Plugging the Gaps: How IPT Practitioners Draw on Theory and Evidence

By

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Submitted in partial fulfillment of the degree of Doctor of Psychology
(Clinical Psychology)

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University of Surrey
September 2014

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Acknowledgements

With gratitude firstly to the IPT practitioners who agreed to take part in the research, your reflections were open, honest and insightful. Thank you to Dr Kate Gleeson for your generous, caring, rigorous and thoughtful supervision throughout the project. Your patience, advice and encouragement have been greatly appreciated. Thank you to Dr Susan Howard for introducing me to the topic area, for sharing your own experiences of IPT and for your help with the recruitment process. Also, a big thank you the course team and my clinical supervisors who have kindly supported me with other aspects of the course.

I would also like to warmly thank my awesome family and friends who have been encouraging, tolerant, kind, and distracting when needed. I am so excited about having the time to catch up with you all properly! Special thanks go to Jane and Cad for always being there when I needed a break from work, making me those amazing cheese sandwiches, and for bringing Lila into my life; her cheeky grin has never failed to lift my spirits. Finally, a heartfelt thank you to my parents for your unconditional love and support and for listening to my stress-laden rants – I really appreciate all that you have done for me.
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Major Research Project

Plugging the gap: how IPT practitioners account for theory and evidence.

Year 3
April 2014
Word Count: 9996
Abstract

IPT was originally derived from what were considered to be appropriate clinical techniques, in order to mimic ‘good supportive therapy’ in clinical trials. IPT was not developed from a theoretical model and consequently it does not have a specific theoretical foundation for practitioners to draw on. Existing IPT research has focused on outcomes, but little is known about how or why IPT works. Literature pertaining to the epistemology of professional knowledge suggests that professionals make use of espoused and implicit theories to guide their work. Those wishing to train in IPT are required to have completed training in a relevant field and therefore may approach IPT with an existing repertoire of theories. This study aimed to explore how IPT practitioners account for theory and evidence in their practice. Interviews were conducted with eight IPT practitioners, and analysed using interpretative phenomenological analysis (IPA). The practitioners made use of a repertoire of implicit and espoused theories, applied during practice and retrospectively. The way practitioners drew on theory and evidence was influenced by their professional context, perceived level of experience, and their individual experiences and values. This study highlights differences in the way practitioners currently make sense of IPT, and the potential implications of appending theory in a post-hoc fashion. Future research might focus specifically on examining the range of espoused and implicit theories IPT practitioners employ, and their implications for practice.

Keywords: Interpersonal Psychotherapy, Process, Qualitative, Reflective Practice, professional development.
Introduction

Interpersonal Psychotherapy (IPT) is a brief psychological intervention that is recommended by the National Institute for Health and Care Excellence (NICE, 2009) for use with individuals with a diagnosis of depression. IPT aims to facilitate improvements in mood by tackling current interpersonal difficulties, and developing strategies for managing future problems (Weissman et al., 2000). The focus of IPT is on the here and now of interpersonal relationships and current life situation as opposed to the past. The aims of IPT are to work through a specific interpersonal difficulty related to grief, change, isolation or conflict, and to facilitate the recruitment and utilisation of social support. Therapeutic strategies that therapists might employ during IPT include: psycho-education on the effect of interpersonal difficulties on mood; emotionally guided exploration of social-roles and expectations; reducing stigma surrounding depression; interpersonal problem solving; role-playing, communication analysis and instilling hope (Stuart & Robertson, 2012).

IPT has an extensive evidence base in outcome research. A recent meta-analysis found moderate to large effects of IPT in the acute treatment of depression (Cuijpers, van Straten, Smit, Mihalopoulos & Beekman, 2011). However, IPT was not found to have greater efficacy than other psychotherapies, and the quality of the studies included in the analyses varied; only nine of the 38 studies included met all of the quality criteria.

The focus on outcomes appears to have been at the cost of developing an understanding of the therapeutic processes that are specific to IPT. Process research is difficult to define; the subjective experience of psychotherapy consists of a number of intricately related interactions between patients and therapists that are difficult to capture in research (Jones, 2003). Broadly speaking, process research can be defined as the exploration of the phenomena that occur in therapy, the contributions of the
A recent review of the process research in IPT found that existing process research has been mainly quantitative and nomothetic (Foster, 2012). Much of the research reviewed focused on associating predefined elements of process with outcomes (see Ravitz et al., 2011 for a review), describing IPT process using objective measures (e.g. Albon & Jones, 1999) or looking for differences in process between IPT and CBT (e.g. Connolly-Gibbons et al., 2002; Connolly-Gibbons, Crits-Christoph, Levinson, & Barber, 2003; Crits-Christoph, Gibbons, Temes, Elkin, & Gallop, 2010). Only a handful of qualitative studies have been published, the results of which suggest that therapists make use of both the techniques that are common across psychotherapy and specific to IPT, and that the process of change involves the therapists assisting patient reconstruct a sense of self that is less likely to factor in future episodes of low mood (Crowe and Luty, 2005a, b, c, d). However, the quality of these studies varies and most use data from two research samples; either in the Treatment of Depression Collaborative Research Programme (TDCRP; Elkin et al., 1989) or the Christchurch Psychotherapy for Depression Study (CDPS; Luty et al., 2007). As a result, little is known about IPT process outside of these two trials.

The extant literature suggests that researchers have focused their efforts on establishing that IPT is effective, rather than trying to understand when and why it is effective. Consequently, IPT research has focused predominantly on the psychotherapy itself, rather than on the therapists who use it in their work.

Lipsitz, & Markowitz, (2013) acknowledge that the question of when and why IPT is effective has been neglected and offer two explanations. Firstly Klerman, One of the founders of IPT emphasised this bias towards outcome research IPT when he argued “if a treatment doesn’t help, who cares how it works?” (Markowitz, Skodol, & Bleiberg,
Klerman’s words highlight the ‘pragmatic’ stance taken in IPT, which may in part explain the reason that process research has largely been neglected. Secondly, IPT was developed to draw on a variety of specific and common change factors (Klerman, Weissman, Rounsaville, & Chevron, 1984). Consequently, advocates of IPT might have questioned the use of cherry picking a single or a handful of specific change mechanisms, and theoretical underpinnings, because it was not known whether they would apply when taken out of context.

The performance driven society we live in may also have resulted in a drive to find the psychological therapies that work the most quickly and cheaply. In the UK, the focus on ‘evidence-based practice’ in the NHS may be maneuvering us towards the premature implementation of techniques and models that seek to uniform therapy rather than explore heterogeneity in potential application. For example, the introduction of NICE guidelines (Clark, 2011) and Payment By Results (PBR) to mental health services (Department of Health, 2013). A consequence of this is that the factors therapists bring are in danger of being ignored.

The history of the development of IPT may also explain why process research has been neglected. IPT was initially developed by a group of researchers, who wanted to produce a psychotherapy milieu condition to a randomized controlled trial (RCT) in order to mimic community practice at the time (Klerman, DiMascio, Weissman, Prusoff & Paykel, 1974). No firm evidence for the efficacy of psychotherapy existed at this time, so the researchers set about defining what they thought were important components of good clinical supportive practice. The result was a ‘common-sense’ clinical approach initially termed ‘high contact’ (in contrast to a low therapist contact alternative), that later became IPT (Weissman, 2006). Despite the fact that the research team claimed that IPT was as ‘empirically derived as possible’ (Weissman, 2006;
Markowitz and Weissman, 2012), there are no examples of clear theory-practice links in the IPT manuals or wider literature at this time.

It has only been in the last decade or so, that advocates of IPT have directed their attention towards theory. The first offering came from Stuart and Robertson (2003), who suggested that a triad of theories underpinned IPT: attachment theory (Bowlby, 1969), communication theory (Kiesler and Watkins, 1989), and social theory (Weissman and Paykel 1974). Though the theories themselves were supported by research at the time of publication, none of this research was specific to IPT. More recently attachment theory and interpersonal theory (formerly known as communication theory; Kiesler, 1992, 1996; Horowitz, 2004) has been recognised as the primary theories underpinning IPT; social theory has been relegated to a secondary role (Stuart and Robertson, 2012). A number of studies have focused specifically on attachment theory in IPT, with their findings supporting its elevated position (e.g. McBride, Atkinson, Quilty & Bagby, 2006; Ravitz, Maunder, & McBride, 2008). The most recent account of the theoretical basis of IPT, proposes an interpersonal framework that integrates a number of theories, and research findings to explain the theoretical basis of IPT and its change mechanisms (Lipsitz and Markowitz, 2013). Four mechanisms were proposed:

- IPT increases social support.
- IPT decreases interpersonal stress.
- IPT facilitates the processing of emotions.
- IPT improves interpersonal skills.

Although some of the evidence they used to support their proposals was specific to IPT, most comes from the wider literature and it remains unclear whether or not it is applicable to IPT.
In order to explore how IPT practitioners use theory, it is first helpful to consider the literature concerning the development and epistemology of professional knowledge. Wenger (1998) asserts that becoming a psychotherapist is a process of socialisation into a community of practice. This process involves the gradual learning of the attitudes, beliefs, and norms of their profession (Wollmer and Mills, 1966). In addition research has shown that therapists’ professional, methodological and technical growth and personal development was a long and sometimes even life-long process (Skovholt and Jennings, 2004). This suggests that therapists’ professional self is a product of their training and experiences in psychotherapy. Those wishing to train in IPT come from a range of different professional backgrounds, and consequently, will already have been socialised into different communities of practice, which may influence their IPT practice.

Donald Schön’s theories of reflective practice are directly concerned with the epistemology of professional knowledge. Reflective practice is a popular theory of professional knowledge; is the dominant model of practice across education, health and social care services (Bleakley, 1999). According to Schön and colleagues, therapists develop theories of practice composed of ‘espoused theories’ (what one is able to say about what one knows), and ‘implicit theories’, which may be tacit, or unconscious and are revealed in action. Implicit theories can be compared to the use grammar in speech; they contain assumptions about self, others, and the environment (Argyris and Schön, 1974).

Schön also suggested that two types of knowledge were required for competence in a given profession: technical-rational knowledge (e.g. learning of manualised therapy

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1 In order to ascertain the current state of knowledge in this area literature searches of PsychINFO, PsychArticles, PsychBOOKS, and MEDLINE were performed. Search terms included: (therapy OR psychotherapy) AND (professional, OR knowledge OR development OR theory). Titles and abstracts were scanned for relevance, as were references of relevant papers.
protocols, and formal theories), and professional artistry (e.g. timing of interventions, attention to the therapeutic relationship, and instillation of hope). Schöhn also made the distinction between ‘reflection-in-action’ and ‘reflection-on-action’. Reflection-in-action, involves looking to our experiences, connecting with feelings and attending to theories in use, in order to generate new understanding and change the situation. Reflection on action occurs after the encounter, for example in supervision, and allows time to be spent examining why we acted as we did. As a result, a new set of ideas and questions are generated about our practice (Schöhn, 1983).

Schöhn’s work has been subject to a number of criticisms such as failing to account for the importance of language and interaction in developing shared understandings (e.g. Solomon, 1987), or neglecting the interaction between the professional and the wider social setting (Carr and Kemmis, 1986). Despite this, Schöhn’s meditations on the epistemology of professional knowledge have left an enduring legacy, that have implications for understanding what, if anything IPT therapists might be drawing on to inform their practice. IPT therapists are required to have prior experience in the healthcare or therapeutic professions; Schöhn’s ideas suggest that IPT practitioners might make use of a repertoire of ‘espoused theories’ that they have acquired over the course of their practice, that they use to reflect on their practice in a manner consistent with technical rationality. Schöhn’s ideas indicate that, they might also draw on implicit theories that they are constantly forming, as they encounter, and reflect on new situations in their practice.

In a critique of the development of IPT, Stuart (2008) compares the process by which theory has been appended to IPT as comparable to the process of building the house and then digging the foundation. This is in direct contrast to many other therapies, which have been explicitly developed from a theoretical basis, for example
Cognitive Analytic Therapy (Ryle & Kerr, 2002), Compassion Focused therapy (Gilbert, 2009) and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999). Therapies such as these outline the theoretical basis for therapists to draw on to inform their practice, although whether and how therapists do this is unclear.

It has been suggested that in therapy, a comprehensive theory base is necessary because it informs clinicians about the nature of patient’s difficulties and the different interventions that might be used to facilitate change (Stuart and Robertson, 2012). A psychotherapy theory is a systematic way of viewing therapy, of outlining therapeutic methods to intervene to help others. (Mikulas, 2002), and it helps to organise and to integrate the information therapists receive into a coherent body of knowledge that informs therapy (Prochaska & Norcross, 2003). IPT practitioners have not been afforded the luxury of an empirically supported theoretical framework, and there has been little research directed towards establishing one. Consequently it is unclear whether and how IPT practitioners draw on theory and evidence to inform and explain their practice, or whether the lack of a coherent theoretical impacts on fidelity to the model.

Although attempts have been made to introduce theory to IPT within the last few years, the consequences of this for IPT practitioners are unclear. Literature pertaining to the nature and development of professional knowledge suggests that both implicit and espoused theories are acquired and developed throughout professional life. Consequently, IPT practitioners are likely to draw on previously acquired professional knowledge (espoused and implicit theories) to make sense of their experiences in IPT.

The focus on outcome research also suggests that IPT is seen as a set of methods and techniques that are independent of the therapist using them. However, it has been shown that therapist variables contribute more to outcome than the techniques they use
(Wampold, 2001). The diverse backgrounds of IPT practitioners mean they are likely to hold equally diverse repertoires of theories that they draw on to explain IPT and inform their therapeutic interventions. Therefore, understanding how practitioners are currently negotiating the gaps in theory is important because it is possible that as formal theory is appended to IPT, it will clash with the practitioners existing implicit theories, which could threaten fidelity to the model.

**Objectives**

The aim of the present study was to explore how practitioners draw on theory and evidence to inform their practice.
Methodology

To date no research has been conducted examining the therapy experiences of IPT practitioners. Qualitative methodologies allow detailed exploration of phenomena that are not easily quantifiable, such as experiences of therapy. This is because they are concerned with the experiences of the individual as they live through them and the importance given to the interaction between the researcher and the participant as they negotiate an understanding of the meaning of those experiences (Elliot, Fischer, & Rennie, 1999). Furthermore, qualitative methodologies emphasise the participant’s uniqueness and context, taking the position that reality consists of multiple truths and co-constructed meanings (Yardley, 2000). As such, the current study attempted to understand IPT practitioners’ experiences of the therapy process from their own perspective (Elliot et al., 1999) using a qualitative research design.

IPA

IPA is a qualitative methodology designed specifically to facilitate rigorous exploration of idiographic subjective experiences and social cognitions (e.g. Smith, Harré and Van Langenhove, 1995). It is now well established within British psychology (for a full list of published studies see http://www.psyc.bbk.ac.uk/ipa).

IPA was selected because it was developed specifically to allow detailed examination of subjective experience and social cognitions (e.g. Smith, Harré and Van Langenhove, 1995). Furthermore, IPA is a phenomenological approach aiming to explore experience on its own terms rather than trying to reduce it to predefined and overly abstract categories (Smith, Flowers, Larkin, 2009). To do this, IPA implements a ‘double hermeneutic’; that is the researcher tries to make sense of the participant trying to make sense of their experiences. Fundamentally, IPA is committed to the exploring how individuals make sense of their life experiences (Smith et al., 2009).
IPA was also selected because of its idiographic nature. IPA is committed to the specific and particular. It aims to facilitate an understanding of each individual participant’s experience, and to say something in detail about the participant group. Depth of analysis and detail is one of the primary aims of IPA and it attempts to develop an understanding of how particular people, in a particular context understand particular experiential phenomena such as processes, relationships and events (Smith et al., 2009). Furthermore, rather than making generalisations about larger populations, IPA arrives tentatively at more general conclusions, and only after rigorous analysis of individual cases (Smith & Osborn, 2003; Smith et al., 2009). Thus IPA appears an appropriate tool for investigating the research question, especially given the idiographic and subjective nature of the processes, events and relationships that occur in therapy.

Discourse analysis (DA) was also considered as a method of analysis. However, in contrast IPA, which is concerned with sense-making and cognitions, DA questions whether cognitions can be accessed through language, focusing on language as a function of constructing social reality. Therefore IPA was chosen because it acknowledges cognitions are not transparently available from verbal reports, but it engages with the analytic process in the hope of being able to say something about the sense- and meaning-making involved in such thinking (Smith, Flowers & Osborn, 1997; Smith et al., 2009). As a result, IPA is considered well suited to research attempting to relate findings to bio-psychosocial theories dominant in current understanding in the healthcare professions (Smith, 1996; Willig, 2001).

Grounded Theory was also considered but was rejected because of its demanding sampling strategy, which stipulates that participants are recruited until no further information is found (Glasser and Straus, 1967). This would have been difficult, given the limited time for this study and the limited range of IPT practitioners to draw
on. Therefore IPA was chosen above grounded theory because it strives to produce a more nuanced and detailed account of the personal experiences of a small sample (Smith et al., 2009).
Method

Participants

A purposive sampling strategy was employed to recruit a narrowly defined group, for whom it was hoped the research question would be relevant (Smith et al., 2009). Participants were identified through word-of-mouth, with IPT practitioners providing introductions. The inclusion criteria were that participants must have achieved IPT practitioner status, meaning they had successfully completed four cases under the supervision of an accredited supervisor. Practitioners from different professional backgrounds were considered, which resulted in a sample that differed in some respects (e.g. professional training, preferred therapeutic orientation and past and present areas of clinical practice). However, this variation in professional training and experience is typical of IPT practitioners, who must have qualified in a relevant profession prior to IPT training. Therefore, the sample was considered representative of IPT practitioners and in line with requirements of IPA (Smith et al., 2009), was considered homogenous because all participants shared similar experiences of the topic in question (i.e. they all practiced IPT).

A total of eight practitioners agreed to participate. Seven participants were clinical psychologists, or trainee clinical psychologists and one was a counsellor. Two worked in private practice and had completed or were in the process of completing psychoanalytic training. The remaining six worked in NHS community settings. Six of the participants had achieved supervisor status, meaning they were approved to supervise the work of other IPT practitioners and trainees. All participants were female. The identification of participant characteristics is hoped to provide some context to participants’ accounts. All participants were given a participant information sheet explaining details of the study and provided written consent. Opportunities for debriefing and responding to questions were provided.

2 The pool of IPT therapists in the UK is relatively small. Therefore, in order to protect anonymity only limited contextual and demographic information has been provided.
Professional practice standards were followed, including procedures for data anonymisation and storage (BPS, 2010).

**Ethical approval**

IPT is still in the relatively early stages of implementation in the UK, which means that the pool of IPT therapists it was possible to draw from was relatively small. Consequently there was a risk that practitioners might be identified from their comments. In order to protect the practitioners’ confidentiality, all transcripts were fully anonymised and only minimal demographic information has been included in this paper. Furthermore because the study was enquiring into clinical practice, confidential clinical material was discussed at times. Care has been taken to ensure that all clinical material included in the write up has been fully anonymised. Practitioners were also informed of the limits of confidentiality, and that the researcher had a duty of care to break confidentiality should a situation arise where it was thought that a patient was at risk. Informed consent was obtained from all participants (see Appendices C and D) and a favourable ethical opinion was granted by the University of Surrey Faculty of Arts and Human Sciences (FAHS) Research Ethics Committee (see Appendix E for ethics documents).

**Procedure**

Each IPT practitioner participated in a semi-structured interview conducted by the primary researcher. Semi-structured interviews were loosely guided by an interview schedule (see Appendix B for a copy of the schedule), developed according to principles outlined in Smith, Flowers and Larkin (2009), with the aim of facilitating opportunities for participants to speak reflectively and freely about their experiences. The interview structure was designed to be flexible, to ensure that main areas of interest were covered, and allow participants to explore their experiences in an order that made sense to them. It was used flexibly to encourage participants’ exploration of the research question, glean rich accounts of their perspectives and experiences and capture the vast array of experiences encountered
by IPT practitioners in therapy. Questions followed a ‘funneling’ system (Smith et al., 2009); general topics were tackled first and more focused questions asked towards the end (Smith & Osborn, 2003).

Interviews were between 41 and 63 minutes long. Seven interviews were conducted face-to-face and held at the participants’ place of work; one interview was conducted over the phone. All interviews were carried out at a time convenient to participants. All interviews were digitally recorded and transcribed by the researcher.

**Data Analysis**

Transcripts were analysed according to the principles of IPA (Smith, Jarman, Osborn, 1999). Initially, transcripts were read and re-read in order to develop familiarity with the data. The next stage involved using the left hand margin notes of items of particular interest, associations and comments at a descriptive, phenomenological level. Following this, the interpretive stage was commenced; the right hand margin was used to document inferences made about the meaning of participants’ accounts, and emergent themes were highlighted and connections between themes noted. A list of initial themes was then generated.

Once the above process had been completed for each transcript, similar themes were assimilated across transcripts, taking variability and repetition into account. Meaning was made of the connections and patterns between codes so that initial broad clusters are developed creating emerging superordinate themes and subthemes was developed. Transcripts were continually referred to throughout this process to ensure that interpretation did not lose or change the original meaning.

Yardley (2000) outlines four guidelines that were followed to ensure credibility of the research:

- **Sensitivity to context:** In order to ensure data was collected and analysed sensitively, the research acknowledged the epistemological basis of IPA (Smith et al., 2009;
Smith & Osborn, 2003; Smith et al., 1999; Smith, 1995) ontological matters inherent in qualitative research (Mason, 2002). In addition, sociocultural context was considered. Attention was paid to the researcher’s current training in, understanding of and beliefs about therapy and therapeutic processes. Therefore efforts were made to step out of the ‘natural attitude’ of being a trainee clinical psychologist and adopt a phenomenological attitude (Smith et al., 2009).

- **Commitment to Rigour**: Literature reviews and immersion in data via interviews, transcription and analysis facilitated a prolonged engagement with the topic.

- **Coherence and Transparency**: The researcher kept reflective notes relating to the experience, observations and reflections of different elements in the research process including: recruitment, interviews, transcription and analysis. Supervisors and peers were consulted at each stage of the research to explore and scrutinise interpretations and developing themes, in order to establish credibility and validity. A transparent account of the process of interpretation and meaning making has been described above and is supported by examples of a worked transcript (see Appendix F), lists of initial themes for each participant (see Appendix G) and links between initial and final themes (see Appendix H). Verbatim quotations from participants’ transcripts have been provided to allow the reader to see the original source of interpretation.

- **Impact and Importance**: This was assessed after a review of the literature identified a gap in the current body of knowledge. The discussion section reflects on the importance and impact of the research.

**Reflections**

Prior to commencing this research I had previously worked as a qualitative research assistant and therefore felt reasonably comfortable adopting this methodological approach. Since graduating from university I have developed an interest in social constructionism and
had spent much time thinking about how language is used to construct realities and how these constructions can become truth in their own right. As a result I believed that IPA fitted with my own epistemological stance.

I was aware of my own preconceptions and expectations about the research and how these were likely to be influenced by my experiences. I have previously accessed mental health services and I initially felt more compelled to explore aspect of IPT process from the perspective of those accessing therapy and initially saw little relevance in exploring the experience of IPT practitioners. In addition, during the literature review process I began to notice aspects of IPT that conflicted with my own understanding of human distress. For example, IPT is based on the medical model, promotes the use of the ‘sick role’ and places the clinician in the ‘expert role’.

I was also aware of how my positions as a Trainee Clinical Psychologist, and later a Trainee IPT practitioner were likely to have influenced the way I viewed the interviews. As a result of these experiences I have been exposed to a range of espoused theories, developed my own implicit theories, and have my own relationship to theory. I was interested in how this may have shaped my analysis. For example, I became aware that I was initially paying particular attention to evidence that was consistent or that conflicted with my own ideas. I was mindful to engage deeply with the text when these assumptions occurred to me, in order to remain open to experiences of the participants.
Results

The results of the analysis are presented below. In order to preserve anonymity, pseudonyms have been used to identify participants’ quotes. Themes were grouped under two superordinate themes: *The Different Ways of Relating to Theory* and *Adherence and Integration* (see Table 1).

*Table 1: Superordinate and Sub-themes*

<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>The different ways of relating to theory</th>
<th>Adherence and integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-themes</td>
<td>Theory guides practice</td>
<td>Sticking to the rules</td>
</tr>
<tr>
<td></td>
<td>Theory is sometimes applied retrospectively</td>
<td>The value and management of integration</td>
</tr>
<tr>
<td></td>
<td>The application of theory requires experience</td>
<td>Comparison to other theories and models</td>
</tr>
<tr>
<td></td>
<td>Theory becomes implicit</td>
<td>Repertoire of theories influenced by professional system</td>
</tr>
<tr>
<td></td>
<td>Not just about theory</td>
<td>Attachment theory is key</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managing the elements that resonate or conflict</td>
</tr>
</tbody>
</table>

*The different ways of relating to theory*

There were differences and commonalities in the way that the practitioners described their relationship to theory. Their descriptions of the extent to which, and whether their practice is informed by theory and evidence varied with their level of experience of practicing IPT, and range of other professional training experiences. Most of the practitioners talked explicitly about how theory guided their practice.
Theory guides practice. The practitioners’ accounts of the extent to which theory guided practice varied. Everyone except Jo gave examples of times when theory guided their practice. For example Roxy discussed how attachment theory influenced the way she would conduct assessment and formulation, and Pippa described her use of mentalisation theory to guide her practice.

Well I mean, kind of when you’re assessing a client, you kind of keep an ear out for what you think their attachment style might be, um so and if they appear to have an insecure attachment, kind of use that in the formulation um, and uh talk about that with the client. Roxy (409-412)

Like one of the key things that I did with somebody was increasing his ability to mentalise. Pippa (567-568)

Valerie’s view of how theory guided practice was more definitive; she was the only practitioner to clearly state that she thought IPT was theory driven.

Oh yeh, oh it’s theory driven. There’s no question, there’s no question it’s theory driven for me. Valerie (754-755)

Jo was the only practitioner who could not give an account of how theory guided her practice. Jo thought she was unable to answer the question of whether there were specific theories that she drew on to inform her work.

...which totally didn’t answer your question because I don’t think I can. Jo (287-288)

Theory is applied retrospectively. It was evident that there were times when all of the therapists applied theory retrospectively, to explain phenomena that occurred during their practice. Kate explicitly acknowledged that there were times when she was not necessarily using her espoused theories in an explicit manner. Kate also
acknowledged that she was later able to apply theory retrospectively back and apply theory when reflecting on their practice.

_I don’t know if I would have been aware of [theory] at the time, but afterwards I was aware that, that I wasn’t just making stuff up, that it was really was based in something more concrete._ Kate (652-655)

Sheri also acknowledged that she does not always use her espoused theories to make sense of her practice. Sheri’s comments suggest that she has developed her own tacit understanding of when things in her espoused theories (in this case a theory about neuronal growth) might be occurring, based on the phenomena she has experienced in her practice.

...that’s when I really do start getting into theory, because then you’re talking about the potential for hormonal changes in the brain, which leads to neuronal growth. I don’t think when you’re sitting down as a therapist you’re thinking that, but um, although sometimes I do, but what you’re aware of is that, that it’s that moment of connection that actually changes, that means that the client is open to changing the way they experience something. Sheri (554-562)

**The application of theory requires experience.** Several of the therapists reported that they thought their ability to apply theory, either during practice, or on reflection, was influenced by their perceived level of expertise or experience. Sheri appears to place herself in the position of an expert; she explains that her experiences of teaching, supervision and authoring of academic texts allow her to more easily draw on theory to explain her practice, than those with less experience.

...these are things I think about all the time because I teach and supervise and so I’m in the position I’m in. These things are much more at the tip of my tongue, you know I’ve only just finished writing a chapter this weekend on IPT
and what I think the change mechanisms are and things like that, so you know, so
um it, I think for me it’s at the tip of my tongue. Sheri (768-775)

Roxy and Kate appeared to place themselves in the novice role. Kate questioned
whether her perceived inexperience may explain the difficulties she has applying theory
during her practice. Roxy though that the application of theory might become more
automatic with experience.

...I don’t know if this is because I’m relatively inexperienced, but I
suppose at the time you’re concentrating on just doing it alright that you just kind
of act quite instinctively. Kate (645-658)

...but I’m a trainee so perhaps [the application of theory] will become
more automatic in time. Roxy (458-459)

**Theory becomes implicit.** For all of the therapists it was clear that the theories
and models they had been exposed to throughout their careers became implicit and
influenced their practice. Some of the therapists spoke directly about this process.

*I don’t have to think about the transference, that’s fairly automatic of how
I understand someone.* Sheri (70-72)

*I think as well it becomes implicit in the way that you kind of work so you
don’t necessarily think oh well it’s that theory, so it just kind of comes naturally,
that actually it has got that basis.* Kate (658-661)

For the other practitioners, their unselfconscious use of language reveals that
they are informed by theories and discourses that they do not explicitly identify when
asked about how they use theory. For example, in the following extract Mary uses the
word ‘containing’; she appears to be referring to the psychodynamic process of
containment.

...*I think that’s very containing for a lot of people.* Mary (267-268)
Another example is the use of the term ‘positive reinforcement’ by Pippa, which suggests she behavioural theory is informing her understanding.

*Or they get the positive reinforcement that they need outside of their lives.* Pippa (698-700)

**Not just about theory.** All of the practitioners gave examples of times when things other than formal theory and evidence influenced their practice. For example, Sheri, Roxy and Jo appeared to utilise their clinical experiences of what they found to be helpful to explain and guide their practice. Their comments indicate that at these times, they were making use of practice-based evidence, as opposed to conducting evidence-based practice.

*I suppose that’s where I fall back on saying well you know IPT is a pragmatic approach if it works you do it.* Sheri (471-473)

*Having seen it work so well with patients, um which is the crux of it for me really as a therapist, if it works for the patient, then you can convince me on most things.* Jo (74-77)

All of the practitioners appeared to make use of implicit theories derived from their life experiences and personal values in order to explain the nature of human distress and the process of change in therapy. For example, Jo and Roxy also spoke about times when they were drawing on evidence based on their experiences of life outside of the therapy room to make sense of their practice.

*But uh, for the culture clash, um, no theory in particular, just an awareness of the importance of culture in human life.* Roxy (189-191)

*I think if someone actually is living on the poverty line, um so much of what we do in life, and get pleasure from involves money and I think it’s quite flippant to not accept that.* Jo (651-654)
Mary’s understanding of what constituted effective therapy was influenced by the IPT competencies (or techniques) outlined in the manual, rather than espoused theory. However her comments suggest that she has developed her own implicit theory about how the techniques outlined in the IPT manual can be used to practice ‘good’ therapy.

*It’s about looking at the interweave really, between the general and specific competencies, um the competencies of the focus and the stage of therapy, and it’s the kind of the choreography and the interweave between those, which I think if you, you know it’s a bit like conducting an orchestra, if you can get all the parts to come in in the right place, and play and harmonise, and still keep the tempo, then you’ve got a really beautiful piece of music, and certainly in therapy, you’ve got an opportunity for really effective therapy, if you can keep that interweave in that sort of optimal tempo.* Mary (481-491)

**Fidelity versus integration**

A meta-narrative about therapist’s relationship to the IPT model was present in all interviews. The opinions that the therapists held regarding fidelity to the IPT model varied. Many appeared to hold contradicting beliefs about wanting to adhere to the IPT model, but also wanting to integrate aspects of theory and evidence that they had been exposed to before, during and after training in IPT.

**Sticking to the rules.** Many of the practitioners expressed a belief that they should be adhering to the IPT model and the theories they believed to have been associated to it. Those that were more experienced, for example Holly and Mary expressed that they thought it was important to adhere to the IPT model.

*If you embrace the model, then you embrace it.* Holly (392-393)
...you’ve got to stick to the focal area, if you don’t suddenly the therapy is four years too short. Mary (288-289)

The practitioners that perceived themselves as less experienced appeared concerned about deviating from the model. For example Roxy appeared to think it was important that she refrained from applying theories that had not already been linked to the IPT model.

I mean I definitely draw on those [attachment theory, communication and social theory] I think so, um, and I would try not specifically draw on others because you know that’s the IPT sort of theories. Roxy (156-158)

Pippa appeared concerned that she might be falling back on theoretical models that she had more experience of.

I did obviously find, as you do when you take on a new therapeutic model, you thinking “am I doing CBT, am I falling back on things that I know better? Pippa (447-449)

The value and management of integration. All of the participants except Jo thought that they integrated other theories when practicing IPT. As noted above, the more experienced practitioners thought it was important to adhere to the IPT model. However, the more experienced practitioners also stated with confidence that they thought IPT not only allowed them to integrate other theories, but all theory and evidence they had acquired throughout their careers.

I also felt that it brought together all the things that I’d ever done before. So you know harping back to the early days of my practice when I was using CBT and thinking cognitively, rather than dynamically, you know behavioural experiments and things like that. So it felt as though I could draw on everything I had ever done, which felt very fulfilling and rewarding. Sheri (33-40)
You can bring what you like when you’re thinking about something, so you know, everything, everything I’ve ever learnt about and talked about probably. But it doesn’t stop you from doing IPT really if that makes sense? Holly (163-166)

Pippa, a less experienced practitioner was also concerned about adhering to the model, and also thought that it was possible to integrate other theories. However, her comments show her concern that using theories not already attached to IPT might be seen by some as deviating from the model. This appeared to be related to power, and a fear that those further up the IPT hierarchy might disapprove of her stance.

So I suppose what I’m thinking now that I’m talking to you about which is, I won’t get struck off or anything going to get into trouble or anything am I? This is the worst sin ever [laughs], the theory, like applying the theory perhaps, without having to work within that model? Pippa (638-643)

Despite the tension Pippa appeared to feel, it was clear that she thought integration was possible without compromising fidelity.

...when I was speaking to other people about [working on mentalisation] they were like, “are you allowed to do that, to work on mentalisation in IPT, doesn’t mentalising belong to MBT?” um and I don’t think and I think we do have this tendency, to carve things up and say oh “this fits with this theory so you use this if you’re working in this way”. Pippa (568-574)
Kate, also one of the less experienced practitioners, thought that integration was possible. Kate's surprise suggests that she may have initially shared Pippa's view that integration might not be permitted.

*I was quite surprised at how much scope there was for things I thought there wouldn’t be scope for. So things like creativity, things like using your own ideas and drawing on different kind of approaches even within that model.* Kate (47-50)

Roxy, Pippa and Holly made the distinction between drawing on theory to inform their thinking about their practice, and explicitly applying techniques from other models. They appear to highlight a key difference between applying theory and technique.

*I guess CBT does come into it a little bit as well. Just you know thinking about cognitive processes. So I wouldn’t necessarily apply it, but in the back of my mind I think, well this lady was you know was having feelings and thoughts, you know negative feelings and thoughts about herself and other, and world views and I guess that’s sort of in the back of my head, but I’m not directly using CBT techniques, but that’s how I’m kind of making sense of it really in my head.* Roxy (164167)

*I think you can touch upon these things [theories] without having to necessarily shift into that mode where now I’m doing behavioural activation or now I’m doing challenging learned helplessness. You can reflect them to people, and you can touch on them.* Pippa (599-603)

...we could think about that in CBT terms, but I won’t you know talk about core beliefs and so on and events happening and all of that being challenged.

Holly (224-226)
To summarise, all of the practitioners except Jo thought that they integrated other espoused theories to inform their practice. Two of the most experienced practitioners confidently stated that it allowed them to integrate everything they had ever learned, without compromising fidelity to the model. The less experienced practitioners also thought integration was possible. However, one of them appeared concerned that others might consider this heretical. This may be related to power, with the less experienced therapists feelings as though they needed to conform to the perceived rules of IPT dictated by more experienced practitioners.

**Comparison to other models and theories.** All of the practitioners had completed professional training prior to IPT that included: psychoanalytic training, clinical psychology, counselling psychology and counselling training courses. The practitioners' training would have included teaching on a variety of theories, models and evidence. IPT does not have formal foundations of espoused theory, so it is up to practitioners to make theory-practice links. One of the ways practitioners in this study appeared to do this, was to compare IPT to other theories and models in their repertoire of espoused theories. For example, Mary compares the experience of reconstructing an interpersonal event in IPT to the process of thought challenging in CBT.

*I suppose by definition, the reconstructing might involve actually challenging, some of the ways that someone has remembered thinking and feeling about the event.* Mary (365-367)

Jo and Kate rationalised the process of getting patients to try out new things, by comparing it to behavioural experiments found in the CBT model.

*I think in a way kind of the, in a semi-behavioral experiment kind of way, which isn't specific in that way, but that trying you, you say "can you actually just go somewhere this week and talk to someone".* Jo (482-485)
IPT is very much about going out there and trying things and looking at the impact, so in that way it's got kind of a CBTish kind of um influence as well. Kate (268-270)

Roxy compared the process of exploring role expectations and analysing communication to the theory of mentalisation.

...[mentalisation] is kind of what you're doing in, you know when you look at people's role expectations and all sorts of other, and communication analysis and um, yeh, that's often, yes I guess that's one of the theories. Roxy (304-307)

Kate rationalised the process of diagnosis by comparing it to the process of externalising in narrative therapy.

I was thinking about [diagnosis] in Narrative terms, so it's like externalizing in narrative therapy, you know it's not something about the person that means they've got depression; depression's this kind of thing, and you might call that the black monster in narrative therapy or you might give a diagnosis in IPT, I'm not sure there's that much difference in the effect, it seems to be the same. Kate (302-309)

**Repertoire of theories is influenced by professional systems.** All of the therapists except Jo reported that the theory and evidence that they drew to inform their practice of IPT was influenced by their personal interests, and the interests of those in their professional systems such as supervisors and trainers.

Once you start working you're influenced by the things that you're interested in and the things that you know about and you're influenced by the things that your supervisor's interested in and know about. Pippa (678-681)

A lecturer did a CPD training day and she started to talk about it, and what's happened since then is, I've started to talk about it with my trainees and
we're thinking about it more, in terms of our thinking, it's more explicitly referred to and um, and actually they're now trying to write it in their case studies. Holly (295-300)

I think the psychoanalytic training that I've had means there's a whole load of processes going on without me even thinking about it. Sheri (68-70)

Attachment theory is key. Jo was the only practitioner not to mention attachment theory, and this was because she was unable to provide a theoretical account of IPT. However the rest of the practitioners thought that attachment theory was a key theory that they drew on to guide and explain their practice.

Well I think you know possibly it starts with attachment. Holly (170)

When I think about the literature that I draw on you know and this isn't going to making you surprised hopefully, it's the psychodynamic literature. It's the literature about attachment. Valerie (744-747)

Managing the elements that resonate or conflict. Most of the therapists spoke about the IPT model, or specific aspects of it that resonated or conflicted with their personal and professional knowledge, values and experiences. For example, Mary though that IPT was compatible with her existing approaches to understanding and working with individuals with a diagnosis of depression

As a psychologist thinking about a biopsychosocial model of mental health, the emphasis on um interpersonal relationships, made the model of IPT seem congruent to other ways that I'd been working and thinking about depression. Mary (99-103)

Valerie also thought that IPT was compatible with her existing knowledge and practice, and also with her vision of how she might develop as a practitioner.
IPT came along and I leapt at it frankly because it fitted with my thinking about psychodynamic, it fitted alongside my ideas that had grown in terms of psychodynamic psychotherapy and it was a brief treatment, it was evidence based, I fundamentally view myself as an evidence based practitioner, even though I’m now training to become a psychoanalyst um and so it fitted with all of those sorts of things really. Valerie (57-65)

However, Roxy described how the medical model, the basis for understanding distress in IPT, conflicted with her own understanding of the nature of human distress.

I mean I don’t see depression in any way shape or form as an illness, myself personally, I see it as an experience of distress that’s caused socially and that it’s just sort of natural and probably evolutionary based reaction, so, but you know so it’s not in an illness in the same way that a cold is an illness, so I don’t think of it as an illness philosophically. Roxy (500-505)

Kate described the discomfort she felt about utilising the medical model and the sick role. Kate’s attempts to resolve her discomfort can be seen above, when she compares the process of diagnosis to externalising in Narrative Therapy.

I mean I was saying that it can feel a bit uncomfortable wanting to diagnose depressions and give someone the sick role because that feels quite medical and we maybe, that’s not something that we maybe want to align ourselves with. Kate (285-289)

These results demonstrate a range of ways that the IPT practitioners interviewed negotiate the gaps in IPT’s theoretical foundations. The relevance and implications of these results will be explored in the discussion.
Discussion

This study aimed to investigate how IPT practitioners draw on theory and evidence to inform their practice. The results show how the practitioners negotiated the gaps in the theoretical underpinnings of IPT in a conscious and unconscious manner. The way that the practitioners drew on theory and evidence was elucidated by their use of explicit narratives and their uninhibited use of language. Consistent with existing theories of professional knowledge (Agyris and Schön, 1974; Schön, 1983), the practitioners drew on formal espoused theories, their own implicit theories, and applied theory retrospectively and ‘in-the-moment’ during their practice. The way in which the practitioners drew on theory and evidence appeared to be related to a number of factors, such as: their professional context, perceived level of experience, and their values and experiences.

Understanding the links practitioners make between theory and practice in IPT are important because of the atypical relationship IPT has to theory compared to other therapeutic models, which has resulted in a relative lack of theorisation about why or how IPT works. Consequently the job of plugging the gaps in IPT’s theoretical basis has largely been left to practitioners. The results of this study demonstrate the ways in which practitioners negotiate this task.

Comparison to existing literature

The range of espoused theories that the practitioners drew on appeared to be influenced by their professional systems such as supervisors and training experiences. This is consistent with research in which therapists have rated supervision as one of the most influential factor in their professional development (Orlinsky, Rønnestad et al., 2005), and the idea that therapists become socialised into a community of practice (Wenger, 1998). IPT practitioners are required to have completed previous training in a
relevant field. This means that they will have had previous experiences of supervision and training and professional practice, which, in addition to their experiences of training and supervision in IPT, were likely to have influenced the range of theories that they had to draw from.

Although a range of espoused theories were mentioned, attachment theory was the only theory referred to by all of the practitioners (with the exception of Jo, who could not explicitly refer to espoused theory). This may reflect the fact that attachment theory has been adopted as a key theory underpinning IPT (Stuart and Robertson, 2012). The implication of attachment theory in IPT is beginning to gain empirical support (e.g. McBride, Atkinson, Quilty & Bagby, 2006; Ravitz, Maunder, & McBride, 2008). However, it might also reflect the current fashion in the understanding of human distress that is highlighted by the fact that there are more than 20000 journal articles on attachment theory listed in EBSCO, an international electronic research database (Keller, 2012).

The practitioners’ prior professional training may also have impacted on the extent to which they perceived their practice to be guided by espoused theory. Jo was a counsellor prior to commencing IPT training, whereas the other practitioners had all completed or were in the process of completing professional qualifications in clinical psychology. Since the notion of the scientist-practitioner was introduced in 1949 (Raimy, 1950), clinical psychology training programs have prided themselves on producing psychologists that are able to systematically apply espoused psychological theory to their practice. Therefore it is likely that the practitioners that came from a clinical psychology background were experienced in making theory-practice links, and thus were more likely to approach their IPT work in this way, or feel that this was what they ought to convey when interviewed.
Practitioners who considered themselves less experienced, expressed uncertainty or anxiety about integrating other espoused theories. This is consistent with research that has demonstrated that novice therapists are concerned with their therapeutic efficacy, anxious in their new role, self-critical, and filled with self-doubt (Bischoff, Barton, Thober & Hawley, 2002; Hill, Knox & Schlosser, 2007; Howard, Inman & Altman, 2006). Others have found that therapists gain more confidence in their abilities and feel more freedom to develop their own style as they become more experienced (Carlsson, Norberg, Sandell, & Schubert, 2011). This may explain why the more experienced practitioners felt more comfortable with integration. Furthermore, the less experienced practitioners may also have been influenced by power. The discourse surrounding fidelity and integration that came from the more experienced practitioners was that it was important to adhere to the IPT model, and that the application of theory requires experience. The less experienced practitioners may have experienced similar discourses from those in their professional system, resulting in the anxiety the therapists expressed.

The range of different implicit theories held by the practitioners is congruent with suggestions that all therapists are theoreticians who have unique ideas about how the world works and how therapy should be conducted (Burrell, 1987; Kottler, 1986; Schön, 1983). Regardless of which theories the practitioners espoused, they all had individual notions about how to practice. Najavits (1997) argues that therapists’ implicit theories are their private assumptions about how to conduct therapy that can be distinguished from, but coexist with their espoused theory. The practitioners’ use of implicit theory may be to be related to the fact that IPT does not have an empirically supported espoused theory. It has been suggested that therapists develop these implicit theories because the formal or explicit theories do not always address the problems that
therapists encounter in practice (Sandler, 1983). Therefore, one of the ways that IPT practitioners appear to plug the theoretical gap they are faced with, is by generating their own implicit theories.

Najavits (1997) suggested that the theories proposed in a particular therapy might compete against the implicit theory held by a therapist. This was something the practitioners in this study appeared to experience, particularly in relation to the medical model and sick role (two of the only espoused theories in IPT). They resolved the conflict they experienced over the use of the medical model and sick role by either drawing on other espoused theory to rationalise its presence (e.g. narrative therapy); or by generating implicit theories about how it facilitated change. This supports the idea that the extent to which therapists rely on espoused theory varies, and that whether and which espoused theory they choose is partly based on how well it corresponds with their implicit theories (Shohen, 1962). Research has also shown that therapist choice of theoretical orientation is in part determined by how it fits with their existing implicit theories (Poznanski and McLennon, 1995).

Implications

It is important to explore the links IPT practitioners make between theory and practice because of the atypical nature of IPTs development. Other therapies, such as CBT, are comprised of a collection of strategies and procedures that directly focus on different aspects of human distress (such as thoughts and behaviours), that have been designed to be used in concert with the aim of addressing the maintaining mechanisms proposed by the model. In contrast, we know that IPT works, but we do not have a coherent understanding of why or how. Furthermore, the lack of clear theory or evidence underpinning IPT makes it difficult to assess which aspects of IPT result in successful outcomes and which aspects distinguish it from other therapies. As a result
IPT has to be used as the whole manualised package each time, because it is not possible to discriminate between the important and unimportant aspects.

The nature of the development of IPT means that it is possible that some of its components were incidental, and were added to the manual for general clinical use because they fitted the zeitgeist at the time. For example IPT was developed in the 1970s when the medical model prevailed, hence the assumption that ‘depression’ has a biological basis and the inclusion of the sick role. This means that practitioners might be reluctant to use parts of IPT because they disagree with aspects of it, such as the sick role, or diagnosis, which may not be crucial to IPT. On the other hand they might avoid, or adapt the aspects of IPT that they have a problem with. However it is then not clear whether what they are practicing is really ‘IPT’, because the aspects they omit may be crucial to the process of change.

This study provides evidence that practitioners sometimes replace or amend espoused theories such as these, if they conflict with their own implicit theories. This is something that has actually happened at the top of the IPT hierarchy; Stuart and Robertson (2012) have abandoned the sick role from the iteration of IPT because it does not fit with their own implicit theories, despite others in the field maintaining that it is important.

Lipsitz and Markowitz, (2013) acknowledge that one approach to understanding the mechanism of change in IPT is to dismantle the therapeutic components, in the same way that Jacobson did in his study comparing cognitive behavioural therapy for depression to its behavioural component alone (Jacobson, 1996). To date, no such research has been carried out in IPT and some have suggested that it would be too difficult to dissect the intervention into viable parts (Murphy, 2009). Even if it was possible to carry out research that assessed contribution of individual components of
IPT, if this was done in the absence of theory there is a danger that it would produce a miscellany of techniques that lacked theoretical coherence. Furthermore, in research settings fidelity is examined, but in clinical settings clinicians may be poor observers of their own practice.

Due to the nature of development of IPT, it is possible that theory might be added in because it is currently in fashion (e.g. attachment theory). As a result IPT might be fundamentally changed for some, whilst others may resist embracing it because they are reluctant to move away from the implicit theories they have developed over the course of their careers.

Consideration of how practitioners make use of espoused and implicit theories could be helpful in establishing theoretical underpinnings for IPT. However the less experienced therapists were concerned that others in the field might judge them negatively if they were to find out they deviated from the model, or that they utilised their own implicit theories or espoused theories from other orientations. This is congruent with suggestions that therapists hide their implicit theories because they believe that their actions in therapy are not “kosher” and that they would be criticised by colleagues if they found out (Sandler, 1983) and that less experienced therapists feel the need to conform to their chosen model (Carlsson, Norberg, Schubert, & Sandell, 2011). However, as others have argued these implicit theories could give birth to espoused theories (Sandler, 1983; Sternberg, 1985), which could lead to increased understanding and innovation in IPT.

Limitations of study and directions for future research

Although the results of this study are likely to have transferability, the nature of the qualitative methodology used in this study limits the ability to generalise from these findings. The nature of IPA allowed for a rich understanding of how IPT practitioners
draw on a rich array of formal and implicit theories, in a variety of different ways. However the consideration of the epistemology of professional knowledge only occurred after it was noted to be relevant to the practitioners’ dialogues. Consequently, the questions asked during interviews were not necessarily aimed at exploring the practitioners’ espoused and implicit theories specifically; this would be an area that warranted further examination. Furthermore, although psychology originated in implicit theory, there has been little research on this topic as it relates to therapists. Further research into the implicit theory concept might establish whether it can be used to increase effectiveness or to create research that would help us to understand the variability amongst therapists. It might also be helpful to explore how therapists’ implicit theories differ from their espoused theories, and whether their implicit theories could be used to fill gaps in formal espoused theories such as IPT.

Conclusion

The present study’s exploration of how IPT therapists account for theory and evidence provides an insight into how practitioners negotiate working within a therapeutic model that does not have a clear theoretical basis. The practitioners drew from a number of different implicit and espoused theories in order to inform their practice. A number of factors influenced which theories they chose to adopt, and those that they adapted or dismissed. This highlights potential implications of appending new theories to IPT, and indicates that it may be helpful to consider how practitioners already make use of theory, when trying to establish the theoretical basis of IPT.
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Appendix B

Interview Schedule
Interview Schedule

- Tell me a brief history of your practice of psychotherapy to date, from when you started to now?

- Describe what it is like to practice IPT in your own words?

  *Prompt: How do you feel, what are you thinking?*

- What is it that you are trying to do when you practice IPT?

- What effect do you think your practice of IPT has on your patients?

- Could you tell me about a time when you feel IPT has facilitated change in a patient?

- What do you think happens in your practice of IPT that produces change in patients?

  *Prompt: Between you and the client? In your client? Between your client and other people?*

- What informs your understanding of how change happens in IPT?

- If you had to describe key elements of process in IPT, what would you say?
Appendix C

Participant Information Sheet
Participant Information Sheet

Full Project Title: What is the experience of delivering IPT like for therapists and what informs their understanding of the therapy process?

Researcher: Jennifer Foster (Trainee Clinical Psychologist)
Email: j.e.foster@surrey.ac.uk

Research Supervisors: Dr. Kate Gleeson and Susan Howard

My name is Jen Foster and I am a Trainee Clinical Psychologist. I would like to invite you to take part in a research study. I am interested in learning about IPT therapists’ therapy experiences.

Consent
You are invited to take part in this research project. This statement contains detailed information about the research project and its purpose is to explain to you as clearly and openly as possible all the procedures involved in this project so that you can make a fully informed decision whether you are going to participate.

Purpose
I am planning on interviewing a sample of interpersonal psychotherapy (IPT) therapists about their experiences of practicing IPT and what informs their understanding of the process of IPT. To date, most IPT research has focused on outcomes. Whilst demonstrating efficacy is important it appears to have been at the expense of research that focuses on developing an understanding of the process of change in IPT from the perspective of the therapist. Importantly, everyone’s experiences of therapy will be different. I would like to find out about your experience of practicing IPT. I am conducting this research project under the supervision of Dr. Kate Gleeson and Susan Howard. A total of 10 IPT therapists are estimated to participate in this project.

Why have I been invited?
I am asking IPT therapists to take part in this study.

Do I have to take part?
No. It is up to you to decide whether or not you want to take part. If you decide to take part you will be given this information sheet to keep and asked to sign a consent form. The consent form is a way of making sure you know what you have agreed to. If you decide to take part you will be free to withdraw up to two months after the date of the interview and you do not have to give a reason.

What will happen next?
If you would like to take part please tell the person who gives you this information sheet and I will get in contact. Or you are welcome to contact me directly. We can then arrange a time and place to conduct the interview that is convenient to you.

Who is funding this research?
This research is primarily funded by the University of Surrey Clinical Psychology Training Programme.

**What does taking part involve?**
Participation in this project will involve taking part in one semi-structured interview, which may last up to one hour. The interviews will be recorded so that the dialogue will be transcribed. You will be free to stop the recording at any time during the interview. The themes of the interviews will be focused on your experiences and understanding of what happens in IPT sessions between you and your client.

All information will be stored and processed in the strictest confidence and held in accordance with the data protection act (1998). All identifying information will be removed during the transcription process and quotes may be used for the write up of this research and any resulting journal articles. Only my supervisors and representatives from academic and professional bodies, and I will be privy to anonymised transcripts. I will only share information obtained during the interview process if I thought somebody was at risk of harm.

**What are the disadvantages to taking part?**
There is a small possibility that our meeting may cover topics that are difficult or distressing for you to talk about. However if you do not continue you can end the interview at any time. You can also take a break at any time.

**What are the benefits to taking part?**
There are no direct benefits to taking part in this study. However, the interviews may provide you with an opportunity to reflect on your clinical work. The information we learn from this study may help plan future research and inform future psychotherapy and service developments.

**What will happen to the results of this study?**
If you wish, I will proved you with a summary of the results of the study. The final results and conclusions of the study may be published in a peer-reviewed academic journal and will form part of my qualification in clinical psychology.

**Who has reviewed the study?**
This study has been reviewed by the University of Surrey Faculty of Arts and Human Sciences Ethics Committee (FAHS EC) to ensure that it meets important standards of ethical conduct.

*Thank you very much for reading this and for any further involvement with this study.*
Appendix D

Consent Form
Consent form

**Name of study:** What is the experience of delivering IPT like for therapists and what informs their understanding of the therapy process?

**Name of Researcher:** Jennifer Foster (Trainee Clinical Psychologist at the University of Surrey).

- I agree to being interviewed for the research project to explore therapist experiences of IPT.
- I have read and understood the Information Sheet.
- I understand that my decision to take part in this project is entirely voluntary.
- I have been given information by the researcher about what the project is about, where and why it is being done, and how long it is likely to take.
- I have been given information by the researcher of what I will be expected to do.
- I will tell the researcher immediately if I become upset or worried by any questions that I am asked during the interview, or if I have any concerns afterwards. I have been given the opportunity to ask the researcher questions about the research and have understood the answers to all of the questions I have asked.
- I understand that all personal data is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I have been informed that audio recordings will be destroyed once the study has been completed and that written transcripts will have any information that could identify me will be taken out to ensure my anonymity.
- I am happy for the researcher to write about what I say during the interview and publish this as long as this information remains anonymous. I understand that quotes from the interviews may be used, but these will be made anonymous.
- I understand that I can change my mind about participating in the study up to two months after I sign this consent form and I don’t have to give a reason for wanting to do this.
- I have read and understood everything written above and have chosen to consent to participating in this study. I have been given enough time to think about this and agree to comply with the instructions and restrictions of the project.

Name of participant (BLOCK CAPITALS)

Signed

Date

Name of researcher/person taking consent (BLOCK CAPITALS)

Signed

Date

Jennifer Foster, Trainee Clinical Psychologist, University of Surrey. Phone Number:
Appendix E

Ethics Documents
Dear Jennifer

Reference: 809-PSY-12
Title of Project: What informs IPT therapists understanding of the therapy process?

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has now given a favourable ethical opinion.

If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.

Yours sincerely

Professor Bertram Opitz
Chair
Chair’s Action

Ref: 809-PSY-12

Name of Student: JENNIFER FOSTER

Title of Project: What informs IPT therapists understanding of the therapy process?

Supervisor: DR KATE GLEESON

Date of submission: 6TH NOVEMBER 2012

Date of re-submission:

The above Project has been submitted to the FAHS Ethics Committee.

A favourable ethical opinion has now been given.

Signed: Professor Bertram Opitz
Chair

Dated: 04/12/12
Appendix F

Example of a Worked Transcript
And did, when you think about that now, when you look back at it, or at the time do think there are any theories that underpin that?

L: Yeh, well theories underpinning it, well possibly, um, communication theory and looking at patterns of communication and how they work. Um, in my mind of course attachment theory came into it for her somewhat. She had, uh, attachment issues and she uh, you know had difficulty in forming relationships, so the women that she sort of quite liked, she tended to sort avoid or not make overtures towards, because she assumed that she'd be rejected, you know the way that her mother had been. So, so it was a way of not getting kind of close to people. So, and also maybe social theory, the kind of social support or lack of came into it somewhat.

J: And um do you think that they're just related to that client in particular or do you think its something that you see in all your clients?

L: Well, I mean like a lot of theories if you use it, you can see it. So you can use those lenses to sort of make sense of quite a few different situations. So you know I do see it applying definitely. Yeh, yeh.

J: Um, so are, um in general when you're working with IPT are they the theories that you're drawing on? If you're drawing on any?

L: Yeh, um, I mean I definitely drawing on those three. I think so, um, and I would try not specifically draw on others because you know that's the IPT sort of theories. Um, but I guess that I just more generally draw on the wider ideas or theories about you know human beings being social animals. So you know, just [long pause] I guess CBT does come into it a little bit as well. Just you know thinking about cognitive processes. So I wouldn't necessarily apply it, but in the back of my mind I think, well this lady was you know was having feelings and thought, you know negative feelings and thoughts about herself and other, and world views and I guess that's sort of in the back of
my head, but I'm not directly using CBT techniques, but that's how
I'm kind of making sense of it really in my head.

J: So you kind of made sense of how your clients are presenting sort
of using the CBT theory that you were first taught.

L: Yeh, yeh, but just somewhere in the back of my mind yeh.

J: One thing I noticed when you were talking about the lady who was
having problems at work. You talked a little bit about the difference
between her and her colleagues

L: Yes, yes

J: Yeh, and I wondered whether you can sort of think of any theories
that would encompass that.

L: Um, well, basically it was a clash of two cultures, she was a middle class girl,
woman should I say, and she because of her various difficulties she
didn't get a middle class job, she got a job working with more kind of
working class people. So she didn't feel as though she fitted in and
she didn't, she had a whole different set of assumptions and world
views and hobbies. And that was one of the problems you know, she
didn't fit in she was culturally quite different. So that's one of the
things we came to understand, but I don't know whether I had a
particular theory for, just you, maybe role expectations, trying to use
IPT, the role expectations of some of from a middle class colleague
are quite different to those of a working class colleague. So I guess I
used role expectations. But uh, for the culture clash, um, no theory in
particular, just an awareness of the importance of culture in human

J: u huh. So I guess we're talking about IPT today, but um my
understanding of how it was developed was that the theory was kind
of appended to it

L: Yes, yes like lots of the therapies
Appendix G

Tables of Themes for each Practitioner
Table G1. Initial Themes - Pippa.

<table>
<thead>
<tr>
<th>Theory guides practice</th>
<th>Getting it right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory is sometimes applied retrospectively</td>
<td>Believe in integration but not sure it's 'allowed'</td>
</tr>
<tr>
<td>Theory becomes implicit</td>
<td>Comparison to other theories and models</td>
</tr>
<tr>
<td>Influenced by life experiences</td>
<td>Repertoire of theories influenced by professional system</td>
</tr>
<tr>
<td></td>
<td>Attachment theory is key</td>
</tr>
<tr>
<td></td>
<td>IPT fits</td>
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</table>
Table G2. Initial Themes - Kate

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<thead>
<tr>
<th>Theory guides practice</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>I might get better with experience</em></td>
<td><em>Comparison to other theories and models</em></td>
</tr>
<tr>
<td><em>Retrospective application of theory</em></td>
<td><em>Repertoire of theories influenced by training and supervision</em></td>
</tr>
<tr>
<td><em>Theory becomes implicit</em></td>
<td><em>Attachment theory is key</em></td>
</tr>
<tr>
<td><em>Influenced by life experiences</em></td>
<td><em>IPT fits</em></td>
</tr>
<tr>
<td></td>
<td><em>IPT conflicts</em></td>
</tr>
</tbody>
</table>
Table G3. Initial Themes - Jo

<table>
<thead>
<tr>
<th>Not theory driven</th>
<th>Comparison to other theories and models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory is sometimes applied retrospectively</td>
<td></td>
</tr>
<tr>
<td>Implicit theory</td>
<td></td>
</tr>
<tr>
<td>Practice based evidence</td>
<td></td>
</tr>
<tr>
<td>Influenced by life experiences</td>
<td></td>
</tr>
</tbody>
</table>
**Table G4. Initial Themes - Holly**

<table>
<thead>
<tr>
<th>Theory guides practice</th>
<th>Sticking to the rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory is sometimes applied retrospectively</td>
<td>Integration</td>
</tr>
<tr>
<td>The application of theory requires experience</td>
<td>Comparison to other theories and models</td>
</tr>
<tr>
<td>Theory becomes implicit</td>
<td>Repertoire of theories influenced by training and supervision</td>
</tr>
<tr>
<td>Practice based evidence</td>
<td>Attachment theory is key</td>
</tr>
<tr>
<td>Influenced by life experiences</td>
<td>IPT fits</td>
</tr>
</tbody>
</table>
Table G5. Initial Themes - Mary

<table>
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<tr>
<th>Theory guides practice</th>
<th>Fidelity to the model is important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory is sometimes applied retrospectively</td>
<td>Integration</td>
</tr>
<tr>
<td>Theory becomes implicit</td>
<td>Comparison to other theories and models</td>
</tr>
<tr>
<td>Competencies are important</td>
<td>Repertoire of theories influenced by training and supervision</td>
</tr>
<tr>
<td>Influenced by life experiences</td>
<td>Attachment theory is key</td>
</tr>
<tr>
<td>Practice based evidence</td>
<td>IPT fits</td>
</tr>
</tbody>
</table>
Table G6. Initial Themes - Valerie

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<tr>
<th>IPT is theory driven</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective application of theory</td>
<td>Comparison to other theories and models</td>
</tr>
<tr>
<td>Theory becomes implicit</td>
<td>Repertoire of theories influenced by training and supervision</td>
</tr>
<tr>
<td>Not always reliant on theory</td>
<td>Attachment theory is key</td>
</tr>
<tr>
<td></td>
<td>IPT fits</td>
</tr>
</tbody>
</table>
Table G7. Initial Themes - Roxy

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<th>Theory guides practice</th>
<th>Sticking to the rules</th>
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<td>Theory is sometimes applied retrospectively</td>
<td>Integration of theory but not technique</td>
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<tr>
<td>I might get better with experience</td>
<td>Comparison to other theories and models</td>
</tr>
<tr>
<td>Theory becomes implicit</td>
<td>Repertoire of theories influenced by training</td>
</tr>
<tr>
<td>Influenced by life experiences</td>
<td>Attachment theory is key</td>
</tr>
<tr>
<td>Not always reliant on theory</td>
<td>IPT fits</td>
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<tr>
<td></td>
<td>IPT conflicts</td>
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</table>
### Table G8. Initial Themes - Sheri

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<tr>
<th>Theory guiding practice</th>
<th>IPT allows integration of everything</th>
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</thead>
<tbody>
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<td>Retrospective application of theory</td>
<td>Comparison to other theories and models</td>
</tr>
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<td>The application of theory requires experience</td>
<td>Repertoire of theories influenced by training</td>
</tr>
<tr>
<td>Theory becomes implicit</td>
<td>Attachment theory is key</td>
</tr>
<tr>
<td>Practiced based evidence</td>
<td>IPT fits</td>
</tr>
<tr>
<td>Influenced by life experience</td>
<td>Sticking to the model is important</td>
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</tbody>
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Appendix II

Table demonstrating Links Between Initial and Final Themes
Table H1. Demonstrating links between initial and final themes

<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>The different ways of relating to theory</th>
<th>Adherence and integration</th>
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<tbody>
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<td>Sub themes</td>
<td>Theory guides practice</td>
<td>Sticking to the rules</td>
</tr>
<tr>
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<td>- <em>Theory guiding practice</em></td>
<td>- <em>Getting it right</em></td>
</tr>
<tr>
<td></td>
<td>- <em>IPT is theory driven</em></td>
<td>- <em>Fidelity to the model is important</em></td>
</tr>
<tr>
<td></td>
<td>- <em>Not theory driven</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Theory is sometimes applied retrospectively</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <em>Retrospective application of theory</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The application of theory requires experience</td>
<td>Comparison to other theories and models</td>
</tr>
<tr>
<td></td>
<td>- <em>I might get better with experience</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Theory becomes implicit</td>
<td>Repertoire of theories influenced by professional system</td>
</tr>
<tr>
<td></td>
<td>- <em>Implicit theory</em></td>
<td>- Repertoire of theories influenced by training and/or supervision</td>
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<td></td>
<td>Not just about theory</td>
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</tr>
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</tr>
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<td></td>
<td>- <em>Influenced by life experiences</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <em>Competencies are important</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managing the elements that resonate or conflict</td>
<td>- <em>IPT fits</em></td>
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<tr>
<td></td>
<td></td>
<td>- <em>IPT conflicts</em></td>
</tr>
</tbody>
</table>
Major Research Project Proposal

What is the experience of delivering IPT like for therapists and what informs their understanding of the therapy process?

Year 1
August 2012
Word Count: 2663
**Background and theoretical rationale**

Interpersonal psychotherapy (IPT) is a brief psychological intervention aiming to reduce distress and improve interpersonal functioning. Although initially developed for treatment of individuals with a diagnosis of depression, it has recently been adapted for use with individuals with a range of presenting difficulties and is recommended by the National Institute for Health and Clinical Excellence (NICE; 2009) for individuals with a diagnosis of depression and has been adapted for use with a variety of presenting difficulties. The focus of IPT is on interpersonal relationships as a way of bringing about change; the goal is to help patients improve their interpersonal relationships or change their expectations about them. IPT also aims to facilitate improvements in patients’ social support networks in order that they can better manage interpersonal distress (Stuart and Robertson, 2003).

IPT formulates distress and interpersonal difficulties as arising out a combination of interpersonal and biological factors, following the bio-psychosocial stress-vulnerability model. Social factors, including existing social and support and relationships provide the context for this stress-vulnerability interaction to occur. At the end of the assessment phase of therapy, patients choose one of four interpersonal areas to work on for the remainder of therapy: role disputes, grief, role transitions or sensitivities. The premise of IPT is that it facilitates an improvement in mood by tackling current interpersonal difficulties and helping patients develop strategies for the future (Weissman, Markowitz, & Klerman, 2000).

IPT was first developed for use in research settings. Researchers combined the ‘common factors’ of psychotherapy process, which were then codified in the IPT manual developed by Klerman and colleagues (1984). Other than employing ‘common factors’, theory underlying IPT process was not considered until after efficacy was
established. Stuart (2008) describes this as analogous to building a house before digging the foundations. Despite this, theory is beginning to be appended to IPT and it is now widely believed there are a triad of underpinning theories including: attachment theory (McBride, Atkinson, Quilty & Bagby, 2006; Ravitz, Maunder, & McBride, 2008), communication theory (Kiesler and Watkins, 1989), and Social theory (Henderson, Byrne, & Duncan-Jones, 1982; Weissman and Paykel, 1974).

Research shows that most patients undertaking psychological therapies make improvements and this is true for IPT. Of the outcome studies conducted over the last three decades, most indicate IPT is an effective therapy for individuals with a diagnosis of depression across the lifespan, cultures and settings (Bolton et al., 2003; Frank, Kupfer, Perel & Cornes, 1990; Mufson et al., 2004; Weissman, Markowitz & Klerman, 2007). Comparatively few studies have produced negative or ambiguous results (Lesperance et al., 2007; Markowitz, Kocsis, Bleiberg, Christos & Sacks, 2005). In addition, a recent meta-analysis indicated IPT is a well-evidenced intervention for individuals with a diagnosis of depression (Cuijpers, et al., 2011).

The focus on outcome in psychotherapy research appears to have been at the cost of cultivating an understanding of the process of change in therapy. Most existing process research is quantitative and nomothetic; attempting to evaluate process using pre-determined categories, or by using pre- and post-treatment measures of 'symptoms'. IPT is no exception with the majority of process research focusing on associating predefined elements of process with outcomes (see Ravitz et al., 2011 for a review), describing IPT process using objective measures (e.g. Albon & Jones, 1999) or looking for differences in process between IPT and CBT (e.g. Connolly-Gibbons et al., 2002; Connolly-Gibbons, Crits-Christoph, Levinson, & Barber, 2003; Coombs et al., 2002; Crits-Christoph et al., 1999; Crits-Christoph, Gibbons, Temes, Elkin, & Gallop, 2010).
Although the majority of IPT research has employed quantitative methodologies, four studies have looked at IPT process using qualitative methods. These were conducted in New Zealand and used thematic analysis and discourse analysis to look at the process of change over IPT sessions (Crowe and Luty, 2005a, b, c, d). After analyzing therapy transcripts researchers proposed that the process change in IPT involved the deconstruction and reconstruction of patient subject positions in relation to others. However the participants in these studies were all women who had chosen the area of role-disputes as the focus of their therapy. Therefore little is known about the process of change in IPT for men or individuals focusing on grief, role transition, or sensitivities.

An alternative source of information about the process in change in psychotherapy is to explore experiences of those involved in therapy; that is the therapist and the patient. Although there has been an increase in importance placed on research into patient experiences of psychotherapy over the last two decades (McLeod, 2001) relatively little attention has been paid to this in IPT. Only two studies have investigated patient experiences of IPT and both of these involved administering a post-intervention questionnaire comprised of pre-defined objective measures with the aim of assessing which aspects of IPT and CBT patients in a randomized controlled trial found helpful (Gershelfski et al., 1996) or unhelpful (Levy, Glass, Amkoff & Gershelfski, 1996). Whilst this is useful for determining whether patients find their experiences of IPT acceptable, it does not capture how patients experience and make sense of therapy.

There appears to be no research that explores therapist experience of IPT, qualitative or quantitative. This is interesting given that the theory underpinning IPT was only introduced after outcomes were demonstrated. IPT therapists come from a range of theoretical and professional backgrounds and have been exposed to a variety of
therapeutic models, theories and ideologies. The lack of exploration into how therapists experience and make meaning in IPT means there is little understanding of what theories they are drawing on to do so, and whether these are congruent with the proposed theoretical underpinnings of IPT.

One criticism of the extant IPT process literature is the apparent privileging of quantitative research designs that do not facilitate exploration of the richness of individual experiences. It appears that the performance driven society we live in may have resulted in a drive to find the psychological therapies that work the most quickly and cheaply. There is undoubtedly some clinical, ethical and economical validity to this, but research that explores and values individual experiences should not be overlooked.

Furthermore, the focus on ‘evidence-based practice’ in the NHS may be maneuvering us towards the premature implementation of techniques and models that seek to uniform therapy rather than explore diversity. A consequence of this is that the primacy of the therapeutic relationship is in danger of being neglected. Qualitative and process research exploring the unique experiences of those involved in therapy might address this (Paley & Lawton, 2001). The absence of literature exploring IPT therapists’ experiences forms the basis of the rationale for this research, which aims to serve as an introductory study.
Research Question

With the above aims in mind, the research questions have been framed as:

• What is the experience of delivering IPT like for therapists?

• What informs their understanding of the process of IPT?
Method

Participants

Approximately 10 IPT therapists will be recruited. All IPT therapists will be considered regardless of the setting they work in, their professional background, or their amount of experience. Participants will be recruited using the regional IPT interest group and training course held at the University of Surrey and members of the clinical psychology course team practicing IPT. In the event this does not produce sufficient numbers of participants, NHS trusts will be approached through their Research and Development (R&D) departments.

Design

Qualitative studies of IPT remain relatively few in number compared to the volume of quantitative studies. Whilst quantitative studies have contributed to progress in the establishment and development of IPT, they have limitations. With this in mind, and considering how best to address the research question, a cross-sectional qualitative research design will be implemented. An advantage of qualitative methods is that they can facilitate detailed and in-depth exploration of phenomena that are not easily quantifiable. The also allow unanticipated findings to unfold (Barker, Pistrang & Elliot, 2002). The empirical work of this study will follow the qualitative approach of Interpretive Phenomenological Analysis (Smith, 1996). IPA requires a relatively small and homogenous sample; therefore a purposive sample of participants will be used.

Interviews

Semi-structured interviews will be conducted because they may facilitate the capturing of the complex topics and rich themes of psychotherapy process (Smith & Osborn, 2003). Semi-structured interviews also provide the interviewer with the flexibility to enquire about interesting avenues as they unfold; consistent with IPA’s
double hermeneutic of the researcher trying to make sense of the participant making sense of their world (Smith et al., 2009). All interviews will loosely follow the interview (see Appendix B for a copy of the schedule). This interview schedule is indicative and will be modified as data is collected and analysed.

**Procedure**

Prior to commencing the interviews, participants will review information sheets and sign consent forms (see Appendices C and D). Interviews may be conducted in a variety of settings using a variety of mediums. The first choice will be face-to-face with interviews being conducted on university campus or a location convenient to the participants. In the event that circumstances do not permit this interviews may take place over the telephone, voice over Internet protocol services (for example SKYPE). All interviews will be audio recorded, transcribed verbatim and analysed by the author. If none of these options are possible, interviews may be conducted using email, with the dialogue in these emails being recorded. Participants will be debriefed at the end of interviews and given the opportunity to ask questions.

**Ethical Considerations**

Informed consent to participate will be ensured through providing a participant information sheet, clearly setting out information about the study. It will include the purpose of the research, what their participation will involve, how data will be stored and who will have access to it. All participants will be fully informed about confidentiality and its limits. This will include information that quotes will be used for the write up of the MRP and any resulting journal articles, but all identifying information will be removed. Furthermore, they will be informed that my supervisors and representatives from academic and professional bodies will be privy to anonymised transcripts. Lastly, they will be informed of the limits of this confidentiality in that the
researcher would share information with the appropriate services if they thought somebody was at risk of harm.

Ethical approval for this study will be sought from University of Surrey Faculty of Arts and Human Sciences Ethics Committee (FAHS EC). An application will be submitted between September and November.

**R&D considerations**

NHS R&D approval will not be needed for recruiting therapists through the University of Surrey IPT south interest group, training course, or course team. In the event that this does not provide enough participants, NHS trusts will be approached directly and an application for approval will be submitted to the relevant R&D departments.

**Proposed Data Analysis**

The qualitative approach of IPA (e.g. Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009) has been chosen for the analysis of transcripts for the following reasons:

- IPA is a phenomenological approach; it is focused on ‘exploring experience in its own terms’ as opposed to attempting to reduce it to ‘predefined and overly abstract categories’ (Smith et al., 2009, pg. 1). IPA is interpretative and implements a ‘double hermeneutic’ in which the researcher is trying to make sense of the participant trying to make sense of their experiences. IPA is committed to the exploration of how individuals make sense of their life experiences (Smith et al., 2009).

- IPA is committed to the particular and specific. It aims to reveal something about the experience of each individual participant, and to say something in detail about the participant group. It is commitment to depth of analysis and detail, and to developing an understanding of how particular people in a
particular context understand particular experiential phenomena (events, processes or relationships; Smith et al., 2009). Therefore the aim of IPA is to cautiously arrive at more general claims, as opposed to making premature generalisations about larger populations. Furthermore, these generalisations are only proposed after rigorous analysis of individual cases (Smith & Osborn, 2003; Smith et al., 2009). In sum, the idiographic nature of IPA is consistent with the aims of the study.

- Although IPA focuses on personal experience, it also involves interpretations. Interpretation requires a consideration of context. Therefore IPA can be considered phenomenological and social constructionist. My own epistemological stance lies somewhere between critical realist and social constructionist. This is compatible with the epistemological position of IPA.

- Finally the utility of IPA has already been demonstrated within clinical psychology research (e.g. Rhodes & Jakes, 2000; Pearce, Clare & Pistrang, 2002), this suggests its use in this study is feasible.

Other qualitative methodologies were considered but IPA was selected over these for a variety of reasons. Grounded Theory appears to be a more sociological approach than IPA (Willig, 2003) in that it draws on convergences within a larger sample to evidence wider conceptual explanations. IPA was chosen over Grounded Theory because it is considered to be a more psychological approach. IPA strives to produce a more nuanced and detailed account of the personal experiences of a small sample (Smith et al., 2009); this is felt to be more in keeping with the study’s aims.

Discourse analysis was also considered as a method of data analysis. IPA is concerned with sense-making and cognitions. In contrast, discourse analysis questions
whether cognitions can be accessed through language, focusing on language as a function of constructing social reality. IPA was chosen because although it acknowledges cognitions are not transparently available from verbal reports, however it engages with the analytic process in the hope of being able to say something about the sense- and meaning-making involved in such thinking (Smith, Flowers & Osborn, 1997; Smith et al., 2009).

**Service User and Carer Consultation/involvement**

Service users were given the opportunity to feedback on this project when it was presented in July 2012. The coordinator of service user and carer involvement was consulted as this proposal was being developed.

**Feasibility Issues**

In order to maximize the potential that the target number of participants (10) is reached, the sample will be recruited through a number of avenues and interviews conducted using a variety of methods. However, if it is not possible to recruit ten participants in time for submission six to eight participants will be accepted based on the existing IPA literature that proposes that IPA can be conducted using single case studies (Smith, 2004).

**Dissemination strategy**

It is planned that the results of this study will be presented to the regional IPT interest group at one of their quarterly meetings. It is also planned that a paper will be submitted to a peer review journal. Examples of such journals include: *Psychotherapy Research and Psychology* and *Psychotherapy: Theory, Research and Practice*, however the exact journal has yet to be decided.

**Study Timeline**
Below is an estimate of the time line the project will follow.

**Sept ’12 – Nov ‘12:** Course approval

- Write ethics form
- Submit application for ethical approval
- Finalise first interview schedule
- Write draft method section and give to supervisor

**Nov ‘12 – Sept ’13:** Conduct interviews

- Transcribe interviews
- Analyse transcripts
- Revise interview schedule as needed
- Write draft introduction and give to supervisor

**Sept ’13 – Dec ’13:** Finish data analysis

- Write up results section and give to supervisor

**Dec ’13 – Jan ’14:** Write up discussion

- Amend other sections of paper
- Submit a full draft to supervisor

**Feb ’14:** Amend MRP

- Compose MRP portfolio

**April ’14:** Submit portfolio

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**University Supervisor:** Dr. Kate Gleeson

**Second Supervisor:** Susan Howard
Signature of trainee:  

Date: 6/8/12.

Signature of university supervisor:  

Date: 6/8/12.
References


Literature review

What are the processes involved in IPT and how have researchers characterised them?

Year 1

April 2012

Word Count: 7636
Abstract

Interpersonal psychotherapy (IPT) is an evidence-based psychological therapy recommended by NICE for the treatment of depression in the UK. Much research has focused on the Efficacy of IPT and there has been little focus on how it facilitates recovery. The present review examined the IPT psychotherapy process literature in order to evaluate the current state of understanding. Much of the research focused on comparing IPT to CBT and has identified common and specific psychotherapy process correlates that appear to be interrelated. Qualitative research is minimal but has started to explore the process of recovery in depression and suggests that IPT might facilitate a reconstruction of patients’ sense of self in relation to others. Little attention has been paid to patients’ experience of IPT and none to therapists’. Future research might move away from the objective and nomothetic and focus on idiographic, in-depth and critical exploration of IPT process in order to facilitate development of the intervention and inform clinical practice.
What are the processes involved in IPT and how have researchers characterised them?

IPT is a psychological therapy for depression recommended by the National Institute of Clinical Excellence (NICE, 2009). It was developed specifically as a treatment for individuals with depression (Klerman, Weissman, Rounsaville & Chevron, 1984; Weissman, Markowitz, & Klerman, 2000) that could be reliably delivered by across settings and providers (Swartz, 1999). Outcome research has been conducted on IPT for depression for almost 30 years. Although a few, some trials demonstrated ambiguous or negative results, (Lesperance et al., 2007; Markowitz, Kocsis, Bleiberg, Christos & Sacks, 2005), most indicate that IPT is an effective method of treating depression across the lifespan, cultures and settings (Bolton et al, 2003; Frank, Kupfer, Perel, & Cornes, 1990; Mufson et al., 2004; O’Hara, Stuart, Gorman & Wenzel, 2000; Weissman, Markowitz & Klerman, 2007;). A recent meta-analysis demonstrated the effectiveness of IPT versus other treatment conditions (Cuijpers, van Straten, Smit, Mihalopoulos, & Beekman., 2011).

In IPT, depression is formulated within a triad of bio-psychosocial, predisposing, precipitating and perpetuating factors. Depression is conceptualised as resulting from an interpersonal life stressor and the ability for the patient to manage this is affected by underlying biological and psychological vulnerabilities. Social forces, including current social support and significant relationships provide the setting for a stress-vulnerability interaction to occur. Thus it is assumed that IPT facilitates an improvement in mood by tackling current interpersonal difficulties and developing strategies for the future (Weissman et al., 2000).

The focus of IPT is on the here and now of interpersonal relationships and current life situation as opposed to the past. Patient and therapist work through
interpersonal difficulties related to loss, change, isolation or conflict. One of the areas is chosen as the focus of the therapy. IPT also aims to facilitate the recruitment and utilization of social support. IPT manuals specify therapeutic strategies that therapists might employ during IPT and include: psycho-education of the effect of interpersonal difficulties on symptoms; emotionally guided exploration of social-roles and expectations; reducing stigma surrounding depression; interpersonal problem solving; role-playing, communication analysis and instilling hope.

The aims of IPT are to help patients cope with problems; clarify wishes; correct misinformation and explore alternative ways of improving current interpersonal relationships (Klerman et al., 1984). Perhaps because of its standing next to Cognitive Behavioural Therapy (CBT) on the NICE guidelines for depression, they are frequently compared. However, there are conceptual differences between the two. The primary targets of IPT are not, as in CBT, the experiences of distress. Rather interpersonal relationships and social support are the first targets with reduction in distress expected as a result.

Early iterations of IPT were predominantly atheoretical. Theory was considered only after IPT was deemed effective. Thus there is an emphasis on efficacy as opposed underlying theory. Stuart (2008) used the analogy of building a house before digging the foundations. Despite this counter-intuitive process recent research has started to explore the theoretical underpinnings of IPT; attachment theory is now largely recognised as central to the relationship to change in IPT. Attachment theory proposes that distress arises from disruptions to individuals' attachments to others. Individuals with patterns of relating to others classified as insecure, have increased vulnerability to interpersonal conflicts and losses as a result of fragile primary relationships and social networks (Bowlby, 1973). This corresponds with the four problem areas addressed in
IPT. Attachment research specific to IPT supports this link (McBride, Atkinson, Quilty & Bagby, 2006; Ravitz, Maunder, & McBride, 2008). Communication theory (Kiesler and Watkins, 1989) and social theory (Henderson, Byrne, & Duncan-Jones, 1982; Weissman andPaykel 1974) are conceptualized as offshoots of attachment and are also considered to be salient theoretical components in IPT.

Although little is known about the mechanism of change in IPT, research has demonstrated that the largest proportion of variance of treatment outcome is accounted for by the “common factors” (frank, 1971) shared by all psychotherapy (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Messer & Wampold 2002).

Given that most research has focused on the efficacy of IPT, this review focuses on research exploring the psychotherapeutic process of IPT. Defining psychotherapy process is difficult. Jones (2003) acknowledges that the subjective experience of psychotherapy consists of an infinite number of intricately related interactions between therapists and patients that therapists are aware of, but struggle to capture in research. However attempts have been made to examine aspects of the therapeutic process. Dallos and Vetere (2005) provide a concise account of the many facets of process research and propose seven categories for process research.

The first of these is therapeutic alliance, thought to be a common active ingredient across therapies and perhaps the most explored area in process research. The second type of research includes studies that examine how shifts in meaning occur during therapy. They consist of exploratory, qualitative studies, along with those using more structured approaches looking at range of dimensions. The third type of research looks at significant events in therapy and how these are related to change. Systemic or process studies are the fourth and focus on what therapists actually ‘do’ in therapy in contrast to what they believe they do. This can reveal differences between actual
practice of therapy and theory. Studies that look at patient and therapist variables form
the fifth group and often link these to outcome with the aim of uncovering the
fundamental features of 'good' therapy. The penultimate category 'interpersonal models
of change' involves studies that investigate the fit between patient and therapist factors
and may include structured observations, case designs and in-depth case studies. The
final category, involves studies that see patient-change as a cyclical process.

As noted, much work has focused on the efficacy of IPT rather than the process.
A recent review examined existing evidence on possible predictors (moderators) and
mechanisms (mediators) of change and provided some information on who might
benefit from IPT and how (Ravitz et al., 2011). A review has also been conducted that
compared features of psychodynamic interpersonal therapies (including, but not
exclusive to IPT) to cognitive behavioural therapies (Blagys and Hilsenroth, 2000).
However, there has been no review that specifically explores phenomena occurring
during IPT sessions. Although we are beginning to develop theoretical foundations for
IPT and have an idea of how IPT is supposed to be administered according to manuals,
how this is actually implemented in therapy is unclear. Therefore, the aim of the current
review was to summarise research examining processes occurring within IPT sessions:
that is to investigate what the work of IPT involves.
Search Strategy

A search of the following electronic databases was performed via the Ebsco interface: Psychinfo, Psychology and Behavioural Science Collection, Medline and CINAHL. Search terms were kept broad to maximize the number of articles included. The search strategy search included all articles published between January 1970 and March 2012. Titles and abstracts of papers were searched using the terms “interpersonal psychotherapy OR interpersonal therapy” and “process OR change OR mechanism OR case”. Reference lists of relevant papers were also scanned and individuals with expertise were consulted.

Given that there has been very little research focusing specifically on the process of IPT, all types of process research were considered and any papers examining phenomena occurring within IPT. This includes therapy non-specific factors such as therapeutic alliance; therapist and patient behaviours; specific therapy components or events and patient experiences. Samples characterised by all diagnostic categories were considered as were non-clinical samples. Studies that exclusively examined patient variables and pre-post treatment designs were omitted because the author felt these provided little information about process phenomena occurring within IPT treatment sessions, as were studies of exclusively focusing on therapist competence or adherence. Only journal articles published in English between January 1970 and March 2012, which reported primary research were included. Books, book chapters, reviews, theses and commentaries were not included.
Results

The search yielded a total of 716 unique research papers. After applying the exclusion criteria, 13 primary research papers remained. Five papers were added after searching the reference lists of the papers included and asking experts, which gave a total of 18 papers to be reviewed. These are presented in table 1.

A large proportion of the research examined the process of IPT in relation to CBT or pharmacotherapy. Therefore, data was extracted from comparative process research if it was felt to provide some understanding of the process of IPT specifically. Because so few relevant studies were found, none were excluded on the basis of quality.

The included studies were categorised according to the seven areas of process research delineated by Dallos and Vetere (2005). The majority (12) were categorised as ‘systemic/process’ studies; two as ‘analysis of shifts in meaning; two as ‘therapeutic alliance’; one as ‘patient and therapist variables’ and one as ‘interpersonal models of change’. None of the papers reviewed examined ‘significant events’ or ‘cycles of change’.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample</th>
<th>Process measures</th>
<th>Primary Findings</th>
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</table>
| Albon and Jones, 1999.                    | Systemic/process Comparative | NIHM-TDCRP N=162 Depression | Psychotherapy Process Q-Set (PQS) | **10 most frequently rated PQS items:**  
   63) 'P’s interpersonal relationships are a major theme; 64) ‘love or romantic relationships are a topic of discussion’; 69) ‘P’s current or recent life situation is emphasized in discussion’; 31) ‘Tasks for more information or elaboration; 6) ‘T is sensitive to P’s feelings, attuned to P, empathic’; 18) ‘T conveys a sense of non-judgmental acceptance’; 65) ‘T clarifies, restates, or rephrases P’s communication; 45) ‘T adopts a supportive stance’; 35) ‘Self -image is a focus for discussion; 62) ‘T identifies a recurrent theme in P’s experience or conduct.’ |
| Connolly Gibbons, Crites, Christoph, Levinson, Ladis, Siqueland, Barber & Elkin, 2002. | Systemic/process Comparative | NIHM-TDCRP N=72 Depression | Therapist response mode | • Similarities and difference in IPT and CBT therapist technique  
   • IPT therapist used significantly more statements that linked thoughts feelings and behaviour to early life events than CBT therapists (p<.05)  
   • IPT therapists used significantly less questions, restatements and informational statements than CBT therapists (p<.05) |
| Connolly Gibbons, Crites-Christoph, Levinson & Barber, 2003. | Systemic/process Comparative | NIHM-TDCRP N=72 Depression | Therapist response mode, Barret-Lennard Relationship Inventory (BLRI) Interpersonal Style Inventory (ISI) | • Patients perceived levels of empathy positively related to increased therapist use of clarifications and re-statements in IPT and CBT  
   • Patient narrative completeness related to IPT and CBT therapists use of learning statements (p<.01)  
   • Patient interpersonal involvement not related to therapist response |
| Coombs, Coleman & Jones, 2002             | Systemic/process Comparative | NIHM-TDCRP N=128 Depression | PQS | IPT rated higher than CBT:  
   • Factor 1) ‘collaborative emotional experience’ (p<.001)  
   IPT rated lower than CBT:  
   • Factor 3) ‘educative/directive process’ (p<.01) |
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<th>Study</th>
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<th>Primary Findings</th>
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</table>
| Crits-Christoph, Connolly, Sappell, Elkin, Krupnick & Sotoky, 1999. | Systemic/process | NIHM-TDCRP | Vanderbilt Therapeutic Alliance | • IPT more narratives than CBT ($r=.44, p<.001$)  
• CBT more therapist words per narrative than IPT ($r=-.56, p<.001$)  
• Therapeutic alliance positively related to number of patient words per narrative ($r=.29, p<.01$) |
| | Comparative | Depression | Scale (VTAS) | Interpersonal narratives (IPNs) derived from transcripts |
| | | N=72 | |
| Crits-Christoph, Connolly Gibbons, Temes, Gallop & Elkin, 2010. | Systemic/process | NIHM-TDCRP | Judge rated measures of therapist interpersonal accuracy. | • Therapist accuracy for patient interpersonal narrative classified as ‘response of self’ CBT significantly higher than IPT ($p=.039, d=.079$).  
• No significant difference between IPT and CBT for therapist accuracy and patient interpersonal narratives classified as ‘wish’ or ‘response from other’. |
| | Comparative | Depression | |
| | | N=72 | |
| Crowe and Luty, 2005a. | Analysis of shifts in meaning | CPDS | 14 x 1 hour session transcripts Discourse analysis | Subject positions assumed by patient during therapy:  
1) ‘I wouldn’t fully trust me’; 2) ‘I have always thought that you needed to be somebody’; 3) ‘I don’t want to make a decision’; 4) ‘I don’t know what makes me happy’; 5) ‘I have got to stop living the way everybody else expects me to’; 6) ‘I realise now nothing is ever the wrong decision’  
Construction of relationship with significant other:  
1) ‘He is a gentleman’; 2) ‘He is not actively trying to improve himself’; 3) ‘I 4) wish he was more, much more’; 5) ‘He can only give me so much’  
Therapeutic interventions:  
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<th>Study</th>
<th>Design</th>
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<th>Primary Findings</th>
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<tr>
<td>Crowe and Luty,</td>
<td>Analysis of shifts in</td>
<td>CPDS</td>
<td>12 x 1 hour session transcripts</td>
<td>Subject positions assumed by patient during therapy: 1) 'I am struggling'; 2) 'I don't want to be selfish'; 3) 'I need to trust myself'; 4) 'I just want to be me'; 5) 'I am not such a drop kick after all'; 6) 'I'm feeling like a person'.</td>
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<td>2005b</td>
<td>meaning</td>
<td>Depression</td>
<td>Discourse analysis</td>
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<tr>
<td>Crowe and Luty,</td>
<td>Systemic/process</td>
<td>CPDS</td>
<td>10 sets of 12 x 1 hour session</td>
<td>Four core themes emerged representing psychotherapeutic process: 1) 'Struggling with symptoms'; 2) 'deconstructing interpersonal patterns'; 3) 'altering the pattern'; 'Reconstructing a sense of self'</td>
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<tr>
<td>2005c</td>
<td></td>
<td>Depression</td>
<td>transcripts</td>
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<td></td>
<td></td>
<td>N=10</td>
<td>Thematic analysis</td>
<td>Therapist interventions: 1) 'seeking information'; 2) 'exploring parallels in other relationships'; 3) 'exploring communication patterns'; 4) 'signaling what is significant'; 5) 'providing support'; 6) 'exploring affect'; 7) 'exploring options'; 8) 'problem-solving'; 9) 'drawing analogy'; 10) 'challenging'.</td>
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<tr>
<td>Crowe and Luty,</td>
<td>Systemic/process</td>
<td>CPDS</td>
<td>12 x 1 hour session transcripts</td>
<td>Patient response to IPT: 1) 'Struggling'; 2) 'Deconstructing'; 3) 'Connecting'; 4) 'Practicing'; 5) 'reconstructing'.</td>
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<td>2005d</td>
<td></td>
<td>Depression</td>
<td>Thematic analysis?</td>
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<tr>
<td>DuRubes, Hollen,</td>
<td>Systemic/process</td>
<td>Depression</td>
<td>Minnesota Therapy Rating Scale</td>
<td>Naïve raters able to discriminate between IPT and CBT on 38 out of 48 items of MTRS (p&lt;.05).</td>
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<td>Evans &amp; Bennis,</td>
<td>Comparative</td>
<td>N=6</td>
<td>(MTRS)</td>
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<td>1982</td>
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<td>Study</td>
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<tr>
<td>Gershofski, Ankoff, Glass &amp; Elkin, 1996</td>
<td>Systemic/process</td>
<td>TDCRP Depression</td>
<td>Open ended question</td>
<td>Across treatment factors coded most frequently:</td>
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<tr>
<td></td>
<td>Comparative</td>
<td>N=154</td>
<td></td>
<td>• 'Therapist helped' (41%)</td>
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<td></td>
<td></td>
<td>• 'Learned something new' (36%)</td>
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<td></td>
<td>No significant differences between groups</td>
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<td>Post therapy evaluation form</td>
<td><strong>Treatment specific aspects patients found more helpful:</strong></td>
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<td></td>
<td></td>
<td>• 'Cognitive more in CBT' than IPT (p&lt;.0001)</td>
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<td></td>
<td></td>
<td>• 'Interpersonal' more in IPT than CBT (p&lt;.0001)</td>
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<tr>
<td>Karlson &amp; Kermott, 2006</td>
<td>Patient and therapist variables</td>
<td>TDCRP Depression</td>
<td>Reflective functioning scale (RFS)</td>
<td>• Overall RF higher in IPT than CBT (p&lt;.001)</td>
</tr>
<tr>
<td></td>
<td>Comparative</td>
<td>N=155</td>
<td></td>
<td>• RF decreased significantly across IPT sessions (p&lt;.001).</td>
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<td></td>
<td>• RF greater in IPT than CBT in session 4 (p&lt;.001)</td>
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<td>• No difference between RF in IPT and CBT in session 12.</td>
</tr>
<tr>
<td>Kasper, Hill &amp; Kivlghan, 2008</td>
<td>Interpersonal models of change</td>
<td>N=1F Graduate student</td>
<td>Speaking turns analysis Measure of immediacy Patient involvement</td>
<td>Therapist use of immediacy in speaking turns: $M=.34, SD=.12$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Mood and affect within normal range”</td>
<td></td>
<td>Patient use of immediacy in speaking turns: $M=.37, SD=.16$</td>
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<td>Significant interaction between therapist and patient immediacy (p&lt;.00)</td>
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<td>Time spent using immediacy by therapist and patient positively correlated (r=.81, p&lt;.01)</td>
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<td>Therapist inquiry about therapeutic relationship positively correlated to patient immediacy (r=.58, p&lt;.05)</td>
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<td>No relationship between patient immediacy and therapist feedback (r=-.25, p&gt;.05)</td>
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</tbody>
</table>

**How IPT Practitioners Draw on Theory and Evidence**
Table 1. Included Papers

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample</th>
<th>Process measures</th>
<th>Primary Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Krupnick, Sotsky, Simmen, Moyer, Watkins, Pilkonis, &amp; Elkin, 1996.</td>
<td>Therapeutic alliance</td>
<td>TDCRP</td>
<td>VTAS</td>
<td>TA not significantly different between IPT, CBT, IMI-CM and PLA-CM.</td>
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<tr>
<td></td>
<td>Comparative</td>
<td>Depression</td>
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</tr>
<tr>
<td></td>
<td>Comparative</td>
<td>N=41</td>
<td></td>
<td>No significant difference in TA strength over IPT sessions.</td>
</tr>
<tr>
<td>Levy, Glass, Arnkoff and Gershefski, 1996</td>
<td>Systemic/process</td>
<td>TDCRP</td>
<td>Post-treatment evaluation of</td>
<td>No significant difference between common or specific factors that patients found</td>
</tr>
<tr>
<td></td>
<td>Comparative</td>
<td>N=154 Depressive</td>
<td>therapy form.</td>
<td>unhelpful in IPT and CBT</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No specific factors rated as unhelpful in IPT</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>No participants reported that they found interpersonal aspects of treatment problematic</td>
</tr>
<tr>
<td></td>
<td>Comparative</td>
<td>N=35 Depression</td>
<td>Form</td>
<td>exploration, therapist exploration and therapist warmth (p&lt;.001)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative correlation between IPT competence and patient hostility, patient distress and</td>
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<td></td>
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<td>therapist negative attitude (p&lt;.001).</td>
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Key

CBT = Cognitive behavioural therapy
CPDS = Christchurch psychotherapy for depression study
IPT = Interpersonal Psychotherapy
IMI-CM = Imipramine plus clinical management
N = Number of participants
PLA-CM = Placebo plus clinical management
TDCRP = National Institute of Mental Health Treatment of Depression Collaborative Research Programme
TA= Therapeutic alliance
Therapeutic alliance

Only two studies explored therapeutic alliance as a process factor in IPT. Therapeutic alliance was compared between all treatment conditions in the TDCRP using a modified version of the VTAS. The TDCRP was a randomized controlled trial comparing psychological and pharmacological treatments for depression. A pilot study using 56 participants was conducted and suggested that the therapeutic alliance was significantly stronger in IPT than CBT, IMI-CM and PLA-CM (Krupnick et al., 1994). Inter-rater reliability was good. However, when the complete sample of 162 participants was examined, no significant differences were found between any of the groups. Lower reliability and variability of therapist factors may have contributed to this (Krupnick et al., 1996). The results suggest that therapeutic alliance is related to processes that are independent of type of therapy, for example patient and therapist variables. Further exploration of therapeutic alliance using an interpersonal model of change approach may prove useful.

Systemic/process studies

Discriminating IPT process. Two studies examined the process of IPT sessions in relation to that described in the manual. The first implemented the MTRS to explore whether theoretically meaningful differences could be established between audio and videotaped sessions of IPT and CBT (Derubeis et al., 1982). Relatively inexperienced raters were able to spot procedural differences between IPT in CBT in clinical practice. Factor analysis produced a four-factor solution that accounted for 69% of the variance and included: 1) CBT technique, 2) therapist interpersonal skill, 3) therapist directiveness and 4) IPT technique. IPT group was rated higher on factor 4 and lower on the remaining factors than CBT. There were significant differences between IPT and CBT, but there was some overlap. The study indicates that IPT involves
common and specific therapist processes, but has some limitations. The sample was extremely small and the CBT therapists had considerably more experience than the IPT therapists, this might explain the unexpected difference in therapist interpersonal skill. Furthermore, 50% of raters expressed that their theoretical orientation was CBT but none IPT; a potential source of bias. Some of the factor scores also had low reliability.

Another study examined the relationship between specific and general dimensions of the psychotherapy process in IPT (Rounsaville et al., 1987). General psychotherapy process ratings measures (VPPS) and therapist adherence to the IPT manual (TSRF) was measured. Supervisor ratings of therapist competence (including: quality of IPT techniques, skills in assisting patient-self-disclosure; ability to tend to therapeutic relationship; ability to focus session; ability to maintain IPT stance) were positively correlated with VPPS patient factors: hostility, participation, exploration and distress. Greater supervisor ratings of competence were associated with higher ratings for VPPS therapist processes including: warmth, exploration and friendly attitude. These relationships were consistent across the course of IPT and the strongest associations were seen with therapist processes. Individual subscales were not reported so it is difficult to assess which specific interventions IPT therapists utilised, and whether these were congruent with IPT manuals. The range of therapists was good and TSRF inter-rater reliability was adequate. However, the study was correlational, thus direction of the relationship cannot be established. Furthermore, supervisors completed both competence and VPPS ratings of videotaped sessions, thus findings may have been produced by a halo effect. The study provides some understanding that IPT processes vary across therapists and highlights the complex interaction of specific and common process factors.
Describing IPT process. Several studies looked at the systemic process of IPT and found a variety of common and specific factors. Albon and Jones (1999) investigated IPT and CBT psychotherapy process in the TDCRP. They used the 100-item Psychotherapy Process Q-Sort (PQS) designed to assess therapist-patient interactions in sessions. Judges were relatively inexperienced but reliability across all PQS items was high. The study described the 10 PQS items that were most characteristic of IPT. These included therapist interventions and stances that could be described as common factors of psychotherapy. Three of the 10 most common PQS items appeared to be IPT specific. They were related to the topics covered in therapy sessions and included a focus on interpersonal and romantic relationships. This is a useful starting point in understanding the systemic process of IPT. It also provides some evidence that therapists using IPT implement interventions described in manuals. PQS ratings for IPT and CBT were also compared. Forty-eight of the 100 PQS items were significantly different ($p \leq .01$). It is beyond the scope of the present review to report differences on all PQS 48 items; the results suggest that although IPT shares many common systemic processes with CBT, but there are differences in manner and frequency they are delivered. Within treatment analyses were not conducted but may have increased our understanding of the salience of systemic process variables in IPT. Furthermore, the external validity of the results is limited because the sample was taken from the TDCRP that used strict criteria for therapist adherence. Therefore in-vivo research with more varied samples is needed.

Crowe and Luty (2005d) used thematic analysis to examine transcripts for one female patient that completed 12 sessions of IPT. The focus of the sessions was ‘interpersonal disputes’. The analysis identified and followed the interventions implemented by the therapist and their effect on the patient. These interventions were
compared to manualised descriptions of particular foci for interpersonal disputes (Weissman, Markowitz, & Klerman, 2003): *seeking information on different levels; Exploring parallels in other relationship; Exploring relationship patterns; exploring the communication patterns that the patient draws on.* The results indicate the session involved therapist processes specific to IPT; consistent with those outlined in the manual. In addition the study describes therapist processes that are common across psychotherapy. The therapist appeared to vary her interventions depending on the phase of therapy and the way the patient presented in sessions. This supports the notion the process in IPT is a complex matrix of therapist-patient interactions that are also influenced by the IPT manual. Description of the process of analysis was limited so methodological validity cannot be assumed. In addition this was a single case design so the findings have limited transferability. Similar qualitative studies support the presence of specific and common therapist processes in IPT (Crowe and Luty 2005a). Although the authors state these interventions were drawn from the transcript they were not evidenced by quotes, making it impossible to assess validity.

Connolly Gibbons and colleagues (2002) anlaysed therapist speaking-turns in CBT and IPT using transcripts from the TDCRP. Therapist speaking-turns were coded using previously defined response mode categories (Elliot, Barker, Caskey, & Pistrang, 1982). Therapists in both IPT and CBT used questions, clarifications and learning statements to assist patients to explore their life. They also focused more on the patients’ current as opposed to past situations. This suggests that IPT shares some therapist process factors with other therapies. The study had high methodological validity. Raters were experienced and inter-rater reliability was good. The therapists were well trained in manual-guided therapies and consistently used manual specific
interventions, across phase of therapy. However, a significant amount of variance in therapist response-mode could was explained by therapist and patient differences.

An attempt has been made to explore the effect of patients on IPT process and demonstrated levels of therapist response-modes in IPT and CBT are associated with patient process variables including measures of their involvement and the level of empathy they perceived in sessions (Connolly Gibbons et al., 2003). No relationship was found between patient levels of depression and interpersonal problems. This suggests that therapist processes were influenced by the perceptions and actions of patients in sessions rather than their pre-treatment characteristics. Unfortunately, there was no within-treatment analysis of patient response mode so it is difficult to ascertain whether the results apply specifically to IPT. In addition, patient perception of empathy was only measured at session 2 and may have been different at different phases of treatment. External validity is also limited because no non-manualised control group was used as a comparison, and the patients were part of a research rather than ‘real life’ sample. Despite these limitations, the combined results of these studies provide a tentative indication that therapists follow IPT manuals and implement IPT specific techniques, in addition to common factors. However, their actions in therapy appear to be related to patient differences. Thus it seems process in IPT is an interwoven mix of patient and therapist factors.

Coombs et al (2002) compared in-session patient expression of and therapist stance towards emotion in IPT and CBT. Factor analysis of PQS ratings of 128 transcripts from the TDCRP, revealed 3 primary factors, accounting for 35% of the variance across treatments. IPT therapist were rated higher on the factor describing a stance taken by therapist that encourages emotional exploration and lower on the factor, reflecting a stance that de-emphasises emotion and provides advice and education.
Inter-rater reliability was good and the results indicate that IPT therapists often take a stance and employ techniques that are consistent with manuals. However, the primary factors were not inextricably linked to IPT and CBT; the authors found exceptions when they analysed the transcripts. The study also measured patient levels of affect in IPT and CBT sessions and found no significant differences. However, factor 1 and factor 2 decreased as painful affect increased; in order to navigate displays of painful emotions, therapists veer away from modality specific interventions. This further highlights the effect of patient variables on therapist processes in IPT.

Crits-Christoph and colleagues (1999) identified relationship episodes or interpersonal narratives (IPN) from IPT and CBT transcripts taken from the TDCRP. Inter-rater reliability for narrative completeness ratings was acceptable and the results indicate a positive therapeutic alliance may facilitate discussion of patient interpersonal problems. Consistent individual differences were found in narrative frequency, length and completeness. The results point towards a complex relationship of positive therapeutic alliance and the therapy process. It appears that therapist processes in IPT include fostering a safe environment and encouraging patients to talk about distressing interpersonal experiences. The findings are consistent with a model of reciprocal causation between alliance and interpersonal techniques; positive alliance may facilitate the use of IPT techniques and accurate interpersonal interventions may contribute to or maintain the alliance.

A later study (Crits-Christoph et al., 2010) expanded on the idea of this reciprocal relationship. It investigated the relationship between interpersonal accuracy of therapist interventions in response to patient IPN in IPT and CBT using the same sample. Interpersonal accuracy was defined as therapists' responses being appropriate to the content of each IPN. Inter-judge reliability was good for accuracy ratings but the
study provides little information about specific processes in IPT. Few differences in interpersonal accuracy were found between IPT and CBT. This indicates that interpersonal accuracy may be dependent on therapist, rather than therapy. That is accuracy that it might be a therapist process factor present across psychotherapy. The studies used the same TDCRP sample from 20 years ago so the findings should be generalised with caution. Research with more recent and varied populations is needed to strengthen this finding.

Patient experience of IPT process. Participants from the TDCRP completed a post-treatment questionnaire that included an open-ended question asking which aspects, if any, of their treatment they found helpful (Gershefski et al., 1996). Narrative responses were coded by two experienced raters to very high levels of rater agreement and arranged into categories of common and specific categories. The most commonly coded responses were those congruent with common rather than specific therapy processes. This did not differ between CBT and IPT. Patients reported that they found interpersonal aspects of therapy helpful as frequently in CBT as IPT, but less frequently in the clinical management groups. This suggests that interpersonal processes may not be restricted to IPT. Interpersonal aspects of process were defined as: ‘gained an awareness of and/or change in interpersonal relationships’, ‘learned associations between problems in interpersonal relationships and depression’, and ‘interpersonal interventions’. These processes are consistent with those outlined in IPT manuals and suggest that an interpersonal focus is acceptable to patients, regardless of the specific therapy they receive. Participants found cognitive aspects helpful less often in IPT than CBT. IPT manuals do not specify cognitive techniques, so whether cognitive processes were present is unclear. Within treatment analyses were not performed so it is difficult to establish whether patients had a preference for common or specific process IPT.
However, the means were reported and indicate that common factors were more acceptable. This is consistent with the idea that process factors most important to patient change are common, rather than specific factors and exploratory research could bolster this argument.

A complementary study using the same sample and a similar methodology revealed patients in the TDCRP did not rate aspects of interpersonal therapy as unhelpful in either IPT or CBT (Levy, Glass, Arnkoff, & Gershofski, 1996). This provides further evidence that an interpersonal focus such as the one taken in IPT may be an important and acceptable psychotherapeutic process factor. Very few patients reported unhelpful aspects of IPT. Those that did, felt common process factors such as attributes of themselves or the therapist hindered therapy. The apparent acceptability of interpersonal process factors to patients in this limited sample warrants further exploration. If this is the case for more recent and varied samples it would provide more evidence for extending the use of IPT in the UK clinical practice.

Although these studies (Gershofski et al, 2006; Levy et al, 2006) begin to explain helpful aspects of IPT process in the eyes of patients, they were primarily designed to evaluate differences across and between treatments. Thus, there was no examination of within treatment differences. The categories reported were also broad which may be related to the written nature of the questionnaire. If examples of patient responses were included; this could have enhanced our understanding by clearly defining what patients found helpful or otherwise. Qualitative research using interviews might yield greater information and prove useful in addressing this in the future.

**Interpersonal models of change**

One case study examined therapist use of immediacy events; defined as disclosure within the therapy session of how the therapist was feeling about the patient,
him- or herself in relation to the patient, or about the therapy relationship (Kasper, Hill, & Kilvighan, 2008). Transcripts were analysed to find immediacy events using a measure developed by the author. The therapist used immediacy events in just over a third of all his speaking turns and tended to focus on asking the patient to explore the therapeutic relationship, rather than revealing his immediate feelings to the patient. Patient immediacy was more likely to occur in response to therapist immediacy, but only when the therapist inquired about their relationship or used intimately self-involving statements. Therapist immediacy appeared to stimulate the patient to be immediate. Inter-rater reliability for therapist immediacy, patient immediacy, and patient involvement was good. However, the same judges coded therapist immediacy and patient involvement, which is a potential source of bias.

The study begins to explore the process of immediacy in IPT but causal conclusions are not possible because it was correlational in design. It was a single case and the patient did not meet criteria for diagnostic criteria. None-the-less, this in-depth exploration serves as a good base for further research and indicates that immediacy is an important process in IPT. The relationship between patient and therapist is complex and it is difficult to untangle therapist and patient processes. Further research might examine immediacy in different therapeutic dyads and in a natural setting to enhance address issues of external validity.

**Patient and therapist variables**

Karlsson and Kermott (2006) examined reflective functioning (RF) as a patient variable during the process of IPT. RF (or mentalising) is defined as the ability to recognize the occurrence of mental processes in self and others (Fonagy, 1999). The RF manual was used to rate transcripts of early and late IPT and CBT sessions. Overall levels of RF were significantly higher in IPT than CBT, but when stage of treatment
was taken into account this was only true of early sessions. This was an unexpected finding. The sample was taken from the TDCRP randomized controlled trial so is unlikely to have arisen from pre-treatment group differences. The difference may be associated with differences in therapeutic technique (i.e. therapist processes). The focus of IPT is on understanding interpersonal relationships, particularly during the first 4 sessions when an in-depth interpersonal history is gathered (Klerman et al., 1984), whereas the focus of CBT is on identifying and challenging cognitions (Beck, Rush, Shaw, & Emergy, 1979). A further explanation of this difference is the finding of a greater number of IPNs with less interruption in IPT than CBT (Crits-Christoph et al., 1999), because IPNs are vital for rating RF. RF levels in IPT actually decreased as therapy progressed. The increase in therapist provision of structured and supportive techniques in later stages of IPT (cf. Albon & Jones, 1999) may have reduced the patient’s wish to reflect on themselves and others in interpersonal interactions.

The PQS was used to identify systemic process variables correlated with low and high RF and indicated RF is may be a patient process variable. The results do support the notion that development of RF is affected by therapist skill and empathy. However, the study is not without limitations. The RF scale was designed for use with the adult attachment interview transcripts; thus construct validity is questionable. Furthermore, narratives were rated as mutual constructions so the therapist is an active participant as opposed to an observer in the Adult Attachment Interview (AAI) and may thus impact on the patient’s expressed RF. Research using the AAI at different points in therapy may address this issue.

**Analysis of shifts of meaning**

A series of qualitative papers explored shifts in meaning in IPT using transcripts from the Psychotherapy for depression study (CPDS); a randomized clinical trial
conducted in Christchurch, New Zealand. (Crowe and Luty 2005; 2005a; 2005b; 2005c). Crowe and Luty (2005a) performed a discourse analysis on a set of transcripts for a woman who chose interpersonal disputes as the area she wanted to work on. The authors proposed that the process of IPT involved assisting a reconstruction of her subject position in relation to others. They argued that her subject positions in the early stages of therapy were representative of self-reflexivity that obstructed action and reinforced a sense of detachment. The analysis also demonstrated that IPT fostered the development of subject positions in relation to others that were more meaningful to the participant. For example changing her constructions of her relationship with her husband. Discourse analysis of a different set of transcripts provides further evidence that the process of recovery in IPT involves assisting the participant to deconstruct interpersonal issues they are unhappy with, practice and develop new subject positions and reconstruct a sense of self that is less likely to factor in future episodes of low mood. (Crowe & Luty, 2005b). The process of deconstructing and reconstructing meaning in IPT is also supported by thematic analysis of patients' progression through therapy sessions (Crowe and Luty, 2005c,d)

These discourse analyses (Crowe & Luty, 2005a,b) take an interesting idiographic approach to exploring social and cultural influences on the psychotherapeutic process involved in the recovery from depression in two individual cases. They also appear to show a common pattern of deconstruction followed by reconstruction in IPT. However, the methodological validity of these papers is limited. The papers provide little clarity on how and by whom the data were analysed. There is no mention of how quotes were selected. Patient quotes were reported in isolation and minimal attention was paid to the therapists' contribution to the construction of meaning. Antaki, Billig, Edwards and Potter (2003) argue this is a sign that the texts
have been underanalysed. Furthermore, all participants were female and all chose interpersonal role disputes as the area that was the focus for therapy.

This is a good place to start and allows comparison of like with like. However it would be interesting to explore subject positions and the process of shifts in meaning for male participants or those who chose to focus on grief, interpersonal deficits, or role transitions as opposed to role disputes. Both patients were taken from the same research sample and it is unclear whether a similar process would occur in everyday practice of IPT. Despite methodological issues, the papers complement existing qualitative research by taking a more in-depth approach to examining the process of shifts in meaning as part of the IPT process. They indicate that IPT process may also include individuals not in the therapeutic dyad (such as family and friends) and cultural factors. This highlights an area of future research exploring IPT processes external to the therapeutic dyad.
Discussion

Review summary

This review examined the state of the extant IPT process literature. The paucity of research in this area meant the term ‘process’ was applied in its broad sense. Consequently, the included papers are heterogeneous in design and epistemologies. In contrast, the samples were relatively homogenous, the majority being taken from the TDCRP and CPDS. Furthermore most studies were conducted in a research as opposed to clinical setting and subject to rigorous control of extraneous variables in an attempt to minimise bias. IPT research has been criticised for its rigid adherence to protocols and diagnostic criteria as opposed to an emphasis on treatment of individual patients and unique formulations (Stuart, 2008). The review findings suggest little has changed.

Can we identify specific processes?

The review suggests that although it is possible to differentiate IPT from other therapies (namely CBT), many of the processes involved are common across psychotherapies. As expected IPT therapist processes included exploring patient interpersonal experiences and affect. Most of the research suggests that psychotherapies have more in common than not. It has been suggested that common therapy factors are responsible for the majority in variance in outcome (Messer & Wampold, 2002). Therefore focusing on distinctive features of therapy may not be the most fruitful line of research. It may be more appropriate to explore how these common processes are implemented and co-vary with each other and processes specific to IPT. In addition it might be useful to explore whether they are experienced as acceptable to patients and therapists. One way to approach this would be qualitative analysis of patient and therapist experiences of IPT, or qualitative analysis of transcripts of actual clinical practice.
Is IPT process associated with the therapist or the patient?

Despite adhering to IPT manuals it appears that experienced therapists are able to maintain a degree of flexibility in their work. Their actions in therapy seem to be associated with those of their patients. Only one study directly examined IPT in relation to an interpersonal model of change but it revealed the complexity of therapist-patients interactions. Results of systemic process studies support this. Qualitative research began to explore processes extraneous of the therapeutic dyad including outside relationships and cultural influences. It therefore seems that process in IPT is a hard to delineate web of exchanges between techniques specified in manuals, therapist-patient interactions, social and cultural influences. Further research exploring the relationships and interactions between patients and therapists would enhance our understanding of processes involved in the therapeutic dyad. This may involve structured observations of therapy or inventories of patient and therapist variables. Research moving away from the presumed vacuum of the consulting room, exploring the influence of external processes might also prove useful. For example discourse analyses of transcripts with different populations or qualitative work including experiences of those in relationships with the patient.

The process of change in IPT.

Little research explored the process of change in IPT, but steps have been made to understand the process of change in IPT using qualitative designs. It appears that shifts in patient experiences of meaning are part of the process of IPT. Patients appear to reconstruct their view of themselves in relation to the world following similar patterns. No papers looked at the relationship of significant events to the process of change. It might be interesting to explore this further using interpersonal process recall methods (interviews assisted with audio or video replay).
Future directions

This review started by outlining the popularity and efficacy of IPT across settings and different individual experiences of distress. Despite this, it highlights a paucity of research focusing on measurement and exploration of processes involved in IPT. Perhaps this is the result of IPT being initially developed as a theoretical placebo for use in therapy research (Klerman et al., 1984). This means the evolution of IPT is comparable to that of pharmacotherapy. Much of the existing research is centred on comparing IPT with CBT. This is useful in determining common and specific factors of different therapies and for developing psychometrically sound tools for assessing adherence and competence in different therapies³, but provides little information about the complex interaction of processes in IPT.

The majority of research made use of existing data from RCTs. Much of this had good internal reliability. Using samples from this type of study has the benefit of maximizing therapist adherence to the IPT manual. This is especially important because high therapist competence is considered an important part of the IPT process (Klerman et al., 1984). However, the samples were not recent so whether the results are generalizable to today’s population is questionable. Furthermore repeated use of the same data makes it difficult to argue that their findings have external validity. Research with different, particularly in-vivo samples, would develop our understanding of IPT process in the wider clinical population.

Only two studies examined patient experience of IPT and none looked at therapist experience. It seems to be presumed that a reduction in depressive symptomology indicates patient satisfaction with IPT and an overall improvement in wellbeing. Further research in this area, for example qualitative investigation of which

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³ For example the Patient Psychotherapy Process Scale (Carter et al., 2012).
aspects of IPT patients perceive to facilitate or inhibit recovery could assist
development of the intervention. In addition, qualitative research focusing on
developing an understanding of the experience of IPT from a therapist or supervisory
position could be useful for those aiming to improve their clinical practice.

Attempts have been made at understanding IPT process within cultural and
social frameworks but more is needed. IPT appears to utilize medical discourse, for
example the ‘sick role’. However, a comparison of IPT manuals to patient identified,
recovery facilitating and hindering factors, suggests that IPT is compatible with the
recovery movement (Bledsoe, Luken, Onken, Bellany, & Cardillo-Geller, 2008). IPT
was developed over 30 years ago and it is important to remember that the zeitgeist
surrounding psychotherapy at the time may have changed. Therefore critical analysis
and deconstruction of therapy manuals; transcripts and experience could improve our
understanding of IPT in the context of today, its relevance and acceptability to the
current population and thus facilitate evolution of the therapy. One example of this
might be a discourse analysis of the sick role.

Stuart (2008) argues that because IPT has been developed in research settings
the “critical balance between clinical development and research based evaluation has
been lost”. Although IPT was initially developed for depression and diagnosis is said to
be an essential part of the process, IPT efficacy has since been established in research
settings for individuals who fit other diagnostic categories. The majority of
psychotherapy research continues to use diagnostic systems to allow convenient
connection to the extant literature (Roth & Fonagy, 1996). A move away from this
convention might further our understanding of the processes occurring in IPT and
enhance therapeutic creativity. It might also examine whether diagnosis is an essential
part of the psychotherapeutic practice. Furthermore IPT like other branches of
psychotherapy conceptualises patient difficulties using formulation as opposed to diagnosis. Although this may be more palatable to psychotherapists it is unclear whether this is actually a better alternative. Therefore, research exploring and critiquing formulation in IPT and across psychotherapy could be beneficial.

In conclusion, the majority of IPT research has focused on effectiveness and efficacy. Therefore many areas of theory require empirical and exploratory research. The research that has focused on theory and process is largely quantitative in nature, aiming to define and measure specific units of process. The results of this review suggest IPT process involves complex interactions between therapists and patients and is also influenced by culture. It therefore appears the processes involved in IPT will remain elusive if research continues to focus on nomothetic; objective; process-outcome; and pre-treatment predictive research at the expense of idiographic, exploratory, in-depth, critical research.
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Interpersonal accuracy of interventions and the outcome of cognitive and


An Evaluation of the Effectiveness of a Dialectical Behaviour Therapy Service for Individuals with a diagnosis of Borderline Personality Disorder.

Service Related Research Project

October 2012
Year two

Word Count 2776
Abstract
Dialectical behavioural therapy (DBT) is a time and resource intensive intervention for individuals with a diagnosis of borderline personality disorder (BPD). The National Health service (NHS) is becoming increasingly performance driven. Thus there is pressure to demonstrate effectiveness of interventions. The aim of the current study was to evaluate the effectiveness of a DBT service. BPD symptomology was measured at assessment and at 16 weeks and at the end of treatment, using a within subject, repeated measures design. Single case statistics were used to analyse symptomatic change. Subjective weekly ratings of self-injury and DBT skill-use, and use of other services was also reported. All four clients demonstrated reliable improvements in BPD symptomology; three clients demonstrated clinically significant change at the end of treatment. Three clients demonstrated a reliable improvement in impulsivity scores. There also appeared to be a reduction in the number of services used and self-injury. Participants also appeared to practice DBT skills more frequently as the intervention progressed. The results tentatively suggest that DBT is an effective service for individuals with BPD. The limitations and implications of the evaluation are discussed.
Introduction

Borderline personality disorder (BPD) is a diagnosis given to individuals with severe and complex mental health difficulties. Symptoms include impulsive risking; suicide attempts; self-injury; severe disturbances to identity; chronic feelings of emptiness and a fear of abandonment (DSM-IV; American Psychiatric association, 1994). Linehan (1993) hypothesises that these experiences are at least partly due to invalidating environments, which prevent individuals from developing helpful ways of coping with their emotions.

Linehan (1993) devised DBT in order to offer individuals diagnosed with BPD a comprehensive psychological intervention aimed at increasing emotional regulation and promoting acceptance of the self, the emotional state of the individual and the environment. DBT also aims to reduce psychological distress and frequency of self-injury through behavioural and acceptance strategies. The intervention includes: individual therapy, telephone consultations administered by qualified staff members, and group skills training.

Outcome research has demonstrated that DBT can be an effective psychological intervention for individuals with a diagnosis of BPD (Linehan et al., 1991; Linehan et al., 2006). Furthermore, the National Institute for Clinical Excellence (NICE) recommends DBT as an intervention for individuals with a diagnosis of BPD, but advises further research is needed (NICE, 2009). Individuals with a diagnosis of BPD have until recently been considered ‘untreatable’ (see NICE, 2009). In addition, DBT is both resource and time intensive (see Brazier et al., 2006). Therefore it is important that services evaluate the effectiveness of DBT. In addition, current National Health Service (NHS) policies indicate a need to measure outcomes of psychological treatments (for
example No Health Without Mental Health, HM Government, 2011). The evaluation of services is therefore becoming increasingly important.

The DBT service to be evaluated is based between two Community Mental Health Recovery Services (CMHRGs). The service offers assessment, weekly individual sessions and a skills group. The skills group consists of four modules that clients repeat twice over the period of a year. The modules include: core mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness. Four therapists delivered the service. Their professional backgrounds included three clinical psychologists and a social worker.

The DBT service has been evaluated on two previous occasions (2007/8 and 2011). The latest evaluation demonstrated high client satisfaction and reliable improvement for BPD symptoms and self-destructive and impulsive behaviours for some individuals (Hale, Eke & Warren, 2012). However this evaluation was completed halfway through the DBT programme and so the overall effectiveness of the service was not evaluated. This evaluation recommended standardised outcome measures be supplemented with subjective measures taken from weekly diary cards, and information on use of other services in order to evaluate effectiveness more comprehensively. Therefore the current evaluation was conducted based on these recommendations and a need to demonstrate effectiveness.

The current evaluation was designed to evaluate the effectiveness of the DBT service for treating individuals with a diagnosis of BPD. It was developed in response to the need for routine outcome-based evaluation of the effectiveness of the DBT service. The service hoped to gather ‘snapshots’ of data over the course of the DBT programme to gain a sense of how individuals using the service responded to treatment.
Objectives

To evaluate the effectiveness of the DBT service for individuals with a diagnosis of BPD by investigating:

- Whether service users’ experience symptomatic improvement after completing the DBT program,
- Whether DBT reduced service users’ risk to themselves (i.e. reduced self-destructive/impulsive behaviours); measured by weekly diary cards and outcome measures.
- Patterns of use of other services, for example inpatient and crisis house admissions, accident and emergency, and police.
- The extent to which skills taught in the DBT group is practiced between sessions.

Hypotheses

1. Reliable improvements in BPD symptomatology would be shown for a majority of clients.

2. Reliable improvements in impulsive and destructive behaviours would be shown for a majority of clients.
Method

Design

A within-subject, repeated measures design was used to gather a ‘snapshot’ of data at three time points. The dependent variables were the levels of BPD symptomatology; the levels of self-destructive and impulsive behaviours. The independent variable was the time-point (i.e. commencement of the group; following the end of the second module of the group at week 16; at discharge from the DBT service).

Participants

The sample included four clients with BPD attending the DBT service in November 2010. All clients were new referrals to the service. All four clients agreed to participate.

Measures

The Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD; Zanarini, 2003) was used to measure BPD symptoms. The ZAN-BPD is a 9-item, clinician-rated clinical interview schedule that measures severity of BPD symptoms over the previous two weeks. It is comprised of questions relating to the BPD diagnostic criteria as defined in DSM-IV (American Psychiatric Association, 1994). It demonstrates high internal consistency ($\alpha = .85$), test-retest reliability ($r = .59-.93$), and significant discriminant and convergent validity (Zanarini, 2003). The total ZAN-BPD score (maximum score = 36) and the ZAN-BPD impulsivity sub-scale score (maximum score = 8) were used.

Procedure
DBT therapists completed the ZAN-BPD at assessment, 16 weeks after the end of the second module of the first cycle of the DBT group, and at discharge from the DBT service.

The researcher gathered information on number of skills used and subjective frequency of self-injury from weekly diary cards. Completing these diary cards forms part of the monitoring of behaviours in DBT, which is integral to the model. Information on use of other services was gleaned from the electronic patient record system.

**Ethical Considerations**

This service evaluation did not require ethical approval. All data were anonymised to maintain participant confidentiality. The evaluation was approved by the relevant NHS trust (see Appendix A) and peer reviewed by the University of Surrey. The data analysed for this evaluation were collected as part of routine clinical practice. The purpose of data collection was explained to clients and it was made clear that participation was voluntary.

**Analysis**

Individual case statistics were conducted on total ZAN-BPD and impulsivity subscale scores. These were chosen because of the limited sample size and the importance of assessing within-participant variability over the course of an intervention (Long & Hollin, 1995). Symptom change was analysed in terms of reliable change and clinical significance. The reliable change index (RCI; Jacobson & Traux, 1991) was used to determine whether the level of change for each client was statistically reliable (i.e. not likely to be due to chance). A change of more than 1.96 (Jacobson & Traux, 1991) from one measurement to the next was taken as indication that the change was reliable at a 95% significance level ($p<.05$). The clinical significance criterion was used
to verify whether the reliable change was of a sufficient degree to indicate movement across clinical and non-clinical ranges (Jacobson & Traux, 1991).

The test-retest reliability scores reported by Zanarini (2003) were used in the single-case calculations. Because the sample size for the current study was limited, norms were also taken from Zanarini (2003)\(^4\) to calculate the RCI and the clinically significant change index (Jacobson & Traux, 1991; see Appendix B). The thresholds between clinical and non-clinical scores for the ZAN-BPD total and the impulsivity subscale score were 8.29 and .86 respectively. These were used to determine clinically significant change for clients who showed reliable change (see Appendix C, Table 1 & 2).

Weekly frequencies of self-injury and DBT skills used were recorded from weekly diary cards completed by each client from the time of assessment to their discharge from the service. The frequency of other services (including Accident and Emergency, mental health inpatient stays, home treatment team, crisis house and crisis line) was also counted for each client for the year before they entered DBT, the duration of the DBT programme and three months post discharge from the team.

\(^4\) Clinical mean ZAN-BPD total score = 14.3 (sd. =6.8); non-clinical mean = 5.2 (sd. =3.5); Clinical mean ZAN-BPD impulsivity score = 1.7 (sd. =1.4); non-clinical mean = .5 (sd. =.7).
Results

Demographic Characteristics

The sample consisted of four White British females aged 19, 28, 45 and 52 who had all engaged in psychological interventions in the past.

Single Case Analyses

Reliable change was calculated as outlined by Jacobson and Traux (1991; see Appendix B).

Table 1. Reliable and Clinically significant change Indications for the total ZAN-BPD and ZAN-BPD Impulsivity Subscale Scores.

<table>
<thead>
<tr>
<th>Total ZAN-BPD (r=.93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Client 1</td>
</tr>
<tr>
<td>Client 2</td>
</tr>
<tr>
<td>Client 3</td>
</tr>
<tr>
<td>Client 4</td>
</tr>
</tbody>
</table>

Note. $r = $ Test-retest reliability; $^{Re+} = $ Reliable improvement at time point from previous time point (p<.05); $^{Re-} = $ Reliable deterioration at time point from previous time point (p<.05); *$^{CSC} = $ Clinically significant change from previous time point (p<.05).

Table 1 shows that from pre to mid intervention the total ZAN-BPD scores for clients 1, 2, and 3 improved reliably. This change was clinically significant for client 2. From mid- to post-intervention the total ZAN-BPD score for clients 2 appeared to deteriorate however this change was not reliable. From mid- to post-intervention the
total ZAN-BPD scores for 1, 3 and 4 improved reliably and the change was clinically significant for all clients.

Table 2. Reliable and Clinically significant change Indications for the ZAN-BPD Impulsivity Subscale Scores.

<table>
<thead>
<tr>
<th>ZAN-BPD Impulsivity Subscale</th>
<th>(r=.86)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>Mid</td>
<td>Post</td>
</tr>
<tr>
<td>Client 1</td>
<td>6</td>
<td>1^{Re+}</td>
</tr>
<tr>
<td>Client 2</td>
<td>7</td>
<td>2^{Re+}</td>
</tr>
<tr>
<td>Client 3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Client 4</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. r = Test-retest reliability; ^{Re+} = Reliable improvement at time-point from previous time-point (p<.05); ^{Re-} = Reliable deterioration at time point from previous time point (p<.05); ^{CSC} = Clinically significant change from previous time point (p<.05).

Table 2 shows that Clients 1 and 2 demonstrated reliable improvements on impulsivity scores from pre- to mid-intervention. However, these changes were not clinically significant. Clients 1 and 2 showed no reliable change between mid- and post-intervention. Clients 3 and 4 showed no reliable change between pre- to mid-intervention. However, client three showed a reliable and clinically significant improvement from mid to post intervention. Clients 1, 2 and 4 did not demonstrate any reliable change in their impulsivity scores from mid to post intervention.
Subjective self-injury

Subjective ratings of frequency of self-injury from weekly diary cards were combined into 3-month blocks for each participant to provide a more stable measure of behaviour. Figure 1 shows the mean rates of self-injury per 3-month treatment block for each client. Only client one had ratings for every three month period. Clients 1, 3 and 4 reported a reduction in frequency of self-injury over the course of DBT. Client 2 reported no self-injury behaviours for all three-month periods with the exception of months 7 to 9.

Figure 1. Mean subjective weekly episodes of self-injury as rated on diary cards over the course of the DBT programme.
DBT Skills

Subjective ratings of frequency of skill use from weekly diary cards were combined into 3-month blocks for each participant to provide a more stable measure of behaviour. Figure 2 shows the mean rates of skill use per 3-month treatment block for each client. Only Client one had ratings for every 3 month period. The mean number of skills used increased over the course of the intervention for each client.

Figure 2. Mean subjective number of DBT skills used per week as rated on diary cards over the course of the DBT programme.
Use of other services

Table 3. Number of services accessed including police, emergency department and crisis house.

<table>
<thead>
<tr>
<th></th>
<th>Year Prior to DBT</th>
<th>Intervention period</th>
<th>3 months post DBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client 1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Client 2</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Client 3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Client 4</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3 outlines services used by the clients before, during and after DBT. Three clients accessed services before DBT. There was no record of any of the clients using services during the intervention or after discharge. In addition, three months post-intervention client 3 had been discharged from the CMHRS, the rest remained in the service.
Discussion

Summary of Results

All clients’ total ZAN-BPD scores were lower at the end of treatment than the start. Three out of four clients demonstrated clinically significant change at this point. One client’s score was not in the clinically significant range at the end of treatment. However, this client had achieved reliable and clinically significant change by the mid time point and increased only slightly at the end of treatment. A reduction in impulsivity sub-scale scores was demonstrated by three out of four clients.

In terms of subjective ratings from weekly diary cards, three out of four clients demonstrated a reduction in frequency of self-injury and all four clients demonstrated an increase in the number of skills used across treatment. This suggests that clients experience a reduction in self-injury and that they practice the DBT skills taught in the groups more frequently as the intervention progresses.

There also appeared to be a reduction in the number of services used; none of the clients used any other services during and post intervention. This suggests that although DBT is an expensive intervention, it may prevent costs to other services.

Over all the results suggest a decrease in both overall symptoms of BPD and impulsive and self-injurious behaviours. Therefore the results support both the initial hypotheses.

Strengths and Limitations

Three out of four clients remained engaged with the service at the end of DBT. Client three disengaged a month early but was able to provide a ZAN-BPD score at the end of DBT. This indicates that clients found DBT acceptable, despite its intensity and duration. This reflects the extant literature which has demonstrated significantly higher drop-out-rates for control interventions compared to DBT (Linehan et al., 2006).
The small sample size of the present study means the results of this study have limited generalisability. A further limitation is that data was collected to provide a ‘snapshot’ at only three time-points. Change over time in a long-term treatment is unlikely to be linear throughout the treatment process, and some scores may have reflected fluctuations in state. In addition, there was no symptomology data for the months following the end of the intervention. Therefore it is unclear whether the improvements seen at the end of treatment continue, or whether individuals experience relapse without the intensive input of DBT.

Finally data gleaned from diary cards on number of skills used and frequency of self-injury was subjective and often incomplete, therefore it is not possible to be certain of the accuracy of these ratings.

**Implications**

Given that 100% of clients appear to experience benefits and that subjective self-injury goes down and skill use goes up, the DBT service appears to be effective. The results challenge the perception of this client group being ‘untreatable’ (see NICE, 2009). However, the deterioration of one client from mid- to post-intervention warrants further investigation to identify the factors that may explain this.

**Recommendations**

Given that diary cards were often incomplete it could be useful to discuss the rationale using diary cards in the DBT group. This suggestion was also highlighted in the previous evaluation (Hale et al., 2012) after qualitative investigation, which suggests this may be an area that needs to be repeated regularly.

The current evaluation looked at use of other services. However, these services are funded in different ways so it may also be useful to look at use of services within the
CMHRS; for example amount of medication taken and frequency of contact with other professionals in the team. This may provide a measure of prescribing costs, use of resources and a better indication of the overall and service-level economic impact of the intervention.

It may be useful for future evaluations to include additional time points for data-collection; specifically follow-up measures are recommended to gain an understanding of whether any benefits observed at the end of the intervention remain at a later date. On-going evaluation is also recommended, to increase the sample size; build upon findings described here and provide a more reliable estimate-effectiveness of the service. Qualitative investigation into therapist and client experiences may provide valuable information about the process of DBT and what they experience to be effective and ineffective may be useful. Finally, diary cards could be used to track idiosyncratic target behaviours, in addition to monitoring self-injury and skill use; see Stepp, Epler, Jahng & Trull (2008) for possible methodology.

**Dissemination to Service**

The project will presented to the DBT service team and manager at their monthly meeting on the 31st October, 2012 (see Appendix D).

**Conclusion**

The data suggests that the DBT service is effective. However the sample size was small which means the results are not generalisable. On-going evaluation of the DBT service is needed to provide more reliable estimates of effectiveness and cost-effectiveness of the service.
**References**


therapy by experts for suicidal behaviors and borderline personality disorder.


APPENDIX A

Project Approval

Trainee Clinical Psychologist
University of Surrey
Guildford
Surrey
GU2 5QY

Dear

Ref: An evaluation of the effectiveness of the East Surrey Dialectical Behavioural Therapy (DBT) service for individuals with a diagnosis of Borderline Personality Disorder (BPD)

Thank you for submitting the relevant documentation for the above service evaluation project. We will keep a copy of your project proposal on file. The Trust grants permission for you to undertake this service evaluation as proposed.

We note that the SABP lead super has changed and that Dr Vandana Gupta has kindly agreed to act in this role for this project.

It is your responsibility to comply with the Trust monitoring arrangements and as such you are required to submit a copy of the final report for this study in due course.

All parts reserves and comply with Trust R&D policies and procedures, available on the Trust website

http://www.sabo.nhs.uk/gwyddon/t&p&p/searchterm=POLICIES. Failure to comply with any of the above may result in withdrawal of Trust approval.

I wish you well with your project.


## APPENDIX B

### ZAN-BPD Clinically significant change Data for Calculations

Table 1

*Clinically Significant Change Index Indications for ZAN-BPD Total and impulsivity Subscale Scores.*

<table>
<thead>
<tr>
<th>ZAN-BPD Score</th>
<th>Clinical norms (sd.)</th>
<th>Non-clinical norms (sd.)</th>
<th>CSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ZAN-BPD Score</td>
<td>14.3 (6.8)</td>
<td>5.2 (3.5)</td>
<td>8.29</td>
</tr>
<tr>
<td>Total Impulsivity Score</td>
<td>1.7 (1.4)</td>
<td>.5 (.7)</td>
<td>.9</td>
</tr>
</tbody>
</table>

*Note. Sd. = Standard deviation; CSC = Clinically significant change.*
APPENDIX C

Reliable Change and Clinically significant change Calculations

The following calculations were used for both the SCL-90 and ZAN-BPD scores (based on method outlined in Jacobson & Traux, 1991).


\[ RC = \frac{x_2 - x_1}{S_{\text{diff}}} \]

\[ S_{\text{diff}} = \sqrt{2(SE)^2} \]

\[ SE = S_1 \sqrt{1-r} \]

Where:

- \( RC \) = Reliable change
- \( r \) = Test-retest reliability
- \( x_1 \) = Score at time 1
- \( x_2 \) = Score at time 2
- \( S_{\text{diff}} \) = Standard error of the difference between test scores
- \( SE \) = Standard error


\[ C = \frac{S_0 M_1 + S_1 M_0}{S_0 + S_1} \]

Where:

- \( C \) = Clinical change
- \( M_0 \) = Mean of non-clinical group (‘dysfunctional’)
- \( M_1 \) = Mean of clinical group (‘functional’)
- \( S_0 \) = Standard deviation of non-clinical group norm
- \( S_1 \) = Standard deviation of the clinical group norm
APPENDIX D

Confirmation of plan to disseminate

RE: Presentation

Dr. [Name]

Tel. [Phone]

I am writing to confirm that you will presenting the results for SRRP on 31/03/12 to the local DBT service.

See you at 11.30am at the [Location].

If you have problems finding it please ring reception on [Number].

BW,

[Name]

Consultant Counselling Psychologist
Final Reflective account

On Becoming a Clinical Psychologist: A Retrospective Developmental Reflective Account of the Experience of Training

Year 3

April 2014
When I started training I could not have anticipated the amount that I would change and develop over the three years. It would have been impossible to cover all aspects of my development in this account, so I have chosen to discuss how some of the critical ideas I held at the start of training have evolved and influenced my practice throughout training, and how I think these experiences have shaped the practitioner I hope to become once qualified.

Starting at ‘antipsychiatry’: When I wrote my application form for the clinical psychology doctorate the biomedical understanding of human distress was something that I took for granted and had given little thought to. Prior to my interview for the Surrey course, I read ‘Doctoring the Mind’, a critique of the biomedical understanding of human distress (Bentall, 2009). The book fundamentally changed the way I thought about distress. As a result I positioned myself as taking an ‘antipsychiatry’ stance, and approached the start of training with a naïve excitement that I was joining the profession that I perceived to be the antithesis to psychiatry.

The illusion that clinical psychology had all the answers quickly dissipated. Despite the course team encouraging us to be critical of the medical model, I was frustrated to find that much of our teaching was structured around diagnoses. At the time I felt angry at the course team because I thought their verbal critique was just rhetoric, and viewed the teaching as evidence that they implicitly endorsed the medical model. However later conversations with members of the course team revealed that the intention was to expose us to the reality of working in medically dominated NHS mental health teams. This made me realise that it was unrealistic to expect to be able to start placement without being prepared for the context we had to work in, and that it was impossible to think about how to change services without first understanding their current nature.
I also felt frustrated when others in my cohort expressed their views that they thought medication and diagnosis were helpful. Having spent a lot of time researching and contemplating the validity of the medical model prior to training, I felt secure in the position I took in relation to diagnosis and the use of psychiatric medication. On reflection, I think I was quite critical towards the individuals I perceived to be ignorant during the early stages of the course. It hadn’t crossed my mind that they may not have been exposed to the literature that I had only recently learned about, or that I too had recently held the same views. I felt ashamed when I realised this, but it tempered my frustration. Instead of being judgmental, I realised it was probably more helpful to try to explain some of my thinking, and share relevant literature with my peers.

At the end of the first year I thought these attempts were having little impact, and I was also overwhelmed by how entrenched these ideas were in NHS services. I think this led to me retreating into a state of ‘learned helplessness’ (Seligman, 1972). Later in training some of my peers reported that they had been influenced by what I had said and we have gone on to have some interesting and thought provoking discussions that have both challenged my views and helped me to solidify arguments. Reminding myself of just how challenging it was for me to work in medically dominated services, whilst maintaining a critical stance, helped me to be more tolerant of others’ perspectives. I realised that by asking others to change their views, I was asking them to put themselves in this position too. I also wondered whether my peers (and other NHS professionals) might be holding onto the medical model because it provided structure and certainty, and rejecting the model might have felt unsafe.

**Becoming critical of psychology.** When I started training I was hopeful that the new psychological tools I was learning would provide a more palatable alternative to psychiatric medication. The initial models I was exposed to were Cognitive Behavioural
Therapy (CBT) and Cognitive Analytic therapy (CAT) and these models appeared to make a lot of sense. My first placement was in a community mental health team (CMHT) and all of the people I worked with had complex backgrounds, and were acutely distressed. Everybody I encountered had faced and/or were facing conditions of extreme adversity, such as abuse, poverty and social exclusion. The stories of those I worked with revealed that their distress was predominantly the result of external forces that were impacting on them now, or had prevented the acquisition of resources that help us cope with life’s challenges (e.g. secure attachments and the capacity self-soothe and regulate emotions). I also started to worry that therapy’s attempts to change cognitive processes, promote ‘insight’, or change behavior, neglected the social and material causes of distress, and placed the blame for distress within the individual. In response to these concerns my supervisor at the time encouraged me to emphasise these external contributors to distress in formulations. This was something that appeared to help people to understand that the distress they experience might be the result of things that had happened to them, rather than something that was deficient within them. Although acknowledging social and material contexts in formulations went some way to ameliorating the concerns I had about individual therapy, I still worried that by focusing exclusively on the individual, I was failing to address the social and material factors.

It made me uncomfortable to think that there were aspects of clinical psychology that I was as critical of as psychiatry, but it made me rethink the antipsychiatry position I had previously adopted. I realised that the problems in mental health services are not confined to one profession and thus resolved that it was important to remain critical of clinical psychology and mental health services in general, rather than attacking psychiatry. This is something I remind myself of when I find myself becoming angry at medically dominated services.
The importance of power: Having realised that it was important to think critically about the work of clinical psychology, I started to explore the critical psychology literature. I became particularly interested in the notion that distress was caused by social and political inequalities, and the widespread abuse of proximal (e.g. relationships, school, employment, housing, socio-economic status) and distal powers (e.g. political, cultural, economic, and media influences; Smail, 2005). These ideas appeared to fit with my reflections on my first year experiences. Although I had begun to work with proximal influences in my child and adolescent placement, I realised I was still neglecting distal influences.

My supervisor encouraged me to incorporate power explicitly into formulations. I found a model called ‘power mapping’ (Hagan & Smail, 1997) provided a useful framework to structure formulations (see appendix for an example). Using this tool with Tom enabled me to position myself alongside him, acknowledge the different influences on his wellbeing, challenge blaming, and self-blaming ideas, and to see more clearly where problems resided. Tom explained that it helped him to ‘see all the different things that affect the way I feel’. This demonstrated to me the power that a thoughtful and holistic formulation can have to demystify and relieve distress, and provide a meta-message about personal meaning, agency and hope (British psychological Society; BPS, 2011; Cromby et al., 2012).

In addition to enhancing our understanding of why Tom was experiencing such acute distress, it also helped us to plan how to tackle the problems at different levels. For example at a personal level, we used ideas from Acceptance and Commitment Therapy (ACT) to increase the resources that Tom had available to him to cope with the

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5 The name has been replaced with pseudonym in order to preserve anonymity.
6 Tom was a man who experienced verbal and motor tics, was unable to walk, and who had a diagnosis of learning disability.
tics, worries and physical pain he experienced. We also worked on building Tom’s sense of agency, by finding forums for his voice to be heard (such as meetings with his care manager, and presenting together to staff at his accommodation). In terms of addressing proximal influences, I supported Tom to self-advocate to his residential home and social services. This led to him: reclaiming responsibility for his finances and medication; making plans to move in with his girlfriend; starting an art apprenticeship; and gaining a job a local charity shop.

The process of addressing these wider systemic issues was a learning curve for me. Our attempts to share the formulation with staff at his residential home were initially met with resistance, perhaps because reframing the problem as part of Tom’s social environment, rather than something deficient in him felt like an attack on those involved. This highlighted the need to present formations sensitively, and with respect for existing views to ensure that the formulation was accepted by the wider systemic context (BPS, 2011; Chirstofide, Johnstone & Musa, 2011).

The process of sharing the formulation also caused me significant anxiety; I worried about upsetting others and provoking confrontation. However, at the end of the work those involved in Tom’s care reported that they had found it helpful to think about Tom’s distress in terms of the external forces impacting on him. This demonstrated to me the importance of clinical psychologists’ duty outlined in the leadership framework to ‘advocate a psychological stance in conjunction with or instead of other health care models even in difficult circumstances, demonstrating ethics and values’ (Skinner & Toogood, 2010).

Although we were able to consider and address the impact of numerous external forces on Tom, most of these were at a proximal level. I considered the distal influences
on Tom in supervision, and also with Tom himself\textsuperscript{7}, however it was difficult to find ways to address such issues within the few months I was on placement. This was frustrating and highlighted strength and complexity of distal political, economic and cultural power. However, Tom was motivated by these ideas and thought that a documentary might be one way to challenge these distal influences; he had written to the BBC to share his ideas as I was leaving placement. I was inspired by Tom’s actions; it sparked ideas in my mind about the potential for using the media to disseminate critical narratives in the future. Working this way also encouraged me to think of ways to address distal influences once qualified. This might be through influencing policy, the media, conducting critically aware research, or drawing on ideas from community psychology.

I also found that I felt more comfortable with individual therapy when it was placed in the context of wider systemic work. I think this was because acknowledging and addressing some of the external forces on Tom, meant that individual therapy didn’t seem to imply that his distress was the result of some personal deficiency, as it might have done had therapy been conducted in isolation. I was able to see that therapy might be used to support individuals to acquire resources (such as interpersonal, self-soothing, and emotion regulation skills) that prior adverse social and material circumstances may not have afforded.

The proportion of this paper that I have devoted to discussion of my work with Tom reflects the impact that this has had on my professional development. Until this point in my training I had been anxious about discussing some of the more critical ideas I was entertaining in supervision. Ironically, I think this was partly due to issues of power and interest (Smail, 2005). Although I wanted to practice ethically, I also wanted

\textsuperscript{7} The concepts of cultural, political, and economic power were explained at a level that Tom felt he could engage with.
to impress my supervisors and pass my placements, and I worried that they might perceive critical thinking as an attack on their practice, which may influence their evaluation of my work. An intrapsychic explanation as to why I took a risk at this point might be that the cognitive dissonance I was experiencing had reached a magnitude that necessitated I take action to reduce it (Festinger, 1957). A socially oriented explanation might be that the relationship I had with my supervisor at this time, was more secure than previous supervisory relationships and that my supervisor provided a 'secure base' from which I felt safe enough to explore critical issues (Bowlby, 1969).

Alternatively, my previous supervisors may have been sensitive to my developmental stage of training, and learning needs at the time. Given that I had no experience of formulation or therapy before I started training it would have been unrealistic to expect to be able to practice a new therapy, whilst considering the numerous proximal and distal influences of power at the beginning of training. Perhaps the timing of this case reflected the fact that my supervisors had enabled me to acquire the necessary personal (e.g. confidence) and professional (e.g. psychological theories and leadership skills) resources to tackle increasingly complex pieces of systemic work. This highlights the importance of considering the 'zone of proximal development' (Vygotsky, 1978) in any piece of developmental work, be that therapy or education. This is an idea that I had used when working the CAT model, but had not thought to apply to my own development. It has subsequently influenced my clinical work, and experience of supervising an assistant psychologist in my final year. This is something I hope to take forward into my future career.

Professional responsibility and integrity. Despite my concerns about practicing therapy in isolation, I chose to specialise in Interpersonal Psychotherapy (IPT) because it seemed to have a more systemic and relational focus, and because it
allowed me to train and potentially become accredited in a therapeutic model before qualifying as a clinical psychologist. I still had reservations about IPT, because the model asked that you ‘diagnose’ ‘depression’ part of the ‘therapeutic’ process. However, I knew that the main body of IPT does not rely at all on the medical model; rather it looks at how distress is inextricably linked to the quality and quantity of our past and present relationships, and focuses on supporting an individual to acquire the necessary resources to improve their relationships. Consequently I thought I could to pay lip service to the medical model for the tapes I submitted, and omit this from my practice once qualified, as I was aware a subgroup of IPT advocates were already doing (see Stuart & Roberson, 2012).

I have now been using IPT for over six months, and although like other therapies, the model does not address distal influences, I have found its focus on the interpersonal, rather than the intrapsychic fits better with my developing understanding the causes of distress than other models such as CBT. The focus on relationships, rather than internal processes also seems to have been more relevant to the people I work with. However, I definitely underestimated the level of discomfort I would experience making use of the medical model. It seemed unnecessary, and unethical to tell people that the problem was taking place within them, when they were also offered a formulation that explaining their distress in material and social terms. Some people appeared to find relief in the diagnosis of depression, but the majority of the feedback I received cited the formulation as the thing that helped them to understand how their circumstances contributed to their distress, and stop blaming themselves. Furthermore, when I returned to BPS document specifying the core values of the profession, I was reminded that we should practice with ‘integrity honesty, accuracy, clarity, and fairness in their interactions with all persons’ (BPS, 2010, p. 2). Given that I have an empirically
grounded understanding of the problems with the medical model, I feel that it is my responsibility to ensure that it is not only something that I refrain from endorsing, but also something that I challenge in my future practice. Consequently, when I qualify, if I continue to practice IPT I hope I can advocate for the removal of the medical model from future iterations of IPT and that I can find way to challenge the dominance of the medical model in mental health services.

**Facing challenges.** The highly medicalised CMHT for older people that I currently work in are under numerous pressures including: increasing caseloads, staffing cuts and a Care Quality Commission (CQC) inspection. Based on ideas generated in previous reflective accounts, I suggested that a reflective practice group might facilitate critical thinking in the team, and also provide a safe and containing space for them to reflect on the pressures they face. The idea was rejected because the team felt that it would be another drain on their time. In the past I might have judged the team for not being committed to reflective practice. However, recent experiences allowed me to empathise with their dilemma, despite the fact that I understand reflective practice skills are widely acknowledged as being important in developing effective clinical practice and expertise, and role satisfaction (Hargreaves, 1997; Sainsbury Centre for Mental Health, 2000). For example, I have been completing my final placements concurrently and spend little more than a day per week on each. Although some of my other placements have been busy, I think this is the first time I have been exposed to a similar amount of pressure on my time as other qualified professionals. This has meant that there has been little time to think about and discuss critical ideas, let alone think about ways to implement them. I can therefore understand the team’s reasoning that they didn’t have time for a reflective group.
My final year experiences have also highlighted the importance of considering the influence of proximal and distal power on staff and services, as well as the people they serve. The remit of the services we work in, and thus our professional activities are ultimately controlled by political and economic agendas. In addition, as professionals we are also subject to a whole host of proximal and distal forces that influence how we behave at work. For example my decision to specialise in IPT was motivated by my own interests (e.g. hoping it would improve my chances of getting a job) and the influence of power (e.g. the economic pressure to support myself through paid employment as a single person). Furthermore, I can now see how individuals may be reluctant to speak up about, or contemplate engaging in critical thinking for fear of making their work life uncomfortable, or putting their job, (and therefore their income) at risk. Again, this has made me more tolerant of those who are reluctant to engage in critical thinking.

**Conclusions and future directions:** I hope this account has given a flavour of how my thinking has evolved from being damning of the psychiatric profession, to taking a more critical perspective of all aspects of service and my work. The experience of working with Tom, showed me that it is possible to consider the influence of proximal and distal power in relatively short term pieces of work, whilst at the same time demonstrating how difficult it is to find ways to immediately influence the more distal forces that can cause distress. In addition, the discomfort I experienced when working in a way that conflicted with my professional values, and returning to the core values of the clinical psychology profession, has reinforced the importance of finding ways to maintain my integrity. Furthermore, these experiences have also reinforced the importance of fulfilling our professional responsibility to challenge oppressive practices. Finally, my recent reflections have highlighted the complexity of effecting
change in services that are driven by political and economic agendas, and how these agendas on impact on the scope professionals have to instigate change.

I have already seen the benefits of combining therapy with work that addresses proximal influences, and I have started to think about ways in which I can make changes at a distal level. For example ideas for my future career include: using the media to disseminate alternative discourses; conducting critically aware research; getting involved with training, becoming involved in policy development and commissioning; and drawing on ideas from community psychology to support marginalised groups to have their voices heard. I have also joined the Community Psychology UK network on the basis change is more likely when resources are pooled collectively. I realise the road ahead will be challenging, but I am optimistic about the future, and I look forward to seeing the different opportunities to effect changes on distal influences that arise post qualification.
References


framework. Leicester: British Psychological Society.


Appendix

Example of ‘power mapping’
Example of ‘power mapping’

**Politics**
Neoliberalism

**Economics**
Free market capitalism, austerity, public spending cuts

**Culture**
Western individualism, Materialism, Meritocracy

**Information/media**
'Skivers and scroungers', Mental health agenda, active lifestyle

**Domestic and work situation**
Institutions, unemployed, not expected to work

**Health and social services**
Medicalised, proximalisation of distress, risk averse, safeguarding

**Education**
'Learning disability', 'Special schools'

**Personal relationships**
Girlfriend, Limited social network

**Family**
Close, 'Sick role', Dad – 'depression', Mum – 'post natal depression'.

**Experience**
Lack of agency, isolation, shame, not 'real' man, self as 'needy', 'disabled' and 'sick', must be 'good' and please others

**Embodiment**
Pain, anger, fear, sadness, confusion, agitation, tics, can't walk
Summary of Clinical Experience
Adult – Community Mental Health Recovery Service (CMHRS).

During this first placement I worked with individuals with severe and enduring mental health difficulties. I gained experience of psychological assessment, formulation and intervention with individuals who had experienced complex trauma in their childhood, and who consequently experienced severe emotion regulation and interpersonal difficulties, trauma related experiences (e.g. dissociation, reliving, and hyperasousal), and high risk behaviours (e.g. self-harm, aggression towards others, substance use, eating problems). I also had the opportunity to work with a number of individuals who had unusual experiences and/or beliefs.

I worked therapeutically using a range of models including: Cognitive Behavioural Therapy; third wave approaches such as Compassion Focused Therapy (CFT), Dialetical Behaviorual Therapy (DBT) and Schema Focused Therapy (SFT); and Cognitive Analytic Therapy (CAT). In addition, I co-facilitated the 20-week Systems Training in Emotion Predictability and Problem Solving (STEPPS) group for women with a diagnosis of Borderline Personality Disorder and I evaluated this group and the DBT service using idiographic change indicators and single cases statistics.

I also completed a number of cognitive assessments including dementia and learning disability screenings and an assessment for the effects of acquired brain injury.

Child and Family – Child and Adolescent Service (CAMHS).

My work in this tier-three CAMHS followed the Choice and Partnership Approach (CAPA). As well as building on my existing CBT skills, I also began to develop skills in using Behavioural Therapy, Narrative Therapy, Acceptance and Commitment Therapy (ACT), and taking a systemic approach to work. In addition to direct therapeutic work I began to develop skills in consultation, providing MDT
members with information about how they might draw on psychological concepts such as attachment theory, and simple CBT skills to inform their work.

I also completed a number of cognitive assessments to inform formulations and interventions, ran a support group for parents of children with a diagnosis of autism spectrum disorder, and provided teaching on the NICE guidelines for Conduct Disorder.

**People with Learning Disabilities – Community Team for People with Learning Disabilities (CTPLD).**

During this placement my therapeutic work was predominantly informed by psychodynamic and systemic theory, mindfulness and ACT. I continued to develop my skills in working with clients’ wider systems, such as their families, residential placements, and social services. I was also able to find ways to encourage service user involvement, for example developing and delivering a presentation with a man who I had been working with therapeutically, in order to inform staff at his placement how they might best support him.

I also continued to develop skills in working indirectly, providing consultation to MDT members, a forensic inpatient ward, and residential support services. In addition, I developed and provided mindfulness training to staff on a locked ward. Finally, I conducted a number of cognitive assessments including learning disability screening and dementia assessments.

**Older People – Community Mental Health Team for Older People (OPCMHT), Acute Inpatient Ward and Home Treatment Team.**

During this placement I worked therapeutically with people with a range of presenting problems using models including ACT, CBT, Narrative Therapy, and Narrative Exposure Therapy (NET). I also co-facilitated a transdiagnostic mindfulness group and provided brief mindfulness sessions on the acute inpatient ward.
Consultation was an important part of my work and I supported members of the MDT and third-sector services to formulate and manage risk, develop behavioural interventions, and reflect on the impact of team dynamics.

Finally, I completed a number of cognitive assessments including dementia screening, and to inform post-stroke care. I also supervised the research and clinical activities of the assistant psychologist in the Stroke service.

**Specialist – Sexual Health Clinic and IPT Training.**

As part of my specialist placement I trained in Interpersonal Psychotherapy (IPT) and worked towards accreditation by using IPT to work with a number of individuals who were experiencing low mood as well as their primary sexual health problem. I worked with people with a diverse range of presenting problems including people with vulvodynia, HIV, sexual performance problems, traumatic stress and those who engaged in risky sexual behavior. In addition to IPT, I worked using CBT and motivational interviewing techniques. I was also involved in the development of a group for women with vulvodynia and completed a literature review of psychological interventions for this client group.
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