Interpersonal Psychotherapy for Depression (IPT) Competency Framework

September 2010
Introduction

This document details the competences that staff delivering Interpersonal Psychotherapy for Depression (IPT) need to demonstrate to work in IAPT services. The work to derive these competences was commissioned by the Improving Access to Psychological Therapies (IAPT) programme.

The updated NICE Guidelines for Depression (available at www.nice.org.uk) indicate that these therapies are all effective treatments for depression. In November 2009, the IAPT programme embraced this advice and committed to making these therapies available in IAPT services.

The publication of the competency frameworks, for the modalities additional to the previously published framework for Cognitive Behavioural Therapy (CBT), is a key milestone for the programme.

You can find out more about the Improving Access to Psychological Therapies Programme and download all the competency frameworks by visiting www.iapt.nhs.uk

While NICE recommends a range of interventions, based on a wide-ranging evidence base, for the treatment of depression, choice of therapy and treatment should be made at a local level with the full involvement of the patient, supported by good quality patient information.
Interpersonal Psychotherapy for Depression (IPT)

IPT is a time-limited, interpersonally focussed form of psychological therapy in which the client’s social and interpersonal context are understood to contribute to the onset of and/or maintenance of depressive symptoms. It is aimed at a) reducing the symptoms of depression and b) improving social adjustment and interpersonal functioning.

IPT focuses primarily on current interpersonal functioning and recent life circumstances rather than longstanding conflicts or problems originating in childhood. It is assumed that symptomatic distress is relieved by resolving current interpersonal problems and vice versa. For example, resolving a dispute with a work colleague might help someone feel less depressed, and in turn feeling less depressed will help them work more effectively on resolving the dispute.

IPT is a change-oriented therapy that aims to help the client to change their interpersonal behaviour, not primarily to develop insight. It focuses on relationship problems: on helping the person to identify how they are feeling and behaving in their relationships and then trying out new ways of interacting with others. When a person is able to deal with a relationship problem more effectively, their depressive symptoms often improve.

In practice IPT seeks to maximise the benefit of working in a time limited manner by maintaining a here-and-now perspective on recent, recurrent or even chronic mood difficulties, and by framing the intervention around one of four interpersonal problem areas (role transitions, disputes, grief and loss, and difficulties initiating or sustaining relationships).

IPT has three main phases, each with distinct tasks. The assessment phase focuses on a collaborative review and integration of interpersonal functioning and symptomatic patterns to arrive at a focus for the work. During the middle sessions interventions are targeted at one of four interpersonal problem areas. The final phase addresses issues of ending, with a review of progress and (because depression can be a relapsing disorder) a focus on relapse prevention. A fourth phase (which aims to maintain a good outcome and support relapse prevention), is negotiated for some patients.
Why identify competences?

The IAPT programme involves delivering high quality treatments, and this requires competent practitioners who are able to offer effective interventions. Identifying individuals with the right skills is important, but not straightforward.

Within the NHS, a wide range of professionals deliver psychological therapies, but there is no single profession of ‘psychological therapist’. Most practitioners have a primary professional qualification, but the extent of training in psychological therapy varies between professions, as does the extent to which individuals have acquired additional post-qualification training. This makes it important to take a different starting point, identifying what competences are needed to deliver good-quality therapies, rather than simply relying on job titles to indicate proficiency.

The development of the competences needs to be seen in the context of the development of National Occupational Standards (NOS), which apply to all staff working in health and social care. There are a number of NOS that describe standards relevant to mental health workers, downloadable at the Skills for Health website (www.skillsforhealth.org.uk).

Clinicians need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills; to think not just about how to implement their skills, but also why they are implementing them.

Beyond knowledge and skills, the therapist’s attitude and stance to therapy are also critical – not just their attitude to the relationship with the client, but also to the organisation in which therapy is offered, and the many cultural contexts within which the organisation is located (which includes a professional and ethical context, as well as a societal one). All of these need to be held in mind by the therapist, since all have a bearing on the capacity to deliver a therapy that is ethical, conforms to professional standards, and which is appropriately adapted to the client’s needs and cultural contexts.

A competent clinician brings together knowledge, skills and attitudes. It is this combination that defines competence; without the ability to integrate these areas, practice is likely to be poor.
The Competency Map
The competency map for each of the modalities organises the competences into a number of domains and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The maps show the ways in which the activities fit together and need to be ‘assembled’ in order for practice to be proficient. The descriptions below give details of the competences associated with each of these activities.

Generic Therapeutic Competences
Generic competences are employed in all psychological therapies, reflecting the fact that all psychological therapies, share some common features. For example, therapists using any accepted theoretical model would be expected to demonstrate an ability to build a trusting relationship with their clients, relating to them in a manner that is warm, encouraging and accepting. They are often referred to as ‘common factors’.

Basic Competences
Basic competences establish the structure for therapy and form the context and structure for the implementation of a range of more specific techniques. This domain contains a range of activities that are basic in the sense of being fundamental areas of skill; they represent practices that underpin the modality.

Specific Techniques
These competences are the core technical interventions employed in the therapy. Not all of these would be employed for any one individual, and different technical emphases would be deployed for different problems.

Specific applications
Even within the same therapeutic approach there can be slightly different ways of assembling techniques into a ‘package’ of intervention. Where there is good research evidence that these different ‘packages’ are effective it makes sense to describe them, so that clinicians know how these specific intervention are delivered.

Metacompetences
Metacompetences are common to all therapies, and broadly reflect the ability to implement an intervention in a manner which is flexible and responsive. They are overarching, higher-order competences which practitioners need to use to guide the implementation of therapy across all levels of the model.

Competence Map Key:
- The competences in each of the framework maps are colour coded under each of the headings above.
- The maps outline the competences under each heading and also group some key competences, that are fundamental components in demonstrating competence in that modality.
Interpersonal Psychotherapy for Depression (IPT) Competency Map

Ability to maintain a focus on the interpersonal context of the symptoms

**Knowledge of basic principles and rationale for IPT**

- Ability to make selective use of specific techniques to support the strategies and goals of the focal area
- Ability to use directive techniques
- Ability to use decision analysis and role-playing
- Ability to use communication analysis
- Ability to use clarification, summaries and questions
- Ability to use the therapeutic relationship

**Specific techniques**

- Ability to implement IPT in a manner consonant with its supportive and active 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 focus on an IPT interpersonal problem area(s) linked with the onset and or maintenance of symptoms
- Ability to maintain a focus on an IPT interpersonal problem area(s) linked with the onset and or maintenance of symptoms
- Ability to identify and explore difficulties in communication
- Ability to encourage interpersonal change in-between sessions
- Ability to facilitate the expression and acceptance of a range of emotions
- Ability to engage the client in preparing for ending

**Specific applications**

- IPT for Eating Disorders
  - *Fairburn et al., (1997)*
- IPT for depression
  - *Weissman et al., (2007)*
- Brief IPT for depression (IPT-B)
  - *Swartz et al.*
- IPT for depressed older adults
  - *Hinrichsen & Clougherty, 2006*
- IPT for depressed adolescents (IPT-A)
  - *Mufson et al., (2004)*

**Generic Therapeutic Competences**

- Knowledge and understanding of depression and mental health problems
- Ability to engage client
- Ability to foster and maintain a good therapeutic alliance, and to grasp the client’s perspective and ‘world view’
- Ability to work with the emotional content of sessions
- Ability to manage endings
- Ability to undertake assessments (including relevant history and identifying suitability for intervention)
- Ability to assess and manage risk of self-harm
- Ability to work with difference (‘cultural competence’)
- Ability to make use of supervision
- Ability to use measures to guide therapy and monitor outcomes

**Basic IPT Competences**

- Knowledge of basic principles and rationale for IPT
- Ability to implement IPT in a manner consonant with its supportive and active 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 focus on an IPT interpersonal problem area(s) linked with the onset and or maintenance of symptoms
- Ability to identify and explore difficulties in communication
- Ability to encourage interpersonal change in-between sessions
- Ability to facilitate the expression and acceptance of a range of emotions
- Ability to engage the client in preparing for ending

**Metacompetences**

- Generic metacompetences
  - Ability to implement treatment models in a flexible but coherent manner
  - Ability to use and respond to humour
  - Ability to adapt interventions in response to client feedback

- IPT specific metacompetences
  - Ability to adapt the core IPT strategies to the client’s individual needs and the time available
  - Ability to balance being focused and maintaining the therapeutic alliance
  - Ability to establish an appropriate balance between therapist activity and non-directive exploration
Knowledge and understanding of mental health problems

- During assessment and when carrying out interventions, an ability to draw on knowledge of common mental health problems and their presentation, particularly depression.
- An ability to draw on knowledge of the factors associated with the development and maintenance of mental health problems.
- An ability to draw on knowledge of the usual pattern of symptoms associated with mental health problems.
- An ability to draw on knowledge of the ways in which mental health problems can impact on functioning (e.g. maintaining intimate, family and social relationships, or the capacity to maintain employment and study).
- An ability to draw on knowledge of the impact of impairments in functioning on mental health.
- An ability to draw on knowledge of mental health problems to avoid escalating or compounding the client’s condition when their behaviour leads to interpersonal difficulties which are directly attributable to their mental health problem.

Knowledge of depression

- An ability to draw on knowledge of the cluster of symptoms associated with a diagnosis of depression:
  - depressed mood most of the day
  - marked loss of interest or pleasure in daily activities
  - sleep problems
  - loss of appetite and significant loss of weight
  - fatigue/exhaustion
  - difficulties getting to sleep or excessive sleep
  - psychomotor agitation (feeling restless or agitated) or psychomotor retardation (feeling slowed down)
  - feelings of worthlessness or excessive guilt
  - low self-confidence
  - difficulties in thinking/ concentrating and/or indecisiveness
  - recurrent thoughts of death, suicidal ideation, suicidal intent (with or without a specific plan)
- An ability to draw on knowledge:
  - that a diagnosis of depression is based on the presence of a subset of these symptoms
  - that of these symptoms, depressed mood; loss of interest or pleasure; and fatigue are central
  - that symptoms need to be present consistently over time (e.g. DSM-IV-TR criteria specify two weeks, ICD-10 criteria specify one month)
- An ability to draw on knowledge of the diagnostic criteria for all mood disorders (including minor depression/dysthmic disorder and bipolar disorder) and to be able to distinguish between these presentations
- An ability to draw on knowledge of the incidence and prevalence of depression, and the conditions that are commonly comorbid with depression
- An ability to draw on knowledge of the patterns of remission and relapse/recurrence associated with depression
- An ability to draw on knowledge of factors which are associated with an increased vulnerability to depression e.g.:
  - developmental risk factors (e.g. temperament)
  - quality of early experience with parents or significant others
  - quality of relationships with partner, family and significant others
  - quality of current social relationships
  - social isolation
  - major adverse life-events (e.g. childhood abuse or neglect, financial loss, unemployment, separation from a partner, bereavement, retirement)
  - major life-transitions (e.g. becoming a parent)
  - acute and chronic physical illness (both in the client and in significant others)
• An ability to draw on knowledge of the impact of depressive symptoms on the client’s functioning (e.g. in interpersonal and work domains), and the fact that difficulties in functioning can (in turn) contribute to depressive symptoms

• An ability to draw on knowledge of the evidence for the effectiveness of psychological and psychopharmacological interventions for depression, and their effectiveness in combination

• An ability to draw on knowledge of the ways in which depression is conceptualised within the model of therapy being adopted

Knowledge of, and ability to operate within, professional and ethical guidelines

Knowledge of guidelines

• An ability to maintain awareness of national and local codes of practice which apply to all staff involved in the delivery of healthcare, as well as any codes of practice which apply to the counsellor as a member of a specific profession.

• An ability to take responsibility for maintaining awareness of legislation relevant to areas of professional practice in which the counsellor is engaged (specifically including the Mental Health Act, Mental Capacity Act, Human Rights Act, Data Protection Act).

Application of professional and ethical guidelines

• An ability to draw on knowledge of relevant codes of professional and ethical conduct and practice in order to apply the general principles embodied in these codes to each piece of work being undertaken, in the areas of:
  • obtaining informed consent for interventions from clients
  • maintaining confidentiality, and knowing the conditions under which confidentiality can be breached
  • safeguarding the client’s interests when co-working with other professionals as part of a team, including good practice regarding inter-worker/inter-professional communication
  • competence to practice, and maintaining competent practice through appropriate training/professional development

• recognition of the limits of competence and taking action to enhance practice through appropriate training/professional development

• protecting clients from actual or potential harm from professional malpractice by colleagues by instituting action in accordance with national and professional guidance

• maintaining appropriate standards of personal conduct for self:
  a) a capacity to recognise any potential problems in relation to power and ‘dual relationships’ with clients, and to desist absolutely from any abuses in these areas
  b) recognising when personal impairment could influence fitness to practice, and taking appropriate action (e.g. seeking personal and professional support and/or desisting from practice)

Knowledge of a model of therapy, and the ability to understand and employ the model in practice, including the treatment of depression

• An ability to draw on knowledge of factors common to all therapeutic approaches:
  • supportive factors:
    o a positive working relationship between counsellor and client characterised by warmth, respect, acceptance and empathy, and trust
    o the active participation of the client
    o counsellor expertise
    o opportunities for the client to discuss matters of concern and to express their feelings
• learning factors:
  o advice
  o correctional emotional experience
  o feedback
  o exploration of internal frame of reference
  o changing expectations of personal effectiveness
  o assimilation of problematic experiences

• action factors:
  o behavioural regulation
  o cognitive mastery
  o encouragement to face fears and to take risks
  o reality testing
  o experience of successful coping

• An ability to draw on knowledge of the principles which underlie the intervention being applied, using this to inform the application of the specific techniques which characterise the model.

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Ability to engage client

• While maintaining professional boundaries, an ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to client need.
• An ability to engender trust.
• An ability to develop rapport.
• An ability to adapt personal style so that it meshes with that of the client.
• An ability to recognise the importance of discussion and expression of client’s emotional reactions.
• An ability to adjust the level of in-session activity and structuring of the session to the client’s needs.
• An ability to convey an appropriate level of confidence and competence.
• An ability to avoid negative interpersonal behaviours (such as impatience, aloofness, or insincerity).

Ability to foster and maintain a good therapeutic alliance, and to grasp the client’s perspective and world view

Understanding the concept of the therapeutic alliance

• An ability to draw on knowledge that the therapeutic alliance is usually seen as having three components:
  • the relationship or bond between counsellor and client
  • consensus between counsellor and client regarding the techniques/methods employed in the therapy
  • consensus between counsellor and client regarding the goals of therapy

• An ability to draw on knowledge that all three components contribute to the maintenance of the alliance.
Knowledge of counsellor factors associated with the alliance

- An ability to draw on knowledge of counsellor factors which increase the probability of forming a positive alliance:
  - being flexible and allowing the client to discuss issues which are important to them
  - being respectful
  - being warm, friendly and affirming
  - being open
  - being alert and active
  - being able to show honesty through self-reflection
  - being trustworthy

- Knowledge of counsellor factors which reduce the probability of forming a positive alliance:
  - being rigid
  - being critical
  - making inappropriate self-disclosure
  - being distant
  - being aloof
  - being distracted
  - making inappropriate use of silence

Capacity to develop the alliance

- An ability to listen to the client’s concerns in a manner which is non-judgmental, supportive and sensitive, and which conveys a comfortable attitude when the client describes their experience.
- An ability to ensure that the client is clear about the rationale for the intervention being offered.
- An ability to gauge whether the client understands the rationale for the intervention, has questions about it, or is skeptical about the rationale, and to respond to these concerns openly and non-defensively in order to resolve any ambiguities.
- An ability to help the client express any concerns or doubts they have about the therapy and/or the counsellor, especially where this relates to mistrust or skepticism.
- An ability to help the client articulate their goals for the therapy, and to gauge the degree of congruence in the aims of the client and counsellor.

Capacity to grasp the client’s perspective and ‘world view’

- An ability to apprehend the ways in which the client characteristically understands themselves and the world around them.
- An ability to hold the client’s world view in mind throughout the course of therapy and to convey this understanding through interactions with the client, in a manner that allows the client to correct any misapprehensions.
- An ability to hold the client’s world view in mind, while retaining an independent perspective and guarding against identification with the client.
Capacity to maintain the alliance

• An ability to recognise when strains in the alliance threaten the progress of therapy.

• An ability to deploy appropriate interventions in response to disagreements about tasks and goals:
  • an ability to check that the client is clear about the rationale for treatment and to review this with them and/or clarify any misunderstandings.
  • an ability to help clients understand the rationale for treatment through using/drawing attention to concrete examples in the session.
  • an ability to judge when it is best to refocus on tasks and goals which are seen as relevant or manageable by the client (rather than explore factors which are giving rise to disagreement over these factors).

• An ability to deploy appropriate interventions in response to strains in the bond between counsellor and client:
  • an ability for the counsellor to give and ask for feedback about what is happening in the here-and-now interaction, in a manner which invites exploration with the client.
  • an ability for the counsellor to acknowledge and accept their responsibility for their contribution to any strains in the alliance.
  • where the client recognises and acknowledges that the alliance is under strain, an ability to help the client make links between the rupture and their usual style of relating to others.
  • an ability to allow the client to assert any negative feelings about the relationship between the counsellor and themselves.
  • an ability to help the client explore any fears they have about expressing negative feelings about the relationship between the counsellor and themselves.

Ability to work with emotional content of session

• An ability to facilitate the processing of emotions by the client – to acknowledge and contain emotional levels that are too high (eg anger, fear, despair) and contact emotions when levels are too low (eg apathy, low motivation).

• An ability to work effectively with emotional issues that interfere with effective change (e.g. hostility, anxiety, excessive anger, avoidance of strong affect).

• An ability to help the client access differentiate and experience his/her emotions in a way that facilitates change.

Ability to manage endings

• An ability to signal the ending of the intervention at appropriate points during the therapy (e.g. when agreeing the treatment contract, and especially as the intervention draws to close) in a way which acknowledges the potential importance of this transition for the client.

• An ability to help client discuss their feelings and thoughts about endings and any anxieties about managing alone.

• An ability to review the work undertaken together.

• An ability to say goodbye.

Ability to undertake a generic assessment (including relevant history and identifying suitability for intervention)

• An ability to obtain a general idea of the nature of the client’s problem.

• An ability to elicit information regarding psychological problems, diagnosis, past history, present life situation, attitude about and motivation for therapy.

• An ability to gain an overview of the client’s current life situation, specific stressors and social support.

• An ability to assess the client’s coping mechanisms, stress tolerance, and level of functioning.
• An ability to help the client identify/select target symptoms or problems, and to identify which are the most distressing and which the most amenable to intervention.
• An ability to help the client translate vague/abstract complaints into more concrete and discrete problems.
• An ability to assess and act on indicators of risk (of harm to self or others and the ability to know when to seek advice from others).
• An ability to gauge the extent to which the client can think about themselves psychologically (e.g. their capacity to reflect on their circumstances or to be reasonably objective about themselves).
• An ability to gauge the client’s motivation for a psychological intervention.
• An ability to discuss treatment options with the client, making sure that they are aware of the options available to them, and helping them consider which of these options they wish to follow.
• An ability to identify when psychological treatment might not be appropriate or the best option, and to discuss with the client (e.g. the client’s difficulties are not primarily psychological, or the client indicates that they do not wish to consider psychological issues) or where the client indicates a clear preference for an alternative approach to their problems (e.g. a clear preference for medication rather than psychological therapy).

**Ability to assess and manage risk of self-harm**

• An ability to draw on knowledge of indicators of self-harm, and to integrate research/actuarial evidence) with a structured clinical assessment and the exercise of professional judgment in appraising risk

• An ability to draw on knowledge of the limitations of using risk factors to predict self-harm:
  • that risk factors identify high risk groups rather than individuals
  • that because suicide is a relatively rare event it is difficult to predict at the level of the individual:
    • even where accurate systems of prediction are employed these will incorrectly identify a substantial number of individuals as possible suicides
    • that because most risk factors relate to long-term risk they are less helpful in prediction in the short-term or immediate clinical situation

• An ability to draw on knowledge that individuals with a history of prior suicide have a markedly elevated risk of self-harm

• An ability to draw on knowledge of factors associated with an elevated risk of self-harm that apply across the population:
  • childhood adversity
  • experience of a number of adverse life-events (including sexual abuse)
  • a family history of suicide
  • a history of self-harm
  • seriousness of previous episodes of self-harm
  • previous hospitalisation
  • mood disorders
  • substance use disorder
  • a diagnosis of personality disorder
  • anxiety disorder (particularly PTSD)
  • a psychotic disorder (e.g. a diagnosis of schizophrenia or bipolar disorder)
  • presence of chronic physical disorders
  • bereavement or impending loss (where psychological problems preceded the bereavement)
  • relationship problems and relationship breakdown
  • severe lack of social support
  • socio-economic factors e.g.
    • people who are disadvantaged in socio-economic terms
    • people who are single or divorced
    • people who are living alone
    • people who are single parents
• An ability to draw on knowledge that individuals with depression have a significantly elevated lifetime risk of suicide

• An ability to draw on knowledge that the risk of suicide is highest relatively early in a depressive episode, and less likely during periods of remission

• An ability to draw on knowledge that hopelessness (negative expectations of the future) may be a more important marker of risk than the severity of depression

• An ability to draw on knowledge that the combination of depression, hopelessness and continuing suicidal intent represents a marker of elevated risk

• An ability to assess the client’s strengths and resources by asking them about:
  - external resources (e.g. relationship with care services, self help groups, local associations)
  - supportive relationships (e.g. a partner or close friend who they trust and can confide in)
  - personal resources (e.g. ability to suggest ways of managing their present difficulties)
  - previous patterns of coping (i.e. how they coped with potentially stressful events in the past)

Assessing risk in individuals who have self-harmed

• An ability to draw on knowledge that the risk of suicide is particularly elevated in the three months following attempted suicide, and that this risk remains elevated in the longer-term.

• An ability to draw on knowledge that the risk of suicide is elevated if the following factors are present, and the person:
  - has a history of previous attempts
  - used a violent method in their attempt
  - left a suicide note
  - is older (45 and over)
  - is male
  - is living alone
  - is separated, widowed or divorced
  - is unemployed
  - is in poor physical health

• An ability to undertake an assessment which aims
  - to understand the social, psychological and motivational factors specific to the act of self-harm
  - to assess the degree of suicidal intent:
    - to assess current suicidal intent and hopelessness
    - to assess current mental health and social needs

• An ability to convey a nonjudgmental and tolerant attitude when discussing self-harm with the client

• An ability, where required, to ask direct questions to clarify an understanding of the attempt, and the extent of suicidal intent

• An ability to work with the client to develop a detailed sequential account of the period leading up to self-harm, in order to identify the events which precipitated it
An ability to work with the client in order to assess the degree of suicidal intent e.g.:  
- whether the event was impulsive or planned  
- whether the client was alone, whether someone was present or within easy access, whether the client was likely to be found soon after the attempt  
- whether any steps were taken either to prevent or to ensure discovery  
- if alcohol or drugs were taken prior to or during the attempt, and the intent and/or impact of taking these substances on the attempt  
- client’s expectations regarding the lethality of the drugs or injury  
- presence of a suicide note (including recorded and text messages)  
- the client’s efforts to obtain help after the event

An ability to ask about previous acts of self-harm (including the circumstances and the level of intent)

**Use of standardised scales to assess risk of self-harm**

- An ability to draw on knowledge that if a standardised risk assessment scale is used to assess risk, this should be used only to aid in the identification of people at high risk of repetition of self-harm or suicide

- An ability to administer and interpret standardised measures for assessing suicidality and hopelessness (e.g. Suicide Intent Scale, Suicide Assessment Checklist, Beck Hopelessness Scale (etc))

**Management of risk of self-harm**

- An ability to draw on knowledge of local and national protocols (e.g. NICE 2004) for the management of self-harm, and an ability to ensure that actions taken comply with these protocols

- An ability to draw on knowledge of relevant legislation (e.g. Mental Health Act, Mental Capacity Act) when considering admission of a client who is considered to represent a significant risk to themselves (but is not willing to receive treatment)

- An ability to identify and manage ethical issues in relation to risk management e.g.:  
  - the management of actively suicidal clients who refuse intervention  
  - decisions regarding the involvement of relatives

- An ability to ensure that (so far as is possible) the client is involved in decisions regarding any actions to be taken to manage risk

- An ability to draw up an appropriate plan of action which specifies the ways in which risk will be managed, and is tailored to the needs of the individual

- Where there is a clear risk of repetition, an ability to draw up a plan which is maintained over an extended period (e.g. 3 months) and which includes:
  - frequent access to a therapist when needed  
  - home treatment when necessary  
  - telephone contact  
  - outreach (which include active follow-up when appointments are missed)

- An ability to liaise with and refer to any relevant colleagues and services who need to be involved in delivering the plan of action, or who need to be aware of its content

- Where plans for the management of risk are compatible with the maintenance of the therapeutic contract, an ability to integrate the management of risk with the current intervention  
  - an ability to make appropriate modifications to a treatment contract in order to ensure that it includes elements focus on the management of risk (e.g. a problem-solving orientation focused on identifying potential crises and the strategies for avoiding or resolving these)
• An ability to seek supervision and/or consult with colleagues in relation to decisions regarding risk-management

**Ability to maintain a record of assessments and plans for managing risk**

• An ability to maintain a clear and detailed record of any assessments and of decisions regarding plans for managing risk, in line with local protocols for recording clinical information
• An ability to communicate (verbally and in writing) with relevant clinicians and services in order to ensure that all individuals or services involved in the management of risk are appropriately informed
  • an ability to draw on knowledge of the conditions under which confidentiality can be breached in support of the management of risk, and the national and profession-specific guidance which addresses this issue

**Ability to work with difference (cultural competence)**

Although it is common (and appropriate) to think about ‘difference’ in relation to specific demographic groups, this may be a somewhat narrow perspective. There are many ways in which both therapists and their clients could be ‘different’, partly because some areas of difference will not be immediately apparent, and also because it is the individual’s sense of their difference that is important. On this basis almost any therapeutic encounter requires the therapist to consider the issue of difference.

In what follows the term ‘culture’ is sometimes used generically, so (for example) referring to an intervention as ‘culturally sensitive’ means that the intervention is responsive to the demographic group to which it is applied.

• An ability to draw on knowledge that the term ‘difference’ refers to the individualised impact of background, lifestyle, beliefs or religious practices
• An ability to draw on knowledge that the demographic groups included in discussion of ‘difference’ are usually those who are potentially subject to disadvantage and/or discrimination, and it is this potential for disadvantage that makes it important to focus on this area
• An ability to draw on knowledge that clients will often be a member of more than one “group” (for example, a gay man with disabilities, or an older adult from a minority ethnic community), and that as such, the implications of different combinations of difference needs to be held in mind by therapists
• An ability to maintain an awareness of the potential significance for practice of social and cultural difference across a range of domains, but including:
  • ethnicity
  • culture
  • class
  • religion
  • gender
  • age
  • disability
  • sexual orientation
• For all clients with whom the therapist works, an ability to draw on knowledge of the relevance and potential impact of social and cultural difference on the effectiveness and acceptability of an intervention
• Where clients from a specific minority culture or group are regularly seen within a service, an ability to draw on knowledge of that culture or area of difference
• An ability to draw on knowledge of cultural issues which commonly restrict or reduce access to interventions e.g.:
  • language
  • marginalisation
  • mistrust of statutory services
  • lack of knowledge about how to access services
  • different cultural concepts, understanding and attitudes about mental health which affect views about help-seeking, treatment and care
- stigma, shame and/or fear associated with mental health problems (which makes it likely that help-seeking is delayed until/unless problems become more severe
- stigma or shame and/or fear associated with being diagnosed with a mental health disorder
- preferences for gaining support via community contacts/contexts rather than through ‘conventional’ referral routes (such as the GP)

- An ability for therapists of all cultural backgrounds to draw on an awareness of their own group membership and values and how these may influence their perceptions of the client, the client’s problem, and the therapy relationship

- An ability to take an active interest in the cultural background of clients, and hence to demonstrate a willingness to learn about the client’s cultural perspective(s) and world view

- An ability to work collaboratively with the client in order to develop an understanding of their culture and world view, and the implications of any culturally-specific customs or expectations, for:
  - the therapeutic relationship
  - the ways in which problems are described and presented by the client
    - an ability to apply this knowledge in order to identify and formulate problems, and intervene in a manner that is culturally sensitive, culturally consistent and relevant
    - an ability to apply this knowledge in a manner that is sensitive to the ways in which individual clients interpret their own culture (and hence recognises the risk of culture-related stereotyping)

- An ability to take an active and explicit interest in the client’s experience of difference:
  - to help the client to discuss and reflect on their experience of difference

- to identify whether and how this experience has shaped the development and maintenance of the client’s presenting problems

- An ability to discuss with the client the ways in which individual and family relationships are represented in their culture (e.g. notions of the self, models of individuality and personal or collective responsibility), and to consider the implications for organisation and delivery of therapy

- An ability to ensure that standardised assessments/measures are employed and interpreted in a manner which is culturally-sensitive e.g.:
  - if the measure is not available in the client’s first language, an ability to take into account the implications of this when interpreting results
  - if a bespoke translation is attempted, an ability to cross-check the translation to ensure that the meaning is not inadvertently changed
  - if standardisation data (norms) is not available for the demographic group of which the client is a member, an ability explicitly to reflect this issue in the interpretation of results

- An ability to draw on knowledge of the conceptual and empirical research-base which informs thinking about the impact of cultural competence on the efficacy of psychological interventions

- Where there is evidence that social and cultural difference is likely to impact on the accessibility of an intervention, an ability to make appropriate adjustments to the therapy and/or the manner in which therapy is delivered, with the aim of maximising its potential benefit to the client

- An ability to draw on knowledge that culturally-adapted treatments should be judiciously applied, and are warranted:
  - if evidence exists that a particular clinical problem encountered by a client is influenced by membership of a given community
  - if there is evidence that clients from a given community respond poorly to certain evidence-based approaches
• Where the therapist does not share the same language as clients, an ability to identify appropriate strategies to ensure and enable the client's full participation in the therapy
  • where an interpreter/advocate is employed, an ability to draw on knowledge of the strategies which need to be in place for an interpreter/advocate to work effectively and in the interests of the client

Ability to make use of supervision

• An ability to hold in mind that a primary purpose of supervision and learning is to enhance the quality of the treatment clients receive.

An ability to work collaboratively with the supervisor

• An ability to work with the supervisor in order to generate an explicit agreement about the parameters of supervision (e.g. setting an agenda, being clear about the respective roles of supervisor and supervisee, the goals of supervision and any contracts which specify these factors).
• An ability to help the supervisor be aware of your current state of competence and your training needs.
• An ability to present an honest and open account of clinical work undertaken.
• An ability to discuss clinical work with the supervisor as an active and engaged participant, without becoming passive or avoidant, or defensive or aggressive.
• An ability to present clinical material to the supervisor in a focussed manner, selecting the most important and relevant material.

Capacity for self-appraisal and reflection

• An ability to reflect on the supervisor's feedback and to apply these reflections in future work.
• An ability to be open and realistic about your capabilities and to share this self-appraisal with the supervisor.

• An ability to use feedback from the supervisor in order further to develop the capacity for accurate self-appraisal.

Capacity for active learning

• An ability to act on suggestions regarding relevant reading made by the supervisor, and to incorporate this material into clinical practice.
• An ability to take the initiative in relation to learning, by identifying relevant papers, or books, based on (but independent of) supervisor suggestions, and to incorporate this material into clinical practice.

Capacity to use supervision to reflect on developing personal and professional role

• An ability to use supervision to discuss the personal impact of the work, especially where this reflection is relevant to maintaining the likely effectiveness of clinical work.
• An ability to use supervision to reflect on the impact of clinical work in relation to professional development.

Capacity to reflect on supervision quality

• An ability to reflect on the quality of supervision as a whole, and (in accordance with national and professional guidelines) to seek advice from others where:
  • there is concern that supervision is below an acceptable standard
  • where the supervisor’s recommendations deviate from acceptable practice
  • where the supervisor’s actions breach national and professional guidance (e.g. abuses of power and/or attempts to create dual (sexual) relationships)
Ability to use measures to guide therapy and to monitor outcomes

Knowledge of measures

- An ability to draw on knowledge of commonly used questionnaires and rating scales used with people with depression

Ability to interpret measures

- An ability to draw on knowledge regarding the interpretation of measures (e.g. basic principles of test construction, norms and clinical cut-offs, reliability, validity, factors which could influence (and potentially invalidate) test results)

- An ability to be aware of the ways in which the reactivity of measures and self-monitoring procedures can bias client report

Knowledge of self-monitoring

- An ability to draw on knowledge of self-monitoring forms developed for use in specific interventions (as published in articles, textbooks and manuals)

- An ability to draw on knowledge of the potential advantages of using self-monitoring:
  - to gain a more accurate concurrent description of the client's state of mind (rather than relying on recall)
  - to help adapt the intervention in relation to client progress
  - to provide the client with feedback about their progress

- An ability to draw on knowledge of the potential role of self-monitoring:
  - as a means of helping the client to become an active, collaborative participant in their own therapy by identifying and appraising how they react to events (in terms of their own reactions, behaviours, feelings and cognitions))

- An ability to draw on knowledge of measurement to ensure that procedures for self-monitoring are relevant (i.e. related to the question being asked), valid (measuring what is intended to be measured) and reliable (i.e. reasonably consistent with how things actually are)

Ability to integrate measures into the intervention

- An ability to use and to interpret relevant measures at appropriate and regular points throughout the intervention, with the aim of establishing both a baseline and indications of progress

- An ability to share information gleaned from measures with the client, with the aim of giving them feedback about progress

- An ability to establish an appropriate schedule for the administration of measures, avoiding over-testing, but also aiming to collect data at more than one timepoint

Ability to help clients use self-monitoring procedures

- An ability to construct individualised self-monitoring forms, or to adapt 'standard' self-monitoring forms, in order to ensure that monitoring is relevant to the client

- An ability to work with the client to ensure that measures of the targeted problem are meaningful to the client (i.e. are chosen to reflect the client's perceptions of the problem or issue)

- An ability to ensure that self-monitoring includes targets which are clearly defined and detailed, in order that they can be monitored/recorded reliably

- An ability to ensure that the client understands how to use self-monitoring forms (usually by going through a worked example during the session)

Ability to integrate self-monitoring into the intervention

- An ability to ensure that self-monitoring is integrated into the therapy, ensuring that sessions include the opportunity for regular and consistent review of self-monitoring forms

- An ability to guide and to adapt the therapy in the light of information from self-monitoring
Knowledge of the principles and rationale for IPT

- An ability to draw on knowledge that IPT is a time-limited, focused psychotherapy aimed at reducing symptoms and improving social adjustment and interpersonal functioning

- An ability to draw on knowledge that the client’s social and interpersonal context are assumed to contribute to the onset of and/or maintenance of symptoms

- An ability to draw on knowledge that IPT is rooted in a medical model of psychiatric illness in the context of which the therapist:
  - can reframe the client’s experiences as an illness that is treatable, and hence mobilize hope that the therapy will help
  - can reduce the client’s self-blaming attributions

- An ability to draw on knowledge that IPT focuses primarily on current interpersonal functioning and life circumstances rather than longstanding conflicts or problems originating in childhood

Knowledge of strategies employed in IPT

- An ability to draw on knowledge that the core IPT model conceptualises relationship problems within four specific interpersonal problem areas (grief, role disputes, role transitions and interpersonal deficits/sensitivities) that provide the focus of the therapy

- An ability to draw on knowledge that the selected focal area informs the strategies and goals of the therapy

- An ability to draw on knowledge that the focus is on a primary interpersonal area of difficulty that is identified as being related to the onset and/or maintenance of the symptoms:
  - an ability to draw on knowledge that while the therapist obtains and makes use of an understanding of the client’s history of past relationships and distal life events to arrive at a formulation, sessions are focused on the recent past (i.e. typically, but not exclusively, on the previous week’s events)

- An ability to draw on knowledge that IPT is conceptualized as consisting of three phases (initial, middle and termination), each with its own distinctive strategies and objectives:
  - an ability to draw on knowledge that while IPT is a strategic, focused approach, in the middle phase the therapist may adopt a more ‘fluid’ approach in order to help the client explore their interpersonal experiences and associated feelings

- An ability to draw on knowledge that the focus of the therapy is on interpersonal interactions (and hence not, for example, on dreams, cognitions or homework)

- An ability to draw on knowledge that the fixed time-limit helps the therapist to maintain an active, here-and-now, focused stance which (in turn) conveys to the client the importance of working hard towards interpersonal change during this time frame

- An ability to draw on knowledge that while the positive working alliance between client and therapist is used to mobilize change, exploration of the therapeutic relationship is not the focus of the therapy

Ability to maintain a focus on the interpersonal context of the symptoms

Knowledge

- An ability to draw on knowledge that IPT distinguishes itself from other psychotherapies at the level of its clearly specified and interpersonally focused strategies

- An ability to draw on knowledge that the primary focus of IPT is to help the client identify, and learn how to manage, interpersonal problems connected with the onset and maintenance of symptoms
• An ability to draw on knowledge that a core strategy in all three phases of IPT involves systematically monitoring and linking symptoms to interpersonal difficulties, and vice versa so as to help the client to understand…
• that there is a reciprocal interaction between symptoms and life events
• that symptomatic improvement is facilitated through improvements in interpersonal functioning, and vice versa

Application

Ability to maintain the focus of interventions on the reciprocal relationship between symptoms and interpersonal events
• An ability to use the report of symptomatic changes as a cue for exploring their interpersonal triggers
• An ability to use the report of a difficult interpersonal event(s) as a cue for exploring its impact on symptoms
• An ability to help the client to identify and understand the reciprocal relationship between symptoms and interpersonal events:
  o An ability to systematically highlight and reinforce these connections through the use of clarifying statements/questions and summaries at the end of sessions

Ability to engage the client in reviewing their symptoms
• An ability, in every session, to help the client report on and evaluate their symptomatic state
• An ability to engage the client in using standardised symptom measures and self monitoring to track symptomatic and interpersonal functioning throughout the therapy, and to assess outcome

Ability to implement IPT in a manner consonant with its supportive and active stance
• An ability to establish and maintain a supportive, empathic stance by:
  • validating the client’s experience
  • praising the client’s achievements/strengths where appropriate
  • communicating with the client in a direct manner
  • explicitly inviting feedback from the client about their experience of the therapy and of the therapist
• An ability to explore and resolve any disruptions to the therapeutic alliance through:
  • openly inviting the client to discuss any concerns they may have about the relationship with the therapist
  • responding non-defensively to the client’s negative experience of the therapist
  • openly considering the respective contributions of the therapist and the client to the difficulty
  • helping the client to identify communication failures that result in behaviours that may impede progress (e.g. missing sessions, prolonged silences)
• An ability to maintain an active stance through helping the client:
  • to identify a specified interpersonal problem
  • to discuss material relevant to the agreed focus
  • to work towards interpersonal change
• An ability to balance taking on an ‘expert role’ so as to instil confidence that the client’s difficulties can be worked on and engaging the client as an active participant in the therapy:
  • an ability to maintain a positive, problem solving attitude in the face of interpersonal difficulties to support the client’s confidence in their ability to resolve these
Ability to engage the client in IPT

Application

Ability to develop a therapeutic alliance
- An ability to communicate with the client in a direct manner that acknowledges the client’s experience
- An ability to respond to the client’s presenting problems in a curious, non-judgmental manner by:
  - asking clarifying questions so as to understand the client’s perspective without making assumptions
  - communicating empathic understanding in response to the client’s narrative
- An ability to identify opportunities for both empathizing with the client’s predicament(s) and for noting their strengths through affirming and encouraging statements
- An ability to ‘normalise’ the client’s experiences and/or emotional responses, particularly in relation to knowledge about the presenting problem (e.g. ‘many people who are depressed feel like withdrawing from others’)

Ability to help the client to understand the rationale for IPT
- An ability to provide the client with information about the nature of their presenting problem, and of the proposed therapy and its focus
- An ability to link the rationale to the client’s idiosyncratic experiences and symptom profile
- An ability to work with the client to agree a contract that clearly specifies the duration of the therapy, its focus and the expectations of the therapist and client
- An ability to encourage the client to discuss their reactions to the proposed therapy and focus

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

Knowledge
- An ability to draw on knowledge that IPT is rooted in a medical model of psychiatric illness
- An ability to draw on knowledge that it is assumed that sharing the diagnosis with the client is therapeutically beneficial
- An ability to draw on knowledge that one of the strategies in the initial phase involves:
  - diagnosing the presenting problem, using a medical model
  - providing initial symptom relief through support, psychoeducation and (from the outset) actively engaging the client in working on their problems

Application

Ability to undertake a detailed assessment of the client’s symptomatic profile
- An ability to assess the client’s symptoms, with particular attention to their onset, duration and severity
- An ability to explore the time line of symptom development and its interpersonal context:
  - an ability to use the review of symptom development to introduce the client to the interpersonal emphasis of the therapy
- An ability to convey to the client that the symptoms fit a recognized clinical syndrome

Ability to assign the ‘sick role’
- An ability to share the diagnosis with the client in an explicit and collaborative manner
- Ability to explain the diagnosis and to link it to the client’s current interpersonal context
An ability to use the diagnosis to:
• reduce self-blaming attributions (i.e. through ‘blaming the illness or current life circumstances)
• mobilise hope about recovery (e.g. “we know that many people who are depressed benefit from psychotherapy”)

An ability to encourage the client to take responsibility for working towards change whilst also temporarily relieving them of demanding social obligations through making use of their support networks

An ability to identify when relevant members of the network need to be directly involved in understanding the client’s difficulties and in supporting the therapy (e.g. by inviting them to attend a session/carer group)

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

Knowledge
• An ability to draw on knowledge that a core strategy in the initial phase of IPT is a detailed and systematic review of the client’s interpersonal context (i.e. the ‘interpersonal inventory’):
  • knowledge that this review is used to identify in detail the availability, acceptability and quality of the client’s current social supports and significant relationships, and their current life circumstances
  • knowledge that the ‘interpersonal inventory’ concentrates primarily, but not exclusively, on the client’s present life and relationships

• An ability to draw on knowledge that the ‘interpersonal inventory’ is the basis for formulating the client’s difficulties and identifying the interpersonal problem area(s) that will provide the focus for the middle phase of IPT

Application
• Ability to review significant social and intimate relationships (i.e. carry out the ‘interpersonal inventory’) and identify their contribution to the onset and maintenance of symptoms
• Ability to assess the client’s current interpersonal functioning and life circumstances by:
  • engaging them in a detailed review of current and past significant relationships, and of salient life events
  • considering areas of omission from their descriptions of their relationships (e.g. a pervasive absence of conflict)
  • using observations of the client’s ways of relating within the session to help understand their interpersonal style

In relation to each significant relationship, an ability to focus on the quality and patterning of the relationship by:
• eliciting a detailed account of the frequency of contact, activities shared and the kind of support available
• engaging the client in adopting an evaluative stance when exploring the relationship
• identifying the client’s implicit role expectations of self and other
• helping the client to identify what they might like to change in a given relationship

Ability to agree a primary focal area that is emotionally resonant for the client and is linked to the onset and/or maintenance of the symptoms

• An ability to make use of the interpersonal inventory to identify which interpersonal difficulties are linked with the current symptoms:
  • an ability to help the client to feel understood by summarising the salient interpersonal events (and their response(s) to these events) linked to the onset/maintenance of symptoms
  • an ability to explicitly connect the proposed focal area(s) to the onset/maintenance of symptoms

• An ability to tentatively share with the client a formulation and focal area that links the diagnosis to the client’s current life circumstances and interpersonal context
• An ability to actively engage the client in responding to the proposed formulation and focus:
  • where the client disagrees with the proposed focus of the work, an ability to openly discuss misunderstandings or different perceptions of the problem, and to work with the client in order to agree how to proceed
  • where there are several potential foci, an ability to engage the client in identifying the most pressing concern that has the greatest impact on their interpersonal functioning and symptoms
  • an ability to recognise when the proposed focus or IPT is not viable

Ability to identify and set goals
• An ability to work with the client to identify and agree realistic therapeutic goals, in the light of:
  • the severity and/or chronicity of their presenting problems
  • their interpersonal resources
  • the time-limited nature of the therapy

Ability to maintain a systematic focus on an IPT interpersonal problem area(s) linked with the onset of symptoms

Knowledge
• An ability to draw on knowledge that each of the four focal areas (role transitions, role disputes, grief and interpersonal sensitivity/deficits) specifies the strategies required to help the client to resolve the identified interpersonal problems

• An ability to draw on knowledge that while IPT usually prioritises one primary focal area, it is possible to work on (at most) two related focal areas

• An ability to draw on knowledge that throughout all the focal areas the therapist helps the client to make use of their interpersonal resources to manage their symptoms and to support change

Application - General

An ability to maintain the focus on the agreed interpersonal problem(s) and goals
• An ability to help the client to stay focused on the agreed problem area, for example:
  • by systematically making explicit links to the focus when intervening
  • by sensitively redirecting the client if the client introduces information that is extraneous to the agreed focus
  • by summarising at the end of each session what has been covered to reinforce thematic continuity

An ability to help the client to make use of their interpersonal network to support the work of the agreed focal area
• An ability to help the client to identify the interpersonal resources that may be drawn on and/or developed to help them to manage or reduce the impact of their difficulties:
  • an ability to make use of the ‘interpersonal inventory’ to keep in mind the relationships that are available to the client
  • an ability to help the client to distinguish the different kinds of support they need (e.g. emotional, practical) so that they can make more discriminate and effective use of their interpersonal network
Application - Focal area specific competences

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

Role Transitions
- An ability to help the client to relate their symptoms to a recent life change that has necessitated a role transition
- An ability to help the client to explore the feelings and meanings associated with the role that had to be relinquished, so as facilitate a realistic appraisal of what has been lost:
  - an ability to help the client to identify which aspect(s) of the transition they find most problematic (e.g. letting go of the old role or adapting to the new role)
  - an ability to help the client mourn the loss of the old role and to relinquish it
- An ability to help the client to explore the feelings and meanings about the new role they now have to adjust to, and the opportunities it may provide
  - an ability to identify and engage the client in developing the skills and supports required to adjust to the new role

Role Disputes
- An ability to help the client relate their symptoms to a current covert or overt dispute with a significant other
- An ability to help the client to identify:
  - the nature and stage of the dispute (impasse, renegotiation, dissolution)
  - the non-reciprocal role expectations that maintain the dispute
  - recurring problematic communication patterns, so as to increase awareness of these and help the client to develop more effective ways of communicating
- An ability to use communication analysis systematically so as to help the client become aware of how they communicate and to identify what they might do differently
- An ability to engage the other party involved in the dispute in joining the client for one or two sessions so as to:
  - directly observe the interpersonal dynamics so as to better understand what changes might be required
  - help the other party to understand the client’s current problems and engage them in supporting the therapy
- An ability to help the client to consider the possibilities for change on both sides, including unsatisfying behaviour patterns and expectations,

Grief
- An ability to help the client to relate their symptoms to the death of a significant other
- An ability to help the client to reconstruct the sequence and consequence of events prior to, during and after the death
- An ability to facilitate an affective exploration of the relationship with the deceased:
  - an ability to help the client to identify and accept more ambivalent feelings towards the deceased
- An ability to help the client to (re)establish interests and relationships in their current life

Interpersonal Deficits/Sensitivities
- An ability to help the client to relate their symptoms to problems of social isolation or unfulfilling/impoveryished relationships
- An ability to identify and specify a particular interpersonal deficit/sensitivity that will provide the focus for therapy
- An ability to help the client reconstruct past relationships as the basis for exploring repetitive or parallel problems in these relationships
- An ability to help the client to consider their own expectations and needs in relationships and those of the other party
• An ability to help the client to reduce their isolation by identifying and implementing strategies/skills for developing and/or maintaining relationships

• An ability to use the immediacy of the therapeutic relationship to draw attention to, and understand, the problematic interpersonal pattern/sensitivity that is the focus of the work:
  • an ability to use the therapeutic relationship as an opportunity for:
    o safely providing constructive feedback to the client
    o supporting experimenting with new ways of communicating
    o helping the client to see parallels with relationships outside of the therapy

Ability to identify and explore difficulties in communication

Knowledge

• An ability to draw on knowledge that throughout all the focal areas the therapist aims to help the client to identify and explore communication patterns so as to help them to communicate more effectively:

• an ability to draw on knowledge that the technique of ‘communication analysis’ may be used to this end to help the client to focus in detail on a specific interaction

Application

Ability to identify and clarify negative and/or ineffective communication

• An ability to sensitively draw the client’s attention to overt and covert disputes/communication problem(s) as they arise in their relationships:

• An ability to focus on the way the client communicates with others so as to help them to become aware of:
  • how they feel in the relationship
  • the implicit expectations they hold about their relationship with another person

• how they may undermine the likelihood of gaining support

• An ability to assess when the use of ‘communication analysis’ is indicated to identify and/or elaborate in more detail a specific communication problem/dispute

Ability to help the client develop communication skills

• An ability to help the client to problem solve within their relationships:

• An ability to help the client to reflect on how the other person(s) may experience their attempts to communicate

• An ability to help the client to develop and express empathy for the other person’s experience

• An ability to help the client try out more direct and clear ways of communicating with others

• An ability to selectively use the way the client communicates with the therapist to illustrate problematic communication patterns:

• An ability to model effective communication through the therapist’s response to difficulties in the therapeutic relationship, where appropriate
Ability to facilitate the expression and acceptance of a range of emotions

Knowledge
- An ability to draw on knowledge that throughout the three phases of IPT a core strategy is the exploration of the client’s emotional state

Application

Ability to help the client to express, understand and manage their emotions
- An ability to carefully track the client’s emotional state during the session, and to communicate an understanding of this:
  - An ability to identify and respond to verbal and non-verbal cues from the client in order to help the client explore and understand their emotions
- An ability to help the client to stay with, and explore, what they are currently feeling in order to:
  - recognise and accept their feelings
  - differentiate feelings from actions
  - identify the relationship between what they feel and how they behave in a relationship
- An ability to help the client to explore and manage their painful emotional experiences both within and outside of the sessions:
  - An ability to help the client to understand how the way in which they express or suppress affect may affect their interpersonal relationships
  - An ability to help the client to identify the interpersonal assumptions which underlie their emotional experience
  - An ability to help the client to consider delaying acting in response to painful emotions, including their expression, until the feeling has become less intense:
    - An ability to help them to discriminate when the expression of strong emotions is appropriate outside of the sessions and when it may undermine relationships
  - An ability to normalise negative emotions

Ability to encourage interpersonal change in-between sessions

Knowledge
- An ability to draw on knowledge that IPT is a change-oriented therapy (i.e. it aims to help the client to change their interpersonal behaviour, not primarily to develop insight):
  - knowledge that the time-limit acts as a motivational force, activating the therapist and encouraging the client towards change but not towards adopting a therapist-directed course of action
- An ability to draw on knowledge that while the therapist does not assign formal homework they nevertheless provide consistent encouragement to try out new ways of interacting with others

Application
- An ability to focus on, and support, the client’s attempts to change by helping them to:
  - identify for themselves the interpersonal implications of the focal problem
  - identify interpersonal resources that can support change
  - identify obstacles to change
  - appraise the consequences of change
- An ability to balance the drive towards change with an awareness of, and a sensitivity to, the client’s readiness for change (hence reducing the risk of either overwhelming the client or exposing them to failure):
  - an ability to identify verbal and non-verbal cues that may be indicative of this
  - an ability to help the client to identify manageable goals
  - an ability to keep in mind the need to focus on circumscribed treatment goals, given the time limit
- An ability to make sparing use of more directive, behaviour change techniques to support the client’s attempts to change
Ability to engage the client in preparing for ending

Knowledge

- An ability to draw on knowledge that IPT is a time-limited therapy that explicitly conceptualises the ending of therapy, and separation from the therapist as a role transition, and hence focuses on:
  - exploring the client’s experience of ending
  - helping the client to plan for the future post-therapy

Application

- An ability to prepare the client for ending by explicitly referring to the time limited nature of the therapy at the outset and throughout the therapy

- An ability to facilitate the expression of feelings about ending the therapy by:
  - acknowledging ending as a time of potential grieving
  - normalizing feelings of apprehension or sadness
  - responding non-defensively to the client’s expression of disappointment with the therapy

- An ability to facilitate a realistic review of progress, underscoring both areas of interpersonal competence and of future vulnerability:
  - An ability to communicate praise for what has been accomplished and draw attention to the client’s independent successes
  - An ability to anticipate and discuss potential future areas of difficulty and help the client to consider ways in which these could be handled given what they have learned

- An ability to help 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:
  - An ability to help the client to identify a relapse plan which draws on the support of other people

- An ability to help the client engage significant others in preparing for ending and in planning for the future:
  - An ability to assess of the need for maintenance IPT and/or referral to other professional networks
Specific Techniques

Ability to make selective use of specific techniques to support the strategies and goals of the focal area

Knowledge

- An ability to draw on knowledge of the range of techniques that can be used to help clients focus on (and resolve) problems linked to the agreed interpersonal problem area
- An ability to draw on knowledge that work in the focal areas may be facilitated by a circumscribed exploration of the relationship between client and therapist

Application

- An ability to implement a range of therapeutic techniques (directive, exploratory, decision analysis, communication analysis, role play, use of the therapeutic relationship) to support the specific strategies of the identified interpersonal focal area
- An ability to be responsive to client’s direct and indirect feedback about their experience of the therapist’s interventions

Ability to use Directive techniques

- An ability to facilitate initial engagement by making sparing use of directive techniques (advice, provision of information, reassurance, and psycho-education) in order to foster the client’s confidence in the therapist’s capacity to help

Ability to use decision analysis and Role playing

- An ability to assess when role-playing can be a useful intervention to support the agreed aims of the given focal area e.g. to help the client:
  - to explore their feelings
  - to practise new ways of communicating with others

Decision analysis

- An ability to assess when decision analysis can be a useful intervention to support the agreed aims of the given focal area e.g. to help the client:
  - to consider alternative courses of action in order to resolve a problem
  - to evaluate the likely consequences of different possible courses of action
- An ability to support the client in applying decision analysis outside the therapy setting

Clarification

- An ability to use clarificatory techniques (e.g. asking the client to rephrase what they have said) to:
  - help the client to become more aware of what they characteristically feel and think in relation to others
  - explore particular interpersonal hypotheses
  - highlight contradictions and connections in what the client has said

Exploratory techniques

- An ability to use nondirective techniques, to foster the client’s own sense of competence and autonomy, including:
  - open-ended questions or verbalizations
  - supportive acknowledgement and extension of productive topics
  - refraining from structuring parts of a session to allow the client to elaborate what they are feeling

Ability to use clarification, summaries and questions

Clarification

- An ability to use clarificatory techniques (e.g. asking the client to rephrase what they have said) to:
  - help the client to become more aware of what they characteristically feel and think in relation to others
  - explore particular interpersonal hypotheses
  - highlight contradictions and connections in what the client has said
Exploratory techniques
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  - open-ended questions or verbalizations
  - supportive acknowledgement and extension of productive topics
  - refraining from structuring parts of a session to allow the client to elaborate what they are feeling

Ability to use communication analysis
- An ability to engage the client in reporting and reflecting on a recent, difficult exchange/conflict with another person:
  - an ability to elicit a detailed reconstruction of the interpersonal incident, of the accompanying feelings and link to symptoms, and of the implicit and explicit intentions:
    - an ability to help the client focus on the verbal and non-verbal level of the exchange (e.g. posture, tone of voice)
    - an ability to help the client identify what they would have wanted to communicate, had they felt able to
    - an ability to help the client identify the contradictory or non-reciprocal role expectations that maintain a difficult interpersonal exchange
    - an ability to help the client to reflect on how the other person might have experienced and understood the interaction

- Ability to help the client to consider alternative ways of communicating:
  - an ability to help the client to communicate to the other person that they can understand their point of view
  - an ability to help the client try out new, more effective ways of communicating with others in-between sessions

- An ability to respond empathically and with explicit acknowledgement when the client experiences the therapist as critical or blaming of them for the identified problem

Ability to use the therapeutic relationship
- An ability to identify and provide constructive feedback on recurring interpersonal patterns and communication difficulties when these manifest in the therapeutic relationship:
  - an ability to link these patterns to those that occur with significant others
  - an ability to provide feedback to the client about how they may be coming across to others

- An ability to help the client explore and try out, within the therapeutic relationship, alternative ways of communicating

- An ability to assess whether the therapeutic alliance is sufficiently robust to allow for immediate exploration of the interaction between therapist and client
Specific Applications

This section describes the knowledge and skills required to carry out application of IPT to different client groups/problems. It is not a ‘stand-alone’ description of technique, and should be read as part of the IPT competence framework.

Effective delivery of these applications depends on the integration of this competence list with the knowledge and skills set out in the other domains of the IPT competence framework.

IPT for Eating Disorders (IPT-ED)

Sources:


Knowledge

Knowledge of eating disorders

- An ability to draw on knowledge of eating disorders, including:
  - their key features, co-morbidities and prognosis
  - An ability to draw on knowledge that significant reductions in eating disorder features may not occur until later in treatment and during the follow-up
  - their impact on interpersonal functioning
  - their physical effects (e.g. risks to physical health as a result of under-eating or weight loss, frequent self-induced vomiting/laxative or diuretic misuse

Knowledge of basic principles and strategies of IPT-ED

- An ability to draw on knowledge that the indications for IPT-ED are for bulimia nervosa and binge eating disorder

Application

Ability to focus on the interpersonal context of eating disorder symptoms

- An ability, in the initial phase of IPT-ED, to develop a shared understanding of the relationship between the eating problem and the client’s interpersonal life
- An ability, in the middle phase of treatment, to ensure that sessions largely focus on interpersonal problems and not on eating disorder features:
  - An ability to recognize when it is necessary to monitor eating disorder features on an ongoing basis in order to manage physical risk (e.g. if there is medical concern)
Ability to engage the client in preparing for ending

- An ability to review eating disorder features at the end of treatment and to consider these in light of interpersonal changes that have been made
- An ability to review the rationale of treatment with the client and to remind them of the need to continue to address interpersonal difficulties in order to make further progress with regards to their eating problem
- An ability to consider any risks to physical health which may be present and how best to manage these once treatment has ended

IPT for Depressed Adults


Knowledge

- An ability to draw on knowledge of the psychological and interpersonal difficulties experienced by clients with a diagnosis of depression
- An ability to assess risk of self-harm or suicide

Brief IPT for depression (IPT-B)


Knowledge

- An ability to draw on knowledge that IPT-B is offered over 8 sessions:
  - Knowledge that this represents the major adaptation of the core model and has implications for the number of sessions that can be allocated to the three phases of standard IPT for depression
  - Knowledge that only one focal area can be worked on
  - Knowledge that the focal reap of interpersonal deficits/sensitivity is omitted

Application

Ability to implement the core IPT strategies in a compressed time frame

- An ability to maintain a clear, near-exclusive focus on the client’s current relationships
- An ability to help the client to identify realistic goals given the limited time frame:
  - An ability to assess areas of existing strength and competence that can be built on
- An ability to sensitively but consistently encourage the client to try out new behaviours using the limited time frame to maximize the emphasis on change:
  - An ability to work collaboratively with the client to identify appropriate homework tasks to support change:
    - An ability to identify tasks that will increase the client’s perceived self-efficacy
  - An ability to engage the client in reviewing the outcome of the task the following session and explore any obstacles encountered
  - An ability to assess when the emphasis on change may undermine the therapeutic alliance and/or lead the client to fail
- An ability to use of behavioural activation in the early sessions to encourage the client to actively re-engage with activities and relationships they have withdrawn from
IPT for Depressed Older Adults


Knowledge

- An ability to draw on knowledge of gerontology and of the particular way that depression may manifest in an older client
- An ability to draw on knowledge of the medical and cognitive problems that may co-exist with depression in an older adult

Application

- An ability to adapt the core IPT strategies to the cognitive level of the client (e.g. through use of therapeutic memory aides such as written summaries of sessions)
- An ability to liaise with other relevant professional networks to attend to the medical and/or cognitive problems that an older adult is more likely to present with (e.g. refer for cognitive screening)
- An ability to monitor the therapists’ own prejudices about what can be achieved with an older client

IPT for Depressed Adolescents (IPT-A)


Knowledge

General

An ability to draw on knowledge of the developmental tasks of adolescence and of the capacities of adolescents

Specific

- An ability to draw on knowledge of the psychological and interpersonal difficulties experienced by adolescents with a diagnosis of depression:
  - An ability to draw on knowledge of the particular way depression can manifest in adolescents
- An ability to draw on knowledge of how parental mental health problems may impact on the adolescent’s depression:
  - Knowledge of adult mental health problems and of services that can respond to these problems
- An ability to draw on knowledge that IPT-A normally involves 12 sessions on a weekly basis:
  - Knowledge that in the first four weeks the therapist also has in-between session telephone contact with the client to facilitate engagement
- An ability to draw on knowledge that a primary focus is on problematic relationships within the family, and hence that family members are actively encouraged to become involved in the treatment:
  - Knowledge that this involvement may take different forms (jointly with the adolescent, separately or both) depending on the specifics of the case
- An ability to draw on knowledge that an additional, adolescent specific, focal area is that of transitions due to family structural change (e.g. through divorce or separation):
  - Knowledge that this involves addressing two problem areas: role disputes as well as transitions, with a primary focus on the conflict that complicates the transition
- An ability to draw on knowledge that the grief focal area is also used for normal bereavement in the presence of significant depression symptoms (i.e. not just for abnormal grief)
• An ability to draw on knowledge that IPT-A has modified the goals and strategies of the core model to reflect the developmental tasks and capacities of an adolescent client:
  • Knowledge that these adaptations include:
    o the use of simple rating scales to monitor mood
    o the use of the ‘closeness circle’ to visually map the network
    o use of the ‘depression circle’ to graphically illustrate the connection between relationships and feelings and to highlight repetitive patterns
    o ‘affect training’ to support the development of awareness of what the adolescent feels and how this impacts on relationships
    o basic social skills work, including work on perspective taking
    o helping the adolescent to learn how to negotiate tensions with parents
    o assigning homework tasks
    o flexibility in the scheduling of sessions so as to maximize engagement

• approaching cancellations or lateness to sessions in a flexible, non-judgmental manner, not interpreting this as a sign of resistance, but as potential signs of interpersonal or practical difficulties
• An ability to empathically respond to pressure from the adolescent to turn the therapeutic relationship into a quasi-parental, or friendly, relationship and to clarify with them the limits of the therapeutic relationship:
  • An ability to monitor the need to intervene directly into the adolescent’s life and their choices so as to minimise unhelpful dependence on the therapist
  • An ability to help the adolescent to develop their own coping resources and supports outside of the therapy
  • An ability to monitor the therapist’s own emotional responses to ensure that the therapist maintains appropriate professional boundaries

An ability to assess and respond to risk

• An ability to identify current stressors and/or more chronic stressors (e.g. parental mental health problems) that may place the adolescent at risk of harm to self and/or others

• An ability to respond promptly to an assessment of risk to minimise potential harm:
  • An ability to initiate appropriate referrals to other services to support the adolescent’s family/carer(s) and/or for additional supports for the adolescent

• An ability to identify when IPT is not indicated due to risk factors (e.g. suicide; co-morbid substance abuse)

Application

General

Ability to adapt therapeutic style to meet the needs and capacities of an adolescent client

• An ability to establish a collaborative, supportive stance that respects the adolescent’s need to feel in control and independent whilst also recognizing their need for some direction and structure:

• An ability to adapt the explanation of the treatment and its rationale, and of the expectations of the therapist and client, so as to ensure that the adolescent can understand them and consent to the therapy

• An ability to facilitate engagement through:
  • adopting a more playful, humorous stance
  • implementing the structure of the therapy in a flexible manner (e.g. using phone sessions, flexible scheduling)
Phase specific

Initial phase

Ability to engage the adolescent, their family and the wider network in the initial phase of IPT-A

- An ability to engage both the adolescent and their family prior to starting the initial assessment phase through the provision of psycho-education about the treatment strategy, including a clear explanation of how and when the family will be included:
  - An ability to negotiate clear boundaries around the therapy with the adolescent and the limits to confidentiality
- An ability to actively engage the adolescent in considering and negotiating the option of IPT-A through fostering a sense of working as a ‘team’
- An ability to engage the parent(s)/carer(s) during the initial phase to obtain their perspective on the adolescent’s current difficulties and to support the therapy:
  - An ability to respond sensitively and flexibly to refusal or ambivalence to being involved in the therapy
  - An ability to identify the need for psychological and/or types of interventions to support the family/carer(s) in their role with the adolescent
- An ability to engage other relevant networks (e.g. the school) as appropriate in supporting the therapy
- An ability to provide education about depression and appropriate reassurance at the end of the initial phase so as to mobilize confidence that the depression can be treated and to encourage a supportive response to the adolescent’s current needs

Middle phase

Ability to involve the adolescent’s family in the therapy, as appropriate

- An ability to assess the appropriateness of joint family sessions with the adolescent:
  - An ability to openly negotiate with the adolescent what they feel comfortable discussing with the family/carer(s) so as to protect confidentiality
  - An ability to intervene in the joint sessions to facilitate constructive exchanges between the adolescent and their family and to help the family to manage the expression of strong emotions
- An ability to maintain the focus on the agreed problem area when the sessions include other people besides the adolescent

Ability to identify homework tasks that will support the identified goals and generalization of the therapeutic gains

- An ability to identify ‘homework’ tasks that are:
  - consonant with the identified goals of the focal area being worked on
  - appropriate to the adolescent’s current emotional state and interpersonal skills so as to ensure they can manage the task and succeed
- An ability to actively involve the adolescent in jointly identifying a relevant task
- An ability to engage the adolescent in thinking about any obstacles or anxieties in relation to the identified task
- An ability to enlist the parent(s)/care(s) as a ‘coach’ to support the acquisition of new skills, where appropriate
- An ability to engage the adolescent in reviewing the experience and outcome of the set task in the following session
Ability to implement the strategies for a focus on ‘transitions due to family structural change’

- An ability to keep in mind the dual focus on role disputes and transitions and to implement the strategies pertinent to both
- An ability to use psycho-education to help the adolescent and the adults in their life (i.e. parents and step-parents or other carers) to understand the link between depression and changes in family structure
- Ability to help the adolescent to identify and explore how they have been affected by the changes in their family (e.g. the ways they may feel responsible for parental conflict):
  - Where there are multiple parental figures involved, an ability to:
    - help the adolescent to explore the respective expectations of the adolescent and of the adults
    - help the adolescent to explore and resolve their feelings about separations/losses and other changes to relationships resulting from the changed family circumstances
    - help the adolescent to develop communication and negotiation skills to support them in managing their changed circumstances
    - evaluate the adults’ capacity to work together and facilitate, where appropriate, consensus over expectations of the adolescent

Ending phase

An ability to include the family/carer(s) in a joint session with the adolescent when terminating the therapy:

- An ability to use this final session to:
  - review progress
  - emphasise the adolescent’s accomplishments and help the family/carer(s) to express praise
  - discuss what has changed in the family’s interaction
  - identify future problems/chronic stressors
- An ability to identify when a joint session would be counterproductive if the family/carer(s) are unlikely to be supportive of the adolescent
Ability to implement treatment models in a flexible but coherent manner

- An ability to implement a model of therapy in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components of the model are included.

- An ability to use clinical judgment in order to balance adherence to a model against the need to attend to any relational issues which present themselves.

- An ability to maintain adherence to a therapy without inappropriate switching between modalities in response to minor difficulties (i.e. difficulties which can be readily accommodated by the model being applied).

Capacity to use and respond to humour

- An ability to use humour judiciously, understanding how it can be used as an aid to help clients (e.g. to normalise the client’s experience or to reduce tension), but also recognising its risks (e.g. of invalidating the client’s feelings, acting as a distraction to/avoidance of feelings, or creating “boundary violations”).

- An ability to respond to client’s humour in a manner that is congruent with its intent, and responsive to any implied meanings.

Capacity to adapt interventions in response to client feedback

- An ability to accommodate issues the client raises explicitly or implicitly, or which become apparent as part of the process of the intervention:
  - An ability to respond to, and openly to discuss, explicit feedback from the client which expresses concerns about important aspects of the therapy.
  - An ability to detect and respond to implicit feedback which indicates that the client has concerns about important aspects of the therapy (e.g. as indicated by non-verbal behaviour, verbal comments or significant shifts in responsiveness).
  - An ability to identify when clients have difficulty giving feedback which is "authentic" (e.g. clients who respond in accordance with what they think the therapist wishes to hear, rather than expressing their own view) and discussing this with them.
  - An ability to be aware of, and respond to, emotional shifts occurring in each session, with the aim of maintaining an optimal level of emotional arousal (i.e. ensuring that the client is neither remote from or overwhelmed by their feelings).

Ability to adapt the core IPT strategies to the client’s individual needs and the time available

- An ability to adapt the model and technique in response to the individual needs of the client, e.g.:
  - the client’s developmental level/stage of life
  - changes in the client’s functioning (e.g. risk of suicide)

- An ability to identify and implement the adaptations of the core IPT model which are required in order to work within a specified time frame (e.g. within 8 sessions as opposed to 16).
Ability to balance being focused and maintaining the therapeutic alliance

- An ability to implement IPT flexibly:
  - An ability to note when the client may be reacting negatively to the therapist’s rigorous attention to the agreed focus
  - An ability to respond to the client’s experience through engaging the client in:
    - jointly understanding what they may be experiencing as difficult/challenging
    - problem solving how this may be resolved within the therapy
  - An ability to assess when to deviate from an agreed focus:
    - An ability to identify when the client’s immediate state of mind may require a temporary shift away from the agreed focus (e.g. due to an unexpected life event that precipitates a crisis) so as to maintain engagement

- An ability, where appropriate, to re-negotiate with the client the focus of the work and/or consider the need for further intervention that can encompass a broader focus once IPT is completed

Ability to establish an appropriate balance between therapist activity and non-directive exploration

- An ability to monitor the therapist’s level of activity to ensure that while the agreed focus is maintained the client:
  - is given sufficient space to explore their emotional experience:
    - an ability to allow silences where these help to deepen the client’s exploration of current feelings/experiences
  - is helped to feel they are also actively engaged in the session and in resolving their own difficulties (rather than passively responding to the therapist’s focus):
    - an ability to monitor and limit the use of direct suggestion/advice
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