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Interpersonal Psychotherapy Training and Accreditation in the United Kingdom

ROSLYN LAW AND FIONA DUFFY ■

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CONTEXT OF WORK

Interpersonal Psychotherapy (IPT) training in the United Kingdom covers four nations (England, Scotland, Northern Ireland, and Wales) and their respective healthcare systems. The protocols for training, supervision, and accreditation are standardized by Interpersonal Psychotherapy United Kingdom (IPTUK), the IPT therapist membership and training regulating body in the UK, allowing a broadly consistent approach despite different funding streams. In England, IPT and IPT-A (IPT for adolescents) dissemination is mostly, but not exclusively, supported by UK government funding and delivered through the Improving Access to Psychological Therapy (IAPT) and Children and Young People's IAPT (CYP IAPT) programmes. Funding supports approximately 115 practitioner and 30 supervisor training places each year, based on a national needs assessment conducted by Health Education England (HEE). IPT has been part of IAPT training since 2008, and IPT-A was added to CYP IAPT training in 2012. These programs increase public access to evidence-based treatments for common mental health disorders. IAPT training targets the existing psychological therapies workforce, and CYP IAPT recruits into new posts with IPT-A training provided. IAPT services provide treatments recommended in the National Institute for Health and Care Excellence (NICE) guidelines for depression in adults[1] and young people.[2]

In Northern Ireland, practitioner training is funded biannually by the Department of Health for up to 10 trainees, drawn from the existing workforce. In Northern Ireland, psychotherapy has historically been poorly resourced, and

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consequently therapists complete training in their own time. To date there has only been one funded IPT post in the region.

In Scotland, the University of Edinburgh (UoE) delivers IPT training for 3 target audiences—NHS clinicians completing training based on a centralized strategic needs assessment, clinicians accruing credit as part of an MSc in psychological therapies (UoE), and final year trainee clinical psychologists at the Universities of Edinburgh and Glasgow. Training is either self-funded or funded through National Health Service (NHS) Education Scotland (NES). Approximately 15–20 participants work toward accredited practitioner status following training each year.

In Wales, IPT training is available in the South Wales NHS. Approximately 6 participants from across South Wales can access practitioner training annually and are supported directly or indirectly with NHS funding. Each participating service is supported to develop a sustainable IPT pathway with in-house IPT supervision.

MODEL OF TRAINING

Practitioner

The IPT practitioner training is delivered by 3 training centers in England and 1 training center each in Wales, Northern Ireland, and Scotland. In Scotland, the practitioner course provides combined training for IPT and IPT-A trainees. Practitioner training is delivered over a minimum of 5 days plus 12 months of weekly supervision provided by an IPTUK accredited supervisor. Most supervision in the United Kingdom is delivered remotely, by either telephone or videoconferencing. This allows courses to be supported by a national network of supervisors, frequently working across the country to support trainees' learning. All government- or NHS-funded training includes didactic teaching and supervised casework, which can also be accessed with nongovernment funding. Each trainee is required to complete 4 cases of IPT or IPT-A, reflecting work in at least 2 focal areas. A minimum of 12 hours of recorded therapy sessions are self-assessed and formally rated using a competency-based assessment based on[3] participants in training are mostly qualified therapists from a range of training backgrounds, such as counseling, clinical psychology, and Cognitive Behavioral Therapy (CBT). Participants receive varying degrees of service-level support, ranging from completing training in their own time to having at least 1 day of protected work time for the duration of training.

The IPT-A training in the CYP IAPT program is delivered as a postgraduate diploma combining training in core therapeutic skills and one modality or clinical specialism of choice, including IPT-A. The post-graduate diploma is available through University College London and the Anna Freud Center and aims to upskill the pre- and post-qualification workforce serving young people with common mental health difficulties across England. IPT-A training

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may also be accessed as a 5-day training following by 12 months of supervised practice through the AFC and as part of CYP IAPT post-graduate certificate programme delivered in conjunction with core skills training at the University of Manchester.

Supervisor

Government-funded supervisor training is available in England and Scotland for IPTUK-accredited practitioners. In England, 6 days of supervisor training are delivered over 12–18 months, combining didactic teaching, advanced practice casework, and experience working as a peer and primary supervisor. Following successful completion of expert-facilitated and peer-supervised advance practice, the trainee supervisor works with a novice IPT or IPT-A practitioner under the continued supervision of an accredited IPTUK supervisor.

In Scotland, the UoE 2-day IPT supervisor course follows completion of the comprehensive and cross modality 3-day NES psychological therapy supervisor course, available to individuals 2 years postqualification. This is followed by 2 advanced practice IPT cases and supervision of supervised practice. Approximately 10 places are funded biannually.

ADAPTATIONS TO IPT TRAINING AND SUPERVISION

Interpersonal Psychotherapy training in the United Kingdom primarily focuses on a 16 weekly session model of IPT for depression[3] and a 12 weekly session model of IPT-A for adolescents, with additional sessions with parents and caregivers.[4] Didactic training is also available in family-based IPT[5] and IPT-A Skills Training[6] particularly targeting a new strand of the mental health workforce, the school-based educational mental health practitioners (EMHPs).

Pilot research has supported the development of small Interpersonal Counseling (IPC) and IPT-Group (IPT-G) training and supervision programs. IPC has been evaluated with young people supported in nonspecialist services,[7] with depressed women during pregnancy,[8] and in IAPT primary care services. In collaboration with the Columbia University Global Mental Health Lab, IPT-G is being piloted in perinatal, health psychology, and military settings. Guidelines are being developed by IPTUK for CPD training in empirically supported adaptations of IPT not currently included in the NICE guidelines.

CONTENT AND PROCESS ADAPTATIONS

Three distinct areas of emphasis in UK trainings are (1) focus on clinicians providing detailed formulations, clearly aligned with focal areas; and (2) promotion of the routine use of the interpersonal sensitivities focus area (originally known as

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interpersonal deficits); and (3) emphasis on mentalizing and reestablishing social learning.

Use of the interpersonal sensitivities focus has been the subject of debate in the IPT literature. Historically, it has been discouraged[3] with people experiencing long-standing interpersonal difficulties and with few current supports, argued to be less responsive to short-term interventions. This view has not resonated in the United Kingdom, where all 4 focal areas are routinely used. Comparative outcomes across focal areas were reviewed in a recent survey of 130 IPT training cases conducted over 2 years in IAPT services (Figure 13.1).[9] Interpersonal sensitivities was the second most chosen focus, accounting for 24% of the casework. Of the sensitivities group, 62% achieved recovery by the end of therapy, and 72% reported reliable improvement on the Patient Health Questionnaire-9 (PHQ-9). The routine collection of session-by-session outcome data during IPT training in the United Kingdom allows empirical questions to be explored, and results are fed back into the training discussion.

Mentalizing, the ability to accurately reflect on one's own intentions and feelings and those of the people around us, reinforces the positive attachment cycle from which it emerged. Being understood promotes self-understanding and encourages us to see others as useful and trustworthy sources of information and support, fostering epistemic trust. This ability is inhibited under conditions of social threat and by many mental health conditions, including depression.[10] Lapses in mentalizing increase social alienation—losing sight of oneself and others, at least temporarily. This psychological isolation is fertile ground for the interpersonal difficulties to flourish that are the focal areas of IPT, conflict, unresolved change, and loss. The mentalizing framework has been incorporated as a potential mediator of change in IPT training, facilitating a nuanced formulation of the nature of the interpersonal missteps that surround depression. Unlike mentalization-based therapies, in which the therapeutic relation is an explicit focus, IPT conducted with consideration of mentalizing processes remains primarily focused on the person's social network, navigating the consequences of a breakdown in social learning and consequent interpersonal hypervigilance. Mentalizing also provides a framework for the explicitly reflective practice necessary when social learning

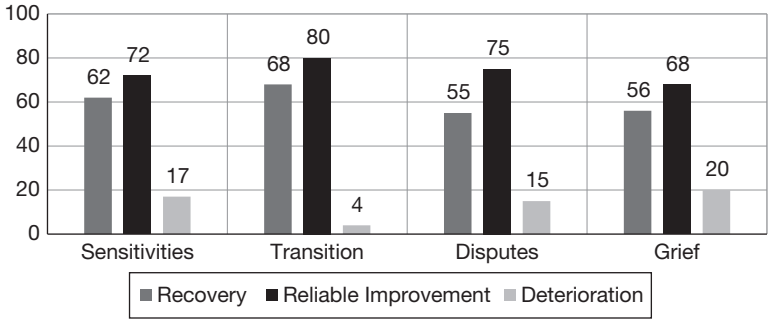

Figure 13.1 Outcomes by focal areas (IAPT sample).

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falters within the therapeutic alliance, as illustrated in the case example in this chapter. Mentalizing has been widely incorporated into practitioner, supervisor, and CPD training in the United Kingdom alongside underpinning attachment and contemporary interpersonal theory.[11,12,13]

CULTURAL ADAPTATIONS

Further adaptations to core training currently in process in the United Kingdom reflect the multidisciplinary training cohorts providing and multicultural populations served by IPT. Some elements of the standard IPT protocol (e.g., medical model, sick role, diagnosis) do not easily translate across disciplines and cultural groups. The United Kingdom training courses are currently undertaking a detailed review of our curricula to ensure they embrace a Multicultural Orientation Framework.[14] This commits us to adopting a stance of cultural humility, exploring cultural opportunities, and attending to cultural discomfort in implementation and adherence to the IPT model across professional and cultural groups.

Also, IPTUK has given explicit attention to equity of training opportunities across therapists from different ethnic backgrounds. A recent survey of the IPTUK membership revealed that while training numbers at practitioner level reflect national population figures, this is not true as trainees move to practitioner, supervisor, and trainer accreditation. Practitioners from non-White backgrounds are underrepresented at higher levels of training. IPTUK is consulting with the membership to identify barriers to progression for clinicians of colour, including lack of representation at higher levels of the IPTUK executive, unnecessary systemic barriers (e.g., previous requirement to be an IPT supervisor to be eligible to chair IPTUK), conscious and unconscious bias in supervision, and a lack of management support for advanced training in the workplace. IPTUK has explicitly committed to improving, including enhancing understanding of cultural and racial bias in selection and training programs for practitioner and supervisors, with the aim of increasing opportunities for advanced training and accreditation across all members.

BARRIERS AND FACILITATORS OF IMPLEMENTATION

Through our collective training experience, we have identified a range of barriers and facilitators for implementation. We have learnt that stand-alone didactic training does not have a discernible or sustainable impact on the subsequent availability of IPT in clinical settings.[15] To achieve high-quality implementation, the UK training model invests resources in fewer individuals with confirmed protected time to attend training and clinical supervision. We would argue that a higher proportion of clinical learning occurs within the supervised practice that follows didactic training than in the training course itself, albeit this is valuable

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for implementation. We recommend that training and clinical supervision be conducted within a clear accreditation framework to maintain quality standards and in collaboration with a national funding or training body providing strategic oversight of national training needs. High-quality clinical practice in IPT is dependent on clinical supervision inclusive of continual self-assessment and competency-based feedback. While acknowledging the contribution of continuing education in evidence-based approaches, supervision, and feedback monitoring, Rousmanier et al.[16] argued for the necessity of moving from routine performance and passive learning to deliberate practice involving "repetitively practicing specific skills with continuous corrective feedback" to generate a cycle of excellence. This approach to implementation of IPT reflects enhanced focus on equitable formal accreditation of psychological therapists from multiple training and ethnic backgrounds and core consideration of adherence to an established competency framework in the United Kingdom.

FUTURE PLANS

The IPTUK is currently undertaking a review of the accreditation process to widen access to training for the expanding low-intensity workforce, such as Child Well-being Practitioners (CWPs) and EMHPs with experience in low-intensity, manualized interventions. Low-intensity training is being developed across both the adult and child and adolescent workforce. This is inclusive of IPC and more formal training, and accreditation standards are currently being developed to support implementation in a standardized way.

CASE EXAMPLE

Sylvia is a 63-year-old White woman living in a small rural village in the south-east of England. Sylvia referred herself to a local IAPT service because she felt lonely and isolated following the death of her partner of 12 years, Emma, 4 years earlier. Sylvia describes having no friends and not having felt the need for anyone else when she and Emma were together. Since her bereavement, Sylvia has tried to make friends but thinks she is "too intense" and other people back off, leaving her feeling even more alone and helpless. She describes this as a lifelong pattern, with Emma being the only person she felt understood and accepted her. Sylvia explains she is frequently sad and tearful, especially in the evening when she finds it difficult to distract herself. She often feels agitated and has difficulty concentrating and taking care of herself. Her appetite is minimal, often resulting in missed meals, and she routinely feels tired and lethargic following poor sleep. She is not suicidal but experiences no pleasure in her life. Sylvia's symptoms are rated on the PHQ-9 each week and tracked in supervision.

Sylvia has been in contact with mental health services throughout most of her adult life, including two short periods of inpatient care, once in her early 20s

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following workplace bullying and again in her mid-30s following the end of a close relationship. She had attended multiple counseling sessions and group interventions, including 1 year of grief-focused counseling following Emma's death. She self-referred to her local IAPT service soon after completing her last episode of care. She believes therapy helped temporarily, but she finds endings very difficult, and depression quickly returns. Sylvia had been prescribed several antidepressants since adolescence but had not found them helpful and has stopped taking them on each occasion.

Sylvia begins her IPT by asking what else will be offered when it ends, highlighting the urgency of her wish for support. It is clear she finds her loneliness intolerable, made worse by the loss of her relationship with Emma. When drawing a timeline of depression in the first session, it becomes apparent that the relationship with Emma offered a partial but not complete reprieve from the loneliness and sadness Sylvia has experienced since childhood and that had been felt very deeply following her loss. It appears that on several occasions, before, during, and since her relationship with Emma, Sylvia has used therapy to fulfill her need for someone to listen to her and felt devastated each time it ended. The IPT therapist uses weekly IPT supervision to discuss how to work with the long-term nature of Sylvia's difficulties in a time-limited treatment and the emotional impact of the urgency of the demand Sylvia expresses. Supervision helped to guide the therapist back to focusing on the here-and-now focus of IPT and the rationale of focusing on current interpersonal relationships to relieve immediate depressive symptoms. The experience of forming a therapeutic relationship with Sylvia was also used to inform thinking about potential focal areas.

Sylvia's Interpersonal Inventory is sparsely populated, with no contact with her family of origin, who disapproved of her sexuality, and minimal contact with Emma's children from her marriage prior to being with Sylvia. Sylvia has had occasional contact with an LGBTQ+ (lesbian, gay, bisexual, transgender, queer/questioning+) support group in recent years but is disappointed by what she perceives as their focus on younger people and has not maintained contact. Sylvia explains that Emma had poor physical health throughout their relationship, and Sylvia acted as carer and partner for most of their time together. She welcomed this role and was good at it, having worked as a nursing assistant for 30 years. However, in her most insecure moments she fears Emma was with her because she couldn't manage on her own rather than because it was what she really wanted. Sylvia never expressed this fear to Emma. Sylvia describes two short, intense friendships that both began and ended badly in the context of support groups in the last 2 years, which she experiences as rejections.

Throughout the assessment phase the importance of losing Emma is acknowledged, and the recurring difficulty of establishing and maintaining relationships, which pre-dated and followed that relationship, is also a central focus of discussion. Ways of understanding Sylvia's current interpersonal difficulties and how to frame the IPT work are discussed weekly in supervision. A written formulation is discussed in supervision prior to sharing the proposed focus with Sylvia. In session 4, a formulation, collaboratively developed with Sylvia over the first 3

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sessions, is tentatively shared and discussed. Sylvia acknowledges that she started therapy assuming the focus would be on losing Emma but recognizes that this is an opportunity to understand the broader context of her continuing struggle to connect with other people, which is at the heart of her depression. It is agreed that a sensitivities focus will be used to capture the recurring nature of Sylvia's interpersonal difficulties, and this will include attention to the way in which her relationship with Emma replicated and avoided the patterns that are powerful in maintaining her current depression. Recorded clips of the therapy are reviewed weekly, and a full-session recording of the formulation session with a competency-based self-assessment is shared with the IPT supervisor, who provides detailed written and verbal feedback.

Following Klerman et al.'s guidance,[17] the early middle phase sessions are used to review a selection of relationships, each of which involved a pattern of intense engagement and then painful ending that Sylvia described occurring several times in her life. This review includes the friendships that broke down during the last 4 years and further examples that pre-dated Sylvia's relationship with Emma, which had been the longest relationship of her life. Sylvia's relationship with Emma is used as comparison to try to understand what worked successfully and to clarify which aspects of maintaining a wider network of relationships have proven so difficult for Sylvia. Each relationship is discussed in terms of how it began, how the acquaintance developed, who initiated contact, what worked well, and where the challenges lay. Given the significance of ending for Sylvia, this is discussed in detail for each example. This review exercise, conducted over 2 sessions, is used to develop a simple representation of a recurring interpersonal pattern that had been significant in maintaining Sylvia's depression over decades of her life (Figure 13.2). It is helpful to capture this pattern visually, in the way that a single example might be captured in a depression circle, to focus attention and create an essential tool for subsequent sessions. Creating a diagram of the recurring pattern helps to interrupt the well-practiced narrative of idealized and rejecting relationships that Sylvia initially expresses and prompts her to become curious about how each step in the cycle leads to the next and in so doing maintains her depression. This also provided a way to navigate current choices when Sylvia explores opportunities for interpersonal contact through a volunteering role she has taken up and the way in which the pattern plays out in therapy.

Mapping the pattern on a page supports Sylvia to revisit what had been discussed in a more concrete way than she has been able to do when previous discussions were forgotten or overshadowed by a change in mood. Having a stable visual representation allows her to work with support to consider different perspectives and identify specific options at each stage of the cycle, integrating core IPT strategies into the discussion as relevant. These include developing a more nuanced recognition and expression of her feelings, using decision analysis and communication analysis to plan when and how to approach those occasions when she would have previously been too intense due to the urgency of her wish for connection. New interactions are carefully planned, creating and role-playing simple scripts. Sessions are used to help Sylvia tolerate and process the

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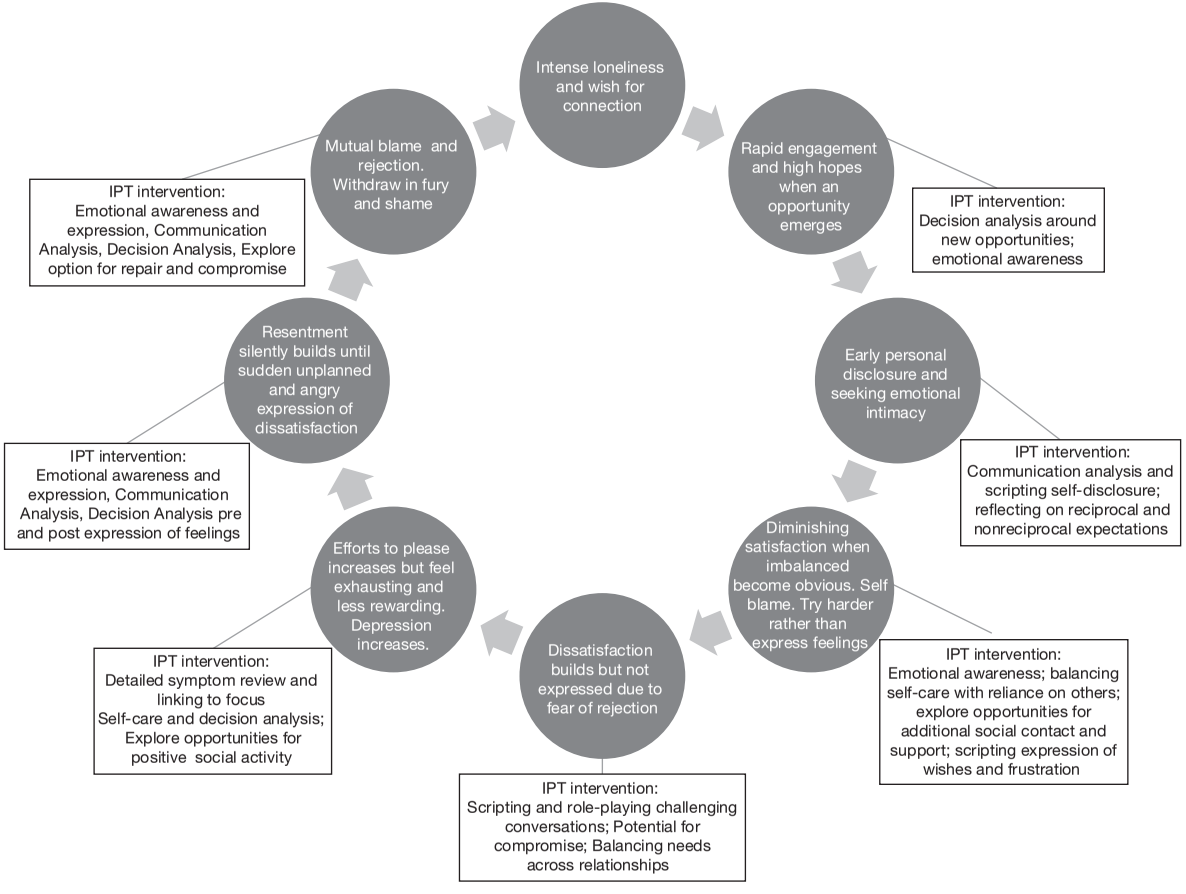

Figure 13.2 Diagram of recurring pattern.

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frustration and disappointment she feels when the opportunities available to her offer some but far from all of what she wishes for in terms of connection and support, including therapy itself. The visual diagrams are used in supervision to support reflective practice, focusing on the core interpersonal patterns, how they perpetuated the depression, choice of specific IPT techniques that may be helpful and how these interpersonal patterns are evident and can be managed in the therapeutic relationship.

The progress in these sessions is slow, something that is characteristic of sensitivities work. At times, the frustration arising from trying to redirect efforts away from the all-or-nothing pattern that has characterized Sylvia's interpersonal style flares up in therapy, temporarily transforming it from being helpful and offering new insights to being too little and too slow with the end of therapy rapidly approaching like another inevitable rejection. Having the pattern mapped out on a page is useful to support Sylvia to consider how the recurring sequence is playing out in therapy. Each example is examined carefully to repair the rupture and inform how to navigate comparable experiences or setback outside of therapy. As this move in and out, a deliberate reflective position became more practiced, Sylvia's confidence in her ability to influence the course of interactions increased, something she had not previously experienced. Previously, she said she felt like she was repeatedly racing toward another inevitable collision, and now she had more ideas about how to steer and pace her own journey. This process of lapse and recovery is mirrored in weekly supervision to build the novice IPT therapist's confidence as an explicitly reflective practitioner within the model.

Part of the IAPT model involves routine outcome monitoring, allowing Sylvia to track the impact of the work she is doing against her weekly PHQ-9 scores and how she rates progress toward her individual goals, set at the time of agreeing to the focus. Both show good progress, with PHQ9 scores gradually reducing week on week from session 7 onward and goals-based outcome charting setbacks and successes in an overall positive trajectory. By the end of therapy, Sylvia's depression scores are within the healthy range, and she has moved more than halfway toward her individual goals.

Given the significance of endings in Sylvia's relationship history, the prospect of ending is consistently held in mind and given explicit attention over the final 4 sessions. Sylvia's feelings about ending are discussed during each session and care is taken in capturing the work that had been done and how this could be sustained in the weeks and months ahead. Sylvia's volunteer role in a local community kitchen has gone well, and she felt supported by people who understand vulnerable mental health and are positive about her ability to help others. This provides an opportunity for Sylvia to share her nurturing side, which had been so important in the success of her career and relationship with Emma. Sylvia can talk about therapy ending with the volunteer coordinator and makes posttherapy plans that relate to her own resources rather than relying on further therapy to sustain her progress. Sylvia accepts the end of therapy and expresses a pragmatic view that something useful had been started and will need more practice to consolidate. For

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the first time, she does not want to be referred for more therapy as she feels able to continue with the help of her map and current support.

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