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A COMPETENCE FRAMEWORK FOR TRAINING COGNITIVE BEHAVIOURAL THERAPY WITH CHILDREN AND ADOLESCENTS: INTEGRATION OF EXISTING MODELS AND COMPARISON WITH NATIONAL TRAINING PROGRAMMES IN FINLAND

ABSTRACT

Mental disorders are common in childhood and adolescence, but access to psychological interventions remains limited. Expanding this access requires training a workforce competent in methods aligned with the needs of service users and the possibilities of service providers. Competence-based education can improve the transparency, consistency and effectiveness of psychotherapy training programmes. Competence frameworks are used to systematically articulate the goals of training and the expected knowledge and skills of the trainee. Cognitive behavioural therapies (CBTs) are the most widely recommended treatments for common internalizing and externalizing disorders. The study develops a competence framework for CBT with children and adolescents by integrating established frameworks, to provide a more comprehensive presentation of expected competence. The presented framework covers 91 competences across six domains: core competences for work with children and adolescents, generic therapeutic competences, assessment and planning, CBT competences/techniques, metacompetences and problem-specific competences. To test the practical applicability of the developed framework, its alignment with the contents of nationwide CBT training programmes for children and adolescents was evaluated. Results showed that 88% (CBT for children) and 81% (CBT for adolescents) of competences were fully covered, with smaller proportions partially addressed or omitted. The competence framework provides a novel tool for presenting, comparing, and evaluating CBT training programme contents internationally. This can be used to support both workforce competence building and scientific research on CBT methods.

KEYWORDS: COGNITIVE BEHAVIOURAL THERAPY (CBT), CHILD AND ADOLESCENT MENTAL HEALTH, COMPETENCE-BASED EDUCATION, PSYCHOTHERAPY, STEPPED CARE

INTRODUCTION

Mental health symptoms and disorders are highly prevalent in childhood and adolescence (1). Cognitive behavioural therapies (CBTs) represent the most widely studied and implemented treatments for both internalizing and externalizing disorders (2–4). However, in the mental health service system, a significant mismatch often exists between the demand for and supply of treatment, as much as 55.8% of children and adolescents with a mental health disorder in high-income countries do not receive any treatment (5). This highlights a systemic issue: even the most effective treatment models cannot improve coverage if they fail to reach the children and adolescents who need them.

A key strategy to tackle this mismatch is to expand timely access to evidence-based psychological interventions, including CBT, across different service settings, by ensuring that professionals are sufficiently trained and competent to deliver these services. Aligning training programmes with the needs of the service system and the standards of evidence-based treatment is essential to this strategy, as it promotes both the quality and scalability of services by ensuring a sufficiently large workforce competent in these treatments. Thus, it is important to describe the competence structure of implemented CBT training programmes in a transparent manner to enable comparability across training, service delivery models, and ultimately, treatment outcomes between countries. In this

paper, competence refers to the overall ability to practice CBT effectively, while competences denote specific, demonstrable skills and capacities within defined areas of practice.

Expanding access to psychological interventions across various service settings often means that the interventions provided in each setting must take into account the context in which they are delivered - for example, the existing workforce, working methods and legal and financial principles. This creates the need for a versatile selection of context-appropriate interventions with varying levels of intensity and complexity.

Stepped care approaches are increasingly used and studied as a solution to optimize cost-effectiveness and access to timely treatment in publicly funded healthcare systems (6–8). In stepped care, the available psychological interventions are offered according to a hierarchy where treatment approaches in higher steps require more resources and are targeted to more severe cases, and lower steps involve less intensive interventions aimed at individuals with milder symptoms. Low-intensity interventions include, for example, guided self-help approaches and higher steps more conventional face-to-face interventions (9). Stepped care approaches have shown comparable clinical outcomes and improved cost-effectiveness in the treatment of child and adolescent anxiety compared to standard treatment (10–13). In practice, most stepped care models are “modified”, meaning that they are combined with some form of clinical staging, assessment and stratification protocols. This allows determining the most appropriate treatment based on each individual’s needs. The determining of appropriate first-line treatment needs to consider factors reflecting symptom severity, daily functioning and contextual needs (e.g. age and developmental state, socioeconomic context) (14,15). For example, in England the i-THRIVE model for children and adolescents allows children and adolescents to access components of different service domains, such as “Getting Advice”, “Getting Risk Support” and “Getting More Help”, tailored to individual and evolving needs, rather than progressing sequentially through steps (16).

In Finland, a modified stepped care model has been developed and implemented under the First-Line Therapies model (“Terapiat etulinjaan -toimintamalli”) since 2020. The model covers all ages, but with different contents and specifications for children, adolescents and adults. Responsibility for organizing mental health services in Finland is divided into 23 regional entities (Wellbeing services counties) each with considerable autonomy. Thus, the First-Line Therapies model does not stipulate which interventions are mandatory, but it facilitates those with strongest evidence base and applicability, and provides nationwide training programmes for professionals

in these interventions adapted for the Finnish healthcare system. In particular, CBT for children and adolescents is one such intervention that has been widely implemented across the public healthcare system within the First-Line Therapies model (17). These associated training programmes are described later in this paper.

When providing nationwide training programmes, both scalability and quality must be taken into account. To improve the scalability of training programmes, e-pedagogics is being increasingly utilized (18). Adopting a competence-based approach is a common strategy for establishing and sustaining the quality of training programmes. Competence-based education is an outcome-focused and learner-centred approach that emphasizes the mastery of specific skills and knowledge (competences) over time spent in training (19,20). In the context of psychological interventions and psychotherapy, competence-based education has been proposed as a solution to improve the consistency, transparency and effectiveness of training (21,22).

Competence frameworks have been developed to cover core working methods with specific clientele, generic therapeutic competences, CBT-specific competences and problem-specific competences (21). For adult populations, these domains are typically presented within an integrated framework. However, to our knowledge, for work with children and adolescents a fully comparable integrated framework for CBT does not yet exist. Carrying out CBT varies when applied to children, adolescents and adults despite some overlap, and different CBT techniques are emphasized in different types of problems (23). Psychological interventions, and especially the associated training programmes, always require some degree of national adaptation to be implementable in practice. Translation of the training and treatment materials is obviously required, but legal, practical, economic and sometimes cultural differences also need to be considered. Thus, it is important to provide a comprehensive map of competences covering both the generic and specific CBT competences for children and adolescents, following existing frameworks to enable more comprehensive international comparisons and co-development of training programmes.

Competence frameworks maintained by the University College London (UCL) have been formally adopted as the basis for National Occupational Standards in the UK. These include detailed frameworks for multiple specific therapeutic approaches – primarily for adult populations – including CBT (24). Following the principles laid out by Roth and Pilling (2008), the UCL CBT competence framework is presented through five domains: generic competences, basic CBT competences,

specific CBT competences, problem-specific competences and metacompetences (25). Additionally, a separate framework for core and generic therapeutic competences for psychological interventions in Child and Adolescent Mental Health Services is also available within the UCL system (26). For CBT with children and adolescents, a competence framework following the original work by Roth and Pilling has been described by Sburlati and colleagues (27).

AIMS

This article addresses a gap in the literature by presenting an integrated competence framework for CBT with children and adolescents, combining established models of core, generic therapeutic, CBT-specific and problem-specific competences. Existing frameworks typically focus on either adult population, general psychotherapy skills, core competences for child and adolescent work or elements of CBT. However, a comprehensive framework that integrates these dimensions specifically for child and adolescent CBT is lacking. Furthermore, the existing criteria do not include problem-specific competences for children and adolescents. This article presents a more comprehensive point of reference for CBT professionals and offers a tool for communicating required and delivered competences to stakeholders and policymakers. It also exemplifies the potential use of this framework by examining the content of a nationwide CBT training programme in Finland in comparison to the identified competences. In sum, the paper aims to contribute to ongoing international efforts to improve transparency, consistency and quality in therapist training.

METHODS

SYNTHETIZING EXISTING COMPETENCE FRAMEWORKS

The synthesis is carried out within the following existing frameworks: A) the UCL framework for Cognitive and Behavioural Therapy (adults, CBT domains, metacompetences) (25), B) the UCL framework for Psychological Interventions in Child and Adolescent Mental Health Services (children and adolescents, core competences) (26), C) the framework by Sburlati and colleagues (generic therapeutic and specific CBT competences with children and adolescents) (27), and D) a recent review of problem-specific CBT models for children and adolescents (28). The review of problem-specific CBT models involved a thorough review of literature to date, consultation

with national and international experts and a review of applied interventions and efficacy in practice. Each of the competence frameworks included in this synthesis contributes distinct elements not fully captured by the others, despite considerable overlap.

The synthesis process followed these steps: 1) Competences listed by Sburlati and colleagues (C) were compared against the UCL framework for Psychological Interventions in Child and Adolescent Mental Health Services (B) to identify areas of overlap and divergence, 2) In cases of overlap, the more precise and detailed description of the competences was selected, 3) All competences that were unique to either framework were included in the final version, 4) CBT-specific competences were incorporated from Sburlati and colleagues, 5) Metacompetences from the UCL framework for Cognitive and Behavioural Therapy (A) were incorporated, 6) Problem-specific CBT models (D) were incorporated, and 7) The overall structure of the framework was organized visually according to the schematic competence map in the UCL framework for Cognitive and Behavioural Therapy (A).

MAPPING THE ALIGNMENT OF A NATIONWIDE CBT TRAINING PROGRAMME WITH THE INTEGRATED COMPETENCE FRAMEWORK

The training content of the nationwide CBT training programmes (CBT for children and CBT for adolescents) (17) were evaluated in relation to the synthesized competence framework by supervising trainers (authors SL and HL). Descriptions of the content and structure of the training programmes are provided in the Appendix. The evaluators worked independently and resolved disagreements through discussion. Following the same method from the mapping of the adult competences (29), the evaluators categorized the competences in three classes as follows: 1) the training programme provides sufficient coverage of the competence, 2) the training partially covers the competence, and 3) the training does not address the competence, or it is outside the scope of the training programme.

RESULTS

The synthesized competence framework included in total 91 competences which were divided under the following six domains: 1) Core competences for work with children and adolescents (12 competences), 2) Generic therapeutic competences (11 competences), 3) Assessment & planning

(8 competences), 4) CBT competences, techniques and metacompetences (50 competences), and 5) Problem-specific competences (10 competences). The number and distribution of competences under each domain and subdomain is presented in *Table 1*.

There was 88% agreement between the two evaluators and the remaining discrepancies were resolved through discussion. The nationwide CBT training programme for children fully covered 88% of the identified competences, partially covered 5%, and did not cover 7%. The corresponding percentages for CBT training for adolescents were 81%, 12% and 7%, respectively. The training did not include education in psychopharmacology,

nor did it address the competences required for coordinating collaboration or task allocation across different agencies or professionals. Training in group-based interventions was absent from the CBT training programme for children. Among specific CBT techniques, response prevention was not included in the training for adolescents, and applied tension was missing from both curricula. Furthermore, the training lacked disorder-specific competences in the treatment of body dysmorphic disorder and trauma-related (including PTSD) disorders as well as OCD (for adolescents). The synthesized competence framework as well as the mapping of the nationwide CBT training programmes can be viewed in *Figure 1*.

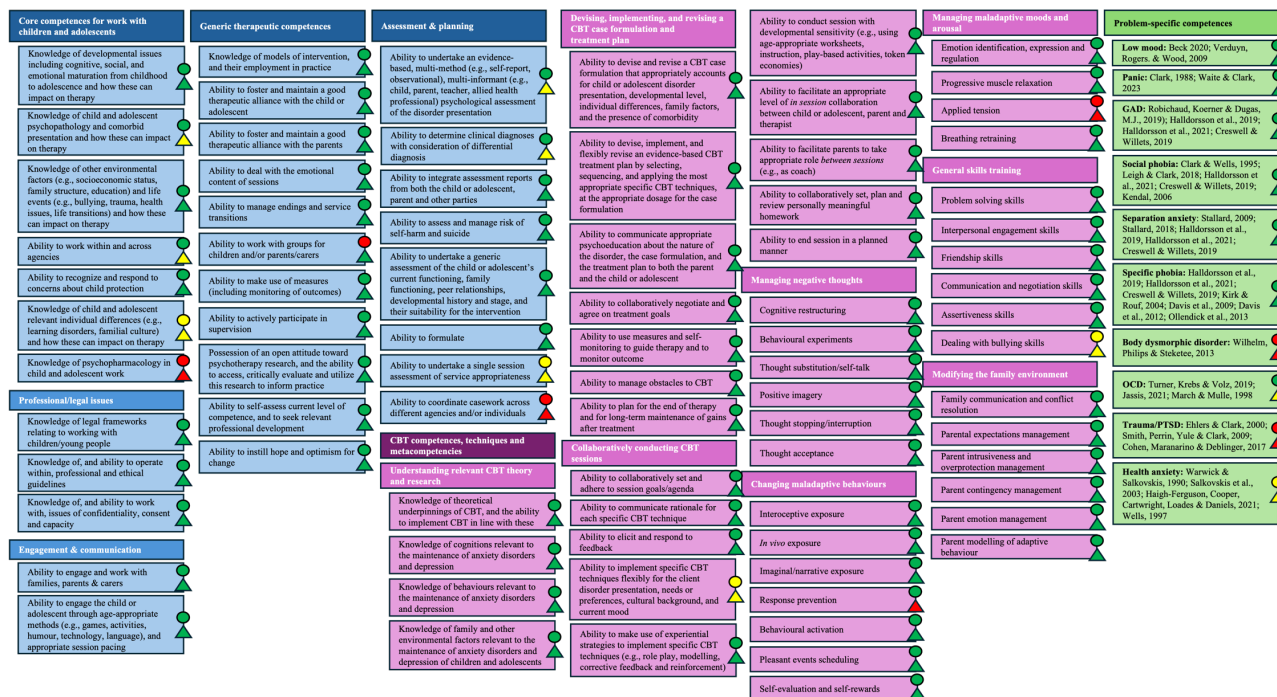
Table 1. Distribution of Cognitive behavioural therapy (CBT) therapist competences for working with children and adolescents across domains and subdomains. Each subdomain competence within a subdomain is also included in the parent domain.

Competence domain/subdomain	Number of competences (% of all competences)
Core competences for work with children and adolescents	12 (13%)
Professional/legal issues	3
Engagement & communication	2
Generic therapeutic competences	11 (12%)
Assessment & planning	8 (9%)
CBT competences, techniques and metacompetences	50 (55 %)
Understanding relevant CBT theory and research	4
Devising, implementing and revising CBT case formulation and treatment plan	7
Collaboratively conducting CBT sessions	10
Managing negative thoughts	6
Changing maladaptive behaviours	7
Managing maladaptive moods and arousal	4
General skills training	6
Modifying the family environment	6
Problem-specific competences	10 (11%)
TOTAL	91 (100%)

Figure 1. Integrated Competence Framework for Cognitive behavioural therapy (CBT) with children and adolescents and its alignment with the nationwide CBT training programmes in Finland.

Green = Training programme provides sufficient coverage of the competences
Yellow = Training programme partially covers the competences
Red = The training does not address the competences, or it is outside the scope of the training programme

Circle = CBT training programme for working with children
Triangle = CBT training programme for working with adolescents



DISCUSSION

In this paper, we describe the development of an integrated competence framework for cognitive behavioural therapy (CBT) with children and adolescents by synthesizing established frameworks to provide a more complete presentation of necessary competences. Additionally, Finnish nationwide CBT training programmes for children and adolescents were assessed identifying competences covered fully, partially or not at all in the training.

The competence framework presented here covers all domains as originally laid out by Roth and Pilling (21). CBT-specific competences account for over half of the competences, while the remainder reflected core working methods with children and adolescents and generic therapeutic skills common to most modalities of psychological interventions. This distribution mirrors a widely discussed position in psychotherapy research, which holds that treatment effectiveness arises from both specific

techniques and common factors shared across therapeutic approaches (30,31).

Well-defined and shared competence frameworks are a valuable tool for addressing gaps in the availability of psychological interventions for children and adolescents. Such frameworks facilitate cross-national benchmarking of training programmes, service delivery models and treatment outcomes. They also support communication of training needs and the qualifications of a competent workforce to stakeholders and policymakers. Furthermore, identifying and articulating key competences can also contribute to psychotherapy research as a scientific discipline by highlighting gaps in further knowledge, creating opportunities for the optimization of treatment methods, and establishing common viewpoints across theoretical orientations (22). Finally, established competence frameworks support CBT trainers in curriculum design and help to identify important competences still missing from shared models.

Although the existing competence frameworks and the integrated model presented here appear comprehensive, it nonetheless invites reflection on possible omissions and areas for further development. For example, the competence framework does not specifically address competences related to adapting CBT for service-relevant subgroups of children and adolescents with distinct developmental or contextual needs, such as those with neurodevelopmental problems or from culturally diverse backgrounds. Adding specific descriptions of competences, such as using visual aids and concrete language when working with individuals with intellectual disabilities, could enhance both the competence framework and clinical outcomes (32–34). In addition, problem-specific competences for behavioural problems and conduct disorders could be added in future iterations (35).

In addition to certain thematic developmental needs, challenges remain in the overall presentation of competence frameworks, which may obscure key distinctions or reduce their practical utility. For example, the framework does not indicate which competences should be prioritized, for example, in training settings with limited resources or low intensity training. Further, the competences within the framework vary in their level of abstraction, with some being more concrete and practice-oriented, while others are formulated in more general or abstract terms. As competence-based education defines competence as outcomes of training programmes, individual competences could be reformulated into more concrete and observable learning objectives, for example, in line with Bloom's taxonomy (36). This would aid in delivering training programmes within the pedagogical framework of constructive alignment where learning tasks and assessment methods are purposefully designed to match predetermined learning objectives (37).

A competence-based review of the Finnish nationwide CBT training programmes revealed that several competences are adequately addressed in both child and adolescent CBT training. Some competences (e.g. psychopharmacology) are omitted due to contextual reasons: some competences are included in the basic education programmes of the CBT trainees, as the training model in question is often delivered to professionals who already possess a relevant clinical qualification. However, the review also identified areas in need of further development. One significant gap is the lack of training in addressing the cultural backgrounds of children, adolescents and their families within therapeutic work. This represents an important area for development, particularly as the proportion of children and adolescents with a foreign background in the Finnish population has increased, reaching 11% of the total child and adolescent

population by the end of 2022 (38). Furthermore, group-based treatment models for children are currently absent from the training and represent an important area for future development. Evidence suggests that group-based interventions for anxiety and behavioural problems are effective in treating children and adolescents (39,40). Incorporating group-based treatment models into the training curriculum could offer evidence-based and cost-effective treatment options. In the adolescent training programme, the role of developmental context outside the home, particularly the school environment, in adolescent growth and development is not addressed. The importance of these settings as sources of information (e.g. teachers) for adaptation, as well as potential partners in treatment collaboration, is not currently included in the training content. Furthermore, certain disorders are not entirely all included in the training programmes: body dysmorphic disorder, trauma-related treatment, obsessive-compulsive disorder (for adolescents) and health anxiety. Some disorder-specific approaches such as trauma-focused CBT (41) are typically delivered within their own established training programmes. It may therefore be more appropriate to address such disorder-specific methods in specialized training rather than incorporating all elements into a single, broad training framework. The selection of treatment models is informed by clinical need within the publicly funded healthcare system, as well as by the established division of roles and responsibilities related to training and treatment across different parts of the service system (e.g. primary and specialized care). Efforts are currently underway to develop and integrate an OCD treatment model for adolescents into the training programme. In the case of health anxiety, the anxiety treatment model is suggested as a general approach (42).

This study has some limitations. First, it is possible that not all relevant competence frameworks were identified prior to conducting the synthesis. However, we deliberately emphasized the most established and widely used models to ensure a solid foundation. Second, we included only two independent reviewers to review the training content and no external or international experts were involved in the evaluation. These reviewers achieved high concordance, and discrepancies were discussed to consensus.

CONCLUSIONS

The synthesized competence framework provides a comprehensive tool for evaluating the content of CBT training programmes for children and adolescents. This increases training transparency and allows for the comparison of training

programmes across countries and service systems. Within a national context, the framework can support communication with stakeholders and policymakers on the criteria and content of treatment, and facilitate in the co-creation and implementation of scalable and cost-effective care models. The nationwide CBT training programmes for children and adolescents in Finland cover most of the identified competences with certain omissions that reflect adaptation to the local service structure and workforce roles.

The competence framework also offers a basis for systematically developing training curricula to meet evolving clinical needs. In the future, it is essential to develop and evaluate assessment methods that align with competence-based education principles and support the evaluation of relevant clinical skills. A wide adoption of structured frameworks like the one presented here may contribute to greater consistency, transparency and equity in the delivery of psychological interventions for children and adolescents across service systems.

Supplementary Material

Supplementary data are available at [Psychiatry Fennica online](#).

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