

## **The competences required to deliver effective Interpersonal Psychotherapy (IPT)**

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**The full listing of the IPT competences described  
in this report is available online at  
[www.ucl.ac.uk/CORE](http://www.ucl.ac.uk/CORE)**

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## **Short summary (reader box)**

This document identifies the activities associated with the delivery of high-quality IPT and the competences required to achieve these. It describes a model of the relevant competences, and discusses how this should be applied by practitioners, its advantages for clinicians, trainers and commissioners, and the uses to which it can be put.

## **Acknowledgements**

This work described in this report was commissioned by the IAPT Implementation Board.

The project team was headed by Alessandra Lemma, Anthony Roth and Stephen Pilling,

The work was overseen by Expert Reference Group (ERG)<sup>2</sup> whose invaluable advice and collegial approach contributed enormously to the development of the work. The ERG was ably chaired by Professor Anthony Bateman, and comprised Dr Jonathan Baggot, Dr Lorna Champion, Dr Roslyn Law, Dr Rebecca Murphy, Dr Liz Robinson, Dr Matthias Schwannauer.

We were extremely fortunate to be able to invite peer-review of the generic and problem-specific competence lists from the originators of the therapy, and are very grateful to the following reviewers for their comments: Dr John Markowitz, Dr Laura Mufson, Dr Helena Verdeli, Dr Myrna Weissman.

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<sup>2</sup> Appendix A shows the professional affiliations of members of the ERG



## **Relationship between the competence frameworks and the development of National Occupational Standards**

The competence frameworks and National Occupational Standards are constituent parts of a programme overseen by the Department of Health. This has the objective of specifying occupational standards for the practice and training of psychological therapists, including to date CBT, psychoanalytic/psychodynamic, systemic and humanistic person-centred/experiential.

The two pieces of work are closely linked, but are intended to have somewhat different applications, and are published independently.

### **What are the similarities and differences between the competence frameworks and the NOS?**

At the present time the National Occupational Standards for IPT have not been developed. It is useful nevertheless to understand the relationship between the competence framework and the NOS and how the IPT competence framework may inform the development of NOS in future.

The competence frameworks are stand-alone, detailed representations of the competences needed to deliver and supervise the various modalities of therapy, and the ways in which these modalities can be applied in relation to specific psychological disorders, or how these modalities are adapted to form distinctive therapeutic interventions. They are already being used, for example, to develop training curricula and training materials, are being applied in research, and are being used as a basis for quality assuring courses.

The draft NOS are a broader description of the way in which each therapy modality is implemented. They focus on the generic, basic and specific competences identified in the competence framework. They do not provide the detail of disorder or problem specific practice found in the competence framework. Nevertheless they are also being used to review and refine training curricula. Instead of the finer detail, NOS have the benefit of being linked to the range of competence standards that Skills for Health have developed for interventions across the field of mental health care. National Occupational Standards are recognised across the UK and therefore support the transparency and transferability of qualifications. They are also mapped to the NHS Knowledge and Skills Framework. This enables them to be used as well in workforce planning and service specification, where they help to identify the standards expected of workers at each level of a multi-disciplinary team, from the generic skills required by all workers through to the more specialised skills needed by workers who are specialising in the delivery of psychological therapies. They are also used to develop job descriptions that in turn can build a career framework; this work is being undertaken through the New Ways of Working for Psychological Therapies programme of work. Lastly, they will provide one of the inputs to the content of the Standards of Proficiency which are being developed by the Health Professions Council for the regulation of Psychotherapists and Counsellors.

More information regarding this project can be found at [www.skillsforhealth.org.uk/page/competences/competences-in-development/psychological-therapies](http://www.skillsforhealth.org.uk/page/competences/competences-in-development/psychological-therapies)

## **How competence frameworks are developed**

**Competence frameworks:** The competence frameworks for CBT, psychoanalytic/psychodynamic, systemic and humanistic person-centred/experiential modality were commissioned by Skills for Health (and, in the case of the supervision competence framework, also by Care Services Improvement Partnership and NHS Education for Scotland). For the purposes of the National Occupational Standard project these competences are referred to as Statements of Evidence. They are developed by a team at UCL, a process which is overseen by an Expert Reference Group constituted of researchers and trainers selected for their expertise in the relevant therapy modality. Competences are identified using an evidence-based methodology (described in detail in the documentation which accompanies each framework). These are clustered according to a ‘map’ of the activities through which therapists carry out the therapy. This process is subject to careful review from the Expert Reference Group. When completed, this work is published by the Department of Health, and made available through the UCL website ([www.ucl.ac.uk/CORE/](http://www.ucl.ac.uk/CORE/)).

The competences for IPT have been commissioned separately by the IAPT Programme Board as part of the planned expansion in the range of psychological therapies on offer within IAPT.

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# The competences required to deliver effective IPT

## Executive summary

The report begins by briefly describing the background to the work on competences for psychological therapies.

It will then outline an evidence-based method for identifying competences, and presents a competence model for IPT. This organises the competences into five domains:

1. **Generic competences** - used in all psychological therapies
2. **Basic IPT competences**
3. **Specific IPT techniques** - the core technical interventions employed in all applications of IPT
4. **Problem-Specific competences/adaptations** - the packages of IPT interventions for particular problems as well adaptations of the IPT model
5. **Meta-competences** – overarching, higher-order competences which practitioners need to use to guide the implementation of IPT

The report then describes and comments on the type of competences found in each domain, before presenting a ‘map’ which shows how all the competences fit together and inter-relate.

Finally the report comments on issues which are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

## How to use this report

This report describes the model of IPT competences and (based on empirical evidence of efficacy) indicates the various areas of activity that, taken together, represent good clinical practice. The report does not include the detailed descriptions of the competences associated with each of these activities. These can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) ([www.ucl.ac.uk/CORE](http://www.ucl.ac.uk/CORE)). They are available as pdf files, accessed directly or by navigating the map of competences (as represented by Figure 2 in this report).

## Background

The Improving Access to Psychological Therapies (IAPT) programme, which was launched in May 2007, provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies. The IAPT programme has focused to date on delivering CBT for adults with common mental health problems because CBT has the most substantial evidence base supporting its effectiveness in the treatment of depression and anxiety in particular (e.g. NICE, 2004a, 2004b, 2005a, 2005b). Consequently, the first wave of work was concerned to identify the competences needed to deliver good quality CBT. The development of the CBT competence model was specifically developed to be a “prototype” for developing the competences associated with other psychological therapies. The work reported here is based on this model.

**National Occupational Standards (NOS):** The work undertaken in this report also 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 NOSs which describe standards relevant to mental health workers, downloadable at the Skills for Health website ([www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)), and the work described in this report will be used to inform the development of standards for IPT therapy.

## How the competences were identified

**Oversight and peer-review:** The work described in this project was overseen by an Expert Reference Group (ERG). This comprised national experts in IPT, selected for their expertise in the development and application of IPT and the development and delivery of supervision and training models in IPT.

The ERG ensured that the right trials and manuals were identified and that the process of extracting competences was appropriate and systematic. Additional peer review was provided by the researchers and clinicians who had developed the therapies contained in the framework. All this was designed to assure the fidelity of the framework in relation to

the therapy it claimed to represent. Overall, this process of open peer-review ensured that the competence lists were subject to a very high level of scrutiny.

**Identifying competences by looking at the evidence of what works<sup>3</sup>:** This project began by identifying the applications of IPT to particular client groups with the strongest claims for evidence of efficacy, based on the outcome in clinical controlled trials. The strongest evidence for the effectiveness of IPT is for the treatment of depression and eating disorders. Consequently this document focuses on these two clinical presentations, but IPT has also been applied to the treatment of other disorders (see Weissman et al, 2000).

Almost invariably the therapy delivered in these trials is based on a manual which describes the treatment model and associated treatment techniques. In the case of IPT the basic and specific competences have been based on the original manual for the treatment of depression developed by Klerman, Weissman and Markowitz (2000, 2007), and which underpins all of the adaptations that have since been developed. Treatment manuals are developed by research teams to improve the internal validity of research studies: they explicate the technical principles, strategies and techniques of particular models of therapy. In this sense the manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Because research trials monitor therapist performance (usually by inspecting audio or video recordings) we know that therapists adhered to the manual. This makes it possible to be reasonably confident that if the procedures set out on the manual are followed there should be better outcomes for clients.

Once the decision is taken to focus on the evidence base of clinical trials and their associated manuals, the procedure for identifying competences falls out logically. The first step is to review the outcome literature, which identifies effective therapeutic approaches. Secondly, the manuals associated with these successful approaches are identified. Finally the manuals are examined in order to extract and to collate therapist competences<sup>4</sup>. A major advantage of using the manuals to extract competences is that by

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<sup>3</sup> An alternative strategy for identifying competences could be to examine what therapists actually do when they carry out a particular therapy, complementing observation with some form of commentary from the therapists in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological therapies set out a theoretical framework which purports to explain human distress, and this framework usually links to a specific set of therapist actions aimed at alleviating the client's problems. In practice these 'pure' forms of therapy are often modified as therapists exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which does not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice

<sup>4</sup> A detailed account of the methodology and procedures used in this project can be found in Roth and Pilling (2008). Although this paper focuses on the development of the CBT framework the methodological issues it raises are relevant to the present framework).

using the evidence base to narrow the focus it sets clear limits on debates about what competences should or should not be included.

### **Scope of the work**

The focus of this framework is on the practice of individual therapy with adults and with adolescents where the presenting problem is depression. The competences for the practice of IPT with eating disorders have also been developed as there is evidence for its effectiveness with this client group.

Although IPT is applied in a group context we could not identify at the present time any robust enough trials to support the inclusion of the competences for group IPT. Such trials will hopefully be forthcoming in the future.

## **The competence model for IPT**

### **Organising the competence lists**

Competence lists need to be of practical use. The danger is that they either provide too much structure and hence risk being too rigid or they are too vague to be of use. The aim has been to develop competence lists structured in a way which reflects the practice they describe, set out in a framework that is both understandable (in other words, is easily grasped) and valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into five domains: the components are as follows:

### **Generic Competences**

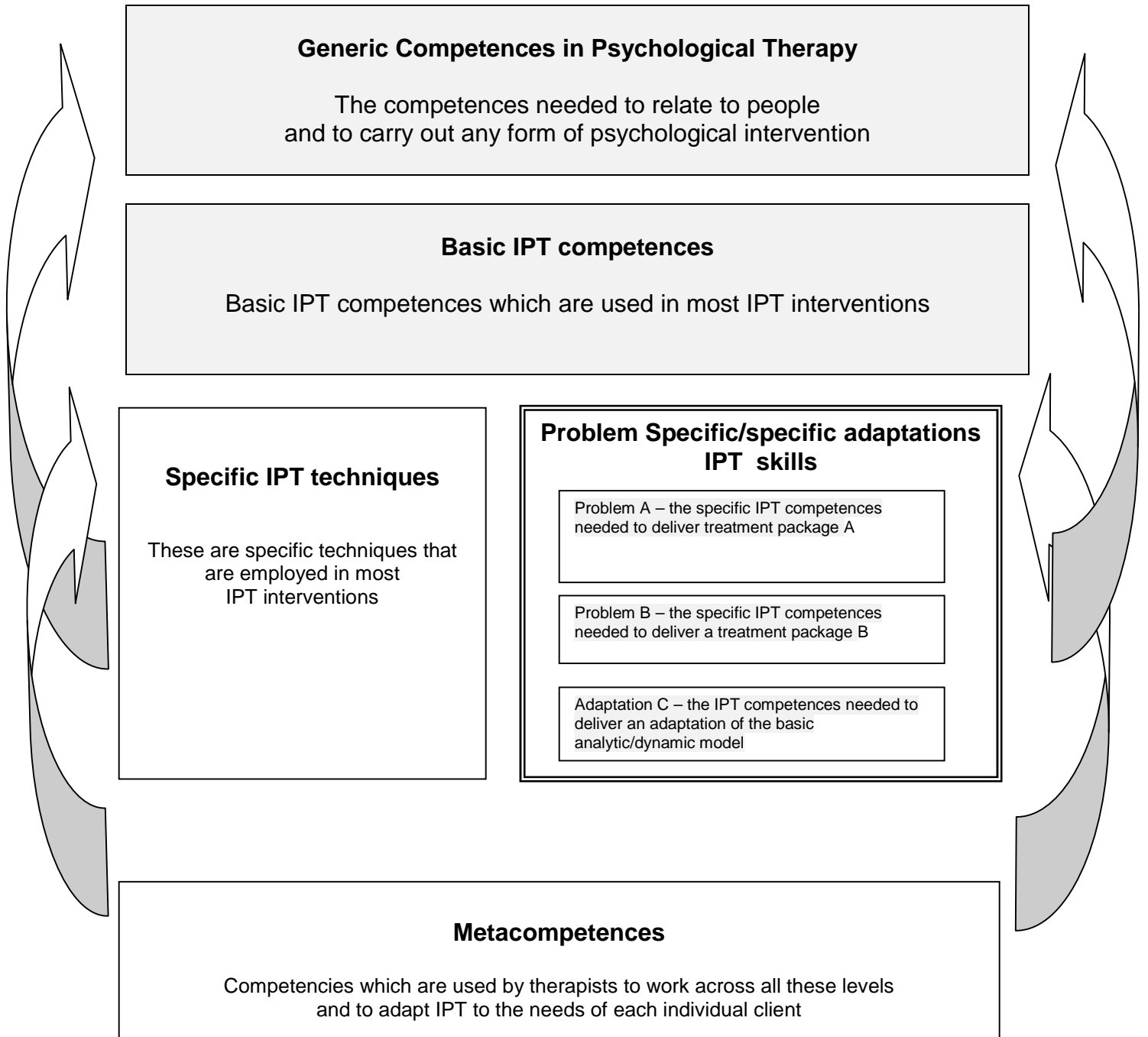
Generic competences are those employed in any psychological therapy, reflecting the fact that all psychological therapies, including IPT, share some common features. For example, therapists using any accepted theoretical model would be expected to demonstrate an ability to build a trusting relationship with their clients, relating to them in a manner which is warm, encouraging and accepting. Without building a good therapist-client relationship technical interventions are unlikely to succeed. Often referred to as 'common factors' in therapy, it is important that the competences in this domain are not overlooked or treated as an afterthought.

**Basic IPT competences**

Basic competences establish the structure for IPT, and form the context and structure for the implementation of a range of more specific IPT techniques. For example, IPT prioritises understanding the client's presenting symptoms in an interpersonal context. While other therapeutic modalities also attend to the client's interpersonal functioning, what distinguishes IPT is its primary focus on the reciprocal relationship between symptoms and the client's *current* relationships.

**Figure 1**

**Outline model for IPT competences**



### **Specific IPT techniques**

These are the set of commonly applied techniques found to a lesser or greater extent in most forms of IPT. Examples would be the selective use of role play or of the therapeutic relationship in order to support the specific strategies and goals of the selected focal area.

### **Distinguishing “Basic IPT competences” from “Specific IPT techniques”**

There is a fine line between these domains. The distinction between the two is as much pragmatic as conceptual, and is intended to improve the legibility and utility of the model. Essentially, “Basic Competences” are necessary in all applications of IPT, and provide the backdrop to the more commonly applied techniques – such as using role play or ‘communication analysis’ - that come under the domain of “Specific Techniques”. Another way of thinking about the distinction is to see the “Basic Competences” as underpinning all the applications of IPT whereas the use made of the specific techniques is likely to vary more greatly between the application of IPT to particular problems or focus areas. For example, a greater focus on the therapeutic relationship is expected when the focal area is ‘interpersonal sensitivities’.

### **Problem-specific competences and specific adaptations**

Competence lists in this domain represent “packages” of IPT interventions, as described in treatment manuals. Some of these outline interventions for specific disorders, where there is evidence of benefit for particular problem presentations (e.g. clients with depression or an eating disorder).

### **Metacompetences**

A common observation is that carrying out a skilled task requires the person to be aware of why and when to do something (and just as important, when not to do it!). This is a critical skill which needs to be recognised in any competence model. Reducing psychological therapy to a series of rote operations would make little sense, because competent practitioners need to be able to implement higher-order links between theory and practice in order to plan and where necessary to adapt therapy to the needs of individual clients. These are referred to as metacompetences in this framework: they are the procedures used by therapists to guide practice, and operate across all levels of the model. These competences are more abstract than those in other domains because they usually reflect the intentions of the therapist. These can be difficult to observe directly but can be inferred from their actions, and may form an important part of discussions in supervision. For example, although IPT has a clear structure with specified strategies and tasks in each of the three phases of the therapy, flexibility does need to be applied depending on the client’s presenting problems and how able they are to work effectively on the task. For example, whilst in the middle phase of the therapy it is expected that the therapist will pay assiduous attention to an agreed focus, it is important for them to also be able to note when the client may be reacting negatively to the therapist’s rigorous

attention to the agreed focus so that they can respond to this and adapt technique accordingly.

## **Specifying the competences needed to deliver IPT**

### **Integrating knowledge, skills and attitudes**

A competent clinician brings together knowledge, skills and attitudes. It is this combination which defines competence; without the ability to integrate these areas practice is likely to be poor.

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 is 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 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.

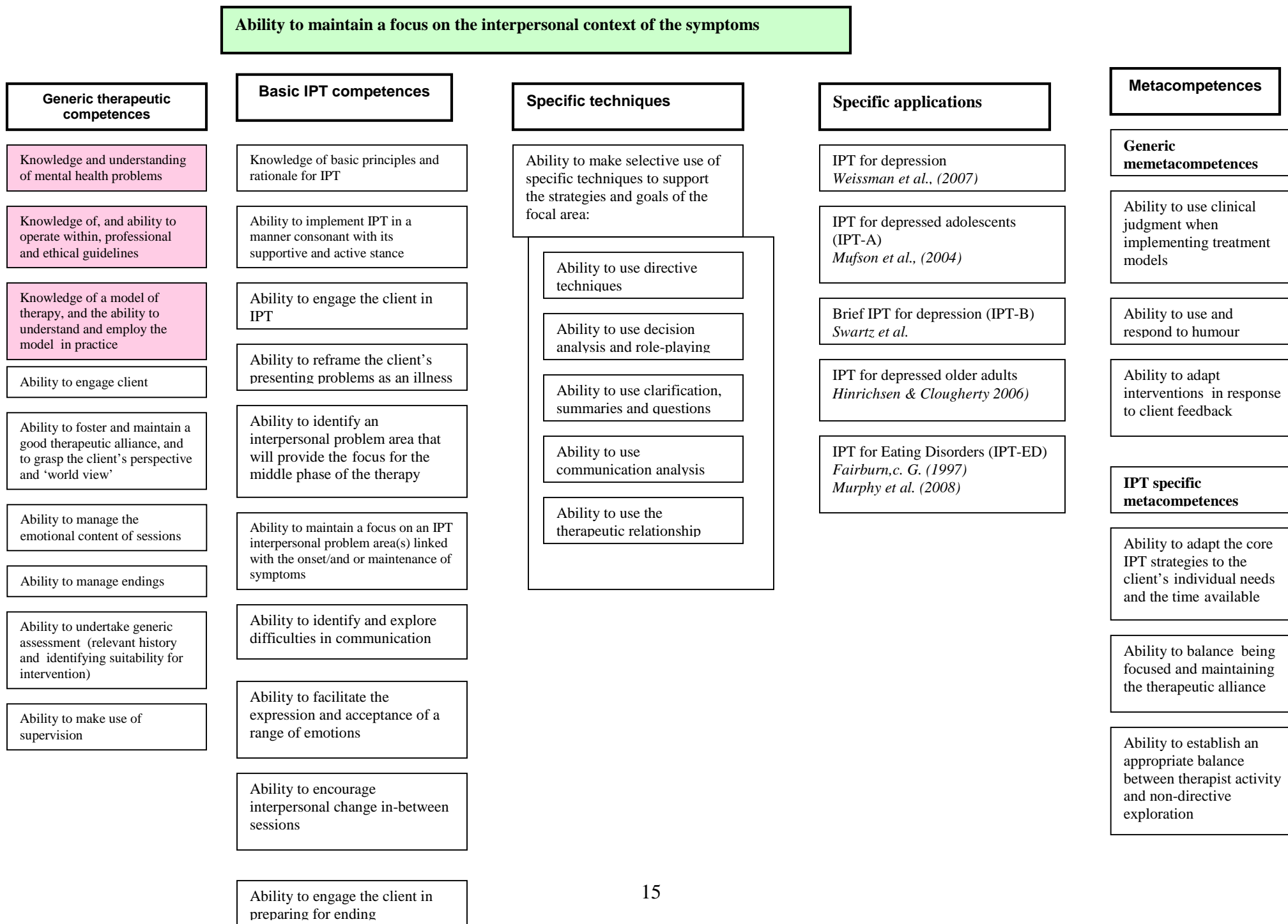
## **The map of IPT competences**

### **Using the map**

The map of IPT competences is shown in Figure 2. It organises the competences into the five domains outlined above and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) ([www.ucl.ac.uk/CORE](http://www.ucl.ac.uk/CORE)).

The map shows the ways in which the activities fit together and need to be 'assembled' in order for practice to be proficient. A commentary on these competences follows.

Figure 2  
Map of IPT Competences



## Generic therapeutic competences

**Knowledge:** Knowledge of mental health problems, of professional and ethical guidelines and of the model of therapy being employed forms a basic underpinning to any intervention, not just to IPT. Being able to draw on and apply this knowledge is critical to the delivery of effective therapy.

The ability to operate within professional and ethical guidelines encompasses a large set of competences, many of which have already been identified and published elsewhere (for example, profession-specific standards, or national standards (such as the Shared Capabilities (Hope, 2004)) and the suites of National Occupational Standards relevant to mental health (available on the Skills for Health website ([www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk))). Embedded in these frameworks is the notion of “cultural competence”, or the ability to work with individuals from a diverse range of backgrounds, a skill which is important to highlight because it can directly influence the perceived relevance (and hence the likely efficacy) of an intervention.

**Building a therapeutic alliance:** The next set of competences is concerned with the capacity to build and to maintain a therapeutic relationship. Successfully engaging the client and building a positive therapeutic alliance is associated with better outcomes across all therapies. Just as important is the capacity to manage the end of treatment; which can be difficult for clients and for therapists. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the ‘management’ of the therapeutic relationship.

**Assessment:** The ability to make a generic assessment is crucial if the therapist is to begin understanding the difficulties which concern the client. This is a different activity to the focussed assessment described in the problem-specific competence lists or the assessment specific to the likely suitability of an IPT approach. In contrast a generic assessment is intended to gain an overview of the client’s history, their perspectives, their needs and their resources, their motivation for a psychological intervention and (based on the foregoing) a discussion of treatment options.

Assessment also includes an appraisal of any risk to the client or to others. This can be a challenging task, especially if the person undertaking the assessment is a junior or relatively inexperienced member of staff. Bearing this in mind, the ability for workers to know the limits of their competence and when to make use of support and supervision, will be crucial.

**Supervision:** Making use of supervision is a generic skill which is pertinent to all practitioners at all levels of seniority, because clinical work is demanding and usually requires complex decision making. Supervision allows practitioners to keep their work on track, and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

## Basic IPT competences

This domain contains a range of activities that are basic in the sense of being fundamental areas of skill; they represent practices that underpin any IPT intervention.

**Knowledge of the basic principles, rationale and strategies of IPT** refers to the set of core assumptions underpinning IPT, most notably that a) IPT is a time-limited, focused psychotherapy aimed at reducing symptoms and improving social adjustment and interpersonal functioning, b) The client's social and interpersonal context are assumed to contribute to the onset of and/or maintenance of symptoms, c) IPT focuses primarily on current interpersonal functioning and recent life circumstances rather than longstanding conflicts or problems originating in childhood, d) IPT formulates relationship problems within four specific interpersonal problem areas (grief, role disputes, role transitions and interpersonal deficits/sensitivities) that provide the focus of the therapy, and e) IPT is conceptualised as consisting of three phases (initial, middle and termination), each with its own distinctive strategies and objectives.

Activities in all domains of IPT therapy competence need to be carried out in the context of an overarching basic competence that distinguishes IPT from other modalities: **the ability to maintain a focus on the interpersonal context of the client's presenting symptoms**. The client's social and interpersonal context are assumed to contribute to the onset of and/or maintenance of symptoms. Consequently IPT therapists need to review the client's symptoms in every session, so as to help the client to understand the reciprocal relationship between symptoms and what is happening in their relationships. The aim is for the client to learn and experience through the course of the therapy how symptomatic improvement is facilitated through improvements in interpersonal functioning, and vice versa.

**Ability to implement IPT in a manner consonant with its supportive and active stance**. IPT therapists work in a supportive, empathic but also active manner with their clients. They strive to instil hope and act as the client's advocate, carefully attending throughout to the therapeutic alliance to maximise the client's active engagement in the therapy within a time-limited frame.

The **ability to engage the client** in the therapeutic work is fundamental to any approach. In IPT this is achieved by listening attentively and responding non-judgementally to the client's experience while also accepting and encouraging the expression of emotion. The therapist thoroughly explores the client's current and past relationships helping them to reflect on their relationships and to adopt an evaluative stance that brings to the fore the strengths and weaknesses in these relationships.

The client will also require a sense of what the therapy can help them with. An important task at this early stage involves working together with the client to identify and agree a focal area and the related therapeutic aims or goals. The therapist provides the client with information about the nature of their presenting problem, and then explains how the therapy will be applied to them by formulating their problem within an agreed focus area

that links interpersonal experience with the presenting symptoms. A focus that is felt to be meaningful to the client is more likely to promote engagement and sustain the momentum required to support change.

The **ability to reframe the client's presenting problems as an illness** reflects a distinctive feature of IPT. In the initial session the therapist undertakes a detailed assessment of the client's symptomatic profile in order to then convey to the client that the symptoms fit a recognized clinical syndrome that is treatable. It is assumed that sharing the diagnosis with the client is therapeutically beneficial as it can reduce self-blaming attributions and mobilizes hope that change is possible. It is an opportunity too for the therapist to help the client to consider who else might be available to support them besides the therapist. Sharing the diagnosis is thus not intended to encourage the client to adopt a passive stance in relation to their difficulties. On the contrary, one of the aims at this early stage of the therapy is to provide initial symptom relief through support, psycho-education and actively engaging the client in working on their problems to encourage a focus on recovery and improvement in well-being.

The **ability to identify an interpersonal problem area that will provide the focus for the middle phase of the therapy and the ability to maintain a focus on an IPT interpersonal problem area(s) linked with the onset/and or maintenance of symptoms** are linked competences. A core strategy in the initial phase of IPT is to engage the client in a detailed and systematic review of their interpersonal context (i.e. the 'interpersonal inventory'). 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. The 'interpersonal inventory', along with an assessment of the client's history including recent life events, provides the basis for formulating the client's difficulties and identifying the interpersonal problem area(s) that inform the choice of focus for the middle phase of IPT.

Typically, by session 4 or 5 the therapist and client will have agreed on a focus for the work and will be able to provide a formulation that is emotionally resonant for the client. There are four focal areas that can be used for the formulation. These focal areas help the client to relate their symptoms to their interpersonal context as follows: to a recent life change that has necessitated a role transition ('*role transitions*'), to a current covert or overt dispute with a significant other ('*role disputes*'), to the death of a significant other ('*grief*'), or to problems of social isolation or unfulfilling/impoverished relationships ('*interpersonal sensitivities/deficits*').

Once the focus is agreed with the client, the therapist is guided by the strategies specified by each of the four IPT focal areas. Typically one primary focal area is chosen, but it is possible to work on (at most) two related focal areas. In the middle phase of IPT the therapist's primary task is to help the client to stay focused on the agreed focal area(s), sensitively redirecting them back to it if necessary. Irrespective of the specific strategies that guide the work in a given focal area(s), the therapist always also helps the client to make use of and, if necessary, improve and build on their interpersonal resources to

improve well being, better manage their symptoms and to support change in their relationships.

**Ability to identify and explore difficulties in communication.** Throughout all the IPT focal areas the therapist aims to help the client to identify and explore communication patterns so as to help them to communicate more effectively. This will include helping the client to identify and clarify negative and/or ineffective communication and supporting the development of communication skills that will allow them to develop more supportive and satisfying relationships.

**Ability to facilitate the expression and acceptance of a range of emotions.** The IPT therapist sensitively tracks the client's current emotional state, focusing on helping the client to express emotion and explore it. Thus, they may often need to intervene with clarifications or questions in order to help the client to express, understand and accept their emotions. For example, they might try to help the client to understand how the way in which they express or suppress affect may affect their interpersonal relationships. IPT therapists need to be able to assess when to refrain from structuring and directing parts of a session to allow the client to express and elaborate on what they are feeling.

**Ability to encourage interpersonal change in-between sessions.** IPT is a change-oriented therapy, that is, it aims to help the client to and to improve their understanding of their current interpersonal relationships and so change their interpersonal behaviour. Thus the therapist emphasises the need to work on making change. This takes priority over developing insight into what might have caused or maintained problems in the past. The time limit is understood to act as a motivational force, activating the therapist and encouraging the client towards change, but not towards adopting a therapist-directed course of action. In IPT the client should be helped to find their own way to achieve change. Indeed, advice is only used very sparingly in IPT with the greater emphasis placed on the therapist maintaining a positive, problem solving attitude in the face of interpersonal difficulties to support the client's confidence in their ability to resolve these. Although IPT therapists do not assign formal homework (except in IPT-B), they nevertheless provide consistent encouragement to try out new ways of interacting with others.

**Ability to engage the client in preparing for ending.** IPT therapists explicitly focus on the client's experience of ending the therapy as well as on helping the client to review the gains and changes they have made with a view to planning for the future, especially regarding the prevention of relapse. Three to four of the final sessions are devoted exclusively to this, however preparing for ending may need to be addressed earlier for some clients if concern about ending is interfering with the agreed focus of the work. The process of ending is aided by ensuring that the likely schedule for sessions is signalled from the outset, and that there is explicit discussion towards the end of therapy about the affective experience of the ending for the client. Each client reacts to termination differently but, generally speaking, ending therapy elicits feelings of loss and often mobilises anxiety about separation. These feelings are not always expressed directly. One

of the therapist's tasks is to help the client to articulate their feelings about ending, sometimes facilitating this through normalizing the experience, for example, by stating that feelings of sadness or disappointment are normal when a relationship ends.

Finishing therapy in a planned manner is important not only because clients (and often therapists) may have strong feelings about ending, but also because this allows for discussion of how the client will manage without the therapist and to consider how they will use their interpersonal resources to support them at the time of ending, and if there are difficulties in the future. In addition the therapist needs to consider what further help, if any, the client might need (for example, monthly maintenance IPT sessions may well be required by those individuals who have more chronic or recurrent difficulties).

## Specific IPT techniques

This domain includes the main techniques employed by IPT therapists, that is, the selective use of directive techniques, communication analysis, role play, clarification, summaries and questions, and the therapeutic relationship, in order to support the strategies and goals of the IPT focal problem area(s) that is being worked on. Not all of these would be employed for any one individual, and different technical emphases would be deployed for different focal areas. None of these techniques per se are specific to IPT, but the way they are deployed to support the work on a specified interpersonal focal area is distinctive to IPT.

**Ability to use directive techniques.** Directive techniques are used very sparingly in IPT, but they can be helpful especially in the initial phase to facilitate initial engagement, for example, through the provision of information, reassurance, and psycho-education, all of which may foster the client's confidence in the therapist's capacity to help.

**Ability to use communication analysis.** IPT therapists actively work with the client's problematic communication patterns. 'Communication analysis' is a particular technique that may be used to support the development of more effective communication. It involves engaging the client in reporting in detail, and reflecting on, a recent, difficult exchange/conflict with another person so that they can identify how they communicated, and what they would have wanted to communicate had they felt able to. The technique also requires that the therapist help the client to examine what they felt at significant points during the communication. This detailed analysis is used to then help the client to consider alternative ways of communicating and to try out these out in-between sessions.

**Ability to use role play and decision analysis.** These two techniques can be very helpful to engage the client in actively working on an immediate problem. For example, *Role-playing* can be a useful intervention to help the client to practise new ways of communicating with others. *Decision analysis* may be used to help the client to consider alternative courses of action in order to resolve a problem and to evaluate the likely consequences of different possible courses of action.

**Ability to use clarification, summaries and questions.** These generic and non-directive therapeutic skills are deployed to support the exploration of relevant interpersonal scenarios, or to help the client to become more aware of what they characteristically feel and think in relation to others.

### **Ability to use the therapeutic relationship**

IPT is a relational therapy, but unlike psychoanalytic/dynamic approaches its underlying mode of therapeutic action is not assumed to rely on working through the exploration of the transference relationship with the therapist. 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. However if the positive working alliance is undermined by events outside or within the therapy this will need to be addressed in the therapeutic relationship to allow the therapy to progress. This would be regarded as the exception rather than the norm in IPT. *Selective* use of the client-therapist relationship may nevertheless support the strategies of a given focal area. For example, it may be used to identify and provide constructive feedback on recurring interpersonal patterns and communication difficulties when these manifest in the therapeutic relationship, and to help the client try out, within the therapeutic relationship, alternative ways of communicating.

### **Problem specific competences/ specific adaptations of IPT**

This domain contains competence lists for four exemplar interventions for depression: IPT for Depression (*Weissman et al., (2000, 2007)*), IPT for depressed adolescents (IPT-A) (*Mufson et al., (2004)*), Brief IPT for depression (IPT-B) (*Swartz et al., no date*) and IPT for depressed older adults (*Hinrichsen & Clougherty 2006*). It also includes IPT for Eating Disorders (IPT-ED) based on the approach developed by Chris Fairburn and colleagues (*Fairburn, 1997; Murphy et al., 2008*). In the UK another group based in Leicester (comprising Debbie Whight, Lesley Meadows, Lesley McGrain, Chris Langham, Jonathan Baggott and Jon Arcelus) have also been working on the development of an application of IPT for eating disorders that is somewhat different in its emphasis: IPT for the treatment of Bulimic Spectrum Disorders (IPT-BN). We have not included this application in this framework because its evidence base is not yet sufficiently developed.

The lists in this domain are intended to read as a coherent description of the critical elements of (and pathways through) each intervention. Working through the list should identify the elements which, taken together, constitute the treatment “package” and hence best practice. By intent the problem-specific lists include some repetition of basic or specific IPT competences, partly because this makes them easier to digest, and partly because some interventions modify standard IPT strategies techniques in order to apply them to a particular disorder. Nonetheless, it should be clear that the effective delivery of problem-specific interventions will always rest on a range of generic, basic, specific and meta-competences.

## Metacompetences

Therapy cannot be delivered in a ‘cook-book’ manner; by analogy, following a recipe is helpful, but it doesn’t necessarily make for a good cook. This domain describes some of the procedural rules (e.g. Bennett-Levy, 2005) which enable therapists to implement therapy in a coherent and informed manner.

Technical flexibility - the ability to respond to the individual needs of a client at a given moment in time - is an important hallmark of competent therapists. The interaction of a particular therapist and a particular client also produces dynamics unique to that therapeutic relationship, resulting in context-dependent challenges for the therapist. In other words, in psychotherapy the problems to be addressed can present differently at different times, the contextual meanings of the therapist and the client’s actions change and the therapist is engaged in a highly charged relationship that needs to be managed. What is required therefore are a range of techniques, complex interpersonal skills under the guidance of very sophisticated mental activities.

On the whole these are more abstract competences than are described elsewhere, and as a result there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Most of the list has been extracted from manuals, with some based more on expert consensus<sup>5</sup> and some on research-based evidence (for example, “an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise”, or “an ability to implement models flexibly, balancing adherence to a model against the need to attend to any relational issues which present themselves”).

The lists are divided into two areas. Generic Metacompetences are common to all therapies, and broadly reflect the ability to implement an intervention in a manner which is flexible and responsive. IPT-specific metacompetences refer to the implementation of IPT in a manner consonant with its philosophy, as well as the way in which specific techniques are applied. As is the case in other parts of the model, this division is pragmatically useful, but it is the case that many of the competences described as “Therapy -specific” could easily be adapted and apply to other interventions or techniques.

### Implementing the competence framework

A number of issues are relevant to the practical application of the competence framework.

**Do clinicians need to do everything specified in a competence list?** Most of the competence lists are based on manuals, which are “packages” of techniques. Some of these techniques may be critical to outcome, but others may be less relevant, or on occasions irrelevant. Based on research evidence we know that the “package” works, but

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<sup>5</sup> Through discussion and review of metacompetences by the Expert Reference Group

we are less certain about which components actually make for change, and exactly by what process.

It needs to be accepted that the competences which emerge from a manual could represent both “wheat and chaff”: as a set of practices they stand a good chance of achieving their purpose, but at this stage there is little empirical evidence which can be used to sift effective from potentially ineffective strategies. This means that competence lists derived from manuals may include therapeutic *cul de sacs* as well as critical elements.

Does this mean that clinicians can use their judgment to decide which elements of an intervention to include and which to ignore? This would be a risky strategy, especially if this meant that major elements or aspects of an intervention were not offered – in effect clinicians would be making a conscious decision to deviate from the evidence that the package works. Equally, manuals cannot be treated as a set of rigid prescriptions, all of which have to be treated as necessary and all of which must be applied. Indeed most of the competence lists for problem-specific interventions include an important metacompetence – the ability to introduce and implement the components of a programme in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components are included. Clearly this involves using informed clinical judgment, rather than opinion.

**Are some competences more critical than others?** For many years researchers have tried to identify links between specific therapist actions and outcome. Broadly speaking better outcomes follow when therapists adhere to a model and deliver it competently (Roth and Pilling, in preparation), but this observation really applies to the model as a whole rather than its specific elements.

Given the relative paucity of research on process in IPT therapy there is only very limited evidence on which to base judgments about the value of specific activities, and comment on the relative value of competences may well be premature.

**The impact of treatment formats on clinical effectiveness:** The competence lists in this report set out what a therapist should do, but do not comment on the way in which therapy is organised and delivered (for example, the duration of each session or how sessions are spaced) except where IPT is clearly specified as a time limited intervention. Although such considerations will undoubtedly shape the clinical work that can be undertaken, the consensus of the ERG was that these variations do not necessarily have implications for the skills that therapists deploy.

Treatment formats are sometimes identified in manuals and research protocols, with the schedule constructed so as to match to clinical need and the rationale for the intervention. All the manuals we reviewed delivered therapy once weekly therapy, with sessions of 45-50 minutes duration (thereby closely reflecting standard practice). Information about the ways in which therapies are best implemented is usually found in clinical guidelines, such as those produced by NICE.

**The contribution of training and supervision to clinical outcomes:** Elkin (1999) highlighted the fact that when evidence-based therapies are ‘transported’ into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (in preparation)) reviewed the training and ongoing supervision associated with the delivery of therapy in the exemplar trials which contributed to this report. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy - a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems which help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

### **Applying the competence framework**

This section sets out the various uses to which the IPT competence framework can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed

**Commissioning:** The IPT framework can contribute to the effective use of health care resources by enabling commissioners to specify the appropriate levels and range of IPT therapy for identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

**Service organisation – the management and development of psychological therapy services:** The framework represents a set of evidence-based competences, and aims to describe best practice - the activities that individuals and teams should follow to deliver evidence-based treatments.

Although further work is required on the utility and associated method of measurement – they will enable:

- the identification of the key competences required by a practitioner to deliver IPT interventions

- the identification of the range of competences that a service or team would need to meet the needs of an identified population
- the likely training and supervision competences of those managing the service

This level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of the research trials on which claims for efficacy rest. In this way it could help to ensure that evidence based interventions are likely to be provided in a competent and effective manner

**Clinical governance:** Effective monitoring of the quality of services provided is essential if clients are to be assured optimum benefit. Monitoring the quality and outcomes of psychological therapies is a key clinical governance activity; the framework will allow providers to ensure that:

- IPT is provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of therapist performance
- Clinical Governance systems in Trusts meet their requirement for service monitoring from the HCC and other similar bodies

**Supervision:** The IPT competence framework potentially provides a useful tool to improve the quality of supervision by helping supervisors to focus on a set of competences which are known to be associated with the delivery of effective treatments. Used in conjunction with the supervision competence framework (available online at [www.ucl.ac.uk/CORE/](http://www.ucl.ac.uk/CORE/)) it can:

- provide a structure which helps to identify the key components of effective practice in IPT
- help in the process of identification and remediation of sub-optimal performance

Supervision commonly has two (linked) aims – to improve the performance of practitioners and to improve outcomes for clients. The IPT framework could achieve these aims through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

**Training:** Effective training is vital to ensuring increased access to well-delivered psychological therapies. The framework will support this by:

- providing a clear set of competencies which can guide and refine the structure and curriculum of training programmes (including pre and post-qualification professional trainings as well as the training offered by independent organisations)
- providing a system for the evaluation of the outcome of training programmes

**Registration:** The registration of psychotherapists and counsellors is a key objective for the Department of Health. Although a clear set of competences associated with the key activities of these professionals groups may well contribute to the process of establishing a register, one caution is that it represents only one aspect of a broad set of requirements for a formal registration system.

**Research:** The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the relationship between therapy process and outcome and the evaluation of training programmes and supervision systems.

### **Concluding comments**

This report describes a model which identifies the activities which characterise effective IPT interventions, and locates them in a “map” of competences.

The work has been guided by two overarching principles. Firstly, it stays close to the evidence-base, meaning that an intervention carried out in line with the competences described in the model should be close to best practice, and therefore likely to result in better outcomes for clients. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cook-book. Delivering effective therapy involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Therapists of all persuasions need to operate using clinical judgment in combination with their technical skills, interweaving technique with a consistent regard for the relationship between themselves and their clients.

Setting out competences in a way which clarifies the activities associated with a skilled and effective practitioner should prove useful for workers in all parts of the care system. The more stringent test is whether it results in more effective interventions and better outcomes for clients.

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## Appendix B – List of manuals

Fairburn, C.G. (1997). Interpersonal psychotherapy for bulimia nervosa. In D.M. Garner and P. E. Garfinkel (Eds.), *Handbook of Treatment for Eating Disorders*. (pp. 278-294). New York: Guilford Press.

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