcome (Vall & Wade, 2015), it may prove to be an obstacle to early change, and in this case making alterations to the therapeutic protocol should be considered collaboratively with the patient and informed by sessional measurement (see generic competence 4). A strategic, stratified approach is required, responding to lack of progress. Where change is limited in such cases, a move to more complex or intensive CBT might improve longer-term outcomes (Angelakis et al., 2022). For example, when offering weekly 20-min sessions of guided self-help CBT to women who had eating disorders featuring binge-eating, Chen and colleagues (2017) moved those not experiencing early change at session 4 to more intensive therapy (dialectical behaviour therapy or CBT). Strong early responders continued guided self-help for up to 24 weekly 20-min sessions. At 6- and 12-month follow-up assessments, outcomes across the three groups were commensurate, indicating that slower responders could achieve similar outcomes to more rapid responders when moved to a more appropriate complex therapy. Five such adaptive trials now exist in eating disorders supporting improved outcomes of this stratified approach, across child and adult populations with diagnoses of anorexia nervosa and disorders with binge-eating (Edney & Pellizzer, 2024). The level of evidence related to the "if" component of this generic competence is rated as indirect and III, whereas the provision of one meta-analysis of RCTs (Angelakis et al., 2022) suggests the level of evidence is rated as direct and as level I for the "then" component of this generic competence. We note, however, that further use of adaptive trial designs in mental health is required to identify the way in which therapy needs to change in the face of gradual progress.

7.3. Postulated key theoretical process

Complexity in therapy can be likened to the "cocktail party problem" where there is difficulty focusing on the speech from one speaker in a crowded room of multiple speakers and other noises. In this respect, theories of attention can be informative. One early model, the Filter Theory of Attention (Broadbent, 1958), posits that attention is a bottleneck through which only a limited amount of information can pass at any given time. With multiple simultaneous competing tasks, a central controller decides which to engage in and when. The decision on how to best execute tasks will depend on history and context. It is likely that complexity in a case will distract therapists away from the big picture of any specific model, rather leading to more of a fractionated approach to specific symptoms of different disorders as they become prominent. Theory would also suggest that in complex environments the therapist is more likely to fall back on preferred therapy modalities or techniques without considering if this is the most suitable approach. The consequence is likely to be an inconsistent delivery of therapy that does not have an evidence base, resulting in limited gains. It has been suggested that there are no current clearly accepted or evidence-based models of maintaining mechanisms on which to base individual formulations that can direct changes in treatment (Wade et al., 2024). There is a need to develop and test models that can more flexibly include the role of interacting conditions.

7.4. Clinical implications

If a lack of early change is evident, a decision about where to start should involve consideration of which comorbidity seems to drive most of the unhelpful behaviours. Sessional measures continue to be collected and discussed after any changes to therapy, to ensure these changes are bringing benefit. For a protocol describing such an approach see Wade and colleagues (2024), and for consideration of the barriers and ways forward to personalisation of therapy see Deisenhofer and colleagues (2024).

8. Generic competence 7: competence in using protocols rather than rigid adherence to, or rejection of, a protocol

8.1. Description

The therapist has a deep understanding of the therapeutic protocol and can adapt it to the patient's characteristics, preferences and situation, avoiding rote application of the manualised therapy. This contrasts with adhering rigidly to protocols, with no variation allowed to adapt to the individual's progress and changing circumstances. At the other end of this continuum, and more commonly occurring, is outright rejection of a protocol by a therapist, preferring to do what they consider to be the best approach in each situation (Addis & Krasnow, 2000). In this latter scenario, Dawes and colleagues (1989) argue that therapists choose between their own observations/impressions and the scientific evidence on the relative efficacy of the clinical methods, and warn that: "Failure to accept a large and consistent body of scientific evidence over unvalidated personal observation may be described as a normal human failing or, in the case of professionals who identify themselves as scientific, plainly irrational" (p.1673). While the evidence for the use of protocols is substantially stronger than the evidence for clinical judgement being used in isolation (see generic competence 6), it can be argued that flexibly applying a protocol (e.g., adapting to the individual patient without losing the essence of the clinical approach) is likely to be more effective than simple adhering rigidly to that protocol, or rejecting it all together.

8.2. Evidence

The literature has differentiated between therapist adherence (the theory-specified techniques or methods of the intervention), therapist competence (the skill with which these techniques or methods are implemented) and treatment integrity (treatment differentiation - the difference in treatment ingredients between intervention groups). The relationship between these three concepts and treatment outcome is somewhat inconsistent across papers (Collyer et al., 2020; Webb et al., 2010). However, the best powered meta-analysis across 62 studies (Power et al., 2022) found that competence and integrity were significantly more strongly associated with improved clinical outcome than was simple adherence to protocol. The ability to personalise treatment (an aspect of competence) has been clearly linked with improved treatment outcomes (Andersson et al., 2023; Delgadillo, Deisenhofer, et al., 2022; Nye et al., 2023). The existence of two meta-analysis (Nye et al., 2023; Power et al., 2022) suggests the evidence is direct and Level I.

8.3. Postulated key theoretical process

The process that links personalisation and better outcomes is postulated to be an interaction between patient aptitude and treatment i.e., different psychological therapy models, components or techniques have differential effects for patients depending upon their specific characteristics (Nye et al., 2023). This process can be likened to machine

learning theory, where models lead to breakthroughs through iteration by learning from experience and making predictions based on relationships between variables. While adopting personalisation is seen to be a promising avenue for better outcomes for about 12.5 % of patients (Nye et al., 2023), our understanding of the specific characteristics and implications for treatment personalisation is still under development (Deisenhofer et al., 2024).

8.4. Clinical implications

Cohen et al. (2021) described three dimensions of personalisation. The first is the timing of when personalisation decisions are made in a patient's treatment pathway (e.g., before, during or after treatment). The second is the level of intervention (e.g., the intensity of treatment, choice of modality or techniques, or style of delivery). The third dimension is method of personalisation, ranging from informal idiosyncratic personalisation to using a formal statistical model. Stratified care (treatment recommendation based on patient characteristics) was found to be significantly more efficacious and cost-effective for the treatment of depressive symptoms compared with stepped care (Delgadillo, Deisenhofer, et al., 2022). A small but significant effect size was found in favour of personalised treatment relative to standardized treatment (Nye et al., 2023). Evidence suggests personalisation should incorporate patient choice. For example, Andersson and colleagues (2023) found a significant difference in favour of online self-tailored treatment over therapist-tailored ($d = 0.26$) in adults with depression, where the self-tailored option offered a selection of six to 13 evidence-based treatments that patients thought would suit them best.

9. Generic competence 8: promote internalisation of challenging ideas

9.1. Description

The therapist uses a variety of skills such that the patient finds themselves arguing for change even while ambivalent about it. One key strategy here is motivational interviewing (MI) that leads the patient to 'talk themselves into' change. This 'change talk' should be used rather instead of the commonly used (but worst) persuasion strategy of 'sustain talk'– evoking the patient to argue defensively for sustaining the problematic behaviour. Described by Schleider et al. (2020) as "saying is believing", this metacompetency involves the therapist using their skills to weave in frequent opportunities in each session for the patient to argue for behaviour change. Patient and therapist ambivalence about utilising cognitive-behavioural change methods is found in most psychopathologies, given that the core CBT techniques involve asking the patient to expose themselves to what they fear and have been avoiding (e.g., interoceptive experience of anxiety, reliving trauma, increasing dietary intake, leaving home without using safety behaviours, exposure to unpleasant obsessions).

9.2. Evidence

In a meta-analysis of 36 primary studies, Magill and colleagues (2018) found that the proportion of therapist MI-consistent skills was related to a higher proportion of change talk from the patient, and that such patient change talk was related in turn to reductions in unhelpful behaviour at follow-up. In an analysis that tested 'change' and 'sustain' talk as two independent effects, patient change talk was not significant, but sustain talk predicted worse outcome. Hence, we must track both types of talk, enhancing change talk while limiting (and ultimately eliminating) sustain talk. Given that one meta-analysis supports the link between greater use of MI-consistent skills and better outcome, we rate this evidence as direct and Level I.

9.3. Postulated key theoretical process

This approach draws from cognitive dissonance (Draycott & Dabbs, 1998), and social psychological theories (Aronson, 1999). These models suggest a self-consistency interpretation of dissonance, and a hypocrite paradigm is used to explain that arguing for change even in the absence of aversive experiences makes a person mindful of the fact that they are not practicing what they are preaching and is sufficient to lead to behaviour change.

9.4. Clinical implications

The evidence for this generic competence is most directly linked to the use of motivational enhancement techniques to help people who are ambivalent about change to experiment with such change. These techniques have been comprehensively described (Miller & Rollnick, 2013). While much of MI is illustrated with chronic health conditions, eating disorders are a good example of ambivalence in a psychological disorder, given reluctance to change or lose the positive aspects of the disorder. In their masterly paper about enhancing motivation for change in treatment-resistant eating disorders, Vitousek et al. (1998) describe patients' ambivalence about forfeiting food restriction, given that it can represent important societal values of competence, self-control, and moral purity. A focus on the patient's values and how the disorder conflicts with these is a particularly pertinent dimension of MI to use with psychological disorders.

10. Generic competence 9: collaborate with the patient to effectively set goals between each session

10.1. Description

The therapist needs to be proficient in training the patient in effective goal setting, directing how we negotiate collaborative homework tasks. To do this requires us to consider the obstacles that prevent both the therapist and the patient from achieving valued goals, planning accordingly. While most therapists are familiar with goal setting, this proficiency focuses on the ability to help the patient develop the skill of mental contrasting to ensure the most powerful impact of goal setting (Oettingen & Reininger, 2016). Evidence shows that thinking only about positive future outcomes decreases goal-relevant efforts, as well as the likelihood of goal achievement. In contrast, after imagining a positive future, thinking about current obstacles that impede the realization of wishes (i.e., mental contrasting) can transform people's positive wishes into binding goals, and gives a greater likelihood of behaviour change. It has been hypothesised that adding implementation intentions ('if-then' plans) can strengthen the effects on change.

10.2. Evidence

Two meta-analyses support the ability of mental contrasting to enhance goal attainment (Cross & Sheffield, 2019; Wang et al., 2021). The first meta-analysis found a main effect of mental contrasting on health outcomes (Hedges' $g = 0.38$) at three months. The combination of mental contrasting with implementation intentions showed a similar effect ($g = 0.28$), suggesting that the addition of implementation intentions did not further strengthen the effects of mental contrasting on health behaviours (Cross & Sheffield, 2019). Given that two meta-analyses support the link between mental contrasting and better outcome, and many of these studies are experimental, we rate this evidence as direct and Level I.

10.3. Postulated key theoretical process

Fantasy realization theory (Oettingen, 2012) suggests that to inspire behaviour change, positive future fantasies need to be complemented

with a clear sense of reality. It has been speculated that positive fantasies about a desired future lead people to feel and behave as though they have already attained that future, sapping their energy and thus reducing attainment of the desired future.

10.4. Clinical implications

The goal setting approach is summarised in the catchy WOOP acronym: wish, outcome, obstacle, plan. The website (https://woopmylife.org/) has many useful descriptions, videos and an interactive exercise that are very patient-friendly.

11. Generic competence 10: prioritise both training and supervision

11.1. Description

This generic competence should really be seen as 'under development' and it reflects higher-order competence of knowing what we don't know and being willing to extend ourselves to find out. The 'finding out" strategy consists of a variety of steps. We know that therapists should not expect that just by reading the book they will then be able to do the therapy. Simply reading the manual will not change therapist behaviour in therapy. At least for MI and CBT, the evidence suggests that training has a greater effect on therapist behaviour change compared to receiving no training or reading a treatment manual (Ragnarsson et al., 2024). However, while training can provide therapists with the knowledge and confidence to use exposure therapy, for example, it is insufficient to promote substantial changes in practice (Trivasse et al., 2020). Training combined with supervision is more effective than training alone for changing therapist behaviour, with no differences found between face-to-face and online training (Ragnarsson et al., 2024).

11.2. Evidence

What is less certain is whether supervision results in better outcomes for the patient. Certainly, some data suggest that trainees under expert supervision can provide as good an outcome for the patient as a more experienced therapist (e.g., Öst et al., 2012). However, the current consensus suggests that any impact of supervision on patient outcome has yet to be proven (Watkins, 2020). This is due to the multiplicity of methodological problems that are attached to studies examining the supervision-outcome relationship. Most such studies are cross-sectional, examining various supervision models that generally lack empirical foundation. Watkins (2020) argues that the quality of research has not improved noticeably over the previous 20 years. This static state might reflect a lack of prioritisation of the importance of supervision in clinical practice. In terms of the evidence supporting a link between supervision and changes in therapist practice, two meta-analyses supporting this effect suggest the evidence is direct and Level I (Ragnarsson et al., 2024; Trivasse et al., 2020). In contrast, there is only indirect and level II evidence for the association between supervision and improved patient outcomes (Öst et al., 2012).

11.3. Postulated key theoretical process

The most likely theoretical mechanism that might account for the lack of a link between therapist training and patient outcomes is that therapists develop explicit declarative memories ('what I know') for the information that they absorb and the experiences that they gain during training, but that they do not lay down implicit, procedural memories ('how to do it') without substantive and repeated experience of delivering the interventions. Thus, supervision has the potential to enhance that procedural memory following training, to increase the likelihood of developing the procedural memories that are needed to implement interventions successfully (e.g., remembering not to provide reassurance during CBT for generalised anxiety disorder). While various models of clinical supervision exist, the developmental model of supervision (Stoltenberg et al., 1998) is likely to be most helpful here - the notion that supervision pushes us to move away from "hereditary predispositions" to develop strengths and growth areas.

11.4. Clinical implications

While we are waiting for further research identifying key processes that mediate the association between supervision and outcomes, a useful protocol for supervision associated with better CBT competencies is available (Alfonsson et al., 2020), utilising the Cognitive Therapy Scale—Revised (CTS-R) (Blackburn et al., 2001). We also direct the reader's attention to the Cognitive-Behavioural Therapy Scale for Eating Disorders (CBTS-ED; Beard et al., 2024).

12. Discussion

In this paper, we have summarised ten CBT generic competences that elaborate and expand the set of five metacompetences that were previously identified by Roth and Pilling (2007), informed by the development of the therapy process and outcome literature since Roth and Pilling's outline. To summarise, our recommendations (Table 1) are that we should focus on these generic competences as part of training, practice and supervision. Simply put, our guidance to therapists using all forms of CBT (across all age groups and all disorders) would be:

1. An effective working alliance requires us to balance firmness and empathy.
2. The patient is likely to be more robust than we think, so don't let your anxiety stop you from using exposure techniques.
3. Push for early behavioural change.
4. Focus on (and respond to) session-by-session progress in therapy.
5. Persuade your patient and service to use weekly sessions in the initial stages of CBT.
6. Complex presentations should initially be met with routine therapy; change to protocol is supported by a review of evidence showing lack of early change and indicating the obstacles that may be most pertinent.
7. Deliver therapy competently (e.g., adapting to patient response) rather than with rigid adherence or completely rejecting protocol.
8. Encourage the patient to argue for behavioural change.
9. Homework completion is critical for therapy to be effective.
10. Positive outcomes require therapists who are well-trained and well-supervised.

12.1. Clinical implications

It is important to stress that these generic competences should be the subject of open discussion between therapist and patient at the outset of therapy. Whilst therapists might be reluctant to detail them all for fear of distressing the patient or driving them away (see generic competence 2), our experience has been that supervising therapists to do so results in delivery of much more effective therapy. Similarly, patients might question whether these approaches are necessary, based on their previous therapy experiences not having used this approach, but we usually find that we can overcome that uncertainty by asking the patient to consider why that previous therapy did not result in their recovering, and suggesting that we might try something new this time.

It is important to note that several of these generic competences showed relatively small-medium effect sizes in the relevant meta-analyses, rather than the large effects that are already demonstrated by many therapies. However, the accumulation of several smaller effects has the potential to enhance the overall outcome of CBT substantially.

When Lambert and Barley (2001) identified 30 % of therapy outcomes being explained by 'common factors' (as opposed to the 15 % explained by the techniques of therapy), that set us the task of identifying those common factors in ways that allow us to enhance therapy outcomes. Evidence suggests that relatively small effects are attributable to the therapeutic alliance (4–7 %; e.g., Martin et al., 2000), therapist effects (5–6 %; Johns et al., 2019; Saxon et al., 2017) and clinic effects (1.9 %; Firth et al., 2019), but we readily acknowledge that those small effects are all important contributors to our overall therapy outcomes. Therefore, the potential for therapists to enhance therapy by working on these small-medium effect generic competences is substantial.

So that therapists can develop these generic competences, we recommend that they should be incorporated into manualised treatments, therapy training and supervision. However, many therapists are relatively undertrained (e.g., von Ranson & Robinson, 2006), do not view manuals as useful (Addis & Krasnow, 2000), and might be supervised using unevidenced models (Simpson-Southward et al., 2017). Therefore, the use of systemic change is also required, rather than reliance on the individual therapist or supervisor. This sort of long-term cultural change is reflected in the achievements of the application of the IAPT framework in the UK. This required not just identification of competences and meta-competences (Roth & Pilling, 2007), and a substantial commitment to training, but also ongoing monitoring of patient progress and publicly reporting these outcomes (Clark et al., 2018).

12.2. Limitations and future research

We have not included some further potential generic competences that we might have considered from a clinical perspective (e.g., what is the evidence for a treatment dose response, where longer therapy is more beneficial than briefer therapy?). Such exclusions are due to a lower level of evidence, where there might be multiple primary studies indicating the presence of such a generic competence, but where there is no meta-analysis-level evidence. We do not include other potential generic competences here, due to a lack of evidence for their effectiveness. However, we do not exclude the possibility that the growing evidence base will result in this list developing over time. In contrast, as we have already stated, we regard this field as a dynamic one, where new generic competences will be added to this list as the evidence base grows. We also note the processes related to each generic competence and subsequent outcomes need further development.

There is already evidence that some of the 10 generic competences that we have summarised here are relevant to a range of disorders and therapies, and it would be valuable to know whether these generic competences differ across contexts or whether they are all applicable across settings, treatments and populations. We encourage therapists and researchers to add to the evidence for these and for other generic competences, in CBT and in other therapies, so that those primary findings can be incorporated into this framework for enhancing treatment outcomes.

Furthermore, as it is possible that some generic competences will share explained variance in outcomes, future research should be open to the possibility that there will be a smaller set of core generic competences that are needed to enhance therapy maximally, allowing us to train and supervise accordingly. However, until there is such evidence of overlapping effects, therapists should be aware of the independent value of these generic competences and implement them for the best outcomes possible.

13. Conclusions

Clinical generic competences are a key element of the skill mix that therapists need to implement to deliver the strongest possible outcomes, alongside the key competences that are more usually a part of the manualised approaches that are used. We have reviewed the developing evidence for a range of such generic competences, adding to those already described by Roth and Pilling (2007). We have identified 10 further generic competences that have meta-analysis-level evidence, mostly with small-moderate additive effects. However, it is important to assume that other such generic competences will be demonstrated through future clinical developments and research. Clinical protocols, training and supervision could be rendered more effective for patients if these generic competences were routinely attended to in future.

CRediT authorship contribution statement

Tracey D. Wade: Writing – review & editing, Writing – original draft, Methodology, Conceptualization. **Glenn Waller:** Writing – review & editing, Writing – original draft, Methodology, Conceptualization.

Data sharing

n/a.

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Declaration of competing interest

The authors declare no financial interests/personal relationships which may be considered as potential competing interests.

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Data availability

No data was used for the research described in the article.

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