ISIPT Research and Clinical Report

Training in IPT Groups: Overview & outcomes of groups in the UK using the Wilfley-Welch IPT-G model

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Acknowledgements (our group network)

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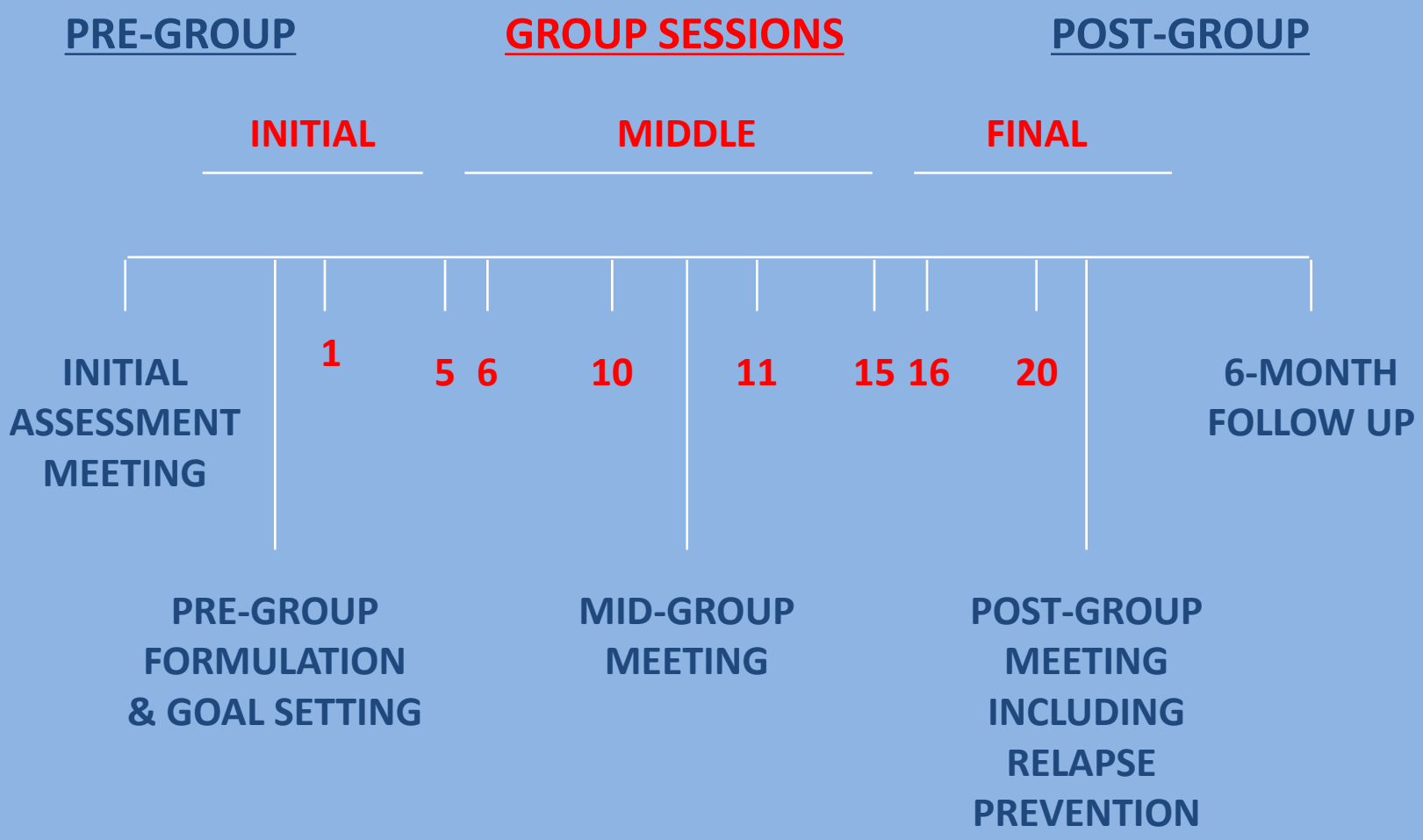
Overview

- What are the key ingredients of IPT-G?
- Is it effective?
- Our UK training model for IPT-G
- What initial outcomes have we seen from running and supervising groups in the public sector (NHS)?
- What have we learnt?
- Going forward

Overview of Treatment Structure



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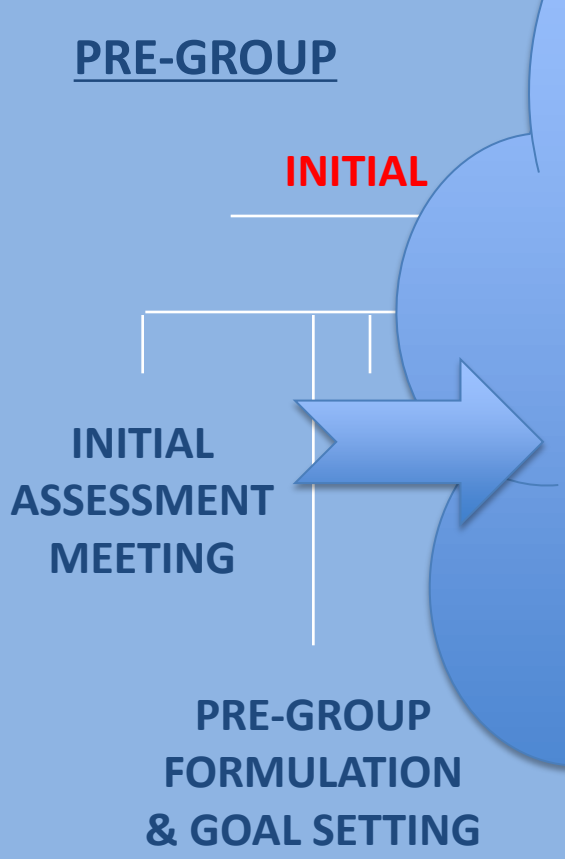

Individual meetings to engage the person, undertake the interpersonal inventory & identify problem area(s); provide information / psychoeducation

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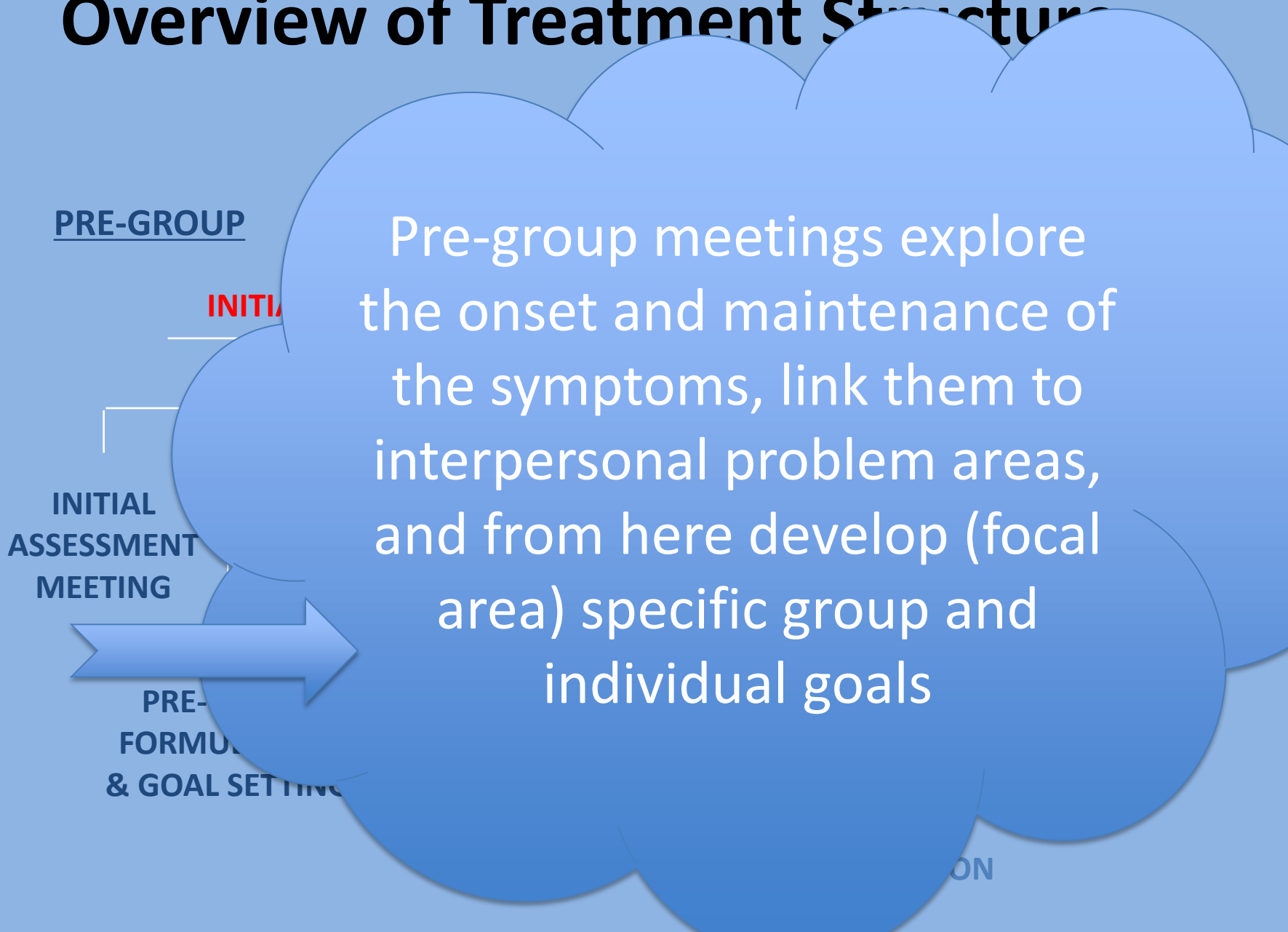
Overview of Treatment Structure



Overview of Treatment Structure

GROUP SESSIONS

INITIAL

Goals are linked to interpersonal problem areas - keeps the group facilitator(s) on track with the IPT work in the context of a semi-structured ‘interactional group experience’

Overview of Treatment Structure

GROUP SESSIONS

INITIAL

Key group facilitation tasks are linked to the beginning (development of cohesion) middle ('the work') and end (dissolution of this temporary social network) phases

Overview of Treatment Structure

GROUP SESSIONS

INITIAL

Emphasis of treatment on changing ***current external*** relationships

Overview of Treatment Structure

Individual mid way meeting – opportunity to reflect on progress and review goals; address motivation

Post-group meeting to review treatment and do a relapse prevention plan

MID-GROUP MEETING

POST-GROUP MEETING INCLUDING RELAPSE PREVENTION

NTH
OW UP

Summary of key ingredients of IPT-G (Wilfley, Welch *et al.*)

- Individual and group approach
- Semi-structured
- Emphasis on changing current interpersonal relationships that exist outside the group context
- Goal and action oriented –'the contract' – to this end an active group leadership style

Developing our IPT-G protocols

- We adapted the US approach for NHS settings:
  - Shorter, more focused notes
  - Individual IPT notes used for the patient care record
  - Group literature and standardized record forms for the assessments, group feedback, and mid- and post-group individual meetings
  - We wrote a protocol for our PPD group that could be adapted for other clinical groups and contexts

The evidence base for IPT-G

In summary – *IPT-G found to be as effective as CBT and waiting list control; the effect of therapy appears to be maintained over longer timeframe*

- **Major depression** (Levkovitz, 2000; Bolton et al., 2003; inc Uganda study, Clougherty)
- **Eating disorders** - see Wilfley, Welch *et al.;* Eating disorder not otherwise specified (Nevonen & Broberg, 2005); Bulimia nervosa (Nevonen & Broberg, 2006); adolescent weight gain group (Tanofsky-Kraff et al., 2007)
- **Female prisoners** with co-morbid depression and substance use disorder (Johnson & Zlotnick, *J Substance Abuse Treat,* 2008)
- **Post-traumatic stress disorder** (Krupnick *et al.,* 2008)
- **Post natal depression** (Mulcahy *et al.,* 2010; Reay *et al.,* 2012)
- **Adolescents** (Mufson, 2004; 2010)

The design of our training programme

- A 3 + 1 day training model and supervision
- PPD group and Older People group gave permission for audio-visual material to be used for our training course
- A curriculum covering:
  - Principles involved in adapting and modifying IPT for different group settings
  - Group theory & process, leadership and group interventions
  - Phases of group development and mapping this on to IPT-G
  - Adapting individual IPT skills to a group context

The groups run/supervised so far

- Perinatal depression group (PPD)
- ‘Complex’ depressed women in prison (2nd in progress)
- 2 x Older people
- Younger people (on-going work)
- Adults in ‘secondary care’ NHS services (2nd in progress)

Perinatal depressed women

- 7 women attended 14-session group model
- No drop outs
- PHQ-9 depression and GAD-7 anxiety scores:

Phase of treatment	Mean PHQ-9 score	Range	Mean GAD-7 score	Range
Pre-group individual meeting	**13.14**	**9-20**	**13.71**	**5-21**
Mid-group individual meeting	**10.4**	**4-21**	**10.4**	**4-17**
Post group individual meeting	**9.2**	**2-19**	**10**	**3-17**

PPD key learning points

- 2 initial sessions needed for pre-group meetings
- Available crèche vital
- Using technology to benefit the patients – if they missed a session they could watch it
- More psychoeducation on the impact of attachment style in relation to partners and impact of new baby
- Helpful to engage partners – pre and post

‘Complex’ depressed women in prison

- First group started with 7
  - 2 chose not to attend (1 pre-group and 1 after first group session)
  - 1 got transferred to another prison (initial phase)
  - 1 chose ‘early release’ (middle phase)
- 3 finished:
  - but 1 woman was released when group finished and did not complete the outcome measures
  - 2 women completed the measures – their depression, anxiety, symptoms of PTSD etc. all ‘moved in the right direction’

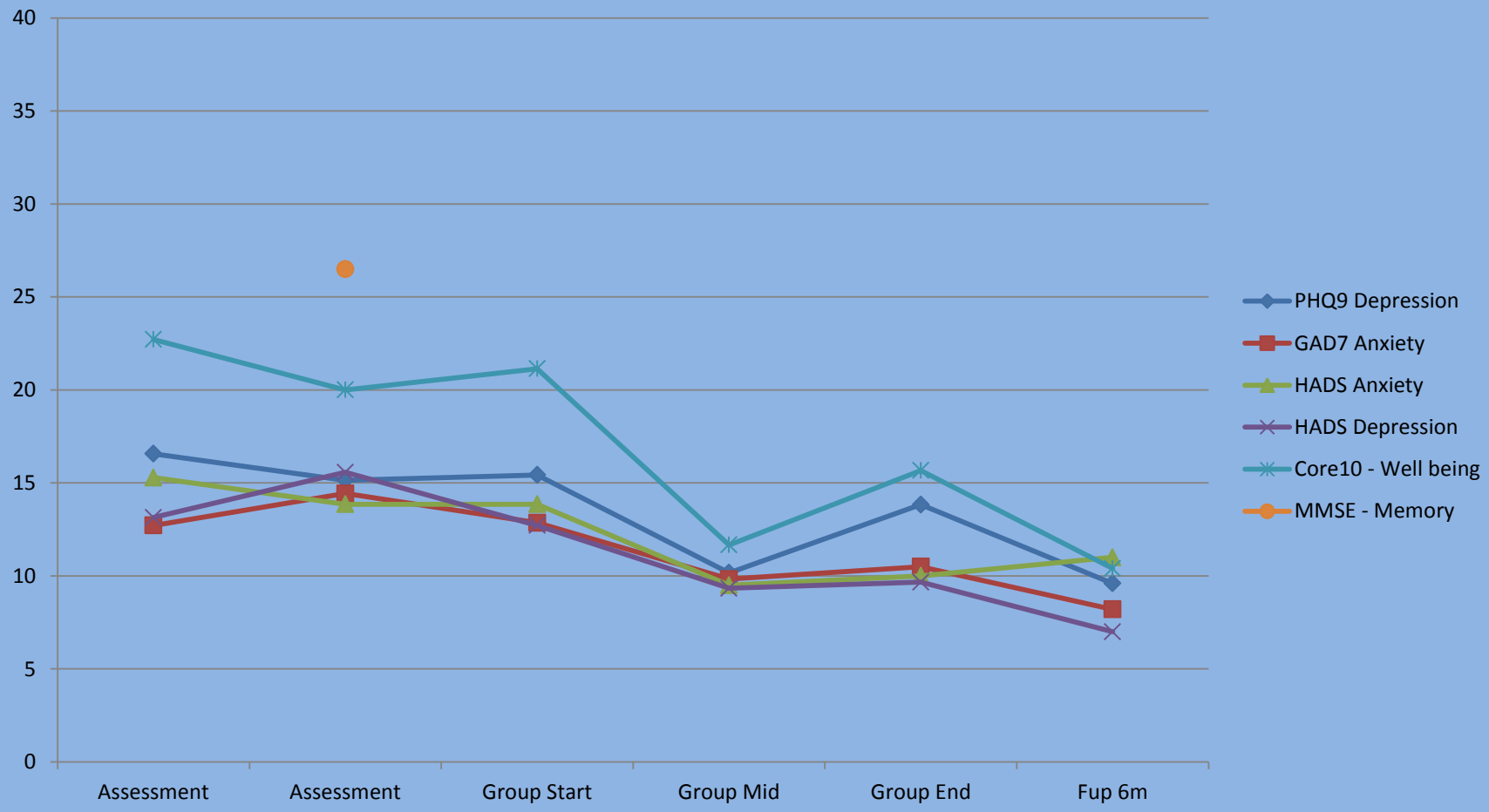
Learning points

- Three rather than two pre group sessions – complex histories
- Need more time working on group rules, boundaries and building basic trust
- Symptom review needs to incorporate wide range of symptoms
- Interpersonal network is more limited – can work on professional network but also *repairing relationships* or *moving away from negative relationships*
- Emotion regulation and history of complex trauma are big issue for group members

Older people

- 18 week group model - depression with co-morbid long term physical health condition
- 7 original members (one dropped out after week 1 due to transport issues); 92% attendance from remaining 6
- Mean age 77yrs (range 65-85yrs)
- Health conditions - diabetes, cardio-vascular and musculoskeletal problems

Older people group outcomes



Learning Points

- Practical adaptations required:
  - Simplification of paperwork for assessment/review
  - Assessment sessions x 2
  - Need to accommodate unpredictability of transport
  - Extended session time to 1 hour 45 mins
- Value of including significant other at individual assessment and end sessions
- Weekly Summaries for both therapeutic progress and as a memory aid

Younger people

- 18 to 25 years grouping – all have depression in the context of other mental health problems, Axis 2 features, as well as significant social issues (work, finance, housing)
- Notes used to reflect difficulties group members are having as well as underlining positive changes ('cheerleading') and to keep members focused on their goals
- Drop outs are low
- Working alongside mental health teams and inpatient really important to contain risk and, if brief admission, to keep the young person engaged in therapy – this can be a real challenge

Adults in ‘secondary care’ NHS services

- Only group supervised with 1 therapist (5 group members)
- By the end of the group, depression **(PHQ-9**) and anxiety **(GAD-7)** had moved to a lower ‘category’ for all members - except 1 person remained ‘severe’ but a lower score
- On the **ECR-R** questionnaire, reported anxiety and avoidance around relationships had lowered for 4 members
- Very cohesive group! – no drop outs

Learning from our experience and do patients like it?

- IPT-G appears to be a very acceptable method of delivering therapeutic interventions
- Low drop out rates in these initial groups
- Participants themselves report substantial learning about themselves in relation to other group members
- We are in the process of setting up a database to routinely record outcomes as the number of groups run via the centre increases

Going forward

Empirical questions:

- What makes a group 'IPT'?
- …and how much IPT makes it an IPT group?
- Role of psychoeducation
- Individual IPT in a group or group IPT?

Training:

- Developing a group IPT competency framework