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Therapist competence and clinical outcome in the Prevention of Parasuicide by Manual Assisted Cognitive Behaviour Therapy Trial: the POPMACT study

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ABSTRACT

Background. Therapist competence may be an important factor in determining clinical outcome in psychological therapies. However, there are few published studies of therapist competence *v.* patient outcome from randomized controlled trials. We tested the hypothesis that higher levels of therapist competence would lead to better clinical outcomes in both patient- and observer-rated measures at 6- and 12-month follow-up.

Method. A random sample of 49 audiotapes of manual assisted cognitive therapy sessions delivered by 21 therapists involved in the Prevention of Parasuicide by Manual Assisted Cognitive Behaviour Therapy trial was rated to assess the level of therapist competence. Patient outcome was assessed using self and observer ratings of depressive and anxiety symptoms, social functioning, global functioning and number of episodes of deliberate self-harm.

Results. At 6-month follow-up, there was a statistically significant association between therapist level of competence and observer-rated depression only. At 12-month follow-up, significant associations were noted between therapist competence and all observer-rated clinical outcomes but not for self-rated outcome measures. However, there was no association between therapist competence and the number of self-harm episodes during follow-up.

Conclusions. When treated by therapists rated as more competent than other therapists who received equivalent brief training, patients with recurrent self-harm show significant clinical improvements. However, this benefit is not identified across all outcome measures and is not fully apparent until 12-month follow-up.

INTRODUCTION

There is increasing awareness that therapist characteristics and therapist competence may be an important, albeit rather neglected variable, in psychotherapy outcome research and that the separation of therapists and therapeutic process from specific forms of psychotherapy may lead to misleading conclusions about efficacy in psychological therapies (see Elkin, 1999). Degree of therapist adherence to a specific therapy (Dobson & Shaw, 1988) and competence of therapists has been shown to have a long-term impact on clinical outcomes in neurotic disorders (Kingdon *et al.* 1996) and schizophrenia (Scott *et al.* 2001) though a more limited effect for therapist competence has been found in clinical outcome for depression (Shaw *et al.* 1999; Scott, 2000). Modest effects on clinical outcomes have been noted favouring more experienced therapists (Stein & Lambert, 1995) though one cannot necessarily equate 'passage of time' and

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training as proxy measures of therapist effectiveness (Beutler, 1997). A meta-analysis of 19 outcome studies by this group demonstrated that the therapy model applied and the therapist's expertise in applying the specific therapy techniques accounted for a significant proportion of the outcome variance explained, particularly in the treatment of more difficult to treat cases (Crits-Christoph *et al.* 1991). As such, Crits-Christoph & Mitz (1991) argued that therapist effects vary considerably and need to be included as a factor in psychotherapy outcome research. Manualized therapies have helped to contribute to the specificity and internal validity of psychotherapy outcome studies (Addis, 1997). One of the implicit assumptions concerning manualized treatments is that they may reduce therapist variability in implementing therapy and in randomized controlled trials, will increase adherence to treatment protocols and improve clinical outcomes.

Manual assisted cognitive therapy (MACT) is a brief cognitively orientated and problem-focused therapy, delivered immediately following an episode of self-harm. As well as individual sessions with a therapist, clients are provided with a 70-page MACT book illustrated with multiple case examples designed to appeal to users from different social and cultural backgrounds (Schmidt & Davidson, in press). This paper examines the relationship between therapist competence in delivering MACT and clinical outcome for patients with recurrent self-harm who received MACT in the recent MRC Prevention of Parasuicide by Manual Assisted Cognitive Behaviour Therapy (POPMACT) trial (Tyrer *et al.* 2003*a*). We hypothesized that higher levels of therapist competence would lead to better clinical outcomes as assessed by both patient- and observer-rated measures at 6- and 12-month follow-up.

METHOD

Study design

The baseline characteristics, clinical outcomes and cost effectiveness of the POPMACT study are reported elsewhere (Byford *et al.* 2003; Tyrer *et al.* 2003*a*, *b*). Patients recruited from nine accident and emergency (A&E) departments at five UK study centres were randomly allocated to treatment as usual or to MACT. Those allocated to MACT, received up to five sessions of therapy over 3 months with the option of two additional booster sessions within 6 months plus the MACT booklet. This helped the patient to deal with specific problems that they identified with their therapist as the most important in leading to the self-harm act. The study found that in patients with recurrent deliberate self-harm, MACT was of limited efficacy in reducing repetition of self-harm compared to treatment as usual (TAU) over a period of 12 months following the index episode of deliberate self-harm. However, when economic evaluation was taken into account, MACT was superior to TAU in terms of cost-effectiveness.

Therapist characteristics and training

At the beginning of the trial, 26 health service staff volunteered to be trained as MACT therapists from the five centres involved in the study. These staff worked mainly in deliberate self-harm or liaison services where these existed, or in local clinical psychology departments and community mental health teams. An additional 11 therapists were recruited later in the trial to provide replacements for those therapists who left the study. The majority of therapists were nurses ($n=20$), followed by clinical psychologists ($n=6$), social workers ($n=4$), psychiatrists ($n=4$) and occupational therapists ($n=3$). The mean age of therapists was 38·2 (S.D. 8·6), nine were male and 28 female. Therapists were not required to have any specialist training in cognitive behaviour therapy (CBT).

The original 26 therapists received 2 days training in MACT prior to commencement of the trial followed by a further 1 day training after the study had begun. Training workshops utilized small group work: videos and role-play allowed the practice use of relevant techniques. Therapists who joined the study at a later date received training in MACT from their local centre coordinator and/or supervisor. All therapists utilized the MACT booklet during training. Local supervision was offered to all therapists by a senior clinician, trained in CBT.

Measures

Patient outcome

Patient outcome was assessed using independent observer ratings and patient self-ratings.

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Self-harm was measured using the Parasuicide History Interview (PHI; Linehan *et al*. 1989), which records parasuicide events by severity and in chronological order. Measures of clinical symptoms and social functioning included the self-rated Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) and Social Functioning Questionnaire (SFQ; Tyrer, 1990), and the observer-rated Montgomery–Åsberg Depression Rating Scale (MADRS; Montgomery & Åsberg, 1979), the Brief Anxiety Scale (BAS; Tyrer *et al*. 1984) and the Global Assessment of Function (GAF) Scale. The latter incorporated a modification of the Global Assessment Scale (Endicott *et al*. 1976) with separate assessments for clinical symptoms and social functioning. Assessments were carried out at baseline, 6 months and 12 months.

Therapist competence

As MACT differed from traditional CBT, being designed to help a specific client group and consisting of a patient manual plus therapy based around the content of the manual, a specific rating scale was developed and piloted to assess overall competence in delivering MACT. The 11-item MACT Rating Scale was designed to measure three aspects of competence (see Appendix) previously identified as important (see Scott, 2000): (1) therapist level of skill in applying techniques such as problem identification, problem solving and cognitive techniques; (2) interpersonal effectiveness; (3) general adherence to the therapy model, which included collaborative style, structuring and pacing of sessions. All items were rated on a 1–7 Likert scale. The possible range of scores was 7–77. Agreement on scores on the rating scale between two experienced CBT trainers (K.D. and J.S.) on a sample of 12 tapes was satisfactory (intra-class correlation $r=0{\cdot}66$; $F=4{\cdot}82$, $\mathrm{df}=11$, $p<0{\cdot}01$). Scores of 7–50 were regarded as indicating low competence, 51–60 mid-level competence and 61 and over a high degree of competence.

Each centre involved in the trial was provided with audiotapes and tape recorders and therapists were asked to tape at least three clinical sessions with each client, providing informed consent was obtained from the client. Twenty-one (57%) of the 37 therapists provided 189 audiotapes of sessions from the 161 (67%) patients referred to MACT. Twenty therapists from the original 26 therapists and one of the 11 therapists recruited at a later date also provided audiotapes. Twelve of the 20 nurses (60%), one out of four psychiatrists (25%), four out of six clinical psychologists (67%), two out of four social workers (50%) and two out of three occupational therapists (66%) provided tapes of sessions. The median number of referrals per therapist was four but, as is typical of populations who engage in deliberate self harm, non-attendance rates were high and 40% of patients did not receive any therapy sessions (Tyrer *et al*. 2003*b*). A total of 49 audiotapes of therapy sessions were recorded sufficiently clearly to allow independent rating using the MACT scale. About 65% of audiotapes from each therapist were rated and an average MACT competency score was calculated for each therapist. Six therapists had an average score suggesting a lower level of competence, seven met criteria for the mid-level of competence, whilst eight therapists demonstrated a high degree of competence.

Statistical analysis

Difference scores were calculated for the patient- and observer-rated outcomes measures between baseline and 6-months follow-up and between baseline and 12-months follow-up. These data were normally distributed and analysis of variance (ANOVA) was used to determine differences between level of competence and difference scores on the outcome measures. Differences between the therapist level of competence and total episodes of deliberate self-harm at 6 and 12 months were analysed using the Kruskal–Wallis test.

RESULTS

Therapist characteristics and competence ratings

The professional qualification of therapists was not related to level of competence with similar proportions in each level of competence. There were no differences between the therapist level of competence (low and mid competence *v*. high competence) and the numbers of patients who attended for three or more sessions (Fisher's exact test $=0{\cdot}67$, N.S.). Nor were there any

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differences in age of therapist and level of competence ($F=1{\cdot}55$, df$=2$, $p=0{\cdot}24$) or in the number of referrals and level of competence ($F=0{\cdot}52$, df$=2$, $p=0{\cdot}60$). The mean age of therapist was 36·9 years (S.D.$=5{\cdot}7$) in the high competence, 32·8 years (S.D.$=7{\cdot}3$) in the mid competence and 38·8 years (S.D.$=5{\cdot}2$) in the low competence group.

Therapist competence and patient outcomes

Scores on clinical outcome measures between baseline and 6-month follow-up data showed no statistically significant difference between change in symptoms and therapist competence except on the MADRS ($F=3{\cdot}32$, df$=2$, $p=0{\cdot}04$). *Post-hoc* test (Tukey HSD) revealed that the significant difference in change in MADRS scores was between group one (high competence) and three (lowest competence), with those with high levels of competence showing the greatest level of change.

There were no differences between level of therapist competence and difference scores between baseline and 12-months data on the HADS or the SFQ. Statistically significant differences were noted in difference scores on MADRS, BAS, GAF symptoms and GAF social functioning for the therapist competence groups. As can be seen from Table 1, *post-hoc* tests (Tukey HSD) revealed that those therapists who were rated as most competent differed from the least competent groups as a whole, except for change in the BAS where the difference between the groups was between the mid and high competence groups.

There were no significant differences between therapist competence and the total number of episodes of self-harm that occurred during the 12 months following the index episode ($\chi^2=1{\cdot}57$, df$=2$, $p=0{\cdot}46$) (where data were available for the whole period).

Table 1. *Therapist competence ratings and difference scores between baseline and 12 months for mood, symptoms and social functioning measures (ANOVA)*

Measures	Competence group	Number of patients	Mean difference	F	df	p
HADS anxiety	1	45	−3·29	2·21	2	0·11
	2	48	−1·85			
	3	46	−2·95			
HADS depression	1	45	−3·93	1·78	2	0·17
	2	48	−3·58			
	3	46	−5·72			
MADRS	1	45	−7·69	6·30	2	0·002
	2	49	−8·00			(1, 2 *v.* 3)*
	3	47	−15·38			
BAS	1	45	−4·11	4·19	2	0·017
	2	49	−4·57			(1, 2 *v.* 3)*
	3	47	−8·74			
GAF symptom	1	45	39·69	3·80	2	0·025
	2	49	39·49			(2 *v.* 3)*
	3	47	45·85			
GAF social	1	45	4·54	3·80	2	0·025
	2	49	1·82			(1, 2 *v.* 3)*
	3	47	12·06			
SFQ	1	45	−3·24	1·29	2	0·27
	2	49	−2·40			
	3	46	−4·33			

* Tukey HSD for *post-hoc* differences between therapist competence groups.

Group 1, low competence; Group 2, mid competence; Group 3, high competence.

HADS, Hospital Anxiety and Depression Scale; MADRS, Montgomery–Asberg Depression Rating Scale; BAS, Brief Anxiety Scale; GAF, Global Assessment of Functioning (symptoms & social); SFQ, Social Functioning Questionnaire.

DISCUSSION

The level of therapist competence in delivering MACT to patients with a history of recurrent deliberate self-harm was significantly associated with a greater amount of change in observer-rated levels of depression, anxiety and global clinical symptoms and social functioning from baseline to 12 months. However, this effect was less apparent at 6-month follow-up, did not extend to a reduction in the risk of further episodes of deliberate self-harm, and was not reflected in changes in scores on patient self-ratings. The number of tests carried out may raise the question that some were significant due to multiple testing. Rather than being more conservative and adjusting for the level of significance, these relatively novel findings deserve further replication to assess robustness. The findings were not accounted for by the possibility that the more competent therapists had more opportunity to practice MACT techniques, as there was no association between therapist level of competence and the numbers of patients seen or therapist competence and the number of patients who attended for three or more MACT

sessions. It was disappointing that therapist competence was not associated with a greater reduction in self-harm rates: this may be a consequence of the power of the study (it was not powered to take account of therapist variables and not all therapy sessions were available for rating) as it is difficult to disentangle non-specific from specific aspects of the therapist, patient characteristics or their interaction. Alternatively, it is possible that the sample of audiotapes available for rating was biased in some way (see below). The lack of an association between scores on self-rated measures and therapist competence suggests that patients may underestimate the degree of change in symptoms and social functioning, that the subjective ratings employed were less sensitive to change than the observer ratings or that subjects do not rate changes in symptoms and problems in a similar manner to trained independent observers.

This study highlights one of the major problems in trying to evaluate the relationship between therapist competence and patient outcome, namely the need to establish an acceptable procedure for making high quality recordings of sessions that are representative of the therapy being practiced by each therapist and representative of the patients being seen for that therapy. Only 57% of therapists returned tapes that could be rated on the competence scale and we did not rate all the available tapes. Many therapists were not able to provide appropriate therapy recordings for some or all of their cases so those who submitted tapes may differ in unknown ways from the therapists who did not provide tapes. As a result, we are unable to assess level of competence for the group of therapists as a whole. Furthermore, we were not able to score therapist competence on the basis of their work throughout the whole course of MACT with a patient. This may affect our assessment of competence as Tang & DeRubeis (1999) have demonstrated that the session from a course of therapy that is rated lowest with regard to therapist competence may be the most robust predictor of client outcome. As well as therapist factors influencing the availability of tapes it is important to note that 33% of participants refused to allow therapy sessions to be recorded. The representativeness of the group who were audiotaped compared to those who refused to be audiotaped remains to be evaluated.

Despite the above problems in conducting studies of therapist competence, we would encourage the development and publication of similar studies. We demonstrated that therapist competence in a brief technique orientated approach (MACT) following equivalent exposure to brief training (3 days in total) was not related to individual characteristics such as professional qualifications, age or gender. Level of competence in this study was therefore unrelated to some of the therapist characteristics that might have been thought to be important, yet often fail to account for variance in treatment effects (e.g. Lafferty *et al*. 1989; Beutler *et al*. 1994).

The findings reported are important to the overall interpretation of the POPMACT results (Byford *et al*. 2003; Tyrer *et al*. 2003*b*). This study suggests that a brief focused treatment is an effective treatment for the depression and anxiety symptoms associated with recurrent self-harm, when delivered by mental health professionals, who are competent in that intervention, but who are not highly trained psychotherapists. It is possible that lengthier training or more specialist CBT practitioners might have produced different results, but the trial was a pragmatic one, designed to reflect routine clinical practice with a variety of health service professionals providing the treatment during the course of their everyday work. These findings, in conjunction with the finding that MACT is a cost-effective treatment, adds weight to the argument for disseminating this approach more widely. However, the failure to demonstrate a reduction in deliberate self-harm rates suggests that determining the components of therapy and of therapist behaviour that lead to better clinical outcomes remains an important challenge.

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APPENDIX: MACT RATING SCALE

Kate Davidson and Jan Scott

1. Structure of session

Did the therapist guide and structure the session appropriately?

1	2	3	4	5	6	7
Total absence of structure			Structure recognizable but not adhered to			Structured clear flow

2. Pacing of session

Did the therapist pace the session appropriately?

1	2	3	4	5	6	7
Therapist showed no sign of pacing session			Adequate pacing			Excellent pacing of session

3. Collaboration

Did the therapist form a collaborative relationship with the client?

1	2	3	4	5	6	7
No collaborative alliance evident			Adequate collaboration: both seem to be understanding each other and agreeing to work on problems			Collaborative relationship evident: client and therapist well meshed

4. Appropriate techniques

Did the therapist suggest appropriate techniques to deal with the client's problems?

1	2	3	4	5	6	7
No			Sometimes but misses opportunity to suggest appropriate strategies			Therapist uses timely and appropriate suggestions for intervention

5. Skilful execution of techniques

Did the therapist appear to be competent at delivering the therapy?

1	2	3	4	5	6	7
Therapist appears to be incompetent, or inept			Adequate: appears to be confident and knowledgeable			Highly competent: appears confident, knowledgeable and skilled at delivering therapy

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6. Helpfulness of session

Did the client appear to find the content of the session helpful?

1	2	3	4	5	6	7
Client seems to be finding session unhelpful: therapist does not check out if session unhelpful			Content appears to be relevant and helpful to client			Content of session appears highly relevant and client appears to be acknowledging this. Appears to help client understand and deal with problem

7. Empathy

Did the therapist convey appropriate levels of warmth and understanding of the client's problems?

1	2	3	4	5	6	7
Therapist fails to convey appropriate understanding of the client's problems. May appear to be disinterested/cold.			Adequate warmth and understanding conveyed			Therapist appears appropriately warm, understanding and conveys this to the client in a skilled manner

8. Client/problem difficulty

Given the problems of this particular client, was the therapist effective?

1	2	3	4	5	6	7
Therapist was not effective and this was *not* due to the client.			Therapist effective but client difficult			Client very difficult to engage but this does not appear to be due to therapist's effectiveness or lack of skill. Most competent therapists would find this client problematic.

9. Linking sessions

Did the therapist make reference to the content of other sessions?

1	2	3	4	5	6	7
No reference made to other sessions.			Adequate reference			Therapist establishes helpful link with another session and utilises information appropriately

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10. Using the manual

Did the therapist make appropriate reference to the manual?

1	2	3	4	5	6	7
No			Cursory but adequate. Could have used it more			Makes reference to manual in helpful way – appears to be integrating manual appropriately into therapy

11. Homework assignments

Did the therapist suggest appropriate homework?

1	2	3	4	5	6	7
No homework suggested			Homework suggested but rationale not clear or not agreed collaboratively			Agreed collaboratively highly relevant assignment

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