IPT Supervision

Dr Roslyn Law
Chair IPTUK
London
Recent Correspondence

• I am interested in what you may be using for rating fidelity in IPT psychotherapy sessions. In the past, I have used adaptation of the Therapy Rating Scale (TRS) (Wagner et al., 1992). This scale has been very efficient in rating specificity when contrasted with other therapeutic conditions. Recently, however, we have used the scale to rate solely IPT sessions and it has been much more difficult to establish inter-rater agreement. If you could let us know of any instruments that you have used in the past to assess adherence to the IPT model we would be most appreciative.

Ellen Frank, May 2008
Response

• I've always used Steve Hollon's CSPRS-6, from the NIMH TDCRP study. It's a bit long, but it nicely distinguishes IPT from CBT and (with minor adaptation) from supportive psychotherapy. John Markowitz, NYC

• Actually that was the basis of our original TRS which used to work fine, but now seems to be floundering in an effort to look at variation exclusively WITHIN sessions. Ellen Frank
Response 2

• We went through a process of reviewing all the scales (including the one from the NIMH study, your scale and the supervisors' scale from the UK group) that we could find several years ago, and developed a rating scale that was a hybrid. However we have not established its validity or applied it as of yet.

Paula Ravitz,

Toronto
Response 3

• A group of us at PI developed a form, which has been used in a couple of projects so far.

Lena Verdeli, NYC
Response 4

We have produced a supervisor's guide, which details the tasks of each stage and how the rating is made i.e. based on recordings or discussion. This is much more of a clinical guide than a research tool and as yet we don't have inter-rater reliability figures. It goes down well with therapists and supervisors alike. I am happy to discuss more if this doesn't seem too far off what you are looking for.

Roslyn Law, London
So........

- The picture is uncertain but there appears to be consensus that some form of guidance and/or rating is required.

- However the usefulness of any rating measure depends on the objective and setting of the supervision – research or clinic, distinguish or fidelity rating, guide or evaluate, novice or experienced.....
What has been tried?


This study evaluates different methods of assessing psychotherapy skills. Nine therapists were evaluated in the following ways: (1) didactic examination, (2) global ratings by trainers, (3) supervisor's ratings based on therapist's retrospective report of therapy sessions in supervision, (4) therapists' self-ratings, and (5) independent evaluators' ratings of videotaped psychotherapy sessions.
What has been tried?

Results show poor agreement among assessments of therapists' skills based on different data sources.

Of the five types of ratings of psychotherapist skill, only the supervisor's ratings were correlated with patient outcome.

Most important, ratings based on review of videotaped sessions were uncorrelated with those based on supervisor’s discussion of process material with the therapist.
Implications

• It is important to actually review the material rather than rely on discussion

• This is true for both the therapist and the supervisor

• Knowledge of the model cannot be assumed to be the same as knowledge of how to deliver the model—this might also be true for therapists and supervisors.

• Ratings are of actual practice not progress or intention or an attempt to be the co-therapist.
Training and certification in IPT

Training Committee ISIPT

Local Training Schemes

Didactic Teaching

Case Supervision

Satisfy ISIPT criteria for competency

Local Accreditation

Diagram 2
Level B: Basic Training as IPT Therapist

- Trainees should have read the IPT manual and attended a training course of 2-4 days.

- Supervision is offered at the discretion of the supervisor.

- Supervisees should have previous clinical training with a good knowledge of mood disorders.

- First case using IPT should be in the treatment of major depression.

- Each trainee should be supervised for a minimum of 2 cases on model.

- All sessions should be recorded (video/audio) & a minimum of 3 tapes from each case selected randomly by the supervisor for formal review e.g. using the IPT competency scale. A minimum of 12 out of 16 sessions per case will be supervised. Supervision can be individual or group, but each trainee should receive at least 4 hours supervision for each case. In group supervision, the trainee will have the opportunity to discuss their own case for 4 hours. The 2 cases should be in 2 different focal areas.

- Satisfactory supervisor’s report provided when the above criteria is met e.g. ‘x has attended an introductory course in IPT and has achieved a satisfactory standard in 2 supervised cases’
Available for health care professionals who are interested in IPT. This will provide an overview in the form of an introductory training course lasting two days or more.

**Note:** Interest in IPT may be expressed by wider groups rather than just purely clinical staff working in mental health
LEVEL C

Continuing Professional Development for IPT Therapists

IPT Therapists should carry an IPT caseload - at least 2 cases a year.

IPT Therapists should receive on going supervision, at least monthly, this may be individual, peer group or even via the telephone

Therapists are recommended to attend conferences/courses detailing IPT developments
Level D
Recommendations for becoming an IPT supervisor

To have achieved a level A, B and to continue level C.

Minimum of 10 supervised cases (at least 2 in each focal area). This supervision may be individual or group, and includes the 2-3 cases in level B. Supervision can be with a level D supervisor or with a level B therapist in peer supervision.

Supervisors would be required to attend a Network of supervisors. It is proposed that regional groups be established and meet at least twice a year.

Supervisors must attend an introductory Supervisor’s workshop before providing supervision. It is proposed that workshops will be run twice yearly by existing supervisors. There will move around the country and are likely to run alongside one of the established training courses.

It is recommended to attend the Annual Meeting of the IPT interest group which will rotate around the UK.

Supervisors should be prepared to keep their IPT clinical & supervisory skills active by supervising at least 2 trainings per year and keeping level C activity for clinical work.
Scottish Project

Psychological Therapies

- **IPT**
  - 9 courses
  - 67 participants
  - Mean satisfaction ratings: 4.3-4.8
  - 27 supervisees

- **IPC**
  - 6 courses
  - 31 participants
  - Mean satisfaction ratings: 4.8-5
  - 22 Continuing practice

- **PST**
  - 6 courses
  - 30 participants
  - Mean satisfaction ratings: 4.4
  - 11 Continuing Practice

- **Mindfulness**
  - 5 courses
  - 50 participants
  - >100 @ tasters sessions
  - Met expectations 85-100%
  - 92% Continuing Practice
Supervision

Graph showing the ratings of Useful, Relevant, Clarity, Constructive, Effective, and Duration.
Supervision - comments

Focusing
• Useful to ”see the wood for the trees” after initially overwhelmed with information. Group supervision enables clarity to be found and a focus to be found
• Essential. East to be side tracked from interpersonal focus of therapy into intrapsychic influences/normative therapeutic style.
• Excellent, intuitive supervisor very able to quickly spot when IPT was going off course & able to help to get it back in focus. Good constructive feedback received.

Training into Practice
• Feedback was instrumental in developing confidence & skills with each IPT case.
• Essential to developing clinical skills and turning theory into practice.
• Supervision succeeded in making training relevant to my clinical practice, treating patients at more severe and enduring end of spectrum

Addresses Difficulties
• Clear, direct and supportive. Open to challenging and questioning. Clear explanation and rationale provided.
• Great in that it was honest and encouraging, allowing you to explore areas of difficulty
Supervision - comments

Learning with and from peers

- Definite benefits to group format for supervision. Learning from peers - peer support, avoidance of isolation. Half hour per supervisee optimal.
- Superb supervision when difficulties arose in practising IPT. Not only did I listen to my own feedback but I also appreciated listening to the feedback my peers were also receiving in the different focus areas.
- Sometimes difficult to share supervision across the group - particularly at early stages. However increasingly more of shared difficulties and able to learn from hearing peer supervision too.

Problems

- Video conferencing isn’t an ideal medium and there are often unavoidable difficulties making available appointments on both sides. Quite difficult to strike up a good dialogue.
- In the group format the last person sometimes got less time
Has it worked?

- Two years on there four groups who remain active. At least three more remain interested.
- All ongoing groups are able to provide peer supervision
- All are approaching completion of supervisor level training.
Improvements

• Protocol for peer supervision
• Two cases universally judged to be insufficient to move on to peer supervision model
• Template for case submission
• Additional follow up training
• Group meetings with other centres
• Ongoing supervision
• Guidelines re delay between training and supervision
• Management support and time allocation
• Training in peer supervision
• Input on process dynamics
Your experience of supervision

- Describe the format, duration range etc. of supervision you have received or provided
- Was a rating scale used? If so, what is your experience of rating/being rated?
- What was most useful about the IPT supervision you received?
- What would have improved the IPT supervision you received?
- What helps you when you provide supervision?
- What would improve the supervision you provide?
What do other models require?
CBT

• Competency Framework
• National Occupational Standards
BABCP

- Basic therapeutic training, experience of working in a therapeutic role, personal qualities demonstrating suitability, use CBT as main therapeutic model
- 4 years of training (including basic training)
- Specialist course covering theory and application
- Skills training accounts for not less than 50% of training programme
- Minimum of 450 hours of study, with 200 hours provided directly by recognised trainers
- Training log completed and reviewed
- 200 hours of supervised assessment and therapy IN ADDITION to that already specified
- Supervision to be carried out by as supervisor who meets BABCP criteria for accreditation
- Minimum of 8 cases from assessment to completion, covering at least 3 types of problem
- Details of supervised practice and case mix recorded in a training log.
- Formal assessment of theoretical understanding
- Evaluated via extended case report, or research dissertation or peer review publication
- Supervised practice assessed in four case studies
ACAT

• Practitioner:
  – Core profession
  – Minimum of 8 Cases under supervision with an accredited CAT supervisor (signed off by senior supervisor)
  – Personal Therapy
  – 2 year training course or 4 years for psychotherapy training

• Supervisor:
  – 16 cases completed prior to commencing supervisor training
  – 6 months of observation of a supervisor
  – 6 months being observed by a supervisor
What has IPT come up with?
Supervision Portfolio Checklist

Evidence of cases completed for accreditation

- Referral Letter - present / not present
- Assessment Letter - present / not present
- Initial ratings - Symptoms - present / not present
  - Social functioning - present / not present
- Consent Form. - present / not present
- Interpersonal Inventory - present / not present
- Written Statement of Formulation - present / not present
- Statement of focus area with Patient - present / not present
- Repeat ratings (middle and end) - present / not present
- Termination statement - present / not present
- Final outcome letter - present / not present
- Supervision Forms- Details - present / not present
- Number of sessions attended -
- Use of therapeutic relationship – discernable / not discernable
Interpersonal Psychotherapy for Depression: Document of Progress
Developed by
Mark D. Miller M.D., Holly Swartz M.D. and Lee Wolfson M.Ed
Western Psychiatric Institute and Clinic, University of Pittsburgh, January 4, 2007

IPT Time Line Worksheet

<table>
<thead>
<tr>
<th>Name/Code</th>
<th>Date</th>
<th>Therapist</th>
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IPT Focus 1: RT G RD ID

IPT Focus 2: RT G RD ID

(Circle and describe)

Psychotropic Medication Changes:

PHQ-9 Over the last 2 weeks, how often have you been bothered by the following
0=not at all 1=Several Days 2=More than half the days 3=Nearly Every Day

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed.
9. Or- the opposite, being so fidgety or restless that you have been moving around a lot more than usual
10. Thoughts that you would be better off dead, or of hurting yourself in some way.

Total Score

10. if any of the above problems are checked, how difficult did they make it for you at work, take care of things at home or get along with people? (circle one) Not difficult/Somewhat/Very/Extremely

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Summary of Session
Interpersonal Psychotherapy for Depression: Document of Progress
Developed by
Mark D. Miller M.D., Holly Swartz M.D. and Lee Wolfson M.Ed
Western Psychiatric Institute and Clinic, University of Pittsburgh, January 4, 2007

IPT Time Line Worksheet Section IV. Final Summary of Case Outcome

The purpose of this section is two-fold, to summarize your learning experience in a formal way and also to create a document for review to fulfill training requirements.

1. Pertinent history of the reason for referral (chief complaint), recent treatment, past psychiatric treatment or untreated psychiatric problems including drug and alcohol problems.

2. Pertinent history of medical problems

3. Pertinent history of family psychiatric problems

4. Pertinent history of social setting

5. Brief mental status exam currently

6. DSM4-TR final diagnoses (diagnoses may have changed with new information)

   Axis I ____________________________
   Axis II ____________________________
   Axis III ____________________________
   Axis IV ____________________________
   GAF ____________________________

7. Chosen IPT focus or Foci and a brief narrative of how you arrived at it

8. Summary of sessions divided into early, middle and final phases

9. A brief description of how termination plans were handled and what the long term plan is in case the patient requests more help of some kind in the future

Finally, especially for beginning students of IPT, include a discussion of “what I learned from this case”. This can be 2-3 paragraphs of how the therapy played out, what surprised you, what went well and seemed to work, what did not go well that also taught you something useful for the next case etc. This is the area where you can describe what you were able to accomplish so that another student or faculty member reading it would glean an accurate account of your learning experience.
Quick Sheets – Holly Schwartz

• IPT-B Middle Sessions Quick Sheet
  I. “How have you been since we last met?”
  Always link events to mood or mood to events. Try not to talk about events as the cause of depression; depression usually has a biological component.
  Get precise details (what day, where, etc.) about mood shifts and events.
  II. Abbreviated mood check and review of symptoms
  Review BDI or HRSD scores.
  If her mood improved, ask her “What do you think made a difference this week?” See if she can come up with the connection between better mood and something she did. If her mood did not improve, reassure her that it takes time and recovery is jagged (up and down). If her mood does not improve toward the end of treatment, blame it on the treatment.
  III. Homework check
  Try to help her discover the link between taking constructive action and mood improvement. If the patient did not successfully complete the assignment, blame the depression (not the patient).
  IV. Maintain focus of session on the problem area
  (e.g., role transition, complicated bereavement, role dispute) A detailed review of the past week will usually bring up the interpersonal problem area. Always bring the focus back to the problem area. It is ok to interrupt the patient; in fact, it may be necessary because of time limitations.
  “Remember this is time-limited treatment; we need to be careful about what we choose to put our energy into.”
  In the middle sessions the responsibility for the session shifts from the therapist to the patient and the patient is actively encouraged to give up the sick role.
  V. Utilize strategies and techniques for facilitating change — see separate sheet for more description
  Pull for the affect in the session, especially negative emotions. Look for hidden anger and validate it when reasonable
  Explore options. Ask “What do you want (in this specific interpersonal situation) now or in the future”
  Communication analysis and role play
  Adjust expectations
  Decision analysis (problem solving)
  Turn stumbling blocks into stepping stones
  Positive reinforcement; affirm strengths
  Provide psychoeducation about depression – “that’s the depression talking”
  VI. Summary of session – affirm small steps toward change
  VII. Collaborative Homework Assignment
  Homework should flow out of the session and ideally be identified by the patient as something related to the problem area.
  If it is not initiated by the patient, be collaborative in suggesting an assignment:
  “What would be helpful to you this week in managing this role transition, dispute, etc.?
  What do you need for yourself this week?”
**IPT-A Consultation Checklist** developed by Laura Mufson, Ph.D., Kathleen Clougherty, M.S.W., Jami Young, Ph.D., Helena Verdelli, Ph.D., New York State Psychiatric Institute, Columbia University College of Physicians and Surgeons, 2004.

<table>
<thead>
<tr>
<th>Competency</th>
<th>SUPERIOR</th>
<th>SATISFACTORY</th>
<th>NEEDS IMPROVEMENT</th>
<th>FAILED TO ATTEMPT</th>
<th>NOT APPLICABLE</th>
<th>COULD NOT ASSESS</th>
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**Overall rating as IPT-A Therapist**

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<tr>
<th>Rating</th>
<th>Poor</th>
<th>Mediocre</th>
<th>Satisfactory</th>
<th>Good</th>
<th>Excellent</th>
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<td>Score</td>
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**How difficult do you feel this patient was to work with?**

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<tr>
<th>Difficulty</th>
<th>Not Difficult</th>
<th>Moderately Difficult</th>
<th>Extremely Difficult</th>
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<tr>
<td>Score</td>
<td>1</td>
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**Strengths:**

**Weaknesses:**

**Suggestions for Therapist:**
# Supervision Checklist

**Developed by Dr Helen Birchall, Dr Roslyn Law, Dr Liz Robinson**

<table>
<thead>
<tr>
<th><strong>IPT Supervision</strong></th>
<th><strong>Initial Sessions</strong></th>
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<tbody>
<tr>
<td>1. Enquiry re depressive symptoms</td>
<td>Rated on tape Discussed in supervision</td>
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<tr>
<td>Present: adequate inadequate Absent: acceptable unacceptable</td>
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<td>2. Review of current depressive episode and development of symptoms in the interpersonal context.</td>
<td>Rated on tape Discussed in supervision</td>
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<td>Present: adequate inadequate Absent: acceptable unacceptable</td>
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<td>3. Review of previous depressive episodes including treatment and interpersonal context.</td>
<td>Rated on tape Discussed in supervision</td>
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<td>Present: adequate inadequate Absent: acceptable unacceptable</td>
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<td>4. Give the syndrome a name and provide psychoeducation on depression, including how depression relates to individual, validation of difficulty and appropriateness of receiving help.</td>
<td>Rated on tape Discussed in supervision</td>
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<td>Present: adequate inadequate Absent: acceptable unacceptable</td>
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<td>5. Explanation of IPT, including providing a rationale which emphasizes that working on understanding and changing the client’s interpersonal relationships and or social roles would alleviate his/her depression. Explanation of the three phase</td>
<td>Rated on tape Discussed in supervision</td>
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<td>Present: adequate inadequate Absent: acceptable unacceptable</td>
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<td>6. Explanation of the sick role, including activation of the network and symptom management, Client’s responsibility to work towards recovery including increasing pleasurable and decreasing onerous tasks.</td>
<td>Rated on tape Discussed in supervision</td>
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<td>Present: adequate inadequate Absent: acceptable unacceptable</td>
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<td>7. Explain that depression is treatable, with reference to evidence and other treatment options. Therapist conveys understanding and expertise.</td>
<td>Rated on tape Discussed in supervision</td>
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<td>Present: adequate inadequate Absent: acceptable unacceptable</td>
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</table>
Checklist or Adherence or Competence

• Good checklists are available for IPT but underused
• Adherence measures are available but largely untested
• Untested status as reliable competence measures
• No cut of points for any of the measures
• All developed for IPT with depression
• Most suitable for novice therapists – what about after that?
• What is the protocol for peer supervision?
• Who has the final say on peer supervised cases?
• Is the ability to deliver IPT the same as being able to teach or supervise it?
Moving forward

• Learn from each other
• Supervision working party
• Develop supervisor training
• Presentation at ISIPT