## **FORM 3: IPT RECORDING RATING SCALE**

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| --- | --- | --- | --- | --- | --- |
| Student Initials | | Person Initials | | Rater Initials | |
| Focal Area | **Case #** | | **Session #** | | **1st submission** |
| **Resubmission** |

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| --- | --- | --- |
| The rating scale is subdivided into four parts. Only those parts relevant to the current phase of treatment should be rated for individual recordings. | | |
| Scoring guide | | **Pass Fail** |
| Items are rated on a 0-6 scale, ranging from 0 = not attempted to 6 = excellent. Items can be rated between anchor points. Decimal point scoring i.e. 3.5, should not be used. | | |
| 0 | **Item was not attempted** | |
| 2 | **Item was attempted but the intervention was incomplete and/or superficial** | |
| 4 | **Item was completed in a manner consistent with IPT**  **competencies and to a good standard** | |
| 6 | **Item was completed in a manner consistent with IPT**  **competencies and to an excellent standard** | |
| Items rated as attempted i.e. rated 1-6, must achieve an average score of 3 in each section completed. The average is the total score for the rated items divided by the number of items rated above zero. | | |
| No more than two attempted interventions must be scored 1 or 2 per recording. | | |
| “Symptom review” and “linking depression to focus” must not be rated at 2 or below more than once per case. The case automatically fails if either of these items fail on two submissions | | |

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| The final accreditation training portfolio must demonstrate evidence of competent practice of all initial phase and ending phase competencies over the collective submissions for four cases. Submissions for middle sessions must demonstrate competence in reviewing symptoms and linking to focus and *at least* one item in examining the focus relationship/role and one in engaging the network per case, as described in the competency rating summary sheet. Colour coding is used throughout this form as a guide. Green items cover essential (symptom review and linking to interpersonal context or focus) and recommended items, which should be addressed in every session, and blue items should be used as appropriate to the stage of post formulation work. |

## **PART ONE: IPT General Strategies**

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| --- |
| Part one of the scale addresses the following IPT Basic Competencies: |
| Ability to maintain a systematic focus on an IPT interpersonal problem area(s) linked with the onset of symptoms |
| Ability to identify and explore difficulties in communication |
| Ability to facilitate the expression and acceptance of a range of emotions |
| Ability to encourage interpersonal change in-between sessions |
| Ability to adapt the core IPT strategies to the person’s needs and the time available |
| Ability to balance being focused and maintaining alliance |
| Ability to establish appropriate balance between the therapist activity and non-directive exploration |
| Ability to make selective use of specific techniques to support the strategies and goals of the focal area |

### 1. Facilitate expression and acceptance of a range of emotions

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not facilitate expression or acceptance of emotions  The therapist infrequently tracked the person’s emotional state during the session and rarely encouraged expression of affect  The therapist identified and responded to verbal and non-verbal emotional cues in the session and used these to help the person explore, understand and express his/her emotions, recognize and accept his/her feelings, differentiate feelings from actions and identify the relationship between what s/he feels and how s/he behaves in a relationship  The therapist consistently and sensitively tracked and explored the person’s emotional state as a core strategy. The therapist supported the person in staying with current acknowledged and unacknowledged emotions in order to more fully recognize, accept and name his/her emotional state, to use affect as a basis for understanding interpersonal experience. The therapist used the depression circle to illustrate the connection between relationships and feelings to help the person to decide when the expression of strong emotions is appropriate outside of the sessions and when it might undermine relationships. Where required the therapist used simple scales to monitor mood. |
| Comments | |

### 2. Attend to the therapeutic relationship

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not acknowledge the person’s experience or attend to the therapeutic relationship  The therapist was inconsistent in demonstrating empathic awareness of the person’s experience and responsiveness to the therapeutic relationship  The therapist demonstrated empathic understanding of the person’s experience and fostered active collaboration with the person by sensitively responded to verbal and non-verbal cues  The therapist maintained a curious and collaborative manner and communicated a non-judgemental understanding of the person’s experience. The therapist identified opportunities for both empathizing with and clarify the person’s predicament(s) and for noting his/her strengths through affirming and encouraging statements |
| Comments | |

### 3. Focus the session on an appropriate topic

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not focus the session on an appropriate topic  The therapist maintained generic attention to interpersonal themes and depression  The therapist consistently maintained attention on the relationship between symptoms and interpersonal context and adapted the specific interventions appropriately according to the phase of therapy  The therapist skilfully combined attention to the key symptomatic and interpersonal goals of therapy in the current interpersonal context, with clear attention to the specific objectives and tasks of the phases of treatment and individual focal areas, integrating pan focus work when appropriate and maintaining awareness of previous and future phases |
| Comments | |

### 4. Monitor, support and acknowledge progress in addressing interpersonal problems

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not acknowledge or support the person’s progress in addressing interpersonal problems  The therapist infrequently acknowledged or supported the person’s progress in addressing interpersonal problems  Therapist helped the person to maintain focus on the goals of and rationale for interpersonal change. The therapist collaboratively tracked and reinforced the person’s attempts to achieve interpersonal change and explored difficulties in making progress, providing social skills training where appropriate  The therapist actively and consistently supported the person to focus on making realistic and specific interpersonal change by helping him/her to understand the symptomatic and interpersonal implications, identify and engage resources to assist with this change and constructively address obstacles. The therapist provided targeted social skill straining, including work on perspective taking, where appropriate. The therapist skilfully balanced the drive towards change with an awareness of and sensitivity to the person’s readiness for change |
| Comments | |

### 5. Maintain the IPT therapeutic stance

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not maintain a supportive or empathic stance  The therapist offered occasional support but did not maintain a consistent, active and collaborative presence in the session  The therapist maintained an active, supportive and empathic stance and collaborated with the person to identify specific interpersonal problems, discuss material relevant to the agreed focus, and work towards interpersonal change  The therapist maintained an active, supportive, empathic and validating stance, praising the person’s achievements, communicating directly, inviting feedback and responding non-defensively to the person’s negative experience of the therapist. The therapist helped the person to identify specific interpersonal and communication problems, focus on relevant material and work towards interpersonal change. The therapist maintained a balance between taking an informed expert stance and instilling confidence in the person in his/her ability to resolve his/her interpersonal problem(s) |
| Comments | |

### 6. Directive techniques (Psychoeducation and advice)

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not use directive techniques  The therapist provided only limited, basic information without adequate explanation.  The therapist provided information and advice sparingly but appropriately to engage the person and foster the person’s confidence in the therapist’s ability to help  The therapist constructively informed and guided the person’s behaviour and thinking by using techniques such as psycho-education and providing relevant factual information and recommendations. This information was used to foster a sense of confidence in the therapist’s knowledge, expertise and ability to help but did not override the person’s independent choices |
| Comments | |

### 7. Role Playing

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not use role play  The therapist used superficial or incomplete role play to generate alternatives to problematic exchanges  The therapist used role play appropriately to explore and practice alternative communication relevant to the focus area  The therapist skilfully selected appropriate opportunities, guided the person through detailed preparation and scripting and used role-play to explore and practice alternative communication strategies and promote the person’s experience of competence in communicating and interacting more effectively |
| Comments | |

### 8. Decision analysis

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not use decision analysis  The therapist demonstrated superficial or overly directive problem solving techniques  The therapist worked with the person to identify decisions relevant to the focus area and discussed the range of alternative options and potential consequences to aid decision-making  The therapist skilfully supported the person to clarify significant decisions related to the focus area, review the full range of options available, give consideration to anticipated positive and negative consequences for the focal area and depression and develop a balanced plan of action. The person was supported to integrate this strategy as an independent competence |
| Comments | |

### 9. Clarification

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not use clarification  The therapist infrequently used clarification to help his/her own or the person's understanding  The therapist regularly and appropriately used clarification, such as asking the person to repeat what s/he said or emphasizing the interpersonal context to help the person to become more aware of what s/he thought and felt.  The therapist skilfully and flexibly used clarification to deepen his/her own and the person's understanding, to attend more clearly and specifically to the person's communication, feelings and thoughts and to explore contradictions and connections in what the person said |
| Comments | |

### 10. Exploratory techniques

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

### 11. Communication analysis

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not use communication analysis  The therapist made generic or superficial enquiries about communication but did not explore examples in detail  The therapist engaged the person in reporting and reflecting on a recent, difficult exchange/conflict with another person through detailed reconstruction of the incident, associated feelings and link to depression  The therapist helped the person to explore specific examples of problematic communication in detail, including the verbal and non verbal content, associated affect, the objective of, effectiveness of and satisfaction with the communication, the associated expectations and evaluation of reciprocity, empathic appreciation of the other's experience and considering and practicing alternative ways of communicating in detail |
| Comments | |

### 12. Explicit reference to the therapeutic relationship (Used infrequently)

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

### 13. Assess and respond to risk

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not assess or respond to risk  The therapist conducted an incomplete or superficial risk assessment and responded slowly or inappropriately to indicators of risk  The therapist identified current and chronic stressors that may place the person at risk of harm to self or others and responded promptly to minimise potential harm  The therapist identified current and chronic stressors that may place the person at risk of harm to self or others, including mental health problems in family members, and responded promptly and with reference to the interpersonal formulation to minimise potential harm, including initiating appropriate referrals to other services to support the person’s family/carer(s) and/or the person.  The therapist identified when IPT is not indicated due to the risk factors. |
| Comments | |

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

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| --- |
| Number of items rated 1 or 2: |
| Part one: Pass/Fail |

## **PART TWO: IPT Initial Sessions**

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| --- |
| The second part of the scale addresses the following IPT Basic Competencies: |
| Knowledge of basic principles, rationale and strategies of IPT |
| Ability to maintain a focus on the interpersonal context of the symptoms |
| Ability to implement IPT in a manner consonant with its supportive and active therapeutic stance |
| Ability to engage the person in IPT |
| Ability to reframe the person’s presenting problems as an illness |
| Ability to identify an interpersonal problem area that will provide the focus for the middle phase of therapy |

### 1.Detailed enquiry about depressive symptoms (Symptom Review)

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist made no reference to depression  The therapist made an incomplete review of depressive symptoms, failing to cover the full range of symptoms or course of the episode  The therapist reviewed the full range of depressive symptoms over the last week and/or over the course of the current episode and involved the person in evaluating this/her symptom experience  The therapist reviewed the full range of depressive symptoms with discussion of frequency, intensity, duration and change. Actively involved the person in tracking his/her symptoms and linking to interpersonal functioning in the past week and/or over the course of the episode. The therapist included review of standardized measures  NB This item can be used torate the initial symptom review for the most recent episode or the past week depending on the session being rated |
| **Comments** | |

### 2. Translate the depressive symptoms into the interpersonal context (Social model of depression and current links)

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

### 3. Review of current depressive episode and development of symptoms in the interpersonal context (Timeline: current episode)

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not review the current depressive episode or interpersonal context  The therapist reviewed the depressive episode and/or interpersonal context but made few or no links between them and did not actively involve the person in considering possible links  The therapist reviewed the course of the most recent depressive episode and linked interpersonal triggers and consequences to evolving symptoms. The therapist involved the person in thinking about their symptoms in an interpersonal context to introduce the interpersonal emphasis of therapy  The therapist conducted a detailed review of the evolving course of the depressive episode, with particular emphasis on onset, duration and severity of depressive symptoms and with active and recurrent collaborative exploration of the interpersonal precipitants and consequences of symptomatic change to develop a shared understanding of the interpersonal context of the current episode. |
| **Comments** | |

### 4. Review of previous depressive episodes including treatment and interpersonal context (Timeline: past episodes)

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not review past history of depression  The therapist reviewed past experience of depression, with limited or no reference to treatment or interpersonal context  The therapist reviewed past episodes of depression (diagnosed, undiagnosed and sub threshold) including treatment received and significant interpersonal factors  The therapist reviewed the full depression history with details of all treatments received and response; conducted a detailed examination of the interpersonal context for each episode; examined the way in which interpersonal patterns of difficulty around focal themes have repeated and are evident in the current episode |
| Comments | |

### 5. Give the syndrome a name (Diagnosis)

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not diagnose depression    The therapist made reference to depression without explaining the range, duration or impact of symptoms required for diagnosis  The therapist made a clear and collaborative diagnosis, naming depression as an illness and explaining the cluster of symptoms and interpersonal difficulties involved  The therapist made a clear and collaborative diagnosis, naming depression as an illness, explaining the cluster of symptoms and interpersonal difficulties and the common interactions between them. The therapist actively related the diagnosis to the person’s personal experience |
| Comments | |

### 6. Provide psycho-education on depression (What is known about depression)

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

### 7. Explain that depression is treatable (Range of EBT for depression)

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not explain that depression is treatable  The therapist informed the person that depression is treatable without providing any additional information  The therapist explained that depression is treatable and provided information about the different forms of treatment that can be used, including reference to research evidence, instilling hope that therapy can help  The therapist explained that depression is treatable and provided information about individual and combined approaches to treatment, research evidence and provided an explanation of the evidence base for the IPT approach. The therapist conveyed that addressing the social and interpersonal context of symptoms is anticipated to contribute to the resolution of the depressive symptoms and instilled hope that therapy will help and reduced self-blaming attributions |
| Comments | |

### 8. The therapist conveys understanding and expertise

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not convey an understanding of the person and did not convey an understanding of depression or IPT  The therapist demonstrated limited understanding of the person and provided a brief explanation of depression and IPT  The therapist communicated directly, acknowledged the person’s experience, and communicated clear and accessible information about the presenting problem and proposed therapy  The therapist demonstrated a curious and non-judgmental response to the person’s narrative, communicated empathic understanding, and linked the rationale for diagnosis and treatment with the person’s individual experience and symptom profile |
| Comments | |

### 9. Explanation of the sick role

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist made no attempt to explain sick role  The therapist acknowledged that the person is unwell but made limited attempt to engage the person in considering the implications of the diagnosis or mobilizing resources or behaviour change to manage symptoms  The therapist shared an explicit and collaborative diagnosis with the person and uses it to reduce self-blame, increase hope of recovery and initiate behavioural change and interpersonal engagement that will promote recovery  The therapist engaged the person in an explicit and collaborative diagnosis that directly targeted self-blame and sought to instil hope. The person was actively encouraged to maintain anti depressant activity, temporarily suspend specific overly demanding activities and obligations and to prioritize recovery by enlisting appropriate assistance |
| Comments | |

### 10. Discuss use of medication as combined treatment

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist made no reference to medication  The therapist made a limited review of current medication e.g. insufficient information about dosage, adherence, response, attitude  The therapist fully reviewed current use of and response to medication and attitudes to and problems with taking A/D medication  The therapist provided a clear explanation of the role of medication in the treatment of depression, including details of the research evidence, fully assessed the person’s current use of and response to medication, sensitively explored any reservations the person has and agreed a review point if medication is currently declined but would be a treatment option based on the person’s symptom profile |
| Comments | |

### 11. Explanation of IPT and phases of treatment

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not explain IPT  The therapist explained that IPT is a treatment for depression or that is has an interpersonal focus but did not explain the link or the phases or goals of treatment  The therapist explained that IPT is a focused psychotherapy aimed at reducing symptoms and improving social adjustment and interpersonal functioning. The therapist explained the three phases of treatment and the primary goals  The therapist explained the rationale for IPT as a time limited, here and now and interpersonally focused treatment which is rooted in a medical model of depression as a treatable illness; the reciprocal interaction between symptoms and life events; the goals of symptoms reduction and improved social functioning; the three phases of treatment with distinct strategies and objectives and selection and resolution of a interpersonally defined focus as the primary means of reducing symptom distress |
| Comments | |

### 12. Complete an Interpersonal Inventory

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| --- | --- |
| 0  2  4  6 | The therapist did not conduct an interpersonal inventory  The therapist made superficial enquiries about relationships but did not link to the depression or selecting an interpersonal focus  The therapist conducted a review of the person’s interpersonal context and network to identify the availability, acceptability and quality of current social supports, significant relationships and life circumstances and their connection to the current episode of depression  The therapist collaboratively and systematically examined the person’s interpersonal experience in detail, giving explicit priority to current relationships as a basis for formulating the current availability, use and acceptability of interpersonal resources and significance and impact of current difficulties. The inventory was explicitly linked to the objective of understanding the current episode of depression and identifying the interpersonal focus for therapy |
| Comments | |

### 13. Potential focus areas are identified with the person (Point of reference in every assessment session)

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

### 14. Presentation of interpersonal formulation of current depression

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not present an interpersonal formulation  The therapist identified the focus area but did not offer a personalized formulation related to the person’s narrative  The therapist helped the person to feel understood by presenting a summary of the salient events linked to the onset and maintenance of the depression and their impact and invited the person to respond to the proposed formulation and focus  The therapist skilfully provided a formulation that integrated the person’s temporal and thematic narrative, emphasizing the way in which specific interpersonal difficulties trigger and maintain the depression and how working within the identified focus area would seek to alleviate symptomatic distress. The person was actively encouraged to respond to the formulation and openly discuss misunderstanding or disagreements in order to agree how to proceed |
| Comments | |

### 15. Negotiation of specific and achievable goals for treatment, which reflect the focus area

|  |  |
| --- | --- |
| 0  2  4  6 | The therapist did not identify any goals for therapy  The therapist identified broad and generic goals for therapy and did not involve the person  The therapist worked with the person to identify and agree realistic the therapeutic goals related to the focus area.  The therapist worked with the person to use the formulation to understand the nature of the current difficulty and to specify the changes which could be realistically and fruitfully targeted to bring about positive symptomatic and interpersonal change in the context of the focus, taking into account the severity and chronicity of the difficulties, the resources available to the person and the time limited nature of therapy. |
| Comments | |

### 16. Explicit contract negotiation

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| --- | --- |
| 0  2  4  6 | The therapist did not negotiate a contract  The therapist agreed to continue therapy through the remaining phases without negotiating a specific agreement with the person  The therapist outlined the duration and frequency of future contact, the character of the work and expectations of the person and therapist in the context of the negotiated focus. The person was invited to discuss the details and any areas of disagreement  The therapist clearly and collaboratively discussed the clinical and practical expectations and responsibilities, planned for potential difficulties such as missed appointments and actively involved the person in preparing to move into a new phase of treatment. The therapist outlined and repeated the practical arrangements agreed at the start of treatment with details tailored to the person at the time of formulation |
| Comments | |

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

|  |
| --- |
| Number of items rated 1 or 2: |
| Part Two: Pass/Fail |