Contents

Series Preface

Tony Rousmaniere and Alexandre Vaz

We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as hopelessness, skepticism about therapy, or becoming very emotional. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role-plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits back down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, uses supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have already-established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

About This Book

The 12th book in the Essentials of Deliberate Practice series is on interpersonal psychotherapy (IPT), a time-limited psychotherapy that focuses on interpersonal issues that are understood to be a factor in the genesis and maintenance of psychological distress. The targets of IPT are symptom resolution, improved interpersonal functioning, and increased social support (Stuart & Robertson, 2012). IPT is best implemented with clients who are presenting with an interpersonal nature of distress. It is a unique relational therapeutic method, and many trainees find that a multifaceted approach to learning is required to achieve IPT competence. Competency in the clinical area requires mastery of knowledge, skills, and attitudes. We have received feedback from clinicians indicating that reading on the IPT theory, practicing IPT skills, and receiving constructive feedback from peers or supervisors is incredibly helpful. Lastly, understanding the mechanism of change within IPT will help clinicians find an appropriate attitude and relational stance with this approach. Practicing IPT skills, with ongoing feedback, will

allow the clinician to calibrate their practice and help them ultimately to integrate their knowledge and skills into deeper IPT clinical practice.

In this book, we adopt deliberate practice methods to support experiential—"learning by doing"—training opportunities. The methods and stimuli described in this volume can facilitate practice of a range of important IPT skills. In addition, it supports fine-tuning the "how" of intervention delivery, including in a flexible manner across diverse clinical scenarios. Importantly, this book is not intended to replace core coursework and exposure to foundational IPT theory and principles of practice. Rather, it is intended to augment other common training components.

Thank you for including us in your journey toward psychotherapy expertise. Now let's get to practice!

CHAPTER 1

Introduction and Overview of Deliberate Practice and Interpersonal Psychotherapy

This book is designed to facilitate the acquisition of the basic skills of interpersonal psychotherapy (IPT). IPT is situated within a rich tradition of psychotherapy training, with a strong emphasis on experiential learning. Deliberate practice is a methodology used by professionals from across many fields that is being applied in psychotherapy training and can be used as an innovative way to enhance the experiential training process for IPT. Through continual practice, fundamental IPT skills eventually become natural. If practice is done effectively, this will provide the trainee the opportunity to draw on the skill automatically when presented with an appropriate moment in a real therapy session.

The fundamental basis for IPT is the *relational frame*. This simple concept means that the client's experience of distress affects the people around them and that people in the client's social support network influence the client's experience of distress. Take, for instance, the experience of distress that might be labeled, in diagnostic nomenclature, depression. The client's distress manifests itself interpersonally, cognitively, behaviorally, and spiritually as withdrawal, low self-esteem, lack of motivation, irritability, hopelessness, and even suicidality, and this profoundly affects those around them. Others may begin to feel distressed as well if the client expresses anger at them, and their distress may increase even more if others feel helpless to understand and stop the individual's thoughts of suicide, not to mention their responses to an actual suicide attempt.

Similarly, the client's friends, family, and community have a profound impact on the client's experience of distress. Consistent, supportive care and understanding from others will likely help alleviate the client's distress. Feeling "understood" and "felt by others" will decrease their distress even further.

Even cultural values, expressed by individuals within the client's community, will influence the client's distress. A cultural taboo against mental health, seeking treatment, or "airing dirty laundry" will exacerbate distress. A cultural norm—expressed in relationships—that the client should "buck up and deal with it" will also increase the client's sense of isolation and distress.

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Deliberate Practice in Interpersonal Psychotherapy, by O. Belik, J. M. Schultz, S. Fairhurst, S. Stuart, A. Vaz, and T. Rousmaniere

The basic principle of IPT is that as humans, we are relational. Relationships matter to us; we are embedded in relationships and community. We affect others, and other people affect us. Our interpersonal communications, cognitions, behaviors, and even our spirituality take place within a relational frame. We are always interacting with others. And those interactions can help or hinder us. When we have a positive relational connection, we feel seen, understood, and have more emotional and cognitive energy to face the world and address potential challenges.

Conversely, much of our distress comes from difficulties within relationships. Those that end through death or disruption, that are in conflict, or in which we struggle to adapt and change increase our distress and isolation. The way in which we ask for help in those crises makes a difference too, as does our inability or reluctance to ask for help. So does the response from others: Reactions of understanding and compassion will be helpful, while lack of support, rejection, or judgment will make the distress worse.

Asking for help and support in an effective way is a function of communication. Communication is a learned skill and can be taught to clients. It can be taught by modeling, reinforcing, and practicing both in session using role-playing as well as out of session with "practice" in which the client engages in asking for help (or practices other communication skills learned during the session) with others in their interpersonal circle.

Because communication is such a critical mediator of change in IPT, the IPT clinician must learn to communicate well. Modeling good communication skills, not to mention teaching them, requires expertise on the part of the clinician. Hence, the deliberate practice approach to mastering language and communication skills is directly applicable for IPT clinicians. In this book, we have taken the opportunity both to teach clinicians to communicate more effectively in therapy and, on a metalevel, to teach clinicians how to teach their clients to communicate more effectively using the same communication skills.

It is always useful, both in teaching and in clinical care, to give practical examples to illustrate key concepts. Storytelling is a critical skill in IPT because it is a way to gain a better understanding of the concept and to make an abstract concrete.

An Interpersonal Psychotherapy Case Example

About a year ago, although it could have been a decade ago, or last month, or even yesterday, a woman came to see one of us after she experienced a miscarriage. The loss was at 12 weeks; she had already told her family and friends about her pregnancy and had been excited and expectant, as she and her partner had been trying for more than 2 years to have a baby.

Consistent with her personal and spiritual experiences, she described the miscarriage as the loss of her child. She described her distress as feeling incredibly lonely and isolated, sad, inert, and hopeless. She even had some thoughts of suicide so that she could be with her child, although she made clear that her religious beliefs would keep her from acting on these thoughts. For her, the most impactful distress came from her experience of being alone in her grief; no one else understood what her loss was like, and her sense of being alone, misunderstood, and even judged by others, was devastating.

The first thing we discussed about her loss was what words she used to understand and describe it. For her, it was, without a doubt, the death of a child. A real person who was forming inside of her body, with whom she was in the most intimate relationship a person could have with another. And she was responsible for that child. Because it was growing inside of her and because her job was to protect and keep it alive, her body had failed her. And in her mind, this meant she had failed her child.

We began discussing the ways others had responded to her grief—the ways in which the people in her relational space were responding. No one, she said, understood her grief, and all her friends and family members were making her distress even worse.

Hers is a universal experience—a lack of interpersonal connection and support—that we could have heard described a decade ago, last month, or even last week. Or even a lifetime ago.

After asking her to complete her Interpersonal Inventory to gain a better understanding of her relationships and connections, we talked about how she had told others of her experience and distress. Most others, including her mother, had responded with a comment or two about how difficult her loss must have been, followed by comments such as, "At least the miscarriage was only 12 weeks—it could have been 20 or 30, and that would have been even worse." Or "You can always get pregnant again." Or "It was only a miscarriage; it's not like you lost a child." Perhaps they were trying to be of help; perhaps they were simply inept. But she—rightly so—experienced all these experiences as rejection, misunderstanding, and disconnection. And she isolated herself even more.

We discussed several interpersonal incidents in which these specific communications had happened and discovered that as soon as she received comments from others about her loss, she would withdraw in anger at being misunderstood and unsupported. Eventually the topic became taboo because those who were trying to be supportive but did not know how to do it well learned that trying to be supportive was met with rejection—it made things worse. And the cycle of isolation, anger, and silence spiraled into even more distress.

A change point in therapy started to occur initially when she felt "seen" and "understood" by her clinician. After working hard to establish a therapeutic alliance by listening well, being empathic, and grieving with the client, I remarked that others, although perhaps trying to be sympathetic, were missing her perspective, missing the mark. Rather than being helpful, the comments such as "hang in there, you'll get over this eventually" were not helpful at all to her—they were making things worse. They were causing her to withdraw, shut down, and isolate herself even more. In the midst of her isolation, she understood what she needed from other people—she wanted a different response conveying empathy and support. Helping others to understand her experience and learning how to ask for support from others directly became one of our primary tasks in therapy.

The first step in that process was to help her describe her experience of loss and her distress in therapy. Making her implicit internal narrative explicit helped the client find words describing her experience and brought clarity to her; she was able to frame it as the loss of a child so that others could better understand the impact it was having on her. We worked to help her describe the support she needed as well—the practical, emotional, and spiritual care she needed. Looking back to the Interpersonal Inventory, we talked about whom she could begin sharing her loss experience with and who would be receptive. We then practiced the conversations in session using generating options, modeling, and role-playing, focusing on what she needed and how she could ask for it directly and effectively.

With that help and her newfound motivation and confidence to ask for the support and understanding she really needed, the client first shared her experience with her partner and then moved on to discuss it with several close friends. They were, fortunately, able to respond well to her request simply to listen and understand, not to offer advice or platitudes, and to comfort her with a hug.

This clinical case had several complexities embedded in it and represents well the reality of interpersonal distress that we encounter daily in our work. As relational human beings, we need others to understand our experiences, to feel "felt" by others on a

daily basis—and even more so during a crisis. We need to be supported emotionally, practically, physically, and spiritually. Support and understanding from others improved our functioning.

Overview of the Deliberate Practice Exercises

The focus of this book is a series of 10 exercises that have been thoroughly tested and modified based on feedback from IPT trainers and trainees. The first two focus on collecting baseline information about the client's relationships and general social support and are used in the initial or assessment phase of IPT. The next four are used throughout IPT; clarification in particular is foundational in IPT. The last four skills are designed to help move the client to action—to improve their communication and then to implement their newly practiced communication skills in relationships outside of therapy. Table 1.1 presents the 10 skills that are covered in these exercises.

Throughout the exercises, trainees should work in pairs under the guidance of a supervisor and role-play as a client and a therapist, switching back and forth between the two roles. (Note that "therapist" and "clinician" are used interchangeably throughout the book.) Each of the 10 skill-focused exercises consists of multiple client statements grouped by difficulty—beginner, intermediate, and advanced—that call for a specific skill. For each skill, trainees are asked to read through and absorb the description of the skill, its criteria, and some clinical examples demonstrating how to apply it. The trainee playing the client should then read the statements, which present various prompts and challenges from clients. The trainee playing the therapist should then respond in a way that demonstrates the specific skill. Trainee therapists will have the option of practicing a response using the one supplied in the exercise or improvising and supplying one of their own.

After each client statement and therapist response couplet is practiced several times, the trainee should pause to receive feedback from the supervisor. Guided by the supervisor, the trainee will be instructed to try statement–response couplets several times, working their way through the examples. In consultation with the supervisor, trainees can go through all the exercises, starting with the least challenging and then moving to the more advanced levels. The triad (supervisor–client–therapist) will have the opportunity to discuss whether exercises present too much or too little of a challenge and to adjust them depending on their assessment.

After the first 10 exercises are two comprehensive exercises, an annotated IPT transcript and improvised mock therapy sessions, that teach practitioners how to integrate all 10 skills into more expansive clinical scenarios.

TABLE 1.1. The 10 Interpersonal Psychotherapy Skills Presented in the Deliberate Practice Exercises

Beginner Skills	Intermediate Skills	Advanced Skills
1. Presenting the interpersonal inventory: interpersonal inventory I 2. Exploring interpersonal relationships: interpersonal inventory II 3. Clarifications	4. Interpersonal framing of distress 5. Helping the client to describe their distress and need for support 6. Reinforcement of effective communication	7. Communication analysis 8. Generating communication options 9. Mobilizing social support 10. Motivating interpersonal action

Trainees, in consultation with supervisors, can decide which skills they wish to work on and for how long. In our testing experience, we have found practice sessions should last about an hour to receive maximum benefit.

Ideally, beginning IPT therapists will both gain confidence and achieve competence through practicing these exercises. Competence is defined here as the ability to perform an IPT skill in a manner that is flexible and responsive to the client. Skills have been chosen that are considered essential to IPT and that practitioners often find challenging to implement.

The skills identified in this book are not comprehensive in the sense of representing all one needs to learn to become a competent IPT clinician. Some will present particular challenges for trainees; we have endeavored to re-create actual interactions with real clients as best we can, and the challenges are the types that occur frequently in clinical practice. We hope that the challenges will stimulate more practice and encourage therapists to seek out more formal training in IPT.

Before presenting the exercises, we would like to give a brief description of deliberate practice methodology followed by an overview of IPT to explain how we have combined them.

The Goals of This Book

The primary goal of this book is to help trainees achieve competence in core IPT skills. Of course, the expression of those skills or competencies may look somewhat different across clients or even within a session with the same client, hence the need to practice with slightly different prompts and different clinical contexts.

The IPT deliberate practice exercises are designed to help IPT therapists develop the ability to apply IPT specific skills across a range of clinical situations by providing IPT therapists with the following opportunities:

- to develop a particular skill using a style and language that is congruent with who they are,
- to use the IPT skills in response to varying client statements and effects, and
- to try out different responses and then to receive feedback about them and ways that they might be further improved.

The practice of these skills is designed to move them into procedural memory (Squire, 2004) so that IPT therapists can access them "in the moment" during therapy, even when they are tired, stressed, overwhelmed, or discouraged. And deliberate practice is designed to build confidence to use these skills in a broad range of circumstances within different clinical contexts. We also aim to help trainees discover their own personal learning style so that they can continue their professional development long after their formal training is concluded.

Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, and continuing education programs. It assumes the following:

1. The trainer/supervisor is knowledgeable about and competent in IPT.
2. The trainer/supervisor is able to provide good demonstrations and model well how to use IPT skills across a range of therapeutic situations, via role-play and/or video.

Alternatively, the trainer may have access to examples of IPT being demonstrated using videos of expert IPT therapists.

3. The trainer/supervisor is able to provide quality feedback to students about their implementation of IPT skills.
4. Trainees will have additional materials, such as books, articles, and video demonstrations, that explain the theory, research, and rationale of IPT and each particular skill. Recommended reading for each skill is provided in the sample syllabus (Appendix D).

The exercises covered in this book series were piloted in training sites from 16 countries across four continents (North America, South America, Europe, and Asia). This book is designed for trainers and trainees from different cultural backgrounds worldwide. For further guidance on how to improve multicultural deliberate practice skills, see the book *Deliberate Practice in Multicultural Therapy* (Harris et al., 2024).

This book is also designed for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned therapists. All exercises feature guidance for assessing and adjusting the difficulty to target the needs of each individual learner precisely. The term *train*ee is used broadly, referring to anyone in the field of professional mental health who is endeavoring to acquire or improve their IPT skills.

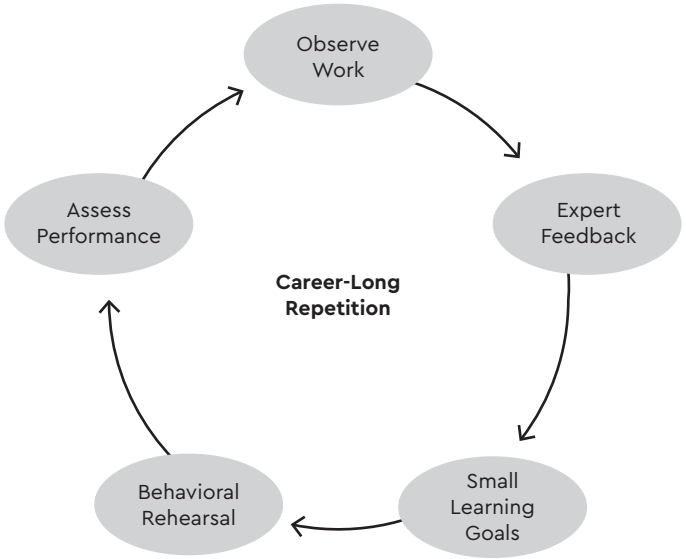
Deliberate Practice in Psychotherapy Training

How does one become an expert in their professional field? What can we be "trained" to do, and what is simply beyond our reach due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development. A mixture of awe and admiration surround people such as Mozart, Leonardo da Vinci, or contemporary individuals such as Serena Williams, Michael Jordan, or Caitlin Clark. What accounts for their consistently superior professional results? Evidence suggests that the amount of time spent on a particular type of training is a key factor in developing expertise in virtually all domains (Ericsson & Pool, 2016). Deliberate practice is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993). They found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting acquisition and mastery. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process deliberate practice, a cyclical process that is illustrated in Figure 1.1.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book *Outliers*. Gladwell's book, however, perpetuated two common misperceptions. The first is that 10,000 is the number of hours of practice needed to attain expertise, no matter the domain. In fact, there can be considerable variability (Ericsson & Pool, 2016). The second is that engagement in 10,000 hours of work performance will lead one to become an expert. This misunderstanding holds

FIGURE 1.1. Cycle of Deliberate Practice



Note. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (https://doi.org/10.1037/0000227-000). Copyright 2021 by the American Psychological Association.

considerable significance for the field of psychotherapy, where hours of work experience with clients has traditionally been used as a measure of proficiency (Rousmaniere, 2016). In fact, research suggests that the amount of experience alone does not predict therapist effectiveness (Goldberg et al., 2016); it appears instead that the quality of deliberate practice is a key factor.

Psychotherapy scholars, recognizing the value of deliberate practice in other fields, have called for deliberate practice to be incorporated into training for mental health professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, however, good reasons to question analogies made between psychotherapy and other professional fields, such as sports or music, because by comparison psychotherapy is more complex and freeform. Sports have clearly defined goals, and classical music follows a written score. In contrast, the practice and implementation of psychotherapy skills shift with the unique presentation of each client at each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction are co-created between master musicians. Like psychotherapy, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) lists 18 skill areas that students must master, each of which has multiple discrete skills including tone quality, intervals, chord arpeggios, scales, and patterns. More creative and artful improvisations are actually a reflection of repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself" (Cook, 2005, p. 112).

The ultimate goal of deliberate practice is to master IPT skills so that therapists can "play like themselves." In other words, the goal is to become so adept at the specific

skills that the therapist can focus attention on the therapeutic relationship and overarching goals of therapy—so adept that the therapist can be fully present and understand their clients rather than having to think about delivering certain techniques well.

Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. Ideally, creativity should be enhanced with continued practice of the basics, just as virtuoso musicians practice the scales daily so that they can free themselves to focus on creativity and emotional expression.

Psychotherapy is an ever-shifting relationship with another real human being, and it is not and should not become formulaic. Strong IPT therapists integrate skills acquired through practice with flexibility. IPT, as noted later, also involves a way of being with the client; to be with someone therapeutically requires focus and attention.

The core IPT responses provided in subsequent exercises are meant as templates or possibilities, rather than "correct answers." Please use and apply them in a way that makes sense to you, and as you master them, be creative. We encourage flexible and improvisational play!

Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning (Ericsson, 2004; McGaghie et al., 2014). The stimulus material for training presented in this book consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to real-world experiences so that they provoke similar reactions. This facilitates state-dependent learning, in which clinicians acquire and practice skills in the same psychological environment where they will perform them (Fisher & Craik, 1977). Pilots, for example, train with flight simulators that present mechanical failures and dangerous weather conditions. Surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively under stress. For the psychotherapy training exercises in this book, the "simulators" are typical client statements that might be presented in therapy sessions and call upon the use of the particular skill.

Declarative Versus Procedural Knowledge

Declarative knowledge is that which a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and is often acquired relatively quickly. In contrast, procedural learning is implicit in memory and "usually requires repetition of an activity, and associated learning is demonstrated through improved task performance" (Koziol & Budding, 2012, p. 2694). Procedural knowledge is that which a person can perform, especially under stress (Squire, 2004).

There is a big difference between their declarative and procedural knowledge. An "armchair quarterback," for example, is someone who understands and talks about athletics well (or at least thinks they understand well) but would have trouble performing when being chased by a 300-pound defensive tackle. Likewise, most dance, music, or theater critics have a very keen ability to write critically about their areas but would be unable to perform.

The sweet spot for deliberate practice is the gap between declarative and procedural knowledge. In other words, effortful practice should target those skills that the learner could write a good paper about but would have trouble actually performing with a real client.

Clinicians start with declarative knowledge, learning skills theoretically and observing others perform them. Once learned intellectually, deliberate practice fosters development of procedural learning, with the aim of therapists having "automatic" access to each of the skills that they can use when necessary.

Although this book focuses on specific IPT skill acquisition and mastery, doing so requires a basic knowledge of IPT generally. What follows is an overview of IPT; we encourage readers to review the suggested readings in Appendix D and the references and to seek out additional training in IPT.

An Overview of Interpersonal Psychotherapy

IPT is based on the fundamental principle that relationships matter; that human connection matters; that being comforted, understood, and especially being held matters. And that, especially in times of crisis, we human beings reach out to others for understanding, support, and care. This principle is directly articulated in IPT by the term *relational frame*. Humans are embedded in a social network—a family, a community, a culture—and experience relational crises within that network. Relational frame means that the individual's experience of distress impacts their social network and that the people in the distressed individual's network reciprocally impact the individual's experience. Our cognitions, behaviors, and hopes all occur within that network. The relational frame means that all human experience must be understood as social phenomena in addition to being an intrapersonal experience.

In sum, human beings are embedded in a social network. All of us at some point or another experience distress within relationships, which in return will impact our mood and our functioning.

IPT was originally developed in the 1960s by Klerman, Weissman, and Paykel, who were interested in prevention of depression relapse. The first IPT manual was written in 1984 (Klerman et al., 1984) and was used as a treatment manual for the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al., 1989), a landmark psychotherapy study that compared IPT, cognitive behavior therapy (CBT; Beck et al., 1979), the antidepressant imipramine, and placebo for the treatment of major depression.

Since the publication of the original manual, IPT has expanded to become transdiagnostic in application (Stuart & Robertson, 2012). Additionally, the theoretical grounding of IPT in attachment and interpersonal theory was added by Stuart and Robertson (2012); they also shifted the conceptual frame from a medical to the biopsychosocial–cultural–spiritual model that has been used in IPT for more than 2 decades.

The Theoretical Basis of IPT

As noted, IPT is based on both attachment and interpersonal theory, which are complementary to each other. Attachment describes the general patterns of an individual's relationships, while interpersonal theory describes how those patterns play out on a microlevel in moment-to-moment communication. Conceptualization occurs at the attachment level, but many of the IPT interventions—particularly those in this book—focus on improving direct communication to help the client increase their social support and improve their interpersonal functioning. Increasing social support and improving interpersonal functioning are change factors (mediators) in IPT.

This theoretical foundation in IPT could be described in the interpersonal triad (Figure 1.2), which explains from an IPT perspective why people become distressed (Stuart & Robertson, 2012). The process begins with an acute interpersonal crisis, such as a loss, a dispute, or difficult life change (or more than one crisis in many cases). In IPT, the term *problem area* refers to one of three general types of crises that clients often experience: role transitions, interpersonal disputes, and grief and loss. These three areas, singly or in combination, capture a great many of the interpersonal crises that clients experience.

Clients respond to interpersonal crises in a particular way because of their attachment and biopsychosocial–cultural–spiritual diathesis and are in a situation in which social support (both emotional and practical) are not sufficient to overcome their crises. The impact of interpersonal distress brings about changes in mood and functioning. Changes in one's functioning often leads to seeking help through psychotherapy.

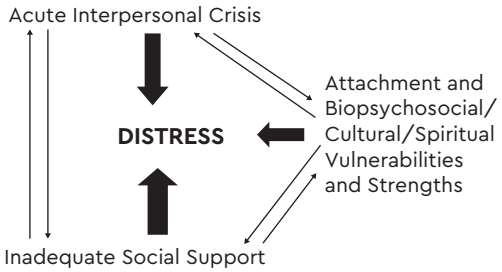
Attachment theory was first described by John Bowlby (1969). In a break from the dominant analytic thinking of the 1950s, Bowlby theorized that humans had an instinctual drive to form relationships. Our drive to form intimate bonds is literally necessary for human survival. We function well when our attachment needs are met; we become distressed when they aren't.

Attachment organizes behavior in interpersonal relationships. It forms the basis for an enduring pattern of inner experience of the self and others that leads us to seek care and support and security from others in a characteristic way. Although heavily influenced by early childhood experiences, particularly by adverse experiences such as neglect, abuse, or abandonment, Bowlby emphasized that attachment-driven behavior continues throughout the lifespan. In IPT, it is understood that early life relationships have a profound impact on attachment style but that this impact is mediated by the quality and consistency of other relationships throughout life.

Although always operating, attachment behavior is activated when we are stressed and our sense of security is threatened. Experiences of distress such as a cancer diagnosis, the death of a loved one, or the breakup of a romantic relationship all escalate our attachment needs and lead us to seek support from others. When we are distressed, our attachment needs increase, and these attachment needs drive care-seeking behavior. We seek someone to hold us and care for us. And we do that seeking well, or not so well, by communicating our distress and our need for support to others. Hence the focus in this book on techniques to improve interpersonal communication.

Our attachment models solidify over time to become relatively rigid expectations about what all relationships are like, as well as expectations about whether others will

FIGURE 1.2. The Interpersonal Triad



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provide care (or not) when we need it. These internal working models of attachment guide our perceptions, emotions, and thoughts and generalize into expectations about both our current and future relationships. In other words, our cumulative relationship experiences inform our views about what our subsequent relationships will be like. And our perceptions, emotions, thoughts, and expectations eventually lead us to seek others to meet our attachment needs through interpersonal communication, which informs how we ask for help and whether we do that well or poorly.

Based on real-life experiences, individuals develop a working model of self as either being capable of caring for their own needs for the most part or as needing to rely on others for care because of their lived experience that they are incapable of caring for themselves. At the same time, based on real-life experience, they also develop a working model of others as either dependable (i.e., others are willing to provide care if asked) or as not dependable.

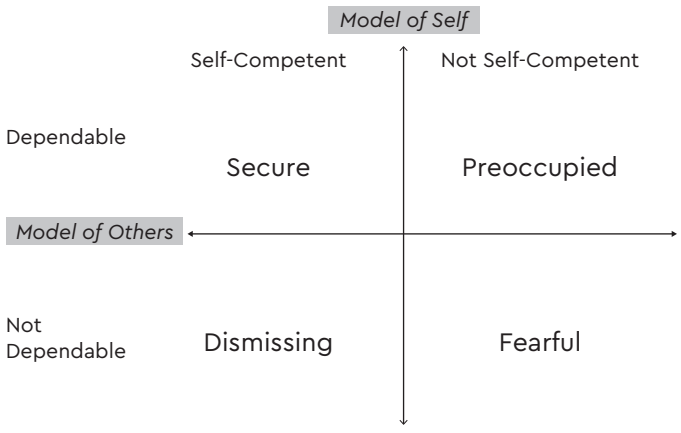
The IPT model of attachment (Bartholomew & Horowitz, 1991; Stuart & Robertson, 2003; Figure 1.3) is formed by the intersection of an individual's working model of self (*x*-axis) and their working model of others (*y*-axis). The intersection of the working models of self and others form the four attachment styles. People have characteristic ways of interacting with others interpersonally that are influenced by their attachment style, and those interactions are expressed in specific moment-to-moment communications, especially when they are distressed and asking for help.

There are three caveats that need to be added to the four-quadrant attachment model. First, the attachment styles are not diagnostic categories—quite the contrary. Nearly all people have characteristics of two or three styles, although often one is predominant. The best way to think about this is to envision the client occupying an area of attachment. That area may well be spread across two or more quadrants.

Second, when we become distressed, our attachment system is activated, and we tend to engage in less secure behavior. Our "area" of attachment does not change, but we move around within it. And when we are depressed, anxious, traumatized, lonely, or distressed in any of myriad ways, we tend to shift away from the secure attachment area. Distress threatens the security of our attachments.

Third, the attachment styles of other individuals we are interacting with have an influence on our care-seeking behavior as well. We engage in slightly different attachment

FIGURE 1.3. The Four Quadrant Model of Attachment in Interpersonal Psychotherapy



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behaviors in different relationships. Our attachment behavior with a partner is slightly different than that with a friend, a colleague, or a parent. The other person and their attachment style always exert an influence.

As a corollary, because the other person influences a client's attachment behavior and communication, this means that we, as clinicians, have an influence on the attachment behavior we observe from clients in therapy. And this means that we need to be acutely aware of our influence and communicate in a way that models security and clarity.

The term *graciousness* describes this way of modeling and of being in IPT. Graciousness is being open, grateful, and appreciative to be in a space with a client. It is looking for the good in others, in yourself, and promoting our clients' welfare. It is coming into the therapeutic space from a secure attachment. Sometimes, on a basic level, it is simply appreciating others and expressing your gratitude by saying "thank you" and "please."

It is critical to note that communicating graciously does not preclude speaking to the truth and being direct. One can be both gracious and direct in communicating and stating needs. But it does mean being appreciative of the help and support you receive.

Graciousness is a way of being in IPT. It encompasses being present, attentive, caring, and genuine as a real human being. It includes modeling good communication so that the client can learn how to communicate well too. It is the foundational way of being—the real human relationship between yourself and your client.

You'll notice, as you go through this book, that the practical examples of statements by the clinician all include these elements of graciousness and collaboration. The IPT therapist, for example, does not direct the client to do practice or homework; instead, the IPT therapist invites the client to collaborate on homework together. The IPT therapist is quick to praise and reinforce good communication from the client. We invite you to notice these kinds of communication in the examples and to use them as a model for your own practice.

Changing a client's fundamental attachment style is incredibly difficult. The difficult task—the Sisyphean task—is that to modify their attachment style, the client would have to literally reconstruct their attachment models of self and others—not just intellectually understand them, but change them at their core. Insight isn't enough to make this change; the client would have to have many new, consistent, and real experiences of being in trusting relationships and of being self-competent over many years.

In contrast, IPT focuses on improving communication as a way of resolving here-and-now crises in the client's social network. The relational foci and points of intervention are the client's relationships with family, friends, and people in their community. IPT is focused on helping people with their current functioning—the immediate crisis—and although IPT requires an understanding of early experiences, the goal of IPT is not to change or restructure fundamental attachment styles. IPT is not designed to change the client's internal psychological structures, ego functioning, defense mechanisms, or attachment style. Instead, IPT focuses on helping the client to identify and then communicate their attachment needs more effectively and on helping them to construct a more supportive social network. Priority is given to rapid resolution of distress and improvement in interpersonal functioning.

Over a decade ago, Stuart and Robertson (2012) placed IPT within a biopsychosocial–cultural–spiritual model in recognition of the cultural and spiritual elements that are critical in understanding grief and loss, family structures, expectations about communication, and differences in social support (Schultz & Stuart, 2014). They hypothesized that interpersonal communication was directly influenced by attachment style and that communication mediated attachment and social support (Stuart & Robertson, 2012).

Combining the attachment work of Bowlby and interpersonal theorists such as Kiesler (1992; Kiesler & Watkins, 1989) and Horowitz (2004), they posited that attachment style was manifest in moment-to-moment interpersonal communications and that maladaptive interpersonal communication led to difficulties in eliciting support from others during times of distress, difficulties in resolving interpersonal conflicts, and problems in generating needed social support. The goal of IPT interventions then shifts from changing fundamental attachment style to helping clients better identify and communicate their attachment needs for support. Communication, in contrast to attachment, is a learned skill and can be modified within a short-term framework.

That is why the skills in this book are focused on communication. Improved communication is a change factor in IPT—a mediator of change. Improved communication can be learned efficiently through therapist modeling, reinforcement of good communication by the client, and of course practicing both in session and in relationships in the client's social network.

Over the past 60 years, a variety of interpersonal models have been developed based on interpersonal and communication theory (Sullivan, 1953; see also Benjamin, 1996; Horowitz, 2004; Kiesler, 1996). All of them share the concept of reciprocity or complementarity in communication: that specific interpersonal communications tend to elicit or provoke particular types of responses from others. This principle of complementarity—that the way we ask for help influences the way others are likely to respond—is a cornerstone of interpersonal theory and of IPT.

In sum, maladaptive attachment styles lead to ambiguous, ineffective, hostile, or withdrawing interpersonal communication; this elicits a negative response from others that keeps the client's attachment needs from being met. The client's verbal and nonverbal communications, especially when they are stressed, tend to elicit or provoke rejection from others. The client's distress then increases further, creating a negative spiral of worsening communication and even greater unmet needs.

It must be noted that poor interpersonal communication is frequently coupled with poor interpersonal relationships generally. In other words, it is frequently the case that it is not only that the client's communication is causing more problems but that others in their social support network are not inclined to be of help or, in some cases, are struggling with healthy communications themselves. Our clients' social networks are sometimes replete with family members who have abused them, neglected them, and who have attachment problems of their own. Thus, the focus on improving communication in IPT must be coupled with helping the client find supporters who will actually be able to understand and help. Assisting our clients' to have realistic appreciation and understanding of others' willingness and relational capability (how to "boundary" toxic relationships or protect themselves from others who will make things worse) becomes one of the aspects of the IPT work. Decreasing the space between relational expectations and reality will assist clients with the acceptance of what others can and cannot help with. When we decrease the space between expectations and reality, we let go of disappointment and can obtain the freedom to find support from other people who are not only capable but also willing to help.

Two exercises in this book are devoted to ways of doing that. The Interpersonal Inventory (Exercises 1 and 2) is designed to get a baseline assessment of the people in the client's life. Using this, the therapist can help identify who among the client's connections will be most likely to respond well to requests for support.

The primary point of intervention in IPT is therefore to assist in improving communication, which is a teachable skill. Improved communication then helps to increase

needed social support. This conceptual approach directly informs the specific IPT techniques described in this book, such as the development of interpersonal incidents, communication analysis, and reinforcement of effective communication.

From Theory to Practice: The Structure, Tools, and Techniques of IPT

Individual IPT is usually delivered flexibly over approximately six to 20 sessions and can be divided into assessment/initial, middle, concluding, and maintenance phases (Figure 1.4).

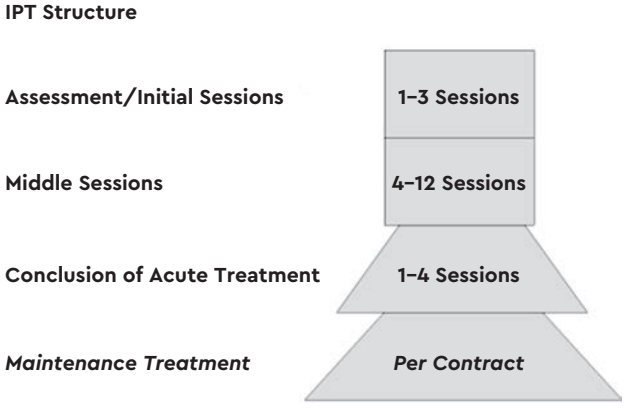
The assessment/initial sessions include a general clinical assessment as well as three tasks specific to IPT. These are collaboratively constructing the Interpersonal Inventory (see Exercises 1 and 2) and the IPT Summary. The therapist should also construct an IPT formulation, which conceptualizes why the client is distressed based directly on the biopsychosocial–cultural–spiritual model.

The middle phase includes work to resolve the client's interpersonal problems within the IPT problem areas (interpersonal disputes, role transition, grief and loss). More complexity usually requires more sessions; the poorer the client's social support, the more difficult their interpersonal problems, and the less securely attached they are, the more sessions that are needed. That is why the number of sessions in IPT is flexible.

IPT is not terminated; instead, the clinician should make a shift to maintenance treatment once the client has recovered. There are several reasons for this. First, most clients we work with are at high risk of relapse. Depression is remitting and relapsing; anxiety tends to relapse; eating disorders, posttraumatic stress disorder (PTSD), substance abuse disorders, and many others relapse too. To terminate acute treatment is to leave your client at greater risk for relapse, particularly when coupled with the data that maintenance IPT does reduce relapse risk (Kupfer et al., 1992). Thus, IPT is structured to reflect the real clients with whom we work.

When concluding acute treatment, the therapist should review progress and plan for future problems, especially relapse. Sessions can be less frequent as the conclusion approaches. Maintenance IPT should be scheduled based on the client's history, severity of distress, and risk for relapse. In all cases, the goal of IPT is to conclude acute treatment when the client has recovered, and then shift to maintenance to keep them well.

FIGURE 1.4. The Structure of Interpersonal Psychotherapy (IPT)



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Assessment/Initial Phase of IPT

The Interpersonal Inventory (Exercises 1 and 2) is a helpful assessment tool to map and evaluate the important current relationships in a client's life. It is usually conducted in Session 2 or 3. It collaboratively engages the client, helping them to understand their general social support and critical aspects of specific relationships.

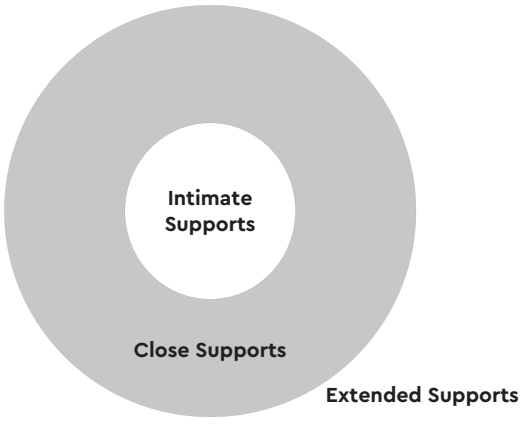
The Interpersonal Inventory (or what we call at times an "Interpersonal Circle" or a "Circle") is a unique feature of IPT. Like all the IPT tools, the Interpersonal Circle (Figure 1.5) is designed to structure therapy while listening well. This is the essence of IPT: listening to the client well while using a structure that facilitates change.

The Interpersonal Circle is a simple series of concentric circles. Using a blank piece of paper, the therapist draws the two circles, then asks the client to imagine that they are in the center of the inner circle and asks them to write the names of seven to 10 (or more) people in their social support network—people relevant to the presenting problem—on the diagram. The innermost circle should include people with whom they feel intimate, the middle circle people with whom they feel close, and the outermost area those who are extended supports. The goal is to get a "big-picture" map of the client's general social support. It is helpful for the client to do the writing on the circle because it could convey that their perspective and story is the important one.

Once names are on the Interpersonal Circle, the therapist is instructed to use open-ended questions to get a sense of the client's relationship with each person. The goal of the Interpersonal Inventory is to get a good general overview of social support, not to begin resolving specific problems. The problem-solving work will take place in the Middle Phase.

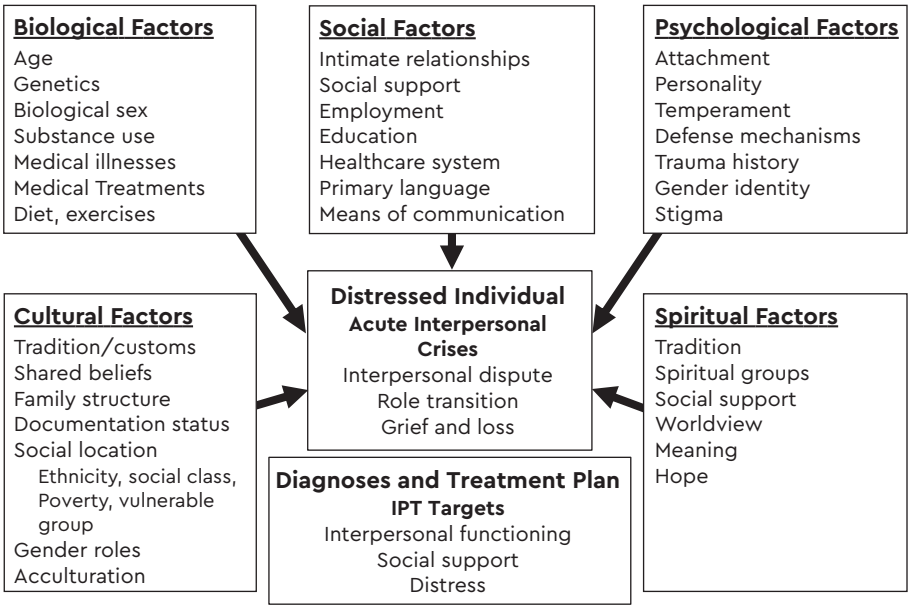
The IPT formulation and summary are two closely related tools unique to IPT. The formulation is a "formal" description of the client's current problems using technical language to denote constructs such as personality, attachment, social support, and biological risk factors. It is structured and included in the client's medical record. The summary, in contrast, is an understanding of the client's problems put in their own language. It is developed collaboratively in session and constructed with a great deal of input from the client. It is a mutually developed road map and treatment agreement for therapy.

FIGURE 1.5. The Interpersonal Circle



Note. "Intimate supports" are individuals who are closest to the client and who the client feels they can rely on the most. "Close supports" are individuals who are still close to the client but not as close and supportive as the intimate supports. "Extended supports" are individuals who are distant from the client and provide either limited or no support. Diagram is a reproduction of training material developed by the IPT Institute, LLC. Copyright IPT Institute, LLC, Scott Stuart, MD, Director. Reprinted with permission.

FIGURE 1.6. Interpersonal Formulation

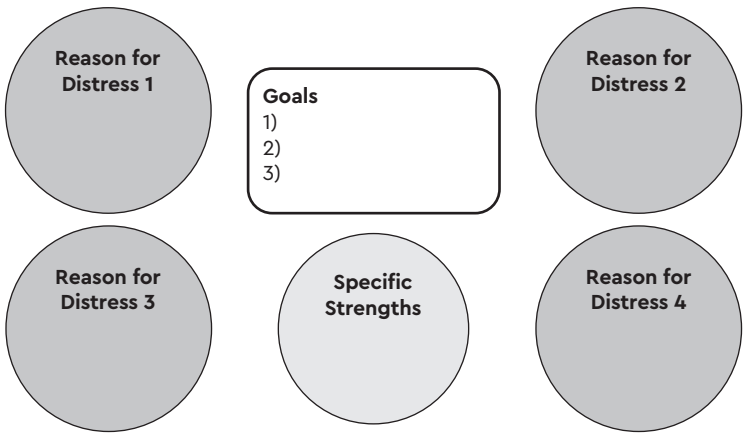


Note. IPT = interpersonal psychotherapy. Diagram is an adaptation of training material developed by the IPT Institute, LLC. Copyright IPT Institute, LLC, Scott Stuart, MD, Director. Adapted with permission.

Both the IPT formulation and summary are based on a biopsychosocial–cultural–spiritual model (Figure 1.6). This is reflected in the structure of the formulation, which includes information in all five of these categories. The formulation includes data from the general psychiatric and medical history, family history, and social history. It also includes information about social support from the Interpersonal Inventory. The formulation should include diagnoses and the target problem areas that will be addressed in therapy.

In contrast, the IPT summary (Figure 1.7) should contain technical language because it uses terms understandable to the client. It is the last element of the assessment,

FIGURE 1.7. The Interpersonal Summary



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following the general evaluation and the Interpersonal Circle. It is literally a collaboratively developed diagram written by the client in session that addresses the following questions: (a) How did their problems develop? (b) What factors are maintaining their problems? and (c) What can be done about them?

The summary is not a diagnosis; it is a collaboratively developed explanation of the client's distress that describes how their symptoms have developed and are being maintained. These "layperson" explanations should be written by the client in the four outer circles of the diagram (Reasons for Distress 1–4). The summary emphasizes the interpersonal factors involved in the origin and context of the problems and suggests the areas in which IPT will help overcome them. It is pivotal—the successful collaboration between client and therapist in developing a personally meaningful summary sets the stage for the middle phase of IPT.

The summary also contains two additional collaboratively developed elements. The first is an explicit description of the client's specific strengths. Discussing and elaborating their strengths is an important therapeutic step emphasizing their ability to overcome the crises. The summary also contains two or three collaboratively developed goals. These general goals, developed in more detail in the middle phase, are the roadmap and treatment agreement for the rest of IPT.

Middle Phase of IPT

In the middle phase, the therapist and client work together on the goals established in the summary and then work to resolve the interpersonal disputes, role transitions, grief and loss issues, or a combination of these.

Role Transitions

Change always happens as people move through life. Transitions are difficult and often require extra effort and resources even when difficulties are expected. Some reflect lifecycle changes such as adolescence, young adulthood, childbirth and becoming a parent, growing older, and changes in health generally. Others include changes in school, employment, retirement, marriage, divorce, moving, and emigration. Particular transitions are experienced very differently by individual clients, and specific and unique cultural expectations often influence them.

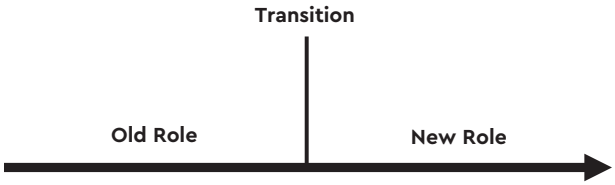
Successful transition requires an understanding and acceptance by the client of what they are leaving behind and what they are about to encounter. This is often accompanied by ambivalence about change, grief and loss regarding their old roles and the relationships associated with them, anxiety about their new roles, and a need for new social skills and additional social support.

The goals when working with role transitions are to assist the client in developing and articulating the complexity of their transition—their story—to relinquish an old role, to accept a new one, and to develop a sense of mastery in their new role. As the client evaluates and communicates their expectations to others, improved social support will be fostered. Because transitions occur within a social context, increased social support contributes to the adaptation to the new role.

Sequentially connecting events and symptoms allows the client to gain a realization of why and how the stressors have emerged during the transition. The primary clinical tool used to assist the client to understand their transition and describe it to others is the Life Events Timeline (Figure 1.8).

To construct a timeline, the clinician, near the beginning of the middle phase, draws a line with an arrow pointing to the right and a vertical line in the middle signifying the

FIGURE 1.8. Interpersonal Psychotherapy Life Events Timeline



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transition. One can visualize the old role to the left and the new role to the right. The paper is then handed to the client with instructions to mark points of relevance to their transition on the timeline.

The timeline is designed to elicit in a structured way the client's story about the events leading up to the point of transition, their current situation, and their hope for the life beyond the transition. Asking the client to complete open-ended statements about the transition greatly assists them to create a coherent story with a beginning, middle, and end. Asking open-ended questions such as "Where does the arrow go for you?" and "What do you aspire to in the future?" are extremely helpful to address forward movement—the arrow on the right of the timeline—and the inevitability of continued change. For many clients, it is helpful to start discussing where this current transition might lead them in the future and while the discussion provides them with a sense of hope as they move forward in their transition. During the discussion, which may take many sessions, the goal is to assist the client to understand and appreciate the complexity of their transition, address and resolve ambivalence about the change, and create a coherent and meaningful story that they can share with others to facilitate understanding and elicit the support and care they need to weather the transition well. Specifically, asking questions such as "What part of your story that we discussed today/so far do you think might be helpful for someone in your life to know?" could assist others to understand the client better and elicit support.

Interpersonal Disputes

Interpersonal conflicts arise when two or more people are not communicating well and have expectations of each other that are not fulfilled. Interpersonal conflict and unmet needs lead to acute distress.

The three treatment goals associated with disputes are (a) to elaborate and understand the dispute, (b) to improve communication skills to resolve it, and (c) to broaden social support generally. At the core is work to improve the client's ability to understand and describe their needs. As people on their interpersonal circle who are likely to respond well are identified, the client and clinician can work on expressing and communicating their needs for support in a way that can be better understood and responded to by others.

Several IPT techniques are often used with interpersonal disputes. Connecting the dispute to affect is imperative because it facilitates change. Communication analysis followed by generating communication options helps to unveil the status of the relationship and to start setting realistic expectations about it. Evaluating expectations is important; anger and disappointment stem from expectations that are not realistic and are not explicitly stated. Assisting the client to see, accept, and appreciate others

for what and how they are able and willing to support them becomes an aspect of the interpersonal disputes work that helps to close the gap between expectations and reality. Lastly, when communications do not go well, emotions arise. It might be helpful in some cases to assist clients with additional understanding and management of their emotional states so that their communications are delivered in a clear, direct, and helpful way.

Grief and Loss

Loss can lead to feelings of emptiness and isolation, often occurring in waves or "pangs of grief" and may sometimes even include thoughts of death related to the loss. The circumstances that lead to the loss can include illness, accidents, addiction, abuse, divorce, and loss of physical health, as well as anticipation of any of these. Complicating the process, grief can also be cumulative; interpersonal stress related to even seemingly minor losses, such as the transfer of a friend in the workplace, is more likely to trigger depression in people who have experienced parental loss in their childhood.

Within IPT, there is an understanding that each person's experience of grief and loss is unique. The first therapeutic step in coping better with loss is for the clinician to listen and appreciate/understand in a way that is supportive to the client and the loss that the client sustained. Some clients experience complicated, often heart-wrenching grief, and the empathy-driven experience of being and feeling understood, as well as a supportive attachment to the therapist at this vulnerable time, begins the healing process.

The clinician's second goal is to help the client to describe the loss experience, first to the therapist and then to others. During this step, the clinician can be directive with clarifying questions such as "What was your reaction when you first found out about the loss?" or "What kind of support do you hope for from others?" Clarification and helping the client to describe their distress and need for support are two specific skills that can be brought to bear. Description of the experience in therapy then becomes a bridge toward the third goal of assisting the client to connect with others—that is, mobilizing social support. This moves toward reducing isolation and meeting the client's social and attachment needs. Finally, the clinician works toward helping the client increase general social support with new or modified relationships, increasing a sense of meaning and purpose.

Conclusion and Maintenance Treatment With IPT

As noted earlier, acute treatment with IPT comes to a conclusion, not a termination. In IPT, provision is specifically made for maintenance appointments. Both clinical experience and empirical evidence consistently demonstrate that a continuing therapeutic relationship is beneficial for most clients (E. Frank et al., 1990, 2007). Because of this, the therapist is obligated to discuss maintenance treatment with all clients.

IPT can be conceptualized as a "family practice" model of care, in which short-term treatment for an acute problem is provided until it is resolved, and then maintenance treatment is provided as needed to keep the client well. The treatment is ongoing: The client is welcome to return should another acute problem arise and is encouraged to return for periodic health maintenance.

Maintenance IPT is designed to enhance the gains made in the acute phase. Clinicians should work collaboratively with clients to create a maintenance treatment plan guided by client history and context (E. Frank et al., 2007; Stuart & Robertson, 2012). Dosing of maintenance IPT might range from monthly for a client at high risk of relapse to every 6 months for one with a single episode of mild depression. In either case, it is critical that the clinician and client have a clear, collaborative agreement about maintenance sessions.

Although the maintenance phase is less intensive than acute treatment, it is not less focused. Maintenance treatment with a clear focus on interpersonal issues is significantly more effective (E. Frank et al., 1991). The acute phase is characterized by active work to improve interpersonal functioning and social support to resolve distress; the maintenance phase is refinement of the newly developed interpersonal skillset to prevent the return of distress (Stuart & Robertson, 2012).

IPT Techniques

In IPT, a good therapeutic alliance is the necessary foundation on which all techniques are built. Genuineness, graciousness, warmth, empathy, and unconditional positive regard (J. D. Frank, 1971; Rogers, 1957), although not sufficient for change in IPT, are all necessary (Stuart & Robertson, 2003, 2012). The primary goal of the IPT practitioner should be to understand the client and provide them with a sense of being understood.

Although several techniques are specific to IPT, it is the focus on current interpersonal relationships which unifies them. Many specific IPT techniques—particularly the ones covered in this book—are designed to improve the client's communication. Primary goals in IPT are to determine how the client is asking for help and support in maladaptive ways, to help them recognize that they are doing so, and to help them implement new and more effective communication. Helping the client to communicate more directly, clearly, and graciously, makes it more likely that their interpersonal problems will be resolved and social support will be more effectively engaged.

Communication analysis is one of the techniques used to help the client communicate more clearly about the help and support they want from significant others and to convey this more effectively. The first step in communication analysis is the elicitation of important interpersonal incidents (Stuart & Robertson, 2003, 2012). Interpersonal incidents are descriptions by the client of specific interactions with another person. To identify patterns of disputes with a partner, for example, the therapist can ask the client to "describe the last time you and your partner got into a fight" or to "describe one of the big conflicts you had with your partner." The therapist should direct the client to describe the communication in detail, re-creating the dialogue as accurately as possible. The client should be directed to describe their affective reactions and both verbal and nonverbal responses, and to describe observations of their partner's nonverbal behavior. The purpose of eliciting interpersonal incidents is to discover patterns—that is, to determine what is not going well with the client's communication so that steps can be taken to improve it (Stuart & Robertson, 2012).

The next step is to examine the consequences of the ineffective communication. The therapist can link this to the client's affect, and particularly to his sense of feeling misunderstood and alone. This provides the client with insight into the communication as well as motivation to change it.

Once maladaptive communication patterns are identified, the interactive process of giving feedback to the client begins. The client is encouraged to understand the dispute as a problem that can be improved with more direct communication. The client and therapist can then begin to develop possible solutions using techniques such as brainstorming and problem-solving.

Practice comes next with an emphasis on role-playing and assigning practicing the skills learned during the session/homework to engage social support. Role-playing can be used to help the client practice the interpersonal skills they have developed in session; practicing outside of the session provides the opportunity to master these interpersonal skills with people in their life and to gain self-efficacy.

IPT Clinical Applications

The application of IPT is best determined by the individual's unique problems, distress, and social context. Although research in IPT is specific to particular diagnoses or populations, restricting its use to these limits both its use and its dissemination. IPT is best thought of as a transdiagnostic approach for interpersonal problems (Stuart, 2019; Stuart & Robertson, 2003, 2012) which may be associated with a variety of diagnoses.

With respect to specific disorders, IPT has been empirically validated for affective disorders, anxiety disorders, eating disorders, and PTSD. Meta-analyses strongly support the effectiveness of IPT for depression with moderate to large effect sizes comparable to other established psychotherapies (Barth et al., 2013; Cuijpers et al., 2011, 2016, 2020, 2021). An IPT-specific meta-analysis from 2016 found it to be as effective as pharmacotherapy alone for treating depression (Cuijpers et al., 2016).

IPT is also validated for anxiety disorders. Meta-analyses of trials of IPT for anxiety disorders found large effects for IPT compared with control conditions and that IPT was equivalent to CBT (Bright et al., 2020; Cuijpers et al., 2016). IPT for anxiety is well tolerated and has low levels of attrition (Markowitz et al., 2014); meta-analytic evidence suggests the 16.1% dropout rate for IPT for anxiety disorders is significantly lower than other psychotherapies, including CBT (Linardon et al., 2019).

IPT has been validated in individual and group formats with bulimia nervosa, binge eating disorder, and anorexia nervosa (Fairburn et al., 2003). Results from a large meta-analysis showed that IPT had significant effects on all eating disorders, although the effect sizes were noted to likely be smaller than that of CBT in acute phases of treatment (Cuijpers et al., 2016). A comprehensive literature review concluded that there were no significant differences between IPT and CBT in treating anorexia (Miniati et al., 2018). Although CBT sometimes had faster gains, IPT had an equivalent improvement at follow-up. The authors concluded that IPT is a reasonable, cost-effective alternative to CBT for treating eating disorders transdiagnostically.

A meta-analysis of 10 clinical trials of IPT consisting of 755 patients with PTSD symptoms concluded that IPT had an overall effect size of 0.44 and was clearly superior to passive controls such as waitlists (Althobaiti et al., 2020). IPT appears to be as effective as other active treatments, but there are not yet enough comparative studies to draw firm conclusions. However, IPT certainly holds promise as a more tolerable and acceptable treatment for PTSD than exposure-based treatments and may be particularly effective for sexual trauma.

IPT has been used effectively with geriatric patients (Reynolds et al., 1992, 1999, 2010), adolescents (Mychailyszyn & Elson, 2018; Pu et al., 2017; Zhou et al., 2015, 2020), and perinatal women (Bright et al., 2020; O'Hara et al., 2000; Sockol, 2018; Sockol et al., 2011). It is also effective in groups (Johnson et al., 2019; Mennen et al., 2021; Mulcahy et al., 2010; Pessagno, 2013; Reay et al., 2012) and with couples (Brandon et al., 2012). IPT has been found to be effective in international settings across many cultures as well (Bass et al., 2006; Bolton et al., 2003; Cuijpers et al., 2018; Verdeli et al., 2008).

IPT Skills in Deliberate Practice

There are 10 specific IPT skills covered in this textbook. The first two exercises in the beginner section cover the Interpersonal Inventory; as noted previously, the inventory is a critical and unique tool in IPT designed to understand the client's social support network. That requires starting the exercise well by enlisting the client's cooperation

(Exercise 1) as well as getting more detailed information about each of the relationships the client lists on the inventory (Exercise 2). This provides an overview of the nature of their interpersonal support, including the quality of each specific relationship.

"Clarifications" (Exercise 3) is another skill covered in the beginner section. Clarification is used throughout IPT, both in information gathering and in exploring options for change; in addition to being a helpful tool for information gathering, it is also a way to model good communication for the client.

The intermediate section includes three intermediate level skills. The first, "Interpersonal Framing of Distress" (Exercise 4), is important because it provides a framework for both the therapist and client to understand the client's distress as arising from, and influenced by, their interpersonal relationships. Setting this framework then leads to clear goals in therapy and to work to improve interpersonal functioning and to increase social support.

Once there is a clear, collaboratively developed understanding of the client's distress, the therapist can work on helping the client to describe it, first in therapy and then to others. Describing why the client is distressed and what their experience is like is immensely helpful in generating attachment support. Once others understand better, they are more likely to respond to the client's need for help. "Helping the Client to Describe Their Distress and Need for Support" (Exercise 5) is a skill the therapist can use to accomplish that.

The last skill in in the intermediate section is "Reinforcement of Effective Communication" (Exercise 6). In addition to modeling good communication, the therapist can provide direct feedback to the client in session to help them improve their communication skills. As with any behavioral change—in this case, change in communication—the best strategy is to reinforce positive change. Noticing good communication when it occurs and then reinforcing it positively is an effective way to do this.

The advanced section builds on these communication skills and begins to move them toward implementation in the client's relationships with family, friends, and people in their community. To improve communication in those relationships, examples of communication must be collected and analyzed. "Communication Analysis" (Exercise 7) is designed to do this in several steps. First, examples of specific communication (interpersonal incidents) are collected as data points for understanding what is not going well in the client's communication with others. These specific incidents collected early in therapy usually focus on interactions in which the client asked for support but did not get their needs met. In IPT, based on the relational frame conceptualization, it is always an understanding that the communication occurs within a system; it is never the "fault" of one person or another, but rather the interactive communication within a system. Those communications should also clarify the emotional experience of the client (Step 2) and the emotions they were trying to communicate to understand the interaction more fully.

It is worth noting here that the same technique of collecting and analyzing interpersonal incidents can and should be used later in therapy to highlight examples of communication which did go well and those in which the client's needs did get met. This allows the therapist to praise the client's effective and specific communication in a meaningful way and to provide positive reinforcement for it, making it even more likely that they will continue to communicate well.

Once samples are collected and examined, the third step in communication analysis is to help the client describe what they were hoping to get from the specific communication in which they were asking for help but did not get it. The therapist should guide

the discussion here; although the client has very legitimate needs for support, the fact that their needs were frustrated leads to the likely conclusion that the communication within the relational system was not going well. If so, then the client can do something about it: They can practice more effective communication in session and then implement that communication with their significant other once again (Step 4).

Once it is clear to the client that their communication has not been effective, the next step is to work with them to brainstorm and develop other communication options. The appropriately titled "Generating Communication Options" (Exercise 8) is designed to do that and to help the client practice different ways of communicating in session. Communicating their experiences to others by "Mobilizing Social Support" (Exercise 9) follows, and the likelihood of implementing these new ways of communication increases using the skill of "Motivating Interpersonal Action" (Exercise 10).

The Role of Deliberate Practice in IPT Training

Deliberate practice fits well with the IPT approach to therapy, which emphasizes improving communication. On a metalevel, the skills you learn and master from these exercises should mirror those you teach your clients. Communication is a learned skill: Modeling it well, reinforcing good communication when it occurs, and practicing it within session and in real relationships will improve that skill. And that, in a nutshell, is what you personally will be doing in these exercises to improve your communication with your clients.

The earlier overview of IPT is just that—an overview. We strongly recommend engaging in more reading about IPT, particularly the theory and structure of IPT. Excellent textbooks include *Interpersonal Psychotherapy: A Clinician's Guide* (Stuart, 2019; Stuart & Robertson, 2003, 2012), which is designed specifically for clinical use, and *Interpersonal Psychotherapy for Adolescents: A Clinician's Guide* (McAlpine & Hillin, 2021), for those working with children and teens. Introductory training, advanced training, and supervision in IPT are available through the IPT Institute (https://iptinstitute.com), as are opportunities to join the community of IPT clinicians in monthly Case Conferences and mentorship groups for IPT supervisors and trainers.

Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. Further guidelines for getting the most about deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 10 skill-focused exercises, which are ordered based on their difficulty: beginner, intermediate, and advanced (see Table 1.1). They each contain a brief overview of the exercise, examples of client–therapist interactions to help guide trainees, step-by-step instructions for conducting that exercise, and a list of criteria for mastering the relevant skill. The client statements and sample therapist responses are then presented, also organized by difficulty. The statements and responses are presented separately so that the trainee playing the therapist has more freedom to improvise responses without

being influenced by the sample responses, which should only be used if the trainee has difficulty improvising their own responses. Exercise 7 follows a different format than the other exercises, using back-and-forth, client–therapist dialogues instead of a single client statement followed by a single response.

The last two exercises in Part II provide opportunities to practice the 10 skills within simulated psychotherapy sessions. Exercise 11 provides a sample psychotherapy session transcript in which the IPT skills are used and clearly labeled, thereby demonstrating how they might flow together in an actual therapy session. IPT trainees are invited to run through the sample transcript, with one playing the therapist and the other playing the client, to get a feel for how a session might unfold. Exercise 12 provides suggestions for undertaking mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. While Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and describes the importance of appropriate responsiveness, attending to trainee well-being and respecting their privacy, and trainer self-evaluation, among other topics.

Four appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form that can be used during a training session's final evaluation to process the trainees' experiences, but its primary purpose is to provide trainees a format to explore and record their experiences while engaging in additional, between-session deliberate practice activities without the supervisor. Appendix C presents additional approaches and guidelines for troubleshooting the implementation of the interpersonal inventory in Exercise 2. Appendix D presents a sample syllabus demonstrating how the 10 deliberate practice exercises and other support material can be integrated into a wider IPT training course. Instructors may choose to modify the syllabus or pick elements of it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Resources" tab online (https://www.apa.org/pubs/books/deliberate-practice-interpersonal-psychotherapy).