NHS Talking Therapies

Curriculum for Practitioner Training in Interpersonal Psychotherapy (Trainee)

CONTINUING PROFESSIONAL DEVELOPMENT FOR QUALIFIED THERAPISTS DELIVERING HIGH INTENSITY INTERVENTIONS

Version 1.1 (Revised December 2023)

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Revisions

December 2023

1- References to IAPT amended to NHS Talking Therapies
2- Amended entry requirements to align with NHS Talking Therapies Manual
3- Updated branding to NHS Talking Therapies

Contents

1. Introduction

This curriculum is for a training that enables experienced psychological therapists to provide a depression-specific 16 session therapy in an NHS Talking Therapies setting for individuals where there is both interpersonal distress and depression.

The competences required to deliver effective Interpersonal Psychotherapy for Depression are drawn from the published IPT manuals and NICE-endorsed research studies.

The training to deliver this therapy within the NHS Talking Therapies programme consists of two linked elements: a six-day course (five training days plus one follow up day), and an additional period of supervised clinical work with an IPTUK accredited supervisor, during which four cases must be satisfactorily completed in order to be accredited as an *Interpersonal Psychotherapy for Depression NHS Talking Therapies Practitioner*. The accrediting body is IPTUK.

Clinicians treating individuals with depression and interpersonal distress within NHS Talking Therapies will be expected to draw on competencies from their existing practice of psychological therapies and integrate these with competencies specified for use with this patient group, as outlined in this training curriculum.

Aims of the Training

1. **To develop practical competencies in Interpersonal Psychotherapy for Depression and integrate with generic competencies in psychological therapy.**
2. **To ensure clinical practice in accordance with local and national NHS Talking Therapies service policy, including the need to work appropriately with difference and to routinely monitor clinical outcomes.**
3. **To enable Interpersonal Psychotherapy for Depression practitioners to act as an expert resource to professional colleagues, thus ensuring appropriate referrals for Interpersonal Psychotherapy for Depression and informed patient choice.**

2. Overarching meta-competency for Interpersonal Psychotherapy for Depression:

Ability to maintain a focus on the interpersonal context of symptoms

www.ucl.ac.uk/clinical-psychology/CORE/IPT_framework.htm

Overarching elements common to high intensity psychological therapies for depression in NHS Talking Therapies

Knowledge of depression

Working with difference

Identifying and managing risk of self harm

Routine monitoring of clinical outcomes

http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm

4. Key Texts

Depression-focused texts

Bhugra, D. & Bahl, V., 1999. Ethnicity: an agenda for mental health. London: Royal College of Psychiatrists/Gaskell.

Department of Health, 2002. A sign of the times: modernising mental health services for people who are deaf. London: HMSO.

Department of Health, 2005. Delivering race equality in mental health care: a summary. London: Department of Health.

Department of Health, 2007. Positive steps: supporting race equality in mental healthcare. London: Department of Health.

Ethnicity Online. Useful web resources and good practice guidelines at www.ethnicityonline.net/resources.htm

Equality Act 2010: http://www.equalities.gov.uk/equality_act_2010.aspx

HM Government Office for Disability Issues: http://www.officefordisability.gov.uk/index.php

MIND information on different community groups: http://www.mind.org.uk/help/people_groups_and_communities/

O'Hagan, K., 2001. Cultural competence in the caring professions. London: Jessica Kingsley.

Prior, P., 1999. Gender and mental health. Basingstoke: Macmillan.

Rogers, A. & Pilgrim, D., 2003. Mental health and inequality. Basingstoke: Palgrave Macmillan.

Royal National Institute for the Blind at http://www.rnib.org.uk/Pages/Home.aspx

Ryan, T. & Pritchard, J. eds., 2004. Good practice in adult mental health. London: Jessica Kingsley.

Stokes, G., 2000. Mental health problems in older people. In Bailey, D. (ed.) At the core of mental health: key issues for practitioners, managers and mental health trainers. Brighton: Pavilion Publishing Ltd, p.80-128.

Thornicroft, G., 2006. Shunned: discrimination against people with mental illness. Oxford: OUP.

IPT focused texts

Elkin, I.M, Shea, M. T., Watkins, J.T. et al (1989) National Institute of Mental Health Treatment of Depression Collaborative Research program: general effectiveness of treatments. Arch of Gen Psych, 46, pp 971-982.

Frank, E. et al (1990): Three Year Outcomes for maintenance Therapies in Recurrent Depression. Arch Gen Psych 47, Dec: pp 1093-1099

Sotsky S.M et al (1991) Patient predictors of response to psychotherapy and pharmacotherapy: Findings in the NIMH Treatment of Depression Collaborative Research Program. Am J of Psych, 148: pp 997-1008

Frank, E. et al (1991) Efficacy of Interpersonal Psychotherapy as a Maintenance Treatment of Recurrent Depression. Arch Gen Psych 48, pp 1053-1059

Elkin I.M et al, (Oct 1995) Initial Severity and differential treatment outcome in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Journal of. Consulting & Clinical Psychology, Vol 63(5) ,pp 841-847

Frank, E. , Spaner, C. (1995) Interpersonal Psychotherapy for Depression: Overview, Clinical Efficacy, and Future Directions. Clinical Psychology: Science and Clinical Psychology: Science and Practice, V2, N4, Winter.

Markowitz, J.C. & Swartz, H.A. (1997). Case Formulation in Interpersonal Psychotherapy of Depression in T.D. Eells (Ed) 192-222 Handbook of Psychotherapy Case Formulation. N.Y., London, Guilford Press.

Weissman, M.M., Markowitz, J.C., & Klerman, G.L. (2000) Comprehensive Guide to Interpersonal Psychotherapy. Basic Books

Frank E et al (Jan 2000) Interpersonal Psychotherapy and antidepressant medication: evaluation of a sequential treatment strategy in women with recurrent major depression. Journal of Clincal Psychiatry61 (1), pp51-57

Stuart, S. & Robertson, M. (2003). Interpersonal Psychotherapy: A Clinician's Guide. London, Arnold

Weissman, M.M., Markowitz, J.C.& Klerman G.L. (2007) Clinician's Quick Guide to Interpersonal Psychotherapy

Frank, E & Levenson, JC (2010) Interpersonal Psychotherapy (Theories of Psychotherapy)

Law, R (2011) Interpersonal Psychotherapy for Depression. Advances in Psychiatric Treatment, Jan.

In addition trainees are provided with a summary of the IPT literature 2005-1010.

5. High Intensity Curriculum - Interpersonal Psychotherapy for Depression

Interpersonal Psychotherapy (IPT) is an effective treatment option for depression, and is among those evidence-based treatments recommended in the National Institute for Health and Clinical Excellence (NICE) guidelines for depression. There has been extensive evaluation of its practice and more recently a focus on widening the dissemination and availability of this treatment approach. IPT's evidence base, short-term nature and interpersonal focus have made it attractive to clients, practitioners and service purchasers.

Many clinicians have had some exposure to IPT; few have had the opportunity to develop competent practice. Courses for qualified and experienced NHS Talking Therapies workers, delivering services at levels 3 and 4, will aim to provide a post-qualification CPD training in evidence based IPT for adults with depression. The training will support trainees to reach a level of competence that would enable them to obtain the outcomes reported in the relevant NICE guidance. It will also be necessary for trainees to be familiar with conditions that are commonly co-morbid with depression such as anxiety, although this will not be the primary focus of the intervention.

The trainees will work in NHS Talking Therapies services, providing the high-intensity IPT component. NICE recommends a stepped-care approach to the management of many cases of depression and NHS Talking Therapies services will be organised around these principles. In addition NHS Talking Therapies services will provide choice across a range of evidence treatments for the treatment of common mental health problems. For the services to work efficiently, it is important that the high-intensity trainees are also familiar with the low-intensity work that many patients may have received before being 'stepped-up' to high intensity treatment as well as the other treatment approaches which are represented in the care pathway. The trainees will also need to be able to use the NHS Talking Therapies national outcomes monitoring system (which includes session-by-session symptom measures). IPT and linked interventions aim to have a meaningful impact on clients' lives, improving social inclusion, employment and productivity as well as alleviating depressive symptoms. Trainees will therefore need to be able to assess employment opportunities and develop close working relationships with employment coaches in order to maximise patients' chances of returning to the workplace.

Course aims and objectives

The course will have an integrated theoretical base, reflecting the integration of medical and interpersonal models. In addition to providing practical, intensive and detailed skills training to a defined standard of competence, the course will aim to increase trainees' knowledge base of theory and research in IPT, and to promote a critical approach to the subject.

It will aim to equip trainees to become skilled and creative independent IPT practitioners, in accordance with IPTUK accreditation guidelines, and to contribute to the further development of IPT.

The course will provide opportunities for trainees to develop and demonstrate knowledge, understanding and skills as follows:

1. To develop practical skills in delivering IPT for depression.

2. To develop critical knowledge of the theoretical origins and research literature relating to IPT for depression.

3. At the end of the course trainees will be able to:

i. demonstrate a systematic knowledge of the principles of IPT and the application of IPT techniques to the treatment of depression
ii. demonstrate a critical understanding of the theoretical and research evidence for IPT for depression and an ability to evaluate the evidence
iii. practise IPT with depression systematically, creatively and with good clinical outcomes
iv. identify an IPT focus area and construct a interpersonal formulation for depression
v. deal with complex issues arising in IPT practice
vi. take personal responsibility for clinical decision making in straightforward and more complex situations
vii. demonstrate self-direction and originality in tackling and solving therapeutic problems
viii. demonstrate an ability to adapt IPT sensitively, and to ensure equitable access for people from diverse cultures and with different values.
ix. demonstrate cultural competence

<u>Equality and cultural competence</u>

Course objective to acquire cultural competence aligns with statutory duties under the Equality Act 2010, requiring public authorities who exercise public functions and organisations carrying out public functions on behalf of a public authority, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations between

people of shared protected characteristics and those who do not.

Achieving cultural competence is a lifelong learning process. Cultural competence for highintensity IPT therapists will aim to develop the student's ability to recognise their own reaction to people who are perceived to be different and values and belief about the issue of difference (cultural competence module). The assessment criteria will include

i. Developing an ability to recognise one's own reaction to people who are perceived to be different and values and belief about the issue of difference.

ii. Understanding a definition of culture, related values and factors effecting culture e.g. age, disability, marital status, ethnicity, parental status, sexual orientation, gender, education, language, socioeconomic status, and religion or belief.

iii. Capable of taking responsibility for responses and actions taken with people who are different or are perceived to be different

iv. Developing ability to accept ambiguity of not knowing what to expect or what to do initially during an inter-cultural situation.

v. Risk taking in order to communicate effectively with people from diverse cultures.

vi. Working effectively with interpreters, establishing ways of working together and considering clinical implications.

vii. Raised awareness of one's reaction to people who are different and the implications of these reactions during sessions.

Entry Requirements- Qualifications and Accreditations/Registrations

Aligned to the NHS Talking Therapies manual the course is available to:

NHS Talking Therapies Specified counselling/ psychotherapy accreditation[1] / BABCP accredited/ General Medical Council registered Psychiatrist/ HCPC registered practitioner psychologist or arts therapist

[1] NHS Talking Therapies specified counselling or psychotherapy accreditations: British Association for Counselling and Psychotherapy (BACP) Accredited; United Kingdom Council for Psychotherapy (UKCP) Registered as a Psychotherapist or Psychotherapeutic Counsellor; Association of Christian Counsellors Accreditation; National Counselling Society Accredited Professional registrants, British Psychoanalytic Council Registered.

Structure of training

The IPT practitioner training course is delivered over five consecutive days and one follow up day. The five day course is broken down into ten units, plus one single day follow up. Each unit is half a day. The training covers all of the specific competencies for IPT for Depression and the current evidence base for IPT practice.

Prior to attending the course trainees use the IPT competencies self assessment tool to identify the general psychotherapy competencies and IPT specific competencies they bring to the training. This exercise is repeated after the training in order to monitor the acquisition of specific IPT competencies and to inform the supervision of initial IPT casework.

Following completion of the initial five days of training trainees begin casework with clients with depression using IPT. NICE guidelines recommends IPT for patients across the severity spectrum for Major Depression, However in practice trainees are directed to select cases with moderate to severe symptoms for their initial casework. This offers some protection against early discontinuation of treatment in the event of rapid symptom resolution and facilitates the process of linking current symptoms to current interpersonal difficulties for new practitioners. Trainees submit four cases for assessment with a view to completing IPT practitioner accreditation. It is advisable that trainees should stagger the start of new cases over approximately six weeks, and where possible, begin with a supervised non accreditation case to gain familiarity with the practical application of the model before being subject to accreditation evaluation.

Trainees attend weekly supervision for the duration of the casework. Trainees complete a brief self assessment following each IPT therapy session and use this as a basis for clinical reflection and supervision. Trainees submit a minimum of three recorded therapy sessions for evaluation per case. Trainees complete a detailed competency-based self-assessment prior to submitting recordings, using the IPT Audio Rating Scale, and receive written feedback on the same competency assessment form following the supervisor's or external rater's review of the recordings of therapy.

At the midpoint of the casework trainees attend a follow up day to provide a refresher to the initial training and to review the transfer of theory into practice. Trainees will also use the IPT competencies self assessment tool again at this stage to monitor the development of competencies and identify areas for specific supervision. Weekly supervision continues until

conclusion of the casework. Trainees produce a reflective statement on each IPT case undertaken and repeated the IPT competencies self assessment for a final time.

Summary of the units

1. **Unit One: Introduction to IPT and theoretical origins**
2. **Unit Two: IPT Assessment – the symptom focus**
3. **Unit Three: IPT assessment – the interpersonal focus**
4. **Unit Four: Formulation and working with IPT focus areas**
5. **Unit Five: Interpersonal Role Transitions**
6. **Unit Six: Complicated Grief**
7. **Unit Seven: Interpersonal Role Dispute**
8. **Unit Eight: Interpersonal Sensitivity/Deficits**
9. **Unit Nine: Endings and Maintenance**
10. **Unit Ten: IPT evidence base and modifications for depression**
11. **Unit Eleven: Follow up training**

6. Method of Training

The 5 day course and one day follow up will be a mix of:

Didactic teaching
Large and small group discussion
Extensive use of case-discussion and role-play
DVD material and live interactive role plays
Ongoing assessment of role-play

7. Supervised Clinical Work

Four cases are brought to supervision with IPTUK supervisors, following the NHS Talking Therapies IPT for Depression protocol. Trainees complete a training portfolio that demonstrates clinical work in at least two focal areas in IPT.

Each trainee will have one main supervisor and one external rater. The main supervisor provides weekly supervision on all four cases and ratings on two cases. The external rater provides rating on two cases. Whenever possible supervision should be conducted in groups.

Three recordings of sessions, one from each phase of the work, are submitted per case. Recordings are rated using the IPT for Depression Therapy Rating Scale. One additional recording can be submitted per case if the original submission does not pass.

Trainees complete session-by-session self-assessment on their own casework using the IPT Targets Form and for each submitted session using IPT for Depression Therapy Rating Scale. Practitioners will also complete a reflective case report for each training case.

On completion of a successful portfolio, the practitioner will be eligible to apply for accreditation.

Assessment of competence

Trainee Practitioners use the IPT self-assessment tool pre and post training and at the mid point and end of their casework to rate their own knowledge and practice against the competencies for IPT for Depression. These ratings are shared with the clinical supervisor to inform and direct the supervision process. Supervisors and external raters will also rate practitioners against the IPT competencies, using the IPT for Depression Therapy Rating Scale.

Practitioners must demonstrate competent practice of all early sessions and ending sessions competencies across the four cases. Competent symptom review and linking to the focus must be evident in each middle session submission, plus at least one focus specific

competency and one engaging the network competency. Competent practice is rated as 3 or above on a 6 point scale.

Accreditation

Trainees are eligible for accreditation as an IPT for Depression NHS Talking Therapies Practitioner with IPTUK when they have:

- successfully completed the IPT for Depression Practitioner training course
- submitted a portfolio of four IPT cases, successfully reviewed by two IPTUK supervisors (supervisor and external rater).

Accredited IPT practitioners will be included in the IPTUK's database of accredited practitioners. Therapists are also encouraged to register their advanced skills with their original Registering body where relevant.

8. The Units

Each unit represents a half-day training and has its own aims and associated competencies and learning outcomes. In some respects the divisions between the units are artificial – the consequence of their underlying competencies – and participants will find that techniques belonging to one competency are also to be found in others. This reflects the ordinary process of therapy, where there is no simple demarcation between competency-use at any one time.

The competencies targeted in each unit are explicitly specified and the text is identical to that in the Self-Assessment Tool. Participants will already have made a judgement as to what degree they feel they already meet the requirements of the unit and this will be reviewed as each unit is introduced.

The Learning Outcomes distil the competencies for each unit.

1. Unit One: Introduction to IPT and theoretical origins

Aim of unit

IPT is derived from and influenced by the research and theoretical writings of a number of authors. This is evident in the integration of a medical and diagnostic perspective on depression and a consistent and explicit focus on the interpersonal context of the symptoms of depression. IPT is structured in three phases and across four distinct focal areas. Each phase addresses the diagnostic and interpersonal targets of IPT and has specific strategies for monitoring and using the links which exist between the two to further the clinical objectives of the therapy. In order to work within the time limited and focused framework of IPT, practitioners must have knowledge of the timeframe and objectives for each phase, the recommended strategies and the theoretical basis for attending to the symptomatic and interpersonal dimensions of depression and the links between the two. IPT will be delivered as a high intensity intervention as part of stepped care service and the practitioner must be able to appropriately inform and support the client in making treatment choices. This unit will therefore equip the student with a good understanding of framework of IPT, the recommended progression through the phases and the ways in which each phase is informed and determined by the therapeutic work in preceding and subsequent phases. The unit will also provide a theoretical context in which to understand the intervention targets and practice of IPT. The unit will focus on the knowledge and understanding of the model and its origins and will illustrate its application with clinical examples. The unit will provide an overview of the principles of the stepped-care system, NHS Talking Therapies as a framework for the treatment of common mental health problems and the role of high-intensity psychological therapy within that framework and will support the practitioner's competence in facilitating patient choice.

Learning objectives

1. Demonstrate knowledge, understanding and critical awareness of the theoretical foundations and development of IPT
2. Demonstrate knowledge, understanding and critical awareness of the fundamental principles of IPT, for example active collaboration in a time limited model, here and now perspective, external interpersonal focus linked to symptom focus.
3. Demonstrate an understanding of the background and underlying principles and philosophy of NHS Talking Therapies services and competence in implementing the stepped care model and patient choice.

Competencies

In particular this unit will address:

Knowledge of the principles and rationale of and for IPT

Knowledge of strategies employed in IPT

Ability to maintain a focus on the interpersonal context of the symptoms (Knowledge)

Learning and teaching strategy

Knowledge will be acquired through lectures, guided reading and case presentations. Skills based competencies will be learnt through supervised practice of direct contact with patients in the workplace.

Assessment strategy

Knowledge will be assessed through a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be assessed by means of self assessment, using the IPT competencies self assessment tool.

2. Unit Two: IPT Assessment – the symptom focus

Aim of the unit

IPT is proposed as a treatment for clients presenting with a current depressive disorder and interpersonal difficulties. In order to guide clients in making appropriate choices about treatment, IPT practitioners must be able to engage the client in identifying the main areas of symptomatic and interpersonal difficulty and key objectives for therapy. They must have good knowledge of the diagnostic criteria, incidence and prevalence of all mood disorders, conditions which are commonly comorbid with depression and patterns of remission, relapse and recurrence. They must be able to assess the risk an individual poses to self or others and the indicators for a combination approach with anti depressant medication. They must have good knowledge of the evidence-based therapeutic options available, and be able to communicate this knowledge in a clear and unambiguous way so that people can make informed treatment choices. They must be able to guide the client in gathering a detailed history of the most recent episode of depression and the interpersonal context, past

episodes, interpersonal triggers, treatment and response. They must be able to clearly explain and engage the client with the diagnosis of depression, and clearly explain the role for the therapist, client and others in working towards recovery. This unit will quip practitioners with the knowledge and skills to identify clients for whom IPT would be a treatment option, knowledge of mood disorders and evidence based treatment options, the role of medication and risk assessment. Skills teaching will develop competencies in collaborative diagnosis and negotiating expectations in treatment.

Learning objectives

1. Demonstrate knowledge and critical understanding of the phenomenology, diagnostic classification and epidemiological characteristics of depressive disorders and competence in effectively communication this information to the client.
2. Demonstrated knowledge and understanding of and competence in conducting a collaborative diagnostic assessment, taking into account clinical manifestations, past history, present life situation, course and outcome of depression and suitability for IPT
3. Demonstrate critical understanding of and competence in conducting risk assessment and management in taking a history of depressive disorders and comorbid diagnoses
4. Demonstrate knowledge of relevant pharmacological interventions and competence in advising and supporting clients on combined treatment approaches
5. Demonstrate knowledge and understanding of and competence in assessing suitability for IPT and contra-indications
6. Demonstrate knowledge and understanding of and competence in the use of standard and idiosyncratic clinical measurement to monitor IPT process and outcome, particularly the NHS Talking Therapies MDS
7. Demonstrate understanding of and competence in conducting a timeline assessment of depressive symptoms in the interpersonal context
8. Demonstrate knowledge and understanding of the sick role and competence in engaging the client in identifying early targets for symptom and interpersonal change and opportunities to engage social support.

Competencies

In particular this unit will address:

An ability to drawn on knowledge of diagnostic criteria for all mood disorders, epidemiological characteristics of depressive disorders and the impact of depressive symptoms on functioning

An ability to draw on knowledge of the evidence for the effectiveness of psychological and psychopharmacological interventions for depression

Ability to maintain a focus on the interpersonal context of the symptoms (Knowledge and Application)

Ability to implement IPT in a manner consonant with its supportive and active therapeutic stance
Ability to engage the client in IPT

Ability to reframe the client's presenting problems as an illness

Learning and teaching strategies

Knowledge will be acquired through lectures, guided reading and large and small group discussions. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment strategy

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be assessed through self assessment using the IPT competencies self-assessment tool.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- collaborating to agree a diagnosis
- using the NHS Talking Therapies MDS as framework for symptom review and diagnosis
- completing a timeline of the most recent and past depressive episodes, including treatment approaches and response
- introducing sick role and negotiating initial symptom management and engaging available interpersonal support

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of practice on each competency over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- clear and accurate diagnosis of depression and psycho-education which actively engages the client in understanding depression as a target for treatment
- completing a focused and specific timeline to place the most recent episode of depression in the interpersonal context
- introducing the expectations associated with sick role and clearly and collaboratively identifying immediate practical and interpersonal changes the client can make to manage symptoms and promote recovery
- assessing risk factors associated with depression and the integration of risk management within treatment plans
- assessing suicidal risk and implementing practical strategies for managing suicidality

3. Unit Three: IPT assessment – the interpersonal focus

Aim of the unit

IPT understands and treats depression in the interpersonal context. IPT practitioners must have knowledge of the common interpersonal factors that increase vulnerability to depression and are common difficulties for people with depression. They must be able to engage the client in identifying the key interpersonal triggers and consequences in the current episode of depression in order to inform joint thinking on the possible interpersonal formulation and focal areas for IPT. Practitioners must have a good understanding of the interpersonal focal areas of IPT in order to systematically assess the significance of each area in the client's current episode of depression. IPT practitioners must also be able to engage the client in a systematic review of their current relationships, the potential for and use of support and identifying key areas of interpersonal difficulty. IPT practitioner must also be able to develop a therapeutic relationship with the client and use the relationship to guide and inform interventions while maintaining primary explicit focus on the relationships outside of therapy. This unit will equip practitioners with good knowledge of the interpersonal factors related to depression, the focal areas that will guide assessment and how the therapeutic relationship is used to support and guide the client. Skills teaching will develop competencies in conducting a systematic interpersonal inventory and linking this to symptomatic narrative and the IPT focal areas.

Learning objectives

1. Demonstrate knowledge and understanding of the interpersonal vulnerability and protective factors associated with depression and competence in translating depressive symptoms into the interpersonal context in a manner that assist the patient in considering the relative impact of current interpersonal triggers

2. Demonstrate competence in developing a constructive therapeutic relationship and using this to model collaborative communication and adaptive interpersonal exchanges
3. Demonstrate competence in conducting an interpersonal inventory

Competencies

Ability to maintain a focus on the interpersonal context of the symptoms (Knowledge and Application)

Ability to implement IPT in a manner consonant with its supportive and active therapeutic stance

Ability to identify an interpersonal problem area that will provide the focus for the middle phase of the therapy

Learning and Teaching strategies

Knowledge will be acquired through lectures, guided reading and large and small group discussions. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be assessed through self assessment using the IPT competencies self-assessment tool.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- conducting an interpersonal inventory

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of competence over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- reviewing significant social and intimate relationships in an interpersonal inventory and identify their contribution to the onset and maintenance of symptoms to inform the interpersonal formulation and focus selection

4. Unit Four: Formulation and working with IPT focal areas

Aim of the unit

An IPT formulation integrates the symptomatic and interpersonal narratives to identify a key theme which will be the focus of the second phase of therapy. The formulation provides a framework to understanding the interaction between depression and interpersonal factors, the mechanisms by which the difficulties have become connected and mutually perpetuating and the suggested route and methods for resolution of the identified difficulties. The model specifies four focal areas – Interpersonal Role Transition, Interpersonal Role Dispute, Complicated Grief, Interpersonal Sensitivity/Deficits – which form the basis of the formulation. The practitioner must have good knowledge of the individual focal areas and the goals and strategies associated with each. They must be able to explain these in a clear way to the client and engage the client in considering how the different strategies relate to their objectives for therapy and the key precipitating and maintaining factors in the current episode of depression. They must be able to maintain attention to the time limited and here and now nature of the therapy in negotiating the focus and select no more than two related current themes. They must be able to engage the client in explicitly identifying relevant and achievable goals which relate to the focal area. The unit will equip the practitioner with methods for integrating the symptomatic and interpersonal narratives, knowledge of the goals and strategies of each focal area, methods of engaging the client in identifying the focal area and related goals and presenting this information in a clear verbal and/or pictorial form.

Learning Objectives

1. Demonstrate knowledge and understanding of the IPT focus areas that specify the strategies required to help the client resolve the identified interpersonal problems
2. Demonstrate knowledge and understanding that while IPT usually prioritises one primary focal area it is possible to work on (at most) two related focal areas and competence in negotiating a meaning and achievable focus of the middle phase of therapy with the client.

3. Demonstrate knowledge and understanding that the therapist uses the focal area to help the client maximise use of their interpersonal resources to manage their symptoms and support change and competence in communicating this clearly to the client
4. Demonstrate competence in using the interpersonal inventory to identify which interpersonal difficulties are linked with the current symptoms of depression and to help the client feel understood by summarising the salient interpersonal events linked to the onset and maintenance of symptoms
5. Demonstrate a competence in actively engaging the client in responding to the formulation, to clarify any misunderstandings or disagreements with the formulation and where there are several potential foci to support the client in identifying the most pressing concern that has the greatest impact on their interpersonal functioning and symptoms.
6. Demonstrate competence in collaborating with the client to identify primary and achievable goals related to the agreed focal area which will direct the individual work within the focal area.

Competencies

An ability to identify an interpersonal problem area that will provide the focus of the middle phase of the therapy

Learning and Teaching Strategies

Knowledge will be acquired through lectures, large and small group discussions and collective and individual case formulations. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, a written formulation exercise, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be assessed through self assessment using the IPT competencies self-assessment tool.

Group work exercises where practitioners are required to work with fellow trainees to select a provisional focal area for pre-prepared cases.

Individual written exercise in which therapists prepare a written formulation to present to a client.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- Delivering an IPT formulation to a client

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of competence over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- Delivering a clear and acceptable IPT formulation, that explicitly links the current symptoms of depression to a specific IPT focal, area to a client
- Where appropriate, openly discussing disagreements in relation to the proposed focus area and using the techniques required to negotiate a way forward for with the client.
- Agree clear and achievable goals related to the focal area as a framework for the individual casework

5. Unit Five: Interpersonal Role Transitions

Aim of the unit

Interpersonal Role Transitions focuses on a significant role change which is experienced as a loss. The IPT practitioner must be able to maintain attention to the current experience of depressive symptoms through the course of the focus work and support the client to identify the key links between symptoms and interpersonal experiences relevant to the focus area each week to inform choice of strategies. The therapist must have a good knowledge of the generic goals and strategies for the focal area and how they specifically relate the client's individual circumstances and personal goals. They must be able to flexibly follow the client's current symptomatic experience to identify key intervention points while maintaining an overall perspective on progress towards the negotiated goals. IPT practitioners must be able to integrate the use of general psychotherapy competencies with the specific IPT competencies related to the focal area. The practitioner must be able to support the client in reconstructing the lost role including unacknowledged or difficult aspects of the role, assess and support the client to process issues related to the manner of the change and encourage and support the client in identifying and developing the skills required to complete the transition and manage the demands of the new role. The IPT practitioner must maintain attention on the interpersonal context and implications of the change and use of resources identified in the interpersonal inventory. The IPT practitioner must be able to maintain a

focus on current symptomatic and interpersonal difficulty while reviewing the old role. The unit will equip the practitioner with good knowledge of the goals and strategies related to focal area and common examples of role transitions related to depression. Skills training will develop practitioners' competence in integrating general psychotherapy competencies with focus specific competencies and selecting strategies from other focal areas as appropriate to the formulation and goals. Practitioners will develop competence in maintaining here and now and symptom focus when reconstructing the old role.

Learning Objectives

1. Demonstrate knowledge and understanding of the importance of continuing to monitor symptoms throughout the middle phase of therapy and competence in conducting a weekly symptoms review with the client which integrates self monitoring and use of standardised measures
2. Demonstrate knowledge and understanding of the focus on the link between the current symptoms and focal area as the basis for each session and competence in helping the client stay focused on the agreed focal area and its link to symptoms
3. Demonstrate knowledge and understanding of the strategies specified for use with the transition focus
4. Demonstrate understanding and competence in the flexible selection and application of transition specific and generic strategies to address current symptomatic and interpersonal distress and move towards resolution.
5. Demonstrate understanding and competence in balancing attention to historical material and a here and now interpersonal focus.

Competencies

An ability to maintain the focus on the agreed interpersonal problem(s) and goals

An ability to help resolve interpersonal difficulties and relieve symptoms by implementing strategies appropriate to the focal area.

Ability to identify and explore difficulties in communication

Ability to facilitate the expression and acceptance of a range of emotions

Ability to encourage interpersonal change in-between sessions

Learning and teaching strategies

Knowledge will be acquired through lectures, large and small group discussions and case presentations. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be assessed through self assessment using the IPT competencies self-assessment tool.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- Conducting a symptom review and selecting and applying a transitions strategy to expand discussion on recent symptomatic changes related to the transition.

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of competence over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- Conducting a comprehensive symptom review and identifying a key recent event that links depressive symptoms and the transition focus
- Flexible application of the range of transition strategies to aid problem resolution

6. Unit b: Complicated Grief

Aim of the unit

Complicated grief focuses on an unresolved bereavement reaction and associated disengagement from current relationships. The IPT practitioner must be able to maintain attention to the current experience of depressive symptoms through the course of the focus work and support the client to identify the key links between symptoms and interpersonal experiences relevant to the focus area each week to inform choice of strategies. The therapist must have a good knowledge of the goals and strategies for the focus area and how they specifically relate the client's individual circumstances. They must be able to flexibly follow the client's current symptomatic experience to identify key intervention points while maintaining an overall perspective on progress towards the negotiated goals. IPT practitioners must be able to integrate the use of general psychotherapy competencies with the specific IPT competencies related to the focal area. The IPT practitioner must be able to support the client in reconstructing the lost relationship, including unacknowledged or difficult aspects and specifically the period around the death. The IPT practitioner must assess the availability and use of social support and opportunities to re-engage or develop new relationships. The IPT practitioner must maintain attention on the interpersonal context and implications of bereavement and use of resources identified in the interpersonal inventory. The IPT practitioner must be able to maintain a focus on current symptomatic and interpersonal difficulty while reviewing the past relationship. The therapist must be able to model and support the client in tolerating intense emotional distress and must use supervision effectively to contain the consequent emotional impact. The unit will equip the practitioner with good knowledge of the goals and strategies related to the grief focal area and features of complicated grief reactions. Skills training will develop practitioners' competence in integrating general psychotherapy competencies with focus specific competencies and selecting strategies from other focal areas as appropriate to the formulation and goals. Practitioners will develop competence in maintaining here and now and symptom focus when reconstructing the past relationship and working effectively and constructively with intense affect.

Learning Objectives

1. Demonstrate knowledge and understanding of the importance of continuing to monitor symptoms throughout the middle phase of therapy and competence in conducting a weekly symptoms review with the client which integrates self monitoring and use of standardised measures

2. Demonstrate a knowledge and understanding of the focus on the link between the current symptoms and focal area as the basis for each session and competence in helping the client stay focused on the agreed focal area and its link to symptoms
3. Demonstrate knowledge and understanding of the strategies specified for use with the grief focus
4. Demonstrate understanding and competence in the flexible selection and application of grief specific and generic strategies to address current symptomatic and interpersonal distress and move towards resolution.
5. Demonstrate understanding and competence in balancing attention to historical material and a here and now interpersonal focus.
6. Demonstrate competence in working constructively and purposefully with intense affect

Competencies

An ability to maintain the focus on the agreed interpersonal problem(s) and goals

An ability to help resolve interpersonal difficulties and relieve symptoms by implementing strategies appropriate to the focal area.

Ability to identify and explore difficulties in communication

Ability to facilitate the expression and acceptance of a range of emotions

Ability to encourage interpersonal change in-between sessions

Learning and teaching objectives

Knowledge will be acquired through lectures, large and small group discussions and case presentations. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be evaluated through self assessment using the IPT competencies self-assessment tool.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- Conducting a symptom review and selecting and applying a grief strategy to expand discussion on recent symptomatic changes related to the bereavement.

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of competence over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- Conducting a comprehensive symptom review and identifying a key recent event that links depressive symptoms and the grief focus
- Flexible application of the range of grief strategies to aid problem resolution
- Constructive and purposeful work with affect

7. Unit Seven: Interpersonal Role Disputes Aim of the unit

Interpersonal Role Disputes focuses on an ongoing implicit or explicit dispute with a significant other. The IPT practitioner must be able to maintain attention to the current experience of depressive symptoms through the course of the focus work and support the client to identify the key links between symptoms and interpersonal experience relevant to the focus area each week to inform choice of strategies. The therapist must have a good knowledge of the goals and strategies for the focus area and how they specifically relate the client's individual circumstances. They must be able to flexibly follow the client's current symptomatic experience to identify key intervention points while maintaining an overall perspective on progress towards the negotiated goals. IPT practitioners must be able to integrate the use of general psychotherapy competencies with the specific IPT competencies related to the focal area. The practitioner must be able to support the client in reconstructing significant unsatisfactory communications and exchanges, identify keys differences in expectation and unresolved issues in the dispute and support the client to experiment with

alternative forms of communication. The IPT practitioner must maintain attention on the wider interpersonal context and implications of the dispute and use of resources identified in the interpersonal inventory. The IPT practitioner must be able to identify and support the client to consider parallels and differences across relationships. The unit will equip the practitioner with good knowledge of the goals and strategies related to focal area. Skills training will develop practitioners' competence in integrating general psychotherapy competencies with focus specific competencies and selecting strategies form other focal areas as appropriate to the formulation and goals. Practitioners will develop competence in detailed communication analysis and helping the client develop new communication strategies.

Learning Objectives

1. Demonstrate knowledge and understanding of the importance of continuing to monitor symptoms throughout the middle phase of therapy and competence in conducting a weekly symptoms review with the client which integrates self monitoring and use of standardised measures
2. Demonstrate a knowledge and understanding of the focus on the link between the current symptoms and focal area as the basis for each session and competence in helping the client stay focused on the agreed focal area and its link to symptoms
3. Demonstrate knowledge and understanding of the strategies specified for use with the interpersonal disputes focus
4. Demonstrate understanding and competence in the flexible selection and application of dispute specific and generic strategies to address current symptomatic and interpersonal distress and move towards resolution.
5. Demonstrate understanding and competence in balancing working with an individual on an interpersonal difficulty that by definition involves more than one person.
6. Demonstrate competence in the detailed reconstruction of interpersonal exchanges and collaboratively developing more adaptive communication strategies.

Competencies

An ability to maintain the focus on the agreed interpersonal problem(s) and goals

An ability to help resolve interpersonal difficulties and relieve symptoms by implementing strategies appropriate to the focal area.

Ability to identify and explore difficulties in communication

Ability to facilitate the expression and acceptance of a range of emotions

Ability to encourage interpersonal change in-between sessions

Learning and teaching objectives

Knowledge will be acquired through lectures, large and small group discussions and case presentations. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be assessed through self assessment using the IPT competencies self-assessment tool.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- Conducting a communication analysis
- Conducting a symptom review and selecting and applying a disputes strategy to expand discussion on recent symptomatic changes related to the dispute.

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of competence over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- Conducting a comprehensive symptom review and identifying a key recent event that links depressive symptoms and the disputes focus
- Flexible application of the range of disputes strategies to aid problem resolution

8. Unit Eight: Interpersonal Sensitivity/Deficits

Aim of the unit

Interpersonal Sensitivity focuses on a long standing inability to establish or maintain satisfying relationships. The IPT practitioner must be able to maintain attention to the current experience of depressive symptoms through the course of the focus work and support the client to identify the key links between symptoms and interpersonal experience relevant to the focus area each week to inform choice of strategies. The therapist must have a good knowledge of the goals and strategies for the focus area and how they specifically relate the client's individual circumstances. They must be able to flexibly follow the client's current symptomatic experience to identify key intervention points while maintaining an overall perspective on progress towards the negotiated goals. IPT practitioners must be able to integrate the use of general psychotherapy competencies with the specific IPT competencies related to the focal area. The practitioner must be able to support the client in reconstructing significant current and past relationships to identify the specific recurring interpersonal difficulties related to depressive symptoms. The IPT practitioner must use the therapeutic relationship explicitly to understand the interpersonal difficulty, as a basis for constructive feedback and as a safe opportunity for the client to experimenting with new forms of interaction and communication. The IPT practitioner must be able to maintain a focus on current symptomatic and interpersonal difficulty while reviewing past relationships. The unit will equip the practitioner with good knowledge of the goals and strategies related to the sensitivity focus area and common examples of interpersonal sensitivities related to depression. Skills training will develop practitioners' competence in integrating general psychotherapy competencies with focus specific competencies and selecting strategies from other focal areas as appropriate to the formulation and goals. Practitioners will develop competence in explicitly using the therapeutic relationships as an interpersonal model and in supporting the client to risk interpersonal change despite low motivation and confidence.

Learning Objectives

1. Demonstrate knowledge and understanding of the importance of continuing to monitor symptoms throughout the middle phase of therapy and competence in conducting a weekly symptoms review with the client which integrates self monitoring and use of standardised measures
2. Demonstrate a knowledge and understanding of the focus on the link between the current symptoms and focal area as the basis for each session and competence in helping the client stay focused on the agreed focal area and its link to symptoms
3. Demonstrate knowledge and understanding of the strategies specified for use with the sensitivity focus

4. Demonstrate understanding and competence in the flexible selection and application of sensitivity specific and generic strategies to address current symptomatic and interpersonal distress and move towards resolution.
5. Demonstrate understanding and competence in balancing explicit attention to the therapeutic relationship and an external interpersonal focus.

Competencies

An ability to maintain the focus on the agreed interpersonal problem(s) and goals

An ability to help resolve interpersonal difficulties and relieve symptoms by implementing strategies appropriate to the focal area.

Ability to identify and explore difficulties in communication

Ability to facilitate the expression and acceptance of a range of emotions

Ability to encourage interpersonal change in-between sessions

Learning and teaching strategies

Knowledge will be acquired through lectures, large and small group discussions and case presentations. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be evaluated through self assessment using the IPT competencies self-assessment tool.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- Conducting a symptom review and selecting and applying a sensitivities strategy to expand discussion on recent symptomatic changes related to the interpersonal difficulty.

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of competence over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- Conducting a comprehensive symptom review and identifying a key recent event that links depressive symptoms and the sensitivity focus
- Flexible application of the range of sensitivity strategies, including explicit reference to and modelling in the therapeutic relationship, to aid problem resolution

9. Unit Nine: Endings and Maintenance

Aim of the unit

The third phase of IPT focuses on ending the therapy and preparing the client to use the skills developed in therapy independently, to prevent relapse and maintain symptom and interpersonal gains. The IPT practitioner must engage the client in discussing the end of therapy, reviewing and evaluating therapy, engaging interpersonal support outside of therapy and making clear plans for relapse prevention. Maintenance IPT (IPT-M) is conducted to reduce the risk of a recurrence of symptoms and maintain treatment gains. The unit will equip the practitioner with understanding of the role of ending in consolidating the work of therapy, good practice recommendations for different forms of consolidation treatment e.g. medication, and good knowledge of the research related to IPT – Maintenance (IPTM). Skills training will develop practitioners' competence in working with ending, systematically evaluating therapy and relapse prevention strategies.

Learning Objectives

1. Demonstrate knowledge and understanding of the importance of adequate preparation for ending therapy to allow accurate evaluation and consolidation of gains, and preparation for independent practice.

2. Demonstrate a knowledge and understanding of the potential for recurrence of depression after ending and competence in collaborating to produce a relapse prevention plan, including medication where necessary, that actively involves the available interpersonal and professional networks.

Competencies

An ability to maintain the focus on the agreed interpersonal problem(s) and goals

Ability to engage the client in preparing for ending

Learning and teaching strategies

Knowledge will be acquired through lectures, large and small group discussions and case presentations. Skills-based competencies will be learnt through a combination of filmed role play demonstrations, live and interactive role play demonstrations, clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be evaluated through self assessment using the IPT competencies self-assessment tool.

Standardised role-play scenarios where practitioners are required to demonstrate skills in:

- Engaging the client in preparing for ending through review and relapse prevention planning

Each role play will be observed by a tutor and peers and assessed against basic competencies by the tutor and practitioner. The basic competencies are applicable across IPT and the practitioner must demonstrate an acceptable level of competence over the course of the five days of training.

Successful completion of the following practice outcomes in supervised casework:

- Conducting a comprehensive review and evaluation of symptomatic and interpersonal change made over the course of therapy
- Clear provision and application of psycho-education on the risk of relapse and psychological, pharmacological and interpersonal prevention strategies

10. Unit Ten: IPT evidence base and modifications

Aim of the unit

IPT has a broad evidence base as a treatment for depression both as an individual therapy and combined with anti-depressant medication. It has been evaluated as a sixteen session intervention, a brief eight session model and as a maintenance therapy. The IPT practitioner must be able to explain the evidence in a clear and accessible way to the client to assist in making treatment choices and understand the importance of maintaining the interpersonal skills developed to achieve greater long terms gains. The unit will equip the practitioner with good knowledge of the evidence base for IPT as a treatment for depression and the limitations of the current evidence. It will help the practitioner develop competency in discussing the evidence base with the client in a therapeutic and beneficial way.

Learning Objectives

1. Demonstrate knowledge and critical understanding of the evidence base for IPT.
2. Demonstrate knowledge and understanding of the role of the evidence base in shaping an individual treatment programme

Learning and teaching strategies

Knowledge will be acquired through lectures, large and small group discussions and directed reading. Skills-based competencies will be learnt through clinical simulation in small groups working intensively under close supervision with peer and tutor guided evaluation and feedback, and supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60% over the five day course. Knowledge will also be assessed through self assessment using the IPT competencies self-assessment tool.

Successful completion of the following practice outcomes in supervised casework:

- Demonstrating understanding of the evidence base for IPT through clear communication of available evidence and limits of the evidence with a client
- Demonstrating competence in modifying an individual treatment package to accurately reflect the current evidence base on practice.

11. Unit Eleven: Follow up training

Aim of the unit

IPT accreditation requires completion of at least four IPT cases with patients presenting with moderate to severe depression. Casework must cover the three phases of treatment and must employ formulations and strategies of at least two of the focal areas. The unit will consolidate learning from the first ten units and reflect on application of knowledge and skills in a clinical setting.

Learning Objectives

1. Demonstrate knowledge and competence in the clinical application of the IPT framework and strategies

Learning and teaching strategies

Knowledge will be acquired through a knowledge quiz, large and small group discussions, case presentations and directed reading. Skills-based competencies will be learnt through supervised practice through supervised direct contact with patients in the workplace.

Assessment Strategies

Knowledge will be assessed by completing a daily knowledge quiz. Participants must achieve a mean score of 60%. Knowledge and skills will also be evaluated through self assessment using the IPT competencies self-assessment tool and supervisor assessment of weekly case presentations and audio recordings of therapy sessions..

Successful completion of the following practice outcomes in supervised casework:

 Demonstrating understanding of and competence in the application of IPT in a clinical setting

Practice portfolio

The portfolio comprises five items, which should be completed according to the guidelines below and put together as a record of training.

1. **Front cover casework summary sheet**
2. **Self assessment record of progress sheet**
3. **Audio recording rating forms summary report**
4. **Four reflective case write ups**
5. **Mid supervision and end of supervision progress report by supervisors**

NHS Talking Therapies

Training materials for Interpersonal Psychotherapy

CONTINUING PROFESSIONAL DEVELOPMENT FOR QUALIFIED THERAPISTS DELIVERING HIGH INTENSITY INTERVENTIONS

Dr Roslyn Law

March 2011

IPT for Depression Competencies
http://www.ucl.ac.uk/clinicalpsychology/CORE/IPT_framework.htm

IPT for Depression Competencies Self Assessment
http://www.NHS Talking Therapies.nhs.uk/downloads/resources

IPT for Depression Practitioner Training Slides
http://www.NHS Talking Therapies.nhs.uk/downloads/resources

Interpersonal Psychotherapy for Depression

IPT COMPETENCIES: RECORD OF PROGRESS

Basic IPT competencies	Pre training	Post training	Mid supervision	Post Supervision
Knowledge of basic principles, rationale and strategies of IPT				
Ability to maintain a focus on the interpersonal context of the symptoms				
Ability to implement IPT in a manner consonant with its supportive and active therapeutic stance				
Ability to engage the client in IPT				
Ability to reframe the client's presenting problems as an illness				
Ability to identify an interpersonal problem area that will provide the focus for the middle phase of the therapy				
Ability to maintain a systematic focus on an IPT interpersonal problem area(s) linked with the onset of symptoms				
Focal area specific competences				
Role transition				
Role dispute				
Complicated Grief				
Sensitivity/Deficits				
Ability to identify and explore difficulties in communication				
Ability to facilitate the expression and acceptance of a range of emotions				

Ability to encourage interpersonal change inbetween sessions				
Ability to engage the client in preparing for ending				

Specific IPT Techniques	Pre training	Post Training	Mid supervision	Post supervision
Directive techniques				
Role playing				
Decision analysis				
Clarification				
Exploratory techniques				
Communication analysis				
Use of the therapeutic relationship				

IPT Targets: ROLE PLAY EVALUATION FORM

Three copies of this form should be completed across the training week.

1. **Completed by trainers**
2. **Completed by the trainee**
3. **Completed by peers acting as role play observers**

Over the course of the role plays conducted over the training week the trainee is required to demonstrate adequate competence i.e. rated 3 or above, on each of the items listed. The trainee does not have to demonstrate competence during every role play. Feedback will be provided by trainers and peer observers after each role play and competent practice confirmed and areas for more attention identified, with suggestions on how to improve practice. Each role play will provide a further opportunity to demonstrate the basic competencies listed below.

Trainers will rotate around practice groups on a daily basis to provide a range of feedback. Trainers will share notes on each trainee's performance to provide a record of their performance and progress across the week.

Practice groups of three trainees will remain constant across the week. Each participant will rotate around the roles of therapist, patient and observer. The observer will provide feedback, with reference to the IPT targets, after each role play. The trainee will also complete a self assessment record of role play practice to guide his or her own learning and skill development.

A copy of the trainers' assessment will be available to the casework supervisor following training to establish baseline competence levels at the start of supervision and to direct attention to areas that require more support to achieve competent practice.

Therapist's name:

Role play rated (Strategy and Trainer's initials):

Early sessions:

Middle sessions:

Ending:

1. Explicit discussion of depressive symptoms

Rating: 0 2 4 6

Comments

2. Explicit discussion of interpersonal relationships

Rating: 0 2 4 6

Comments

3. Explicit discussion of links between symptoms, focus area, and social support

Rating: 0 2 4 6

Comments

4. Explicit discussion of ways of developing better social support

Rating: 0 2 4 6

Comments

5. Interpersonal formulation used to understand interpersonal problems

Rating: 0 2 4 6
Comments

6. Maintained the here and now time frame

Rating: 0 2 4 6

Comments

7. Key issue(s) to be mindful of/address in the remaining role plays

IPT Practitioner Training Quiz Response Form Day Two

Name: Date: Venue:

1. What are the dual goals of IPT?
2. Name three key tasks of the initial phase?
3. Name two key theoretical influences on the development of IPT.
4. What are the focal areas in IPT?
5. Name three factors to assess when considering IPT for a patient
6. Name three interventions that follow from the symptom review.
7. Name two reasons for using standardised measures in NHS Talking Therapies

8. Name three factors that are highlighted when negotiating the sick role
9. Name three factors to consider when assessing risk

IPT Practitioner Training Quiz Response Form Day Three

Name: Date: Venue:

1. Name three types of social support
2. Name three factors to be considered when assessing social support
The Interpersonal Inventory is primarily a review of a) all significant relationships across the lifespan b) significant contemporary relationships c) only problematic relationships or d) only supportive relationships?
4. Name three types of relationship covered in the Interpersonal Inventory.
5. Name three characteristics of the IPT therapist's stance

Does IPT focuses attention primarily on the therapeutic relationship or relationships in the current network?
7. Name three necessary features of an IPT formulation?
8. Name three procedural details which should be included in an IPT contract
9. Name three psychotherapy strategies appropriate for use in IPT.

IPT Practitioner Training: Quiz Response Form Day Four

Name: Date: Venue:

1. IPT aims to restructure attachment style through the interpersonal focus. True or false?
Name three factors the IPT therapist will consider when deciding which material to focus on in the middle sessions?

3. How often are symptoms reviewed during the middle sessions?
4. Name three objectives in working with affect.
5. What is the difference between content and process affect?
6. Give three examples of role transitions in IPT.
7. Name three strategies used to work with role transitions.
8. What condition must be met for a dispute to be the focus in IPT?
9. Name three strategies for working with disputes in IPT.
. Name three features of communication explored in communication analysis in addition to the content of the communication.

Practitioner Training: Quiz Response Form Day Five

Name: Date: Venue:

1. What are the two goals when working with the grief focus?
How does IPT bridge the gap between a historical review of the lost relationship and current difficulties?
3. Name three ways in which to involve the network in focus work.
4. Name three indicators of interpersonal sensitivity.
5. What process difference is evident in sensitivity work compared to the other IPT foci?

How often are symptoms reviewed during the middle sessions when grief or sensitivity is the focus?

PRACTICE

NHS Talking Therapies

Interpersonal Psychotherapy (IPT)

WHAT SKILLS CAN SERVICE USERS EXPECT THEIR THERAPISTS TO HAVE?

Alessandra Lemma, Anthony D. Roth and Stephen Pilling

Research Department of Clinical, Educational and Health Psychology

UCL

What is IPT?

IPT is a time-limited and structured psychotherapy. A central idea in IPT is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships. In turn, the depressed mood can also affect the quality of our relationships.

An example may help. If someone is depressed they may withdraw from those close to them, apparently refusing their help (perhaps because they feel like a failure and are ashamed of this). Family and friends may feel rejected and hurt, unable to understand why their offers of help are not taken up, and they may, in turn, pull away. The depressed person may take this as confirmation of their view of themselves as a failure, and this could make them feel even more depressed and withdrawn, setting up a vicious circle.

The main focus of IPT is on relationship problems and on helping the person to identify how they are feeling and behaving in their relationships. When a person is able to deal with a relationship problem more effectively, their psychological symptoms often improve.

IPT typically focuses on the following relationship difficulties:

- ***Conflict with another person:*** No relationship is perfect, but sometimes a significant relationship at home or at work can become very stuck in disagreements or arguments, and is a source of tension and distress.
- ***Life changes that affect how you feel about yourself and others***: Life changes all the time. As it does it throws up new challenges, such as when we have a child or lose a job. These changes - whether wished for or not - can leave us feeling unable to cope with the demands of the new situation and what is expected of us.
- ***Grief and loss***: It is natural to feel sad following the loss of a significant person in our life. Sometimes, however, it can be very difficult to adjust to life without that person and we may then put our life on hold, unable to carry on with our normal activities and with our relationships.
- ***Difficulty in starting or keeping relationships going:*** Sometimes relationships are difficult because of what is missing, for example not having enough people around us or not feeling as close to others as we would like. Not having someone to turn to for company or support can be very stressful and can leave us feeling alone and overwhelmed by the demands of life.

What does IPT involve?

Everyone's therapy will be a bit different, but we have tried to describe some of the important things that a good IPT therapist will do and what they will help you focus on.

Starting off

All therapists should be able to help you feel respected and comfortable. Many people find it difficult to talk about their problems with someone they do not know, and it is important that your therapist can make you feel that they are to be trusted, and can help you manage if you talk about things which upset you or about which you feel embarrassed.

Talking openly about yourself for the first time to a new person can feel difficult and you may be worried about what your therapist thinks about you. Your therapist will be interested in how you experience them and will help you to make sense of any worries you may have about starting therapy. They should give you the feeling that they know that starting therapy can be difficult and that they understand what life is like for you.

The therapist should convey that they are interested in hearing about how you are experiencing the therapy and your relationship with them at any stage of the therapy. If difficulties do arise the therapist should take these seriously and work out with you a way of overcoming them.

Getting a picture of what you need ("Assessment")

Your therapist will need to get as good a picture as they can of what you are finding difficult in your life and how this is affecting you and people close to you. They will ask some questions, but they should also make it clear that you only need to give as much information as you feel comfortable with. Many people find that as therapy gets going they are able to talk more openly, and in the early stages you shouldn't find yourself under pressure to say more than you want.

In the first sessions of IPT, the therapist will ask you both about your symptoms and also about current and past relationships in your life. This is because they are interested in understanding how difficulties in your relationships may have contributed to your psychological symptoms. Your therapist will ask you questions to help you to take stock of

the relationships that are important to you, looking at their strengths and any problems. The idea is to help you to identify those relationships that it would be most useful to focus on during the therapy.

At the start of therapy your therapist will also ask you to complete some questionnaires. These will give them a better idea of the sorts of problems you have (by asking about the sort of difficulties you have), as well as how badly these affect you (by asking how much each problem affects you). Your therapist will discuss the results of these questionnaires with you. They will ask you to complete the questionnaires again during therapy, often on a weekly basis, because this helps you and your therapist see what progress you are making. This is very useful, because not everyone makes progress at the same rate. If the questionnaires show that you are not benefiting from therapy it gives you and your therapist a chance to think about why this might be.

Once you and your therapist have gained a clearer picture of the relationship difficulties that are connected with your symptoms, you will agree on the main areas that therapy will focus on. Bearing in mind that the therapy is time-limited, your therapist will also invite you to think about what you want out of the therapy and help you to identify goals that are realistic.

Explaining how IPT might work for you

Early on your therapist should explain how IPT works, and help you to think through how the approach makes sense of what you are finding difficult in your life. In fact the assessment should have given you an idea of how the therapy works, what is expected of you and what you can expect of the therapist.

The main thing is that your therapist needs to help you see the ways in which ideas from IPT could be relevant to you and what you want help with. That does not mean you need to be 100% convinced – it's more that the idea of IPT and its focus on your current relationships needs to make some sense to you if you are going to get the best out of it.

What can you expect of your therapist?

Your therapist is responsible for ensuring that your meetings take place at a regular time, in a setting where you can be sure of confidentiality. Wherever possible they should let you know if they expect to be away or need to change the time of your therapy.

You can expect your therapist to be active: they will ask you questions, especially about your symptoms, what is happening in your relationships week-by-week, and how you feel. Because this is a time-limited therapy, your therapist will help you to keep focused on the relationship problem(s) you agreed to work on. This will include helping you to monitor how your symptoms are affected by what is happening in your relationships, and how your symptoms affect your relationships. The therapist will also help you to think about the people in your life who may be able to provide support to help you overcome your current difficulties. Where appropriate they will help you to develop new relationships that can provide the support you need.

The therapist will also support you in making positive changes in your life. For example, they might encourage someone who fears that they will be rejected if they speak their mind to take the risk of trying out different ways of communicating more directly. This may feel difficult at first, but your therapist will be interested in thinking with you about any anxieties you have about putting into action what you discuss in the therapy.

Ending the therapy

Many clients find that ending the therapy is difficult. This is because the relationship that develops between you and your therapist can become quite important. Ending therapy can feel like a big loss and you are likely to experience a range of feelings about it. Your therapist will know and understand this and you should expect them to help you to explore your feelings. They should help you to anticipate problems that may arise in the future and think with you about how you would manage if things became difficult again. However, they will also remind you of what you have learnt and achieved over the course of the therapy.

Length and frequency of treatment

Your therapist will talk with you about the number of sessions you can expect to have; this will depend on the problems you have and the setting you are being seen in. IPT is often offered over 16 sessions, but sometimes it is offered over fewer sessions (8-12). Your therapist might also suggest some follow-up, monthly sessions once you have completed the agreed course of therapy.

Medication and IPT

It is quite common to use IPT alongside medications such as anti-depressants, and for some people this may be more helpful than receiving either treatment alone. Your therapist will discuss this with you where appropriate.

Finding out more about IPT

You can find more information about IPT on the internet from the IPT-UK network site:

www.interpersonalpsychotherapy.org.uk

Interpersonal Psychotherapy for Depression

AUDIO RECORDING CONSENT FORM

_____

_____

I, ... agree to the recording of therapy sessions for the purposes of clinical supervision in the

..... NHS Talking Therapies service.

I agree to mental health professionals associated with the ..... service listening to these tapes in order to monitor the quality of treatment I receive and to enable supervisors to give advice. Yes ☐ No ☐ Initials .....

I agree to details from the recordings being used to teach other mental health professionals being trained to provide psychotherapy. I understand that no details will be included which would allow me to be identified.

Yes ☐ No ☐ Initials .....

I agree to details from the recording being used in professional publications which contribute to knowledge and understanding of psychotherapy. I understand that no details will be included which would allow me to be identified.

Yes ☐ No ☐ Initials .....

I understand that I may listen to the recordings if I wish and that I can withdraw my consent at any time without giving a reason and continue to receive treatment.

Recordings will be stored with password protection for the duration of my therapy and will be erased after three months unless otherwise specified by the patient.

Patient's signature…… Date……

Patient's name.....……

Therapist's signature……. Date…….

Therapist's name……..

SUPERVISION CONTRACT

This contract was drawn up on (date):……..

Between Supervisee:……
(print names)
and Supervisor ……..
A copy of this contract will be held by both the Supervisor and Supervisee. This contract will change as and when necessary and with prior consultation.

Frequency / Length

1. *Supervision sessions will be held weekly for …… weeks.*
2. *When a supervisee is at maximum capacity (i.e. 4 cases) a minimum of one hour will be available for individual supervision and a maximum of three hours for group supervision (maximum group size three). 3. The supervisee is responsible for booking the accommodation or calling for telephone supervision*
4. *If either party is unable to attend supervision he/she will provide 24 hours notice.*
5. *If a supervision session is missed, the Supervisor takes responsibility to rearrange an alternative date*

Confidentiality

1. *All professional and clinical issues discussed are confidential and are not to be discussed outside the supervision session. The exceptions to this are where professional malpractice may be evident, or if requested to release information by a Court of Law, Coroners Office or Professional Body.*
2. *All cases or professionals discussed during supervision must be made anonymous.*
3. *Where tape recording of sessions takes place this must be agreed with and have the informed consent of the service user, carer or professional. Arrangements must also be made to destroy/wipe any recordings. The supervisee is responsible for ensuring this process is followed.*
4. *Supervisee accepts that work issues may be discussed, when appropriate, with other managers.*
5. *Supervisee and Supervisor are to inform each other of anything that needs to be kept confidential.*
6. *Supervisee accepts that their supervision records will move with them in the event of transfer of Supervisor*

Purpose, Goals and Objectives of Supervision

1. *The primary focus of supervision is the welfare of the client through the supervisee's learning process, in terms of knowledge attainment, attitude refinement, and skills development.*
2. *To promote development of supervisee's professional identity and competence in the practice of IPT*
3. *To fulfill requirements for supervisee registration and accreditation as an IPT practitioner/supervisor*

Method of Evaluation

Supervisee:

1. *The supervisee will complete the self assessment form of IPT competencies before supervision begins, at the midpoint of supervision and on completion of supervision. The supervisee and supervisor will both hold copies.*
2. *The supervisee will complete a self assessment using the IPT targets form for each IPT session conducted.*

A copy of each form will be completed and submitted for review at each session.

3. *Supervisees will identify and prepare illustrative segments of therapy recordings for review during the supervision session.*
4. *The supervisee will submit three recordings of complete IPT sessions for each IPT case to be assessed using the IPT adherence and competence scale. Recording should be submitted from the early, middle and ending phase for each case. It is the supervisee's responsibility to select tapes which best demonstrated the competencies assessed by the adherence and competence scale. A maximum of one additional recording can be submitted per case in the event of an unsatisfactory assessment.*
5. *The supervisee will submit a reflective case report for each IPT case completed and submitted as part completion of the IPT accreditation requirements. The supervisee and supervisor will both hold copies.*

Supervisor:

1. *The supervisor will ensure equity of allocation of time across cases to be discussed and supervisees (in group supervision)*
2. *The supervisor will complete the assessment form of IPT competencies with respect observed/discussed practice at the midpoint of supervision and on completion of supervision. The supervisee and supervisor will both hold copies.*
3. *The supervisor will provide written and constructive feedback on three recordings of complete IPT sessions for each IPT case to be assessed using the IPT adherence and competence scale. A maximum of one additional recording will be reviewed per case in the event of an unsatisfactory assessment.*
4. *The supervisor will provide written and constructive feedback on a reflective case report for each IPT case*

Joint:

The supervisor and supervisee will agree a written record of the supervision session and recommendations for practice at the end of each session. The supervisee and supervisor will both hold copies.

Duties and Responsibilities of Supervisor- Supervisee:

Supervisor:

1. *To examine diagnoses, interventions, and treatment plans made by supervisee;*
2. *To challenge supervisee to validate approaches and techniques used;*
3. *To monitor basic micro-skills;*
4. *To present and model appropriate behaviours and directives;*
5. *To intervene where client welfare is at stake;*
6. *To ensure ethical guidelines and professional standards are maintained; and*
7. *To obtain appropriate consultation when necessary.*

Supervisee:

1. *To uphold ethical guidelines and professional standards;*
2. *To be prepared to discuss client cases with the aid of written case notes and / or video / audio tapes;*
3. *To validate diagnoses, interventions, approaches and techniques used;*
4. *To be open to change and use alternate methods of practice if required;*
5. *To consult supervisor or designated contact person in cases of emergency;*
6. *Implement supervisor directives in subsequent sessions*
7. *In event of an emergency, supervisee to contact supervisor. If not available, then contact …… second supervisor /covering supervisor……..*

Supervision Methods and Content

1. *Discussion of therapeutic relationship and engagement issues.*
2. *Case formulation and focus selection.*
3. *Rehearsal of therapeutic techniques.*
4. *Discussion about therapeutic strategies – selection and implementation.*
5. *Case Presentations.*
6. *Review of audio and videotapes.*
7. *Identification of supervisee thoughts, attitudes, beliefs with exploration of the impact of these on therapeutic and professional behaviour.*
8. *Review of risk and therapist/service user safety.*
9. *Review of clinical guidelines/manuals.*
10. *Review of psychoeducational material.*
11. *Review of IPT competencies.*

Conflict

1. *Sessions will be used to discuss issues of conflict and failure of either party to abide by the guidelines outlined in this contract. Every effort should be made to resolve any conflict within supervision.*

2. *If concerns of either party are not resolved in supervision Dr Roslyn Law, National Lead for IPT in NHS Talking Therapies will be consulted;*

3. *We agree, to the best of our ability, to uphold the guidelines specified in this supervision contract and to manage the supervisory relationship and supervisory process according to the ethical principles of our respective accrediting professional body.*

This agreement covers the period ……

Signed by: ..... Date: .....
(Supervisee)

Signed by: ..... Date: .....
(Supervisor)

Interpersonal Psychotherapy for Depression

IPT PROMPTS

Initial Sessions (1-4)

Initial detailed enquiry about depressive symptoms	
1-16	Reviewed the full range of depressive symptoms asking about the frequency, intensity, duration and changes for each symptom. Discuss any standardized measures that are completed.
Review of current depressive episode and development of symptoms in the interpersonal context	
½	Conducted a detailed review of the course of the depressive episode, with particular emphasis on onset, duration and severity of depressive symptoms. Actively involved the client in tracking their symptoms and linking to interpersonal triggers in the past week and/or over the course of the most recent episode using a timeline.
Review of previous depressive episodes including treatment and interpersonal context	
1	Reviewed the full history of depression with details of any treatment received and the client's response to treatment. Ask about the interpersonal triggers or consequences of previous episodes.
Give the syndrome a name	
er a	clear and explicit diagnosis, naming depression as an illness, explaining the cluster of symptoms and interactions between them. Related the diagnosis to the client's personal experience.
Provide psycho-education on depression	
½	Provided detailed information about the nature and course of depression, protective and vulnerability factors. Give particular emphasis to the role of interpersonal factors and use examples from the client's own experience. Invite and answer and questions from the client
Explain that depression is treatable	
1	Explained that depression is treatable and provided information about individual and combined approaches to treatment. Explain that tackling the social and interpersonal context of symptoms is expected to improve depressive symptoms and instilled hope that therapy will help. Use examples to demonstrate the potential for relationships to both trigger and relieve symptoms and as a basis for explaining the interpersonal focus and rationale for treatment. Challenge self blame as part of depression. Provide a clear explanation of the role of medication in the treatment of depression, fully assessed the client's current use of and response to medication, explore any reservations the client has to using medication and agreed a review point if medication is currently declined but symptoms are currently moderate to severe.
Convey understanding and expertise	
1-16	Maintain and demonstrate a curious and non-judgement interest in the patient's narrative, explicitly communicate the rationale for diagnosis and IPT treatment strategies and tailor this communication to reflect and utilize the patient's circumstances, symptom profile and narrative.
Explanation of the sick role	
1	Explain that when we are unwell it is important to take care of ourselves to help ourselves to recover.

	Actively encourage the client to temporarily suspend specific i.e. named, overly demanding activities and obligations and identify opportunities for pleasurable activity. Actively encourage the client to identify who can help them to do this and what specific help they can offer or be asked to provide.
Discuss use of medication and combined treatment as an option	
1-16	Provide a clear explanation of the role of medication in the treatment for depression and the relevant evidence, conduct a thorough review of the client's use, attitude and response to medication, and review use of medication on a weekly basis, including missed doses, and agree and conduct a review if medication is declined but would be recommended based on the symptom profile.
Explanation of IPT and phases of treatment	
1	Explain the rationale for IPT as a time limited, here and now and interpersonally focused treatment which is rooted in a medical model of depression as a treatable illness. Explain the link between symptoms and life events and the goals of reducing symptoms and improving relationships. Explain the three phases with an overview of the strategies and objectives for each and clearly explain the rationale for selecting a focus (use the patient information sheet as a reference).
Translate the depressive symptoms into the interpersonal context	
1-16	Routinely and repeatedly link the client's symptomatic and interpersonal experience and explore the dynamic nature of the interaction in each session, Routinely examine specific examples in detail.
Complete an Interpersonal Inventory	
2/3	Systematically examine the client's significant positive and relationships, giving explicit priority to current relationships. Discuss availability, use of and satisfaction with each relationship and how this relates to the depression. Explicitly use the inventory to improve how you both understand the current episode of depression and pick a focus
Potential focus areas are identified with the client	
1-4	Highlight links between identified areas of individual difficulty and current symptoms and invite the client to consider and discuss the potential to work on each area as the main focus of therapy. Offer tentative formulations by flexibly using the timeline, inventory and symptom profile to explore the possibilities for focusing the work. Do not confirm focus before the assessment had been completed and actively engage and collaborate with the client in evaluating the potential in each area and the nature of the work this would involve.
Presentation of interpersonal formulation of current depression	
¾	Present a summary of the salient events linked to the onset and maintenance of the depression, their impact and invite the client to respond to the proposed formulation and focus. Provide a formulation which integrates the client's temporal and thematic narrative, emphasizing the way in which specific interpersonal difficulties triggered and maintain the depression and how working within the identified focus area would seek to alleviate symptomatic distress. Encourage the client to respond to the formulation and openly discuss misunderstanding or disagreements in order to agree how to proceed
Negotiation of specific and achievable goals for treatment, which reflect the focus area	
¾	Work with the client to use the formulation to understand the nature of the current difficulty and to specify the changes which could be realistically and fruitfully targeted to bring about positive symptomatic and interpersonal change in the context of the focus, taking into account the severity and chronicity of the difficulties, the resources available to the client and the time limited nature of Therapy.
Explicit contract negotiation	
¾	Outline the duration and frequency of future contact, the character of the work and expectations of the client and therapist in the context of the negotiated focus. Invite the client to discuss the details and any areas of disagreement. Clearly and collaboratively discuss the clinical and practical expectations and responsibilities, planned for potential difficulties such as missed appointments and actively involve the client in preparing for moving into a new phase of treatment

Role Transitions (5-12)

Review depressive symptoms over the past week	
All	Engage the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better and worse periods and the associated interpersonal triggers. Engage the client in using standardized symptoms measures as an initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.
Relate depressive symptoms to difficulty in coping with the transition from one social role to another	
All	Engage the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Identify links across the episode of depression but with particular reference to the reciprocal relationship in the last week. Use to reinforce successes and explore relevant difficulties.
Review the positive and negative aspects of the old role and possible new one, and realistic evaluation	
5-12	Create a balanced reconstruction of the old role and in so doing to mourn and relinquish it, empathically examine and address the aspect of the transition which is most problematic for the client and support and engage the client in developing the skills, motivation and supports necessary to adjust to the new role and take up the opportunities it affords.
Explore nature of and feelings about what was lost	
5-12	Demonstrate non judgmental curiosity in examining the different dimensions of what has been lost and the mix of positive and negative feelings associated with relinquishing what must be given up while clarifying those aspects of the old role which may be carried forward.
Explore feelings about the change itself	
upport	the client in a detailed examination of the context and process of the change, the contribution made by the client and others and the range of associated feelings and link to depression symptoms.
Explore opportunities in the new role	
5-**12**	Engage the client in a systematic review of the new role to identify and/or create new opportunities which were anticipated to have a positive impact on depressive symptoms and adjustment to the new role.
Encourage development and effective use of social support system and skills called for in the new role	
All	Explore how existing skills and supports could be employed effectively in the new role and worked creatively with the client to encourage taking risks and using novel strategies to equip them practically and interpersonally to fully engage with the new role and counteract the pessimism and poor motivation characteristic of depression.

Interpersonal Role Disputes (5-12)

Review depressive symptoms over the past week	
All	Engage the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better and worse periods and the associated interpersonal triggers. Engage the client in using standardized symptoms measures as an initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.
Relate symptoms onset to overt or covert dispute with significant other with whom the client is currently involved	
All	Engage the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Identify links across the episode of depression but with particular reference to the reciprocal relationship in the last week. Use to reinforce successes and explore relevant difficulties.

Determine the stage of the dispute	
5-12	Involve the client in examining the form and frequency of communication in the dispute to collaboratively determine and agree the predominant character. Use the stage of the dispute as a basis from which to explain and plan how to initially address the dispute e.g. increase communication, contain explosive communication. Do not propose dissolution as an initial response.
Identify issues in the dispute	
5-12	Support the client in identifying and acknowledging the central spoken and unspoken issues which fuel the dispute and the depressive symptoms and are repeatedly evident in problematic exchanges.
Explanation of how non-reciprocal role expectations relate to the dispute	
5-12	Use the client's own material to illustrate how differences in the give and take of the relationship can trigger conflict and worked with the client to understand how differences in expectations have played this role in the client's experience and fuelled their depression.
Exploration and discussion of differences in expectations and values	
5-**12**	Support the client to identify the spoken and unspoken differences in expectations and values between them and the other person., in acknowledging when expectations and values are unknown and to consider the possibility for change on both sides, including relinquishing expectations or negotiating a compromise.
Exploration of parallels and differences between currently disputed and other past or present relationships	
5-12	Review a broad range of relationships with the client to more fully understand how and when problematic patterns are repeated and how and when they are successfully avoided. Clarify and promote the use of more adaptive interpersonal strategies which avoid or prevent conflict do not trigger depressive symptoms.
Exploration and discussion of options available to the client to further resolution of the dispute and/or bring about desired change	
All	Work with the client to encourage them to identify and evaluate the range of options available or which could be developed to bring about change. Involve direct action by the client and engaging others in the network who could act as a resource to furthering resolution.
Discussion of communication patterns	
All	Support the client to develop a sense of curiosity about the nature of their communication and to examine in detail the subtle and overt factors which determine and change the course of communication and to evaluate how these communication patterns relate to the current dispute and symptom pattern.
Exploration and discussion of how the dispute is perpetuated	
	Work collaboratively with the client to develop a full understanding of the process around the dispute, the contribution the client and others make, the conflicting expectations which create an obstacle to resolution and the way in which depression interferes with communication and reasoning to maintain the
	conflict.
Explore use of wider network to understand or ameliorate the dispute	
5-12	Systematically consider the range of support available or which could be developed with the client and creatively maps the use of those resources onto their shared understanding of the dispute to clarify how the network might contribute change and actively supported the client to mobilize those interpersonal resources.

Interpersonal Sensitivity/Deficits (5-12)

Review depressive symptoms over the past week	
ıgage and as an	the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better worse periods and the associated interpersonal triggers. Engage the client in using standardized symptoms measures initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.
Relate depressive symptoms to the problems of social dissatisfaction or isolation	

All	Engage the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Identify links across the episode of depression but with particular reference to the reciprocal relationship in the last week. Use to reinforce successes and explore relevant difficulties.
Review past significant relationships	
5-12	Engaged the client in a systematic review of the nature, course, strengths and difficulties in past relationships and drew parallels with current relationships
Explore repetitive dysfunctional patterns and expectations in past or present relationships	
All	Work collaboratively with the client to examine past and present relationships in detail to clarify the nature and processes involved in triggering and sustaining problematic patterns and the expectations which sustain them and used this as the basis for specifying the specific sensitivity/deficit that will provide the focus for therapy
Discuss client's + and - feelings re the therapist and explore parallels in other relationships	
5-12	Encourage and support the client in expressing their feelings about the therapist and in experimenting in new ways of communicating. Work collaboratively with the client to understand how the feelings in the therapeutic relationship could be used to more fully and constructively understand parallel feelings and reactions in relationships outside of therapy
The therapist conveys his/her own feelings and uses the therapeutic relationship to facilitate client's awareness of his/her impact on and role in interactions and as model for satisfying	
5-12	Selectively used experience of the therapeutic relationship to safely provide constructive feedback to the client, and to support the client to consider parallels with relationships outside of therapy and how similar constructive and clear communication might improve satisfaction with relationships outside of therapy
Encourage formation of new relationships and development of existing relationships	
All	Encourage the client to identify and pursue opportunities to develop existing relationships and to engage in new relationships in a manner which would reduce the isolation and dissatisfaction resulting from the focal sensitivity. Offered specific and constructive support and direction to assist the client in experimenting with new ways of communicating and behaving which would facilitate this change

Complicated Grief (5-12)

Review depressive symptoms over the past week	
All	Engage the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better and worse periods and the associated interpersonal triggers. Engage the client in using standardized symptoms measures as an initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.
Relate depressive symptoms to death and/or absence of significant other	
All	Engage the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Identify links across the episode of depression but with particular reference to the reciprocal relationship in the last week. Use to reinforce successes and explore relevant difficulties.
Reconstruct the positive and negative aspects of the client's relationship with the deceased	
5-12	Support the client to explore both acknowledged and unspoken aspects of their relationship with the deceased and in so doing helped the client to engage in a balanced affective exploration of the whole relationship and to tolerate and express ambivalent or negative feelings towards the deceased
Describe events just prior to, during and after the death and response	
5-12	Support the client to recall and describe in detail the sequence of events leading to, around and following the death, with particular attention to associated feelings, and communication. Give particular attention to the points which continue to generate distress and provoke depressive symptoms.
Evaluate availability and use of social support at the time of death and for current mourning	

5-12	Encourage the client to evaluate in detail the rang e and type of support which were available at the time of the death and since, the use made and adequacy of this support, the perceived obstacles to using this support, and the contribution this made to the complicated grief reaction and depression
Explore feelings about current impact of loss	
All	Support the client to explore their current unacknowledged affective state in detail and to clarify the ways in which this continued to relate to the loss, maintain their depression and creates an obstacle to moving on
Consider ways of becoming involved with others	
All	Support the client to examine the opportunities which are available and which can be created to establish and maintain relationships with others which can adequately meet their current emotional, social and practical needs

Ending (13-16)

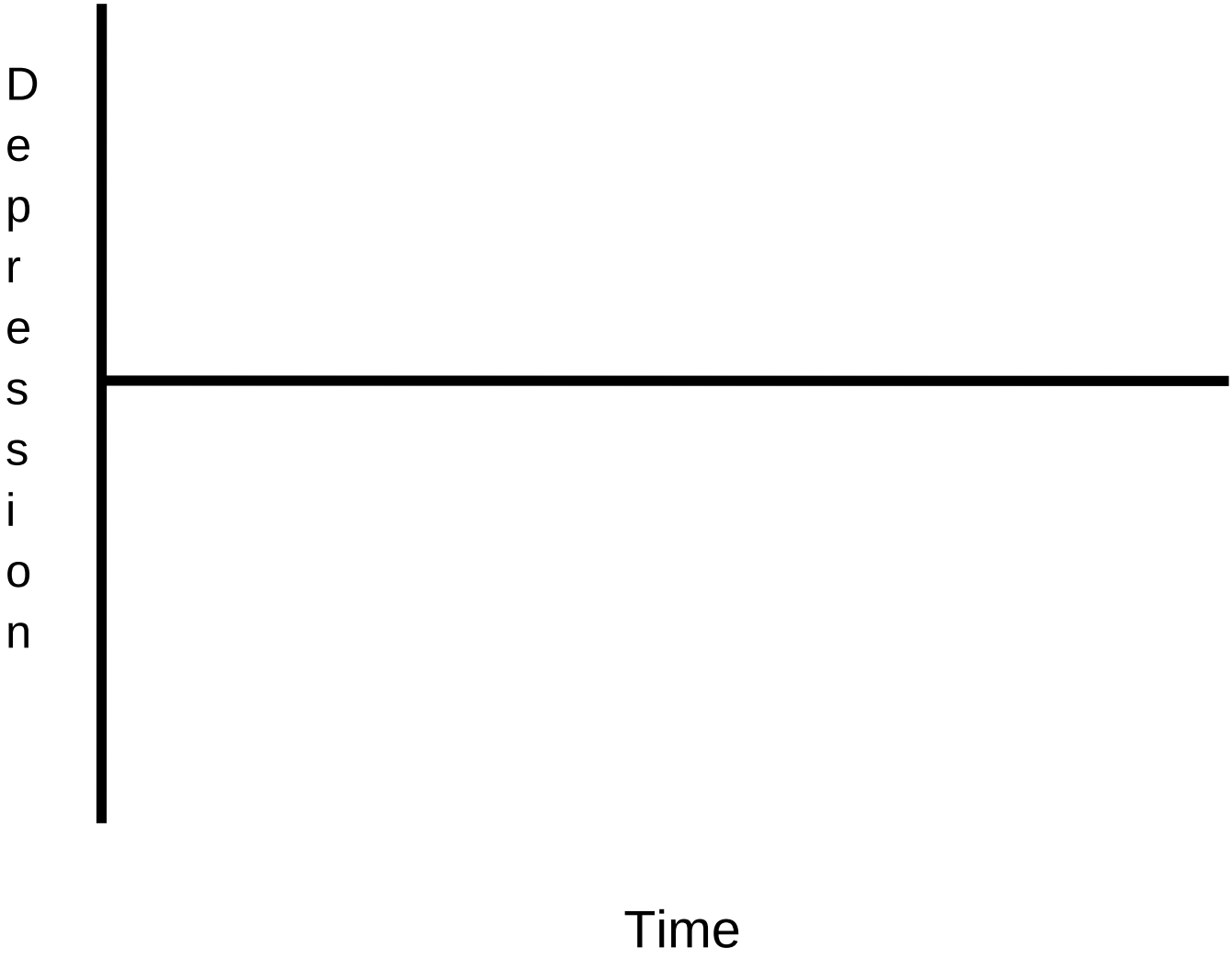
Explicit discussion of the end of treatment	
All	Help the client to prepare for ending and to use this as a motivating factor by clearly maintaining attention on the end of therapy within and across sessions and actively engage the client in expressing their response to and plans in relation to this
Elicit/discuss client's and the therapist's reactions to termination	
All	Encourage the client to express their positive and negative feelings about the end of therapy, respond non-defensively to expressions of non-defensively to expressions of disappointment and model communication by constructively commenting on your own response to therapy coming to an end
Acknowledgement of the end of treatment as a time of potential grieving and distinguish from symptomatic relapse	
13-16	Encourage and support the client in identifying and expressing feelings of sadness and loss about the end of therapy. Distinguish between the transitory and specific nature of an emotional response from the persistent and global nature of a symptomatic relapse. Support the client in discussing their related concerns.
Help client move towards recognition of his/her independent competence	
13-16	Encourage the client to review and acknowledge the ways in which they had achieved and sustained change and actively reinforced and praised this achievement
Review with the client the course of his/her treatment and progress in therapy	
1316	Engage the client in realistically evaluating the symptomatic and interpersonal progress achieved over the course of therapy, with specific reference to the individual goals set by the client at the start of therapy and the overarching goals of IPT
Client invited to evaluate the treatment and to assess future needs, including maintenance strategies in the interpersonal context	
All	Encourage the client to evaluate their experience of and satisfaction with therapy, identify any areas of omission or disappointment, assess their future needs and strategies for maintaining gains including maintaining interpersonal supports and engagement, maintenance IPT and medication and/or referral to other professional networks
Assess with the client his/her early warning signals and discuss procedures for reentry in to treatment if necessary	
13-16	Discuss the early symptom changes characteristic of the onset of a depressive episode for the client in detail and worked collaboratively with the client to develop a clear relapse plan which draws on the support of other people

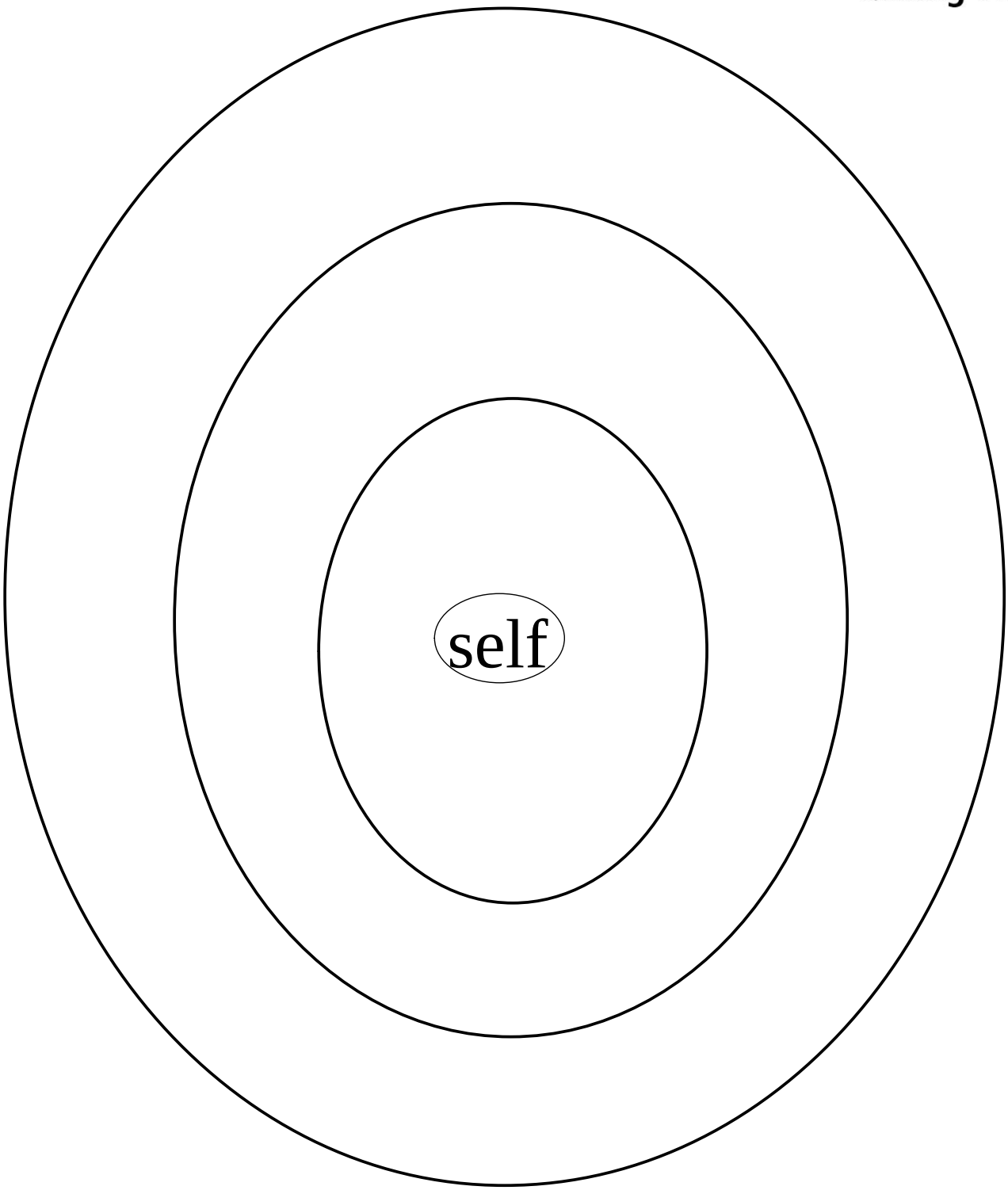
General Strategies (1-16)

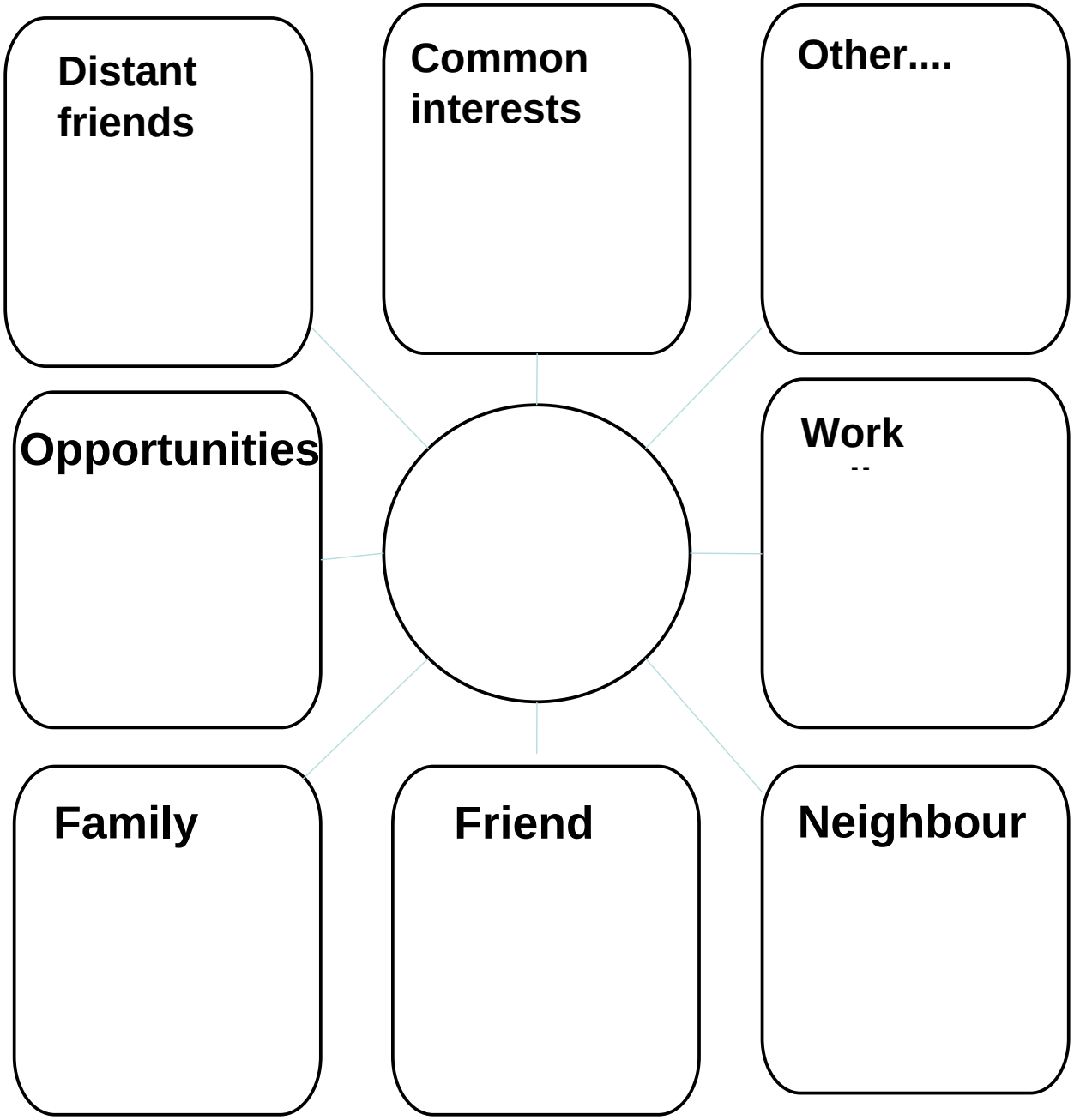
Facilitate expression and acceptance of a range of emotions	
All	Track and explore the client's emotional state as a core strategy. Support the client in staying with current acknowledged and unacknowledged emotions in order to more fully recognize and accept their emotional state, to use it as a basis for understanding interpersonal experience and to help them discriminate when the expression of strong emotions is appropriate outside of the sessions and when it might undermine relationships.
Attend to the therapeutic relationship	
All	Maintain flexible, responsive and empathic engagement with the client and used the therapeutic relationship to give the client feedback and explore about how they might come across to others. Explored primarily in relation to relationships outside of therapy but also sparingly when difficulties were manifest in the therapeutic relationships.
Focus the session on an appropriate topic	
All	Combine attention to the key symptomatic and interpersonal goals of therapy in the current interpersonal environment with clear attention to the specific objectives and tasks of the individual phases and focal areas, integrating pan focus work when appropriate and maintaining awareness of previous and future phases.
Monitor, support and acknowledge progress in addressing interpersonal problems.	
all	Help the client to focus on making realistic and specific interpersonal change by helping them to understand the symptomatic and interpersonal implications, identify and engage resources to assist with this change, constructively address obstacles. Balance the drive towards change with and awareness of and sensitivity to the client's readiness for change.
Maintain IPT the therapeutic stance	
All	Engage the client in the work of therapy by routinely taking up opportunities to acknowledge and encourage achievements, to communicate directly and specifically, identifying and attending to obstacles to progress in therapy and in the focal area and encouraging the client to do the same in order to achieve clarity and progress in addressing the agreed area of interpersonal difficulty.
Directive techniques	
1-16	Balance directive techniques which constructively informed and guided the client's behavior and thinking, such as psycho-education and relevant factual information, with collaborative and exploratory planning to support the client in developing a sense of mutual and independent confidence.
Role Playing	
5-12	Select opportunities and used role play to try out alternatives and provide an experience of competence in communicating and interacting differently after full exploration and discussion of the options available to the client and careful selection and preparation for the specific practice in role play.
Decision analysis	
5-12	Support the client in clarifying the significant decisions relate to the focus area, reviewing the full range of options available with consideration of anticipated consequences for the focal area and depression and arriving at a balanced plan of action. Support to integrate this strategy as an independent competence.
Clarification	
All	Use clarification to deepen understanding of feelings and thoughts, to attend more clearly and specifically to the client's communication, to emphasize the interpersonal; to explore contradictions and symptominterpersonal connections in what the client says
Exploratory techniques	
All	Foster the client's sense of competence and autonomy by routinely demonstrating an open and curious interest, explicitly acknowledging constructive contributions by the client and encouraging the client to expand on productive topics without interrupting or imposing unnecessary structure.
Communication analysis	
5-12	Explore specific examples of problematic communication in detail, including the verbal and non verbal content, associated affect, the objective of, effectiveness of and satisfaction with the communication, the associated expectations and evaluation of reciprocity, empathic appreciation of the other's experience and considering and practicing alternative ways of communicating in detail.

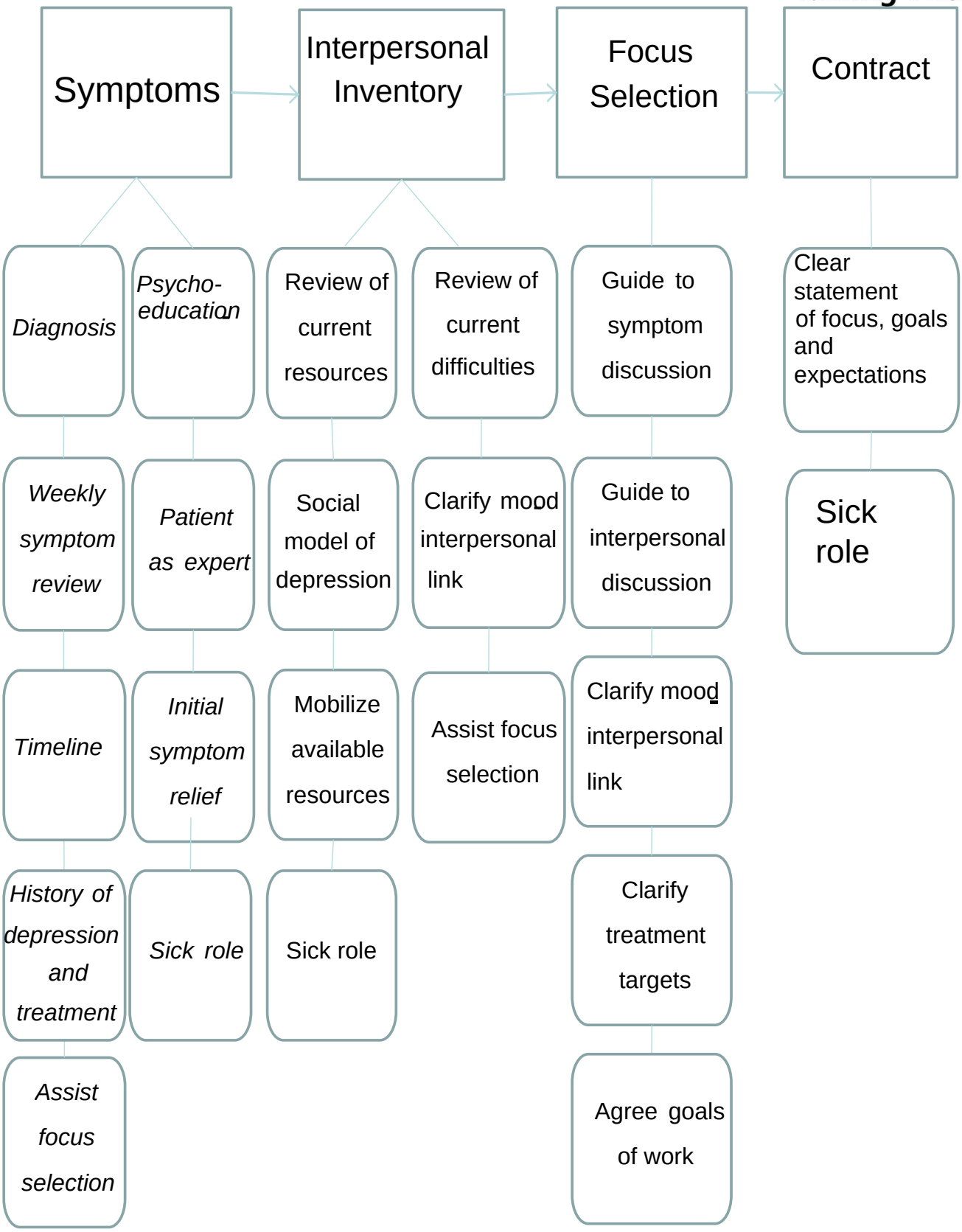
Explicit reference to the therapeutic relationship	
1-16	Use the therapeutic relationship as a vehicle to identify and provide constructive feedback on recurring interpersonal patterns and communication difficulties as they occurred, linking these to patterns with significant others and clarifying potential to trigger depression, and support the client to try out and explore alternative ways of communicating by first attempting these in therapy.

Time line









IPT TARGETS – WEEKLY RATING SCALE

This form should used after every session of IPT to prepare for supervision. Please keep one copy as a record of the session and provide one copy for your supervisor.

Therapists should note specific examples of each intervention to bring to supervision for discussion.

Items should be rated on a scale 0-6. Please refer to the audio recording rating scale for detailed illustrations.

Items can be marked on odd numbers of you feel that performance falls between the two descriptor points.

Scale:

0 Item was not attempted

2 Item was attempted but the intervention was incomplete and/or superficial

4 Item was completed in a manner consistent with IPT competencies and to a good standard

6 Item was completed in a manner consistent with IPT competencies and to an excellent standard

Therapist's name: **Case no.:** **1st** **2nd** **3rd** **4th**

Patient's initials: **Session no.:** **Focal Area:** **Date:**

PHQ-9 score: **GAD score:** **Social functioning score:**

5. Explicit discussion of depressive symptoms in the last week

Rating: 0 **2** **4** **6**

Example(s) for discussion in supervision

6. Explicit discussion of interpersonal relationships in the last week

Rating: 0 **2** **4** **6**

Example(s) for discussion in supervision

7. Explicit discussion of links between symptoms, focus area, and social support in the last week

Rating: 0 **2** **4** **6**

Example(s) for discussion in supervision

8. Explicit discussion of ways of developing better social support

Rating: 0 **2** **4** **6**

Example(s) for discussion in supervision

9. Interpersonal formulation used to understand interpersonal problems

Rating: 0 2 4 6

Example(s) for discussion in supervision

10. What was your experience of the therapeutic relationship in this session?

11. Key issue(s) to be mindful of/address in the next session

ACCREDITATION

Interpersonal Psychotherapy for Depression

IPT AUDIO RECORDING RATING SCALE

Trainee ID **Patient ID** **Case #** **Focal Area**

Session # **1st/2nd submission** **Rater ID**

The rating scale is subdivided into three parts, to reflect the phases and associated interventions in IPT. Only those parts relevant to the current phase of treatment should be rated for individual recordings.

Part One: Initial Sessions form should be used to rate sessions 1-4. Part Two: General strategies form should be used to rate every session, 116. Focus strategies forms should be used to rate the negotiated focus for sessions 5-16.

Part Three: Endings form should be used to rate sessions 13-16

Items are rated on a 0-6 scale, ranging from 0 = not attempted to 6 = excellent. Items can be rated on odd numbers if the therapist's performance falls between the two descriptor points.

Scale:

1 Item was not attempted

3 Item was attempted but the intervention was incomplete and/or

superficial

5 Item was completed in a manner consistent with IPT competencies and to a good standard

7 Item was completed in a manner consistent with IPT competencies and to an excellent

standard

Scoring guide for pass/fail:

- **Items rated as attempted i.e. rated 1-6, must achieve an overall average score of 3 or more for a recording to pass. (The average being the total score for the rated items divided by the number of items rated above zero)**
- **No more than two attempted interventions must be scored 1 or 2 per recording to pass.**
- **"Symptom review" and "linking depression to focus" must not be rated at 2 or below more than once on any case to pass.**
- **The final accreditation training portfolio must demonstrate evidence of competent practice of <u>all</u> early and ending competencies over the collective submissions for four cases. Submissions for middle sessions must demonstrate competence in reviewing symptoms and linking to focus and *at least* one item in examining the focus relationship/role and one in engaging the network as described in the audio rating summary sheet.**

PART ONE

The first part of the scale addresses the following IPT Basic Competencies:

1. **Knowledge of basic principles, rationale and strategies of IPT**
2. **Ability to maintain a focus on the interpersonal context of the symptoms**
3. **Ability to implement IPT in a manner consonant with its supportive and active therapeutic stance**
4. **Ability to engage the client in IPT**
5. **Ability to reframe the client's presenting problems as an illness**
6. **Ability to identify an interpersonal problem area that will provide the focus for the middle phase of Therapy**

Initial Sessions

1.Initial detailed enquiry about depressive symptoms	
0	The therapist made no reference to depression
2	The therapist made an incomplete review of depressive symptoms, failing to cover the full range of symptoms or course of the episode.
4	The therapist reviewed the full range of depressive symptoms over the last week and/or over the course of the current episode and involved the patient in evaluating their symptom state
6	The therapist reviewed the full range of depressive symptoms with discussion of frequency, intensity, duration and change. Actively involved the patient in tracking their symptoms and linking to interpersonal functioning in the past week and/or over the course of the episode using a timeline. The therapist included review of standardized measures. nb this item can be used , rate the symptom review for the most recent episode or the past week depending on the session rated.

Comments	
2. Review of current depressive episode and development of symptoms in the interpersonal context	
0	Therapist did not review the current depressive episode or interpersonal context
2	Therapist reviewed the depressive episode and/or interpersonal context but made few or no links between them and did not actively involve the patient in considering possible links
4	Therapist reviewed the course of the depressive episode and linked to interpersonal triggers for and consequences of evolving symptoms. Therapist involved the patient in thinking about their symptoms in an interpersonal context to introduce the interpersonal emphasis of therapy
6	Therapist conducted a detailed review of the evolving course of the depressive episode, with particular emphasis on onset, duration and severity of depressive symptoms and with active and recurrent collaborative exploration of the interpersonal precipitants and consequences of symptomatic change to develop a shared understanding of the interpersonal context of the current episode.
Comments	
3. Review of previous depressive episodes including treatment and interpersonal context	
0	The therapist did not review past history of depression
2	The therapist reviewed past experience of depression with limited or no reference to treatment or interpersonal context
4	The therapist reviewed past episodes of depression including treatment received and significant interpersonal factors
6	The therapist reviewed full history of depression with details of treatment received and response. And detailed examination of the interpersonal context for each episode and consideration of how interpersonal patterns of difficulty around focal themes have repeated and are evident in the current episode.
Comments	
4. Give the syndrome a name	
0	The therapist did not name depression
2	The therapist made reference to depression without explaining the range, duration or impact required for diagnosis
4	The therapist clearly made a diagnosis naming depression as an illness and explaining the cluster of symptoms involved
6	The therapist clearly made a diagnosis, naming depression as an illness, explaining the cluster of symptoms and interactions between them. The therapist actively related the diagnosis to the client's personal experience.
Comments	
5. Provide psycho-education on depression	

0	The therapist did not provide psycho-education
2	The therapist briefly explained that depression is an illness and provided limited additional information without inviting discussion or comment from the client
4	The therapist explained the nature and course of depression, vulnerability and protective factors and related the information to the client's experience
6	The therapist provided detailed information about the nature and course of depression, protective and vulnerability factors and emphasized the role of interpersonal factors. Input was tailored to the client's experience and invited and addressed specific questions about the client's experience of depression

Comments	
6. Explain that depression is treatable	
0	The therapist did not explain that depression is treatable
2	The therapist informed the client that depression is treatable without providing any additional information
4	The therapist explained that depression is treatable and provided information about the different forms of treatment that can be used and evidence of outcome, instilling hope that therapy can help.
6	The therapist explained that depression is treatable and provided information about individual and combined approaches to treatment, relative outcome and provided an explanation of the evidence for the IPT approach. The therapist conveyed that addressing the social and interpersonal context of symptoms is anticipated to contribute to the resolution of the depressive symptoms and instilled hope that therapy will help and reduced self blaming attributions.
Comments	
7. The therapist conveys understanding and expertise	
0	The therapist did not convey an understanding of the client and did not convey an understanding of depression or IPT
2	The therapist demonstrated limited understanding of the client and provided a brief explanation of depression and IPT
4	The therapist communicated directly, acknowledged the client's experience, and communicated clear and accessible information about the presenting problem and proposed therapy.
6	The therapist demonstrated a curious and non judgmental response to the client's narrative, communicated an empathic understanding, and linked the rationale for diagnosis and treatment with the client's individual experience and symptom profile.
Comments	
8. Explanation of the sick role	

0	The therapist made no attempt to explain sick role
2	The therapist acknowledged that the client is unwell but made limited attempt to engage the client in considering the implications of the diagnosis or mobilizing resources or behavior change to manage symptoms
4	The therapist shared an explicit and collaborative diagnosis with the client and uses it to reduce self blame, increase hope of recovery and initiate change and engagement which will promote recovery.
6	The therapist engaged the client in an explicit and shared diagnosis which directly targeted self blame and seeks to instill hope. The client was actively encouraged to temporarily suspend specific overly demanding activities and obligations and to prioritize recovery by enlisting appropriate assistance.
Comments	
9. Discuss use of medication as combined treatment	
0	The therapist made no reference to medication
2	The therapist made a limited review of current medication e.g. insufficient information about dosage, adherence, response, attitude
4	The therapist fully reviewed current use of and response to medication and attitudes to and problems with taking A/D medication
6	The therapist provided a clear explanation of the role of medication in the treatment of depression, fully assessed the client's current use of and response to medication, sensitively explored any reservations the client has and agreed a review point if medication is currently declined but would be a treatment option based on symptoms profile.
Comments	
10. Explanation of IPT and phases of treatment	
0	The therapist did not explain IPT
2	The therapist explained that IPT is a treatment for depression or that is has an interpersonal focus but did not explain the link or the phases or goals of treatment
4	The therapist explained that IPT is a focused psychotherapy aimed at reducing symptoms and improving social adjustment and interpersonal functioning. The therapist explained the three phases of treatment and the primary goals.
6	The therapist explained the rationale for IPT as a time limited, here and now and interpersonally focused treatment which is rooted in a medical model of depression as a treatable illness; the reciprocal interaction between symptoms and life events; the goals of symptoms reduction and improved social functioning; the three phases with distinct strategies and objectives and selection and resolution of a interpersonally defined focus as the primary means of reducing symptom distress.
Comments	
11. Translate the depressive symptoms into the interpersonal context	

0	The therapist did not translate or link symptoms to the interpersonal context
2	The therapist discussed symptoms and/or interpersonal relationships and made infrequent links between them.
4	The therapist explained and explored the reciprocal relationship between symptoms and interpersonal relationships and life events.
6	The therapist skilfully linked the client's symptomatic and interpersonal experience and illustrates the dynamic nature of the interaction. Examples are routinely used to demonstrate the potential for relationships to both trigger and relieve symptom distress and as a basis for explaining the interpersonal focus and rationale for treatment.

Comments
12. Complete an Interpersonal Inventory

0	The therapist did not conduct an interpersonal inventory
2 The a	therapist made superficial enquiries about relationships but did not link to the depression or selecting focus.
. The their	therapist conducted a review of the client's interpersonal context to identify the availability, acceptability and quality of current social supports, significant relationships and life circumstances and connection to the current episode of depression.
The	therapist collaboratively and systematically examined the client's interpersonal experience in detail, giving explicit priority to current relationships as a basis for formulating the current availability, use and acceptability of interpersonal resources and significance and impact of current difficulties. The inventory was explicitly linked to the objective of understanding the current episode of depression and identifying the interpersonal focus for therapy

Comments
13. Potential focus areas are identified with the client

0	The therapist did not discuss possible focus areas with the client
2	The therapist referred to the focus areas but did not try to engage the client in identifying the most useful focus for treatment.
4	The therapist highlighted links between identified areas of individual difficulty and current symptoms and invited the client to consider and discuss the potential to work on each area as the main focus of therapy.
6	The therapist routinely offered tentative formulations by flexibly using the timeline, inventory and symptom profile to explore the possibilities for focusing the work. The therapist did not confirm focus before the assessment had been completed and actively engaged and collaborated with the client in evaluating the potential in each area and the nature of the work this would involve.

Comments
14. Presentation of interpersonal formulation of current depression

0	The therapist did not present an interpersonal formulation
2	The therapist identified the focus area but did not offer a personalized formulation related to the client's narrative.
4	The therapist helped the client to feel understood by presenting a summary of the salient events linked to the onset and maintenance of the depression and their impact and invited the client to respond to the proposed formulation and focus.
6	The therapist skilfully provided a formulation which integrated the client's temporal and thematic narrative, emphasizing the way in which specific interpersonal difficulties trigger and maintain the depression and how working within the identified focus area would seek
	to alleviate symptomatic distress. The client was actively encouraged to respond to the formulation and openly discuss misunderstanding or disagreements in order to agree how to proceed
Comments	
15. Negotiation of specific and achievable goals for treatment, which reflect the focus area	
0	The therapist did not identify any goals for therapy
2	The therapist identified broad and generic goals for therapy and did not involve the client
4	The therapist worked with the client to identify and agree realistic the therapeutic goals related to the focus area.
6	The therapist worked with the client to use the formulation to understand the nature of the current difficulty and to specify the changes which could be realistically and fruitfully targeted to bring about positive symptomatic and interpersonal change in the context of the focus, taking into account the severity and chronicity of the difficulties, the resources available to the client and the time limited nature of therapy.
Comments	
16. Explicit contract negotiation	
0	The therapist did not negotiate a contract
2	The therapist agreed to continue therapy through the remaining phases without negotiating a specific agreement with the client
4	The therapist outlined the duration and frequency of future contact, the character of the work and expectations of the client and therapist in the context of the negotiated focus. The client was invited to discuss the details and any areas of disagreement.
6	The therapist clearly and collaboratively discussed the clinical and practical expectations and responsibilities, planned for potential difficulties such as missed appointments and actively involved the client in preparing for moving into a new phase of treatment. The therapist outlined and agreed the contract at the start of treatment and repeated with tailored detailed at the time of formulation.
Comments	

Average score for rated items (i.e. > 0):

Number of items rated 1 or 2:

PART TWO

The second part of the scale addresses the following IPT Basic Competencies:

1. **Ability to maintain a systematic focus on an IPT interpersonal problem area(s) linked with the onset of symptoms**
2. **Ability to identify and explore difficulties in communication**
3. **Ability to facilitate the expression and acceptance of a range of emotions**
4. **Ability to encourage interpersonal change in-between sessions**
5. **Ability to adapt the core IPT strategies to the client's needs and the time available**
6. **Ability to balance being focused and maintaining alliance**
7. **Ability to establish appropriate balance between the therapist activity and non-directive exploration**
8. **Ability to make selective use of specific techniques to support the strategies and goals of the focal area**

Completed for all sessions

General Strategies

1. Facilitate expression and acceptance of a range of emotions	
0	Therapist did not facilitate expression of/and acceptance of emotions.
2	Therapist infrequently tracked the client's emotional state during the session and encouraged expression.
4	Therapist identified and responded to verbal and non verbal emotional cues in the session and used these to help the client explore, understand and express their emotions. Also to recognize and accept their feelings, differentiate feelings from actions and identify the relationship between what they feel and how they behave in a relationship.
6	Therapist consistently and sensitively tracked and explored the client's emotional state as a core strategy. Therapist supported the client in staying with current acknowledged and unacknowledged emotions in order to more fully recognize and accept their emotional state, to use it as a basis for understanding interpersonal experience and to help them discriminate when the expression of strong emotions is appropriate outside of the sessions and when it might undermine relationships.
Comments	
2. Attend to the therapeutic relationship	
0	The therapist did not acknowledge the therapeutic relationship with client
2	The therapist demonstrated inconsistent attunement and responsiveness to the therapeutic relationship in the session.
4	The therapist demonstrated empathic understanding and active collaboration with the client, and sensitively responded to verbal and non verbal cues.
6	The therapist maintained flexible, responsive and empathic engagement with the client and used the therapeutic relationship to give the client feedback and explore about how they might come across to others. This was explored primarily in relation to relationships outside of therapy but also sparingly when difficulties were manifest in the therapeutic relationships.
Comments	
3. Focus the session on an appropriate topic	
0	The therapist did not focus the session on an appropriate topic.
2	The therapist maintained generic attention to interpersonal themes and depression.
4	The therapist consistently maintained a linked symptomatic and interpersonal focus and adapted the specific interventions and targets according to the phase of therapy.
6	The therapist skilfully combined attention to the key symptomatic and interpersonal goals of therapy in the current interpersonal environment with clear attention to the specific objectives and tasks of the individual phases and focal areas, integrating pan focus work when appropriate and maintaining awareness of previous and future phases.

Comments

4. Monitor, support and acknowledge progress in addressing interpersonal problems.	
0	The therapist did not acknowledge or support the client's progress in addressing interpersonal problems.
2	The therapist infrequently acknowledged or supported the client's progress in addressing interpersonal problems.
4	Therapist helped the client to maintain focus on the goal of and rationale for interpersonal change. Tracked and reinforced attempts to achieve this and explored difficulties in making progress
6	The therapist actively and consistently helped the client to focus on making realistic and specific interpersonal change by helping them to understand the symptomatic and interpersonal implications, identify and engage resources to assist with this change, constructively address obstacles. Therapist skilfully balanced the drive towards change with and awareness of and sensitivity to the client's readiness for change.
Comments	
5. Maintain IPT the therapeutic stance	
0	The therapist did not maintain a supportive or active IPT stance.
2	The therapist offered occasional support but did not maintain a consistent, active and collaborative presence in the session
4	The therapist maintained an active and supportive stance through a range of interventions which helped and encouraged the client in identifying a specific interpersonal problem, discuss material relevant to the agreed focus, and work towards interpersonal change.
6	The therapist consistently and actively engaged the client in the work of therapy by routinely taking up opportunities to acknowledge and encourage achievements, to communicate directly and specifically identifying and attending to obstacles to progress in therapy and in the focal area, encouraging the client to do the same in order to achieve clarity and progress in addressing the agreed area of interpersonal difficulty.
Comments	
6. Directive techniques	
0	The therapist did not use directive techniques.
2	The therapist provided limited basic information appropriate to the stage of therapy.
4	The therapist provided information and advice sparingly but appropriately to engage the client and foster a confidence in the therapist's ability to help.
6	Therapist skilfully balanced directive techniques which constructively informed and guided the client's behavior and thinking, such as psycho-education and relevant factual information, with collaborative and exploratory planning to support the client in developing a sense of mutual and independent confidence.

Comments	
7. Role Playing	
0	The therapist did not use role play
2	The therapist used superficial role play to generate alternatives to problematic exchanges
4	The therapist appropriately used role play to explore and practice alternative communication relevant to the focus area
6	The therapist skilfully selected opportunities and used role play to try out alternatives and provide an experience of competence in communicating and interacting differently after full exploration and discussion of the options available to the client and careful selection and preparation for the specific practice in role play.
Comments	
8. Decision analysis	
0	The therapist did not use decision analysis
2	The therapist adopted a problem solving stance
4	The therapist worked with the client to identify decisions relevant to the focus area and discussed alternative options and potential consequences to aid decision making.
6	The therapist skilfully supported the client in clarifying the significant decisions related to the focus area, reviewing the full range of options available with consideration of anticipated consequences for the focal area and depression and arriving at a balanced plan of action. The client was supported to integrate this strategy as an independent competence.
Comments	
9. Clarification	
0	The therapist did not use clarification
2	The therapist infrequently used clarification to help their own or the client's understanding
4	The therapist regularly and appropriately used clarification, such as asking the client to repeat what they said or emphasizing the interpersonal component to help the client to become more aware of what they think and feel.
6	The therapist skilfully and flexibly used clarification to deepen their own and the client's understanding, to attend more clearly and specifically to the client's communication, feelings and thoughts and to explore contradictions and connections in what the client says
Comments	
10. Exploratory techniques	

0	The therapist did not use exploratory techniques
2	The therapist infrequently encouraged the client to expand on what they said and used proportionately more closed than open questions
4	The therapist supported and encouraged the client to expand on relevant and productive topics by demonstrating curiosity and interest and inviting more information through open questioning
6	The therapist actively fostered the client's sense of competence and autonomy by routinely demonstrating an open and curious interest, explicitly acknowledging constructive contributions by the client and encouraging the client to expand on productive topics without interrupting or imposing unnecessary structure.
Comments	

11. Communication analysis

0	The therapist did not use communication analysis
The in	therapist made generic or superficial enquiries about communication but did not explore examples detail
The	therapist engaged the client in reporting and reflecting on a recent, difficult exchange/conflict with another person through detailed reconstruction of the incident, associated feelings and link to depression.
The	therapist helped the clients to explore specific examples of problematic communication in detail, including the verbal and non verbal content, associated affect, the objective of, effectiveness of and satisfaction with the communication, the associated expectations and evaluation of reciprocity, empathic appreciation of the other's experience and considering and practicing alternative ways of communicating in detail.
Comments	

12. Explicit reference to the therapeutic relationship

0	The therapist did not explicitly refer to the therapeutic relationship
2	The therapist made reference to the therapeutic relationship but did not link to similar experiences in relationships outside of therapy
4	The therapist constructively identified recurring patterns and communication difficulties when these arise in the therapeutic relationship and linked to those that occur with others and maintain the depression to help the client to develop a better understanding and consider alternatives
6	The therapist used the therapeutic relationship as a vehicle to identify and provide constructive feedback on recurring interpersonal patterns and communication difficulties as they occurred, linking these to patterns with significant others and clarifying potential to trigger depression, and supported the client to try out and explore alternative ways of communicating by first attempting these in therapy.
Comments	

Average score for rated items (i.e. > 0):

Number of items rated 1 or 2:

Completed for agreed focus area

Focus Strategies

Role Transitions

1. Review depressive symptoms over the past week	
0	The therapist did not review the symptoms
2	The therapist made a cursory review e.g. mood only, without exploring changes or triggers across the week.
4	The therapist reviewed a sufficient range of symptoms to confirm current diagnostic status i.e. at least 5, and discussed the course of symptoms over the last week.
6	The therapist engaged the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better and worse periods and the associated interpersonal triggers. The therapist engaged the client in using standardized symptoms measures as an initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.
Comments	
2. Relate depressive symptoms to difficulty in coping with the transition from one social role to another	
0	The therapist did not relate the depressive symptoms to the focus area
2	The therapist discussed depression and/or the focus area but did not relate the two.
4	The therapist collaborated with the client to explore the reciprocal relationship between depressive symptoms and events or relationships associated with the focus area.
6	The therapist actively engaged the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Links were identified across the episode of depression but with particular reference to the reciprocal relationship in the last week. This was used to reinforce successes and explore relevant difficulties.
Comments	

3. Review the positive and negative aspects of the old role and possible new one, and realistic evaluation	
0	The therapist did not review the old or new roles
2	The therapist made a brief summary review of the old and/or new roles but did not engage the client is reflection or evaluation.
4	The therapist helped the client to explore the feelings and meanings associated with the role to be relinquished in order to facilitate a realistic appraisal about the role to adjust to and the opportunities it may provide.
6	The therapist collaborated with the client to create a balanced reconstruction of the old role and in so doing to mourn and relinquish it, empathically examined and addressed the aspect of the transition which is most problematic for the client and supported and engaged the client in developing the skills, motivation and supports necessary to adjust to the new role and take up the opportunities it affords.
Comments	
4. Explore nature of and feelings about what was lost	
0	The therapist did not explore feelings about what has been lost
2	The therapist made a superficial acknowledgement of the past role but did not engage with the associated feelings of loss.
4	The therapist supported the client in examining what has been lost in detail and in acknowledging and expressing the range of emotions associated with the change.
6	The therapist demonstrated non judgmental curiosity in examining the different dimensions of what has been lost and the mix of positive and negative feelings associated with relinquishing what must be given up while clarifying those aspects of the old role which may be carried forward.
Comments	
5. Explore feelings about the change itself	
0	The therapist did not examine feelings about the change
2	The therapist made limited and superficial enquiry about how the change happened
4	The therapist supported the client to evaluate feelings about how the change came about and the factors which contributed to it and how this links to the current depressive symptoms
6	The therapist empathically supported the client in a detailed examination of the context and process of the change, the contribution made by the client and others and the range of associated feelings and link to depression symptoms.
Comments	
6.Explore opportunities in the new role	

0	The therapist did not examine the opportunities in the new role
2	The therapist made limited reference to opportunities in the new role but did not engage the client in exploring them in practice.
4	The therapist encouraged the client in identifying and pursuing anticipated and unexpected new opportunities.
6	The therapist engaged the client in a systematic review of the new role to identify and/or create new opportunities which were anticipated to have a positive impact on depressive symptoms and adjustment to the new role.
Comments	
7.Encourage development and effective use of social support system and skills called for in the new role	
0	The therapist did not encourage use of social support in relation to the new role.
2	The therapist offered general encouragement to use support, without identifying from whom or how this might be related to the client in the new role specifically.
4	The therapist helped the client to identify and develop the skills and support system necessary for them to effectively manage the demands and take up the opportunities in the new role
6	The therapist actively explored how existing skills and supports could be employed effectively in the new role and worked creatively with the client to encourage taking risks and using novel strategies to equip them practically and interpersonally to fully engage with the new role and counteract the pessimism and poor motivation characteristic of depression.
Comments	

Average score for rated items (i.e. > 0):

Number of items rated 1 or 2:

Interpersonal Role Disputes

1.Review depressive symptoms over the past week	
0	The therapist did not review the symptoms
2	The therapist made a cursory review e.g. mood only, without exploring changes or triggers across the week.
4	The therapist reviewed a sufficient range of symptoms to confirm current diagnostic status i.e. at least 5, and discussed the course of symptoms over the last week.
6	The therapist engaged the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better and worse periods and the associated interpersonal triggers. The therapist engaged the client in using standardized symptoms measures as an initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.
Comments	
2. Relate symptoms onset to overt or covert dispute with significant other with whom the client is currently involved	
0	The therapist did not relate the depressive symptoms to the focus area
2	The therapist discussed depression and/or the focus area but did not relate the two.
4	The therapist collaborated with the client to explore the reciprocal relationship between depressive symptoms and events or relationships associated with the focus area.
6	The therapist actively engaged the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Links were identified across the episode of depression but with particular reference to the reciprocal relationship in the last week. This was used to reinforce successes and explore relevant difficulties.
Comments	
3. Determine the stage of the dispute	

0	The therapist did not stage the dispute
2	The therapist named the stage without engaging or discussing with the client
4	The therapist summarized exchanges between the parties in the dispute to characterize the predominant character of the dispute and invited the client to comment on the accuracy of the description.
6	The therapist actively involved the client in examining the form and frequency of communication in the dispute to collaboratively determine and agree the predominant character. The stage of the dispute was used as a basis from which to explain and plan how to initially address the dispute e.g. increase communication, contain explosive communication. The Therapist did not propose dissolution as an initial response.
Comments	
4 .Identify issues in the dispute	
0	The therapist did not identify issues in the dispute
2	The therapist noted areas of disagreement but did not engage the client in identifying the key recurring themes fueling the dispute
4	The therapist involved the client in reviewing a range of exchanges to identify the key recurring issues which are unresolved in the dispute and which contribute to its continuation.
6	The therapist sensitively and skilfully supported the client in identifying and acknowledging the central spoken and unspoken issues which fuel the dispute and the depressive symptoms and are repeatedly evident in problematic exchanges.

Comments	
5. Explanation of how non-reciprocal role expectations relate to the dispute	
0	The therapist did not explain non reciprocal role expectations
2	The therapist named non reciprocal expectations but did not explain or link to depression.
The from	therapist explained how spoken and unspoken differences in what each party wants the other can fuel disagreement if the differences are not identified and an agreement is not negotiated.
The d in	therapist skilfully used the client's own material to illustrate how differences in the give take of the relationship can trigger conflict and worked with the client to understand how differences expectations have played this role in the client's experience and fueled their depression.
Comments	
6.Exploration and discussion of differences in expectations and values	

0	The therapist did not explore differences in expectations
2 The	therapist identified differences in expectations in a general way but did not engage the client in more than superficial acknowledgment
4 The	therapist actively worked with the client to clarify important areas of difference in what they and the other person expects and the values they hold and discussed how this contributed to the dispute continuing.
he	therapist skilfully supported the client to identify the spoken and unspoken differences in expectations and values between them and the other person. The client was supported in acknowledging when expectations and values are unknown and to consider the possibility for change on both sides, including relinquishing expectations or negotiating a compromise.
Comments	

7.Exploration of parallels and differences between currently disputed and other past or present relationships	
0	The therapist did not explore parallels across relationships
2	The therapist made limited reference to similarities and differences across relationships but did not invite further discussion
4	The therapist explicitly identified problematic patterns in the disputed relationship and worked with the client to recognize when the same patterns were repeated or avoided in other contemporary or historical relationships.
6	The therapist skilfully reviews a broad range of relationships with the client to more fully understand how and when problematic patterns are repeated and how and when they are successfully avoided. This was used to clarify and promote the use of more adaptive interpersonal strategies which avoid or prevent conflict and so do not trigger depressive symptoms.

Comments	
8.Exploration and discussion of options available to the client to further resolution of the dispute and/or bring about desired change	
0	The therapist did not discuss options for change
2 The	therapist made generic suggestions for change without clear reference to the client's situation or relied on overly directive problem solving.
4 The	therapist used the shared understanding of the nature and process of the dispute to collaboratively identify and evaluate relevant and realistic options to bring about change and/or resolution.
he	therapist collaboratively and creatively worked with the client to encourage them to identify and evaluate the range of options available or which could be developed to bring about change. These involved direct action by the client and engaging others in the network who could act as a resource
to	furthering resolution.

Comments	
9.Discussion of communication patterns	
0	The therapist did not discuss communication patterns
2	The therapist discussed communication in a superficial manner.
The	therapist worked with the client to review multiple examples of communication to understand the repeating patterns and ways in which verbal and non verbal patterns contributed to the dispute being maintained.
he the	therapist supported the client to develop a sense of curiosity about the nature of their communication and to examine in detail the subtle and overt factors which determine and change course of communication and to evaluate how these communication patterns relate to the current dispute and symptom pattern.
Comments	
10.Exploration and discussion of how the dispute is perpetuated	
0	The therapist did not explore maintaining factors
2	The therapist made generic suggestions about how the dispute is perpetuated without directly linking to the client's experience.
4	The therapist worked collaboratively with the client to identify and understand the range of factors which sustained the dispute including communication, circumstances, the role of others, depression.
6	The therapist worked collaboratively with the client to develop a full understanding of the process around the dispute, the contribution the client and others make, the conflicting expectations which create an obstacle to resolution and the way in which depression interferes with communication and reasoning to maintain the conflict.
Comments	
11. Explore use of wider network to understand or ameliorate the dispute	
0	The therapist did not make reference to the wider network
2 The	therapist made only passing reference to others and did not examine how they might contribute to resolution of the dispute
The	therapist supports the client to identify the interpersonal resources they have available and to engage them appropriately to bring about change in the dispute
he the	therapist systematically considers the range of support available or which could be developed with client and creatively maps the use of those resources onto their shared understanding of the dispute to clarify how the network might contribute change and actively supported the client to mobilize those interpersonal resources.
Comments	

Average score for rated items (i.e. > 0):

Number of items rated 1 or 2:

Interpersonal Sensitivity/Deficits

1.Review depressive symptoms over the past week	
0	The therapist did not review the symptoms
2	The therapist made a cursory review e.g. mood only, without exploring changes or triggers across the week.
4	The therapist reviewed a sufficient range of symptoms to confirm current diagnostic status i.e. at least 5, and discussed the course of symptoms over the last week.
6	The therapist engaged the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better and worse periods and the associated interpersonal triggers. The therapist engaged the client in using standardized symptoms measures as an initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.
Comments	

2. Relate depressive symptoms to the problems of social dissatisfaction or isolation	
0	The therapist did not relate the depressive symptoms to the focus area
2	The therapist discussed depression and/or the focus area but did not relate the two.
4	The therapist collaborated with the client to explore the reciprocal relationship between depressive symptoms and events or relationships associated with the focus area.
6	The therapist actively engaged the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Links were identified across the episode of depression but with particular reference to the reciprocal relationship in the last week. This was used to reinforce successes and explore relevant difficulties.
Comments	

3.Review past significant relationships	
0	The therapist did not review past relationships
2	The therapist looked at past relationships in a superficial and non specific way
4	The therapist engaged the client in a detailed review of past relationships to clarify the client's interpersonal style
6	The therapist actively engaged the client in a systematic review of the nature, course, strengths and difficulties in past relationships and drew parallels with current relationships
Comments	

4. Explore repetitive dysfunctional patterns and expectations in past or present relationships

0	The therapist did not examine patterns or expectations in past relationships
2	The therapist offered superficial comment on past relationships without detailed assessment
4	The therapist collaboratively worked with the client to identify and clarify repeating patterns in past and present relationships
6	The therapist worked collaboratively with the client to examine past and present relationships in detail to clarify the nature and processes involved in triggering and sustaining problematic patterns and the expectations which sustain them and used this as the basis for specifying the specific sensitivity/deficit that will provide the focus for therapy
Comments	

5. Discuss client's + and - feelings re the therapist and explore parallels in other relationships

0	The therapist did not discuss the client's feelings about the therapist
2	The therapist was inattentive or defensive in discussing the client's feelings about the therapist and made few or no links to relationships outside of therapy room
4	The therapist was supportive in discussing the client's feelings about the therapist and used this as a basis from which to examine parallels with other relationships
6	The therapist encouraged and supported the client in expressing their feelings about the therapist and in experimenting in new ways of communicating. The therapist worked collaboratively with the client to understand how the feelings in the therapeutic relationship could be used to more fully and constructively understand parallel feelings and reactions in relationships outside of therapy
Comments	

6.The therapist conveys his/her own feelings and uses the therapeutic relationship to facilitate client's awareness of his/her impact on and role in interactions and as model for satisfying relationships outside therapy

0	The therapist did not discuss their feelings about the therapeutic relationship
2	The therapist made vague, ill-timed or critical comment about their experience of the therapeutic relationship which confused or aggravated the client.
4	The therapist made use of their own feelings and responses to the therapeutic relationship to draw attention to and understand the problematic interpersonal pattern/sensitivity that is the focus of therapy and to illustrate similar interaction patterns in other relationships
6	The therapist sensitively and selectively used their experience of the therapeutic relationship to safely provide constructive feedback to the client, and to support the client to consider parallels with relationships outside of therapy and how similar constructive and clear communication might improve satisfaction with relationships outside of therapy
Comments	

Encourage formation of new relationships and development of existing relationships

0	The therapist did not encourage new relationships
2	The therapist offered encouragement for the client to pursue new relationships but did not offer specific support or guidance
4	The therapist actively and repeatedly encouraged the client to develop their existing networks and to expand the network to include new relationships
6	The therapist actively and repeatedly encouraged the client to identify and pursue opportunities to develop existing relationships and to engage in new relationships in a manner which would reduce the isolation and dissatisfaction resulting from the focal sensitivity. The therapist offered specific and constructive support and direction to assist the client in experimenting with new ways of communicating and behaving which would facilitate this change
Comments	

Average score for rated items (i.e. > 0):

Number of items rated 1 or 2:

Complicated Grief

1.Review depressive symptoms over the past week	
0	The therapist did not review the symptom
2 The	therapist made a cursory review e.g. mood only, without exploring changes or triggers across the week.
4 i.e.	The therapist reviewed a sufficient range of symptoms to confirm current diagnostic status at least 5, and discussed the course of symptoms over the last week.
ıe	therapist engaged the client in a detailed and collaborative review of the range of depressive symptoms over the past week, tracking better and worse periods and the associated interpersonal triggers. The therapist engaged the client in using standardized symptoms measures as an initial summary communication to be expanded upon and reinforced the client's role as expert in their own depression.

Comments	
2. Relate depressive symptoms to death and/or absence of significant other	
0	The therapist did not relate the depressive symptoms to the focus area
2	The therapist discussed depression and/or the focus area but did not relate the two.
4	The therapist collaborated with the client to explore the reciprocal relationship between depressive symptoms and events or relationships associated with the focus area.
6	The therapist actively engaged the client to track and evaluate the interaction between their depressive symptoms and the focus throughout the session. Links were identified across the episode of depression but with particular reference to the reciprocal relationship in the last week. This was used to reinforce successes and explore relevant difficulties.
Comments	
3.Reconstruct the positive and negative aspects of the client's relationship with the deceased	
0	The therapist did not attempt to reconstruct the relationship with the deceased
2	The therapist discusses the client's relationship with the deceased in a vague and uninformative manner which provides little or no insight into the nature of the relationship.
4	The therapist constructively supported the client to explore the range of positive and negative aspects of their relationship with the deceased and helped the client to acknowledge unwanted or painful feelings and memories
6	The therapist sensitively supported the client to explore both acknowledged and unspoken aspects of their relationship with the deceased and in so doing helped the client to engage in a balanced affective exploration of the whole relationship and to tolerate and express ambivalent or negative feelings towards the deceased
Comments	
4. Describe events just prior to, during and after the death and response	
0	The therapist did not invite the client to describe the events around the death
2	The therapist invited a brief overview without exploring associated feelings, impact, beliefs or social context.
4	The therapist supported and guided the client through a detailed reconstruction of the events and feelings prior to, during and after the death.
6	The therapist skilfully supported the client to recall and describe in detail the sequence of events leading to, around and following the death, with particular attention to associated feelings, and communication. Particular attention was sensitively given to the points which continue to generate distress and provoke depressive symptoms.
Comments	

5.Evaluate availability and use of social support at the time of death and for current mourning	
0	The therapist did not evaluate social support at the time of the death or currently
2	The therapist made a superficial enquiry about the past and present social network but did not attempt to actively evaluate the role of the network for the client.
4	The therapist explored what social support was available and used at the time of the death and since and used this to develop a better understanding of why mourning has not progressed
6	The therapist encouraged the client to evaluate in detail the rang e and type of support which were available at the time of the death and since, the use made and adequacy of this support, the perceived obstacles to using this support, and the contribution this made to the complicated grief reaction and depression
Comments	
6.Explore feelings about current impact of loss	
0	The therapist did not explore feelings about the loss
2	The therapist made infrequent enquiries about the client's current feelings about the loss
4	The therapist routinely encouraged the client to become aware of and express the ongoing emotional impact of the loss
6	The therapist skilfully supported the client to explore their current unacknowledged affective state in detail and to clarify the ways in which this continued to relate to the loss, maintain their depression and creates an obstacle to moving on
Comments	
7.Consider ways of becoming involved with others	
0	The therapist did not examine ways for the client to become more involved with others
2	The therapist offered limited and non specific suggestions that the client should be more involved with others but did not support the client in doing so.
4	The therapist actively encouraged the client to (re)establish and pursue interests and relationships in their current life
6	The therapist skilfully supported the client to examine the opportunities which are available and which can be created to establish and maintain relationships with others which can adequately meet their current emotional, social and practical needs
Comments	

Average score for rated items (i.e. > 0):

Number of items rated 1 or 2:

PART THREE

The third part of the scale addresses the following IPT Basic Competencies:

1. Ability to engage the client in preparing for ending

Ending

Item	
1. Explicit discussion of the end of treatment	
0	The therapist made little no reference to the end of treatment
2	The therapist briefly referred to the end treatment but did not engage the client in discussion
4	The therapist helped the client prepare for the ending by explicitly referring to the time limited nature of treatment and specifies time remaining
6	The therapist helped the client to prepare for ending and to use this as a motivating factor by clearly maintaining attention on the end of therapy and actively engaging the client in expressing their response to and plans in relation to this
Comments	
2. Elicit/discuss client's and the therapist's reactions to termination	

0	The therapist did not explore or discuss the client's or therapist's reaction to the end phase of IPT
2	The therapist only briefly asked about the client's feelings about coming to the end of therapy
	The therapist encouraged the client to express their feelings about ending therapy
4	The therapist encouraged the client to express their positive and negative feelings about the end of therapy, responded non-defensively to expressions of disappointment and modelled communication by constructively commenting on their own response to therapy coming to an end
6	
Comments	

Acknowledgement of the end of treatment as a time of potential grieving and distinguish from symptomatic relapse	
0	The therapist has made no reference to feelings of grief/loss at the end of therapy nor distinguished this from depressive symptoms
2	The therapist has made only brief reference to feelings of grief at the end of therapy and limited distinctions from depressive symptoms
4	The therapist acknowledged the end of treatment is a potential time of grieving and explicitly discusses how this differs from depressive symptoms
6	The therapist actively encouraged and supported the client in identifying and expressing feelings of sadness and loss about the end of therapy. This was used to distinguish between the transitory and specific nature of an emotional response from the persistent and global nature of a symptomatic relapse. The therapist supported the client in discussing their related concerns.
Comments	

4. Help client move towards recognition of his/her independent competence	
0	The therapist did not acknowledge the client's independent competence
2	The therapist has provided only limited praise for what the client has accomplished
4	The therapist has clearly communicated praise for what the client has accomplished, making specific reference to the increased level of competence achieved
	The therapist actively encouraged the client to review and acknowledge the ways in which they had achieved and sustained change and actively reinforced and praised this achievement
6	
Comments	

5. Review with the client the course of his/her treatment and progress in therapy

0	The therapist did not review the course of treatment or progress throughout therapy with the client
2	The therapist briefly addressed progress achieved throughout therapy
4	The therapist facilitated a realistic review of symptomatic and interpersonal progress, underscoring both areas of interpersonal competence and of future vulnerability
6	The therapist actively engaged the client in realistically evaluating the symptomatic and interpersonal progress achieved over the course of therapy, with specific reference to the individual goals set by the client at the start of therapy and the overarching goals of IPT
Comments	

Client invited to evaluate the treatment and to assess future needs, including maintenance strategies in the interpersonal context	
0	The therapist did not ask the client to evaluate treatment or assess his/her future needs including maintenance strategies or access to interpersonal support
2	The therapist made superficial review of treatment and future needs
4	The therapist encouraged the client to evaluate treatment and to engage significant others in preparing for ending and in planning for the future
6	The therapist actively encouraged the client to evaluate their experience of and satisfaction with therapy, identify any areas of omission or disappointment, assess their future needs and strategies for maintaining gains including maintaining interpersonal supports and engagement, maintenance IPT and medication and/or referral to other professional networks
Comments	

Assess with the client his/her early warning signals and discuss procedures for reentry in to treatment if necessary	
0	The therapist did not discuss or assess early warning signs
2	The therapist made limited reference to early warning signs and interpersonal triggers but did not develop a response plan with the client
4	The therapist clearly helped the client consolidate their understanding of interpersonal problems as a potential sign of relapse and to understand how symptomatic changes may serve as 'markers' of current interpersonal problems
6	The therapist discussed the early symptom changes characteristic of the onset of a depressive episode for the client in detail and worked collaboratively with the client to develop a clear relapse plan which draws on the support of other people
Comments	

Average score for rated items (i.e. > 0):

Number of items rated 1 or 2:

Interpersonal Psychotherapy for Depression

CASE SUMMARY FOR INCLUSION IN IPT SUPERVISION PORTFOLIO

Please note this summary should not contain information which enables your case or your service to be identified. If you are able to include formal assessment measures or have other documentation, please include it.

Your Name	
Name of Supervisor	
Case identifier (give number or pseudonym)	
Case number (1st – 6th)	
Patient's age	

Patient's sex	
Source of referral e.g. GP, Step-up, Self Referral	

Which audio recordings were reviewed by your supervisor? Please state phase of treatment e.g. early, middle, ending and session number. Please indicate if recordings for any phase had to be resubmitted, and if so which. Please provide copies of written feedback on therapy recordings.	
What was the duration of this treatment? Please include number of sessions offered and attended, and duration of contact e.g. 6 months	
Type of supervision received .e.g. group, individual, peer.	
Briefly outline the patient's mental health history including the most recent episode of depression; symptoms at time of referral; baseline ratings on symptom and social measures; current diagnosis (es); previous episodes of depression or other disorders; previous treatments; current reason for referral; why did you consider them suitable for IPT. (maximum 200 words)	
Provide a very brief social history including any key relevant recent and distal life	
events, and significant changes in social life e.g. losses or transitions where social life adversely affected or symptomatic distress increased; please provide a copy of timeline (maximum 500 words)	

Briefly describe patient's response to diagnosis and what changes were agreed in taking on the sick role (max 100 words)

Briefly describe the Interpersonal Inventory and provide a copy

Summarise the formulation including the focus area(s)

Provide a brief outline of the main negotiated treatment goals

Provide an outline of the middle sessions: include the sequence and progression through the focus specific techniques; working with the target role/relationship; working with affect; working with communication patterns; working with the wider network; key points of change; pattern of symptom and interpersonal change (max. 500 words)

Describe the ending phase and how this went including extent to which treatment goals were achieved. What was the outcome of treatment? Include graph of scores on outcome measures across treatment and comment on changes. What strategies were agreed to maintain gains achieved in treatment? (approximate 200 words)
Provide a brief reflection on the outcome of the IPT treatment for this case: including a brief description of how the model was useful; what did you learn; what where the challenges or difficulties in applying the model to this case; including any contribution from supervision in contributing to your intervention; what would you do differently in the future; what went very well (approximate 500- 700 words)

Therapist ID: Supervisor ID:

Focal Areas Used: Transition Disputes Grief Sensitivity

Sections for assessment	Competency Demonstrated	Quality
Initial Sessions		
Addressing depression (1, 2, 3, 4, 5, 6, 7, 8, 9)	**Y/N**	**Pass/Fail**
Addressing interpersonal context (10, 11, 12,)	**Y/N**	**Pass/Fail**
Linking and contracting (13, 14, 15,16)	**Y/N**	**Pass/Fail**
General Strategies		
Addressing emotions (1)	**Y/N**	**Pass/Fail**
Addressing Therapeutic Relationship (2,3,4,5,12)	**Y/N**	**Pass/Fail**
Applying Techniques (6,7,8,9,10,11)	**Y/N**	**Pass/Fail**
Role Transition		
Monitoring symptoms and link to focus (1,2)	**Y/N**	**Pass/Fail**
Examine focus relationship/role (3, 4,5,6)	**Y/N**	**Pass/Fail**
Engage network (7)	**Y/N**	**Pass/Fail**
Role Dispute		
Monitoring symptoms and link to focus (1,2)	**Y/N**	**Pass/Fail**
Examine focus relationship/role (3, 4,5,6,8,9,10)	**Y/N**	**Pass/Fail**
Engage network (7,11)	**Y/N**	**Pass/Fail**
Sensitivity		
Monitoring symptoms and link to focus (1,2)	**Y/N**	**Pass/Fail**
Examine focus relationship/role (3, 4,6,7)	**Y/N**	**Pass/Fail**
Engage network (5,8)	**Y/N**	**Pass/Fail**
Complicated Grief		
Monitoring symptoms and link to focus (1,2)	**Y/N**	**Pass/Fail**
Examine focus relationship/role (3, 4,6)	**Y/N**	**Pass/Fail**
Engage network (5,7)	**Y/N**	**Pass/Fail**
Ending		
Discuss ending (1,2,3)	**Y/N**	**Pass/Fail**
Review and evaluate (4,5,)	**Y/N**	**Pass/Fail**

Relapse prevention (6,7)		Y/N	Pass/Fail
Reflective statements			
Case 1 Y/N	**Case 2 Y/N**	**Case 3 Y/N**	**Case 4 Y/N**

Signed (Trainee): Date:

Signed (Supervisor): Date:

Interpersonal Psychotherapy for Depression IPT

CASEWORK – SUMMARY SHEET

Therapist's name: **DATE:**

Supervisor's name: **External rater's name:**

Case ONE:

Patient's initials: Number of sessions attended: Focal Area:

Baseline: PHQ-9 score: GAD score: WSAS score:

End point: PHQ-9 score: GAD score: WSAS score:

Tape 1: Pass/Fail Tape 2: Pass/Fail Tape 3: Pass/Fail N/A Resubmission: Pass/Fail/

Case TWO:

Patient's initials: Number of sessions attended: Focal Area:

Baseline: PHQ-9 score: GAD score: WSAS score:

End point: PHQ-9 score: GAD score: WSAS score:

Tape 1: Pass/Fail Tape 2: Pass/Fail Tape 3: Pass/Fail N/A Resubmission: Pass/Fail/

Case THREE:

Patient's initials: Number of sessions attended: Focal Area:

Baseline: PHQ-9 score: GAD score: WSAS score:

End point: PHQ-9 score: GAD score: WSAS score:

Tape 1: Pass/Fail Tape 2: Pass/Fail Tape 3: Pass/Fail Resubmission: Pass/Fail/ N/A

Case FOUR:

Patient's initials: Number of sessions attended: Focal Area:

Baseline: PHQ-9 score: GAD score: WSAS score:

End point: PHQ-9 score: GAD score: WSAS score:

Tape 1: Pass/Fail Tape 2: Pass/Fail Tape 3: Pass/Fail Resubmission: Pass/Fail/ N/A

Case FIVE:

Patient's initials: Number of sessions attended: Focal Area:

Baseline: PHQ-9 score: GAD score: WSAS score:

End point: PHQ-9 score: GAD score: WSAS score:

Tape 1: Pass/Fail Tape 2: Pass/Fail Tape 3: Pass/Fail Resubmission: Pass/Fail/ N/A

Case SIX:

Patient's initials: Number of sessions attended: Focal Area:

Baseline: PHQ-9 score: GAD score: WSAS score

End point: PHQ-9 score: GAD score: WSAS score

Tape 1: Pass/Fail Tape 2: Pass/Fail Tape 3: Pass/Fail Resubmission: Pass/Fail/ N/A