The IPTF in Practice: Stages One and Two

THE TALKING THERAPIES UK PRACTITIONER SERIES



The IPTF in Practice: Stages One and Two

Delivering stabilisation, safety, cognitive mapping and schema work

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the The IPTF in Practice: Stages One and Two course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 4. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 Foundations and Crisis Management 3

1. Aims, targets and delivery structures 4
2. The skills curriculum and the individual component 11

How to use this manual

The second course in the IPTF pathway turns the framework's first two stages into practice you can run this week. Stage One is taught as a working machine: the target hierarchy that puts life-threatening behaviour first, chain analysis as the stage's workhorse, the four-module skills curriculum spanning mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness, the individual session structure that applies it, and the crisis pathway, a rehearsed, stepped safety plan with disciplined between-session contact. You will learn the stage-gate criteria that make progression a judgement against evidence rather than a feeling. Stage Two is then taught phase by phase: the collaborative history that locates what the person learned and where, schema and mode mapping in the person's own words, and the processing and restructuring work, imagery rescripting, chair work, behavioural experiments and the deliberate use of the therapeutic relationship, that revises old conclusions and consolidates new responses. Eleven detailed lessons include worked session fragments, single-practitioner adaptations for smaller services, and written exercises that build your own stage plans and maintenance-loop maps. For clinicians who hold, or intend to hold, personality disorder caseloads, this course is where the IPTF stops being a model you understand and becomes a treatment you deliver.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in

supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Conduct stage-one work: engagement, stabilisation, risk containment and shared goals
- Build the stage-two formulation: pattern, origins, maintenance and the change plan it implies
- Select and justify modality methods for each formulation element
- Track stage progress and recognise genuine readiness to move on, versus flight into health
- Revisit earlier stages deliberately when destabilisation or new material requires it
- Document IPTF work so that another practitioner could pick up the thread

PART 1

Foundations and Crisis Management

Covers aims, delivery structures, skills curriculum, crisis safety planning, and grounding techniques for stabilisation.

CHAPTER 1

Aims, targets and delivery structures

Stage One of the Integrative Psychotherapy Treatment Framework (IPTF) is conceived as a deliberately bounded therapeutic stance rather than a vague prelude to later work. Its central purpose is to create a secure platform from which the client can safely engage in the relational and narrative work that characterises Stage Two. The evidence base for this stabilisation focus is extensive. Judith Herman's seminal model of trauma treatment (1992) identified safety, remembrance, and reconnection as the three pillars of recovery, and subsequent empirical work by Bessel van der Kolk (2014) and Janina Fisher (2016) has reinforced the necessity of establishing physiological and emotional regulation before any intensive trauma processing. Within IPTF, the hierarchy of targets is explicitly ordered to reflect the same logic: life-threatening concerns are addressed first, followed by therapy-interfering problems, and finally stability-interfering issues. This ordering is not arbitrary; it mirrors the risk-management frameworks used in emergency psychiatry (e.g., the NICE guideline for self-harm, 2022) and the trauma-informed care principles advocated by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). By foregrounding safety, the therapist reduces the probability that exposure to distressing material will destabilise the client, thereby protecting the therapeutic alliance and preserving the client's capacity for learning.

The first aim of Stage One is the establishment of safety, both physical and emotional. Physical safety involves assessing and managing any imminent threats to the client's life, such as suicidal ideation, self-harm, or severe psychosis. Emotional safety requires the therapist to create a holding environment in which the client feels heard, respected, and free from judgement. The therapeutic alliance, a construct repeatedly shown to predict outcome across modalities (Horvath & Symonds, 1991), is cultivated through consistent, transparent communication, collaborative goal-setting, and the demonstration of competence in managing risk. The alliance is not merely a pleasant by-product; it is an active ingredient that enables the client to tolerate the affective arousal that inevitably arises when trauma-related material is later introduced.

Stability, the second aim, refers to the client's ability to regulate affect, maintain basic self-care, and engage in daily functioning without being overwhelmed by trauma-related intrusions. Research on affect regulation, particularly the work of Schore (2003) on neurodevelopmental trauma, underscores the importance of teaching concrete skills that can be rehearsed in the present moment. Within IPTF, these skills are delivered through a dual-track structure that combines group-based skills training with individual psychotherapy. The group setting provides a socially rich context for practising interpersonal behaviours, normalising distress, and fostering peer support. It also offers an efficient vehicle for disseminating psychoeducational content, such as the neurobiology of stress, the role of the autonomic nervous system, and the mechanics of interpersonal skills. The individual sessions, by contrast, allow the therapist to tailor the skills to the client's specific relational patterns, to monitor adherence, and to address any idiosyncratic barriers that emerge.

The third aim is the strengthening of the therapeutic alliance itself. While safety and stability are prerequisites, the alliance is the conduit through which the client learns and internalises new interpersonal patterns. Empirical studies of IPTF (e.g., Cloitre et al., 2011) have demonstrated that a strong alliance predicts greater reductions in PTSD symptom severity, even when controlling for baseline symptom load. Therapists are encouraged to use validated outcome measures such as the PHQ-9 and GAD-7 not merely as symptom checklists but as collaborative tools that invite the client to reflect on progress, thereby reinforcing a sense of agency and partnership.

The fourth aim is the acquisition of concrete coping skills. IPTF draws heavily on the skill-sets articulated in Dialectical Behaviour Therapy (Linehan, 1993) and Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 2011), adapting them to an interpersonal framework. Clients are taught grounding techniques, paced breathing, and emotion-labelling strategies, as well as interpersonal skills such as assertive communication, boundary setting, and conflict resolution. These skills are rehearsed in the group, where role-plays and feedback loops provide immediate reinforcement, and then refined in the individual session where the therapist can observe the client's application of the skill within their lived relational context.

The target hierarchy that guides Stage One is operationalised through a systematic assessment process. First, the therapist conducts a thorough

risk assessment to identify any life-threatening issues. This includes evaluating suicidal ideation, self-harm behaviours, severe substance intoxication, and acute psychotic symptoms. If any of these are present, they become the primary focus of intervention, and the therapist may employ crisis-intervention protocols, safety planning, and, where necessary, liaison with emergency services. Once life-threatening concerns are stabilised, the therapist turns to therapy-interfering problems. These are factors that impede the client's ability to engage meaningfully in therapy, such as chronic avoidance, substance misuse that leads to missed appointments, or pervasive distrust of the therapist. Addressing these problems often involves motivational interviewing techniques (Miller & Rollnick, 2013) and the integration of harm-reduction strategies. Finally, stability-interfering issues are tackled. These include persistent dysregulation, fragmented sleep, or interpersonal patterns that erode the client's sense of safety in daily life. Interventions at this level are typically skill-focused and may involve the use of behavioural activation, sleep hygiene education, and the practice of interpersonal skills within the group context.

It is equally important to delineate what Stage One deliberately does not attempt. The phase is not designed for intensive trauma narrative processing, nor for deep exploration of early attachment wounds that may have seeded the client's current difficulties. While the therapist may gently inquire about the client's trauma history to contextualise safety planning, any detailed recounting of traumatic events is postponed until the client has demonstrated sufficient emotional regulation and a robust alliance. This restraint is grounded in the findings of Resick, Monson and Chard (2017), who showed that premature exposure to trauma memories can exacerbate dissociation and increase dropout rates. Similarly, Stage One does not aim to resolve entrenched personality pathology; rather, it seeks to create a therapeutic window in which such work can later be pursued with greater efficacy.

The dual delivery structure of group skills training and individual therapy is central to achieving the aims outlined above. In the group, the therapist adopts a facilitative stance, encouraging participants to share experiences of affect dysregulation, to model adaptive interpersonal behaviours, and to provide peer feedback. The group curriculum is typically organised into modules that progress from psychoeducation about the stress response, through skill acquisition, to the rehearsal of interpersonal scenarios. The

therapist monitors group cohesion, intervenes when safety is threatened, and ensures that each participant receives sufficient practice time. In the individual sessions, the therapist conducts a more granular case formulation, linking the client's presenting problems to specific interpersonal patterns identified in the group. The therapist then co-creates a personalised skill-use plan, schedules in-vivo practice assignments, and reviews the client's self-monitoring logs. This integrative approach maximises the generalisability of skills across contexts and reinforces the therapeutic alliance through consistent, personalised attention.

A concrete worked example illustrates how the hierarchy of targets, the delivery structure, and the aims of Stage One interlock in practice. Consider Maya, a 34-year-old woman referred for treatment following a series of interpersonal traumas, including a recent violent breakup and a history of childhood emotional neglect. On intake, Maya reports chronic anxiety, frequent panic attacks, and a recent episode of suicidal ideation after a heated argument with her ex-partner. She also discloses that she has been using alcohol to "numb" the intensity of her emotions, leading to missed appointments and a strained relationship with her primary care physician.

The therapist begins by conducting a comprehensive risk assessment. Maya's suicidal thoughts are rated as moderate on the Columbia-Suicide Severity Rating Scale, and she admits to having a plan involving overdose. This places a life-threatening target at the forefront of the treatment plan. The therapist collaborates with Maya to develop a safety plan that includes identifying warning signs, securing a means-reduction strategy for medication, and establishing a crisis contact list. Maya is also offered a brief medication review with her psychiatrist to address any underlying depressive symptoms that may be amplifying her suicidal risk.

Having secured a safety net, the therapist moves to the therapy-interfering tier. Maya's alcohol use is identified as a barrier to consistent attendance and to the therapeutic process itself. Using motivational interviewing, the therapist explores Maya's ambivalence about drinking, highlights the discrepancy between her desire for stability and the destabilising effects of alcohol, and negotiates a harm-reduction goal of limiting intake to no more than two drinks per week. Maya is invited to attend the group skills training sessions, where she learns grounding techniques such as the 5-4-3-2-1 sensory exercise and the "STOP" skill (Stop, Take a breath, Observe,

Proceed). In the group, Maya also practises assertiveness by role-playing a scenario in which she must set a boundary with a friend who repeatedly makes intrusive comments about her personal life.

During individual sessions, the therapist integrates Maya's group learning into her personal relational context. The therapist helps Maya map out the interpersonal triggers that precipitate her panic attacks, noting that arguments with her ex-partner often lead to a cascade of physiological arousal and subsequent alcohol use. Together, they develop a step-by-step plan: when Maya feels the early signs of agitation, she will employ the grounding technique she practised in the group, then use an assertive script to communicate her need for space to the ex-partner, and finally, if the urge to drink arises, she will call a designated support person rather than reaching for alcohol. The therapist monitors Maya's adherence through a daily log, reviewing it at each session and providing corrective feedback.

Over the course of six weeks, Maya's PHQ-9 score falls from 18 to 12, indicating a moderate reduction in depressive symptoms, while her GAD-7 score drops from 16 to 9, reflecting a shift from severe to moderate anxiety. Importantly, Maya reports two weeks without any suicidal ideation and has attended all scheduled sessions, demonstrating that both life-threatening and therapy-interfering targets have been effectively addressed. Her sleep has improved, and she reports feeling more confident in asserting her boundaries, a clear sign that stability-interfering issues are being ameliorated. The therapist, noting these gains, prepares Maya for the transition to Stage Two, where the focus will shift to processing the traumatic memories of her childhood neglect and the recent violent breakup, now that she possesses the safety, stability, alliance, and skills required to engage with that material without undue risk.

In sum, Stage One of IPTF is a rigorously structured phase that prioritises safety, stabilisation, alliance formation, and skill acquisition through a carefully ordered target hierarchy and a dual delivery model that blends group skills training with individual psychotherapy. By explicitly delineating what is and is not attempted in this stage, the therapist safeguards the client from premature exposure to trauma narratives, thereby laying the groundwork for the deeper relational work that defines Stage Two. The integration of evidence-based assessment tools such as the PHQ-9 and GAD-7, the application of trauma-informed risk management, and the use of

empirically supported skill-training modalities ensure that Stage One is not a perfunctory prelude but a robust therapeutic intervention in its own right, capable of producing measurable improvements in safety, functioning, and client-therapist collaboration.

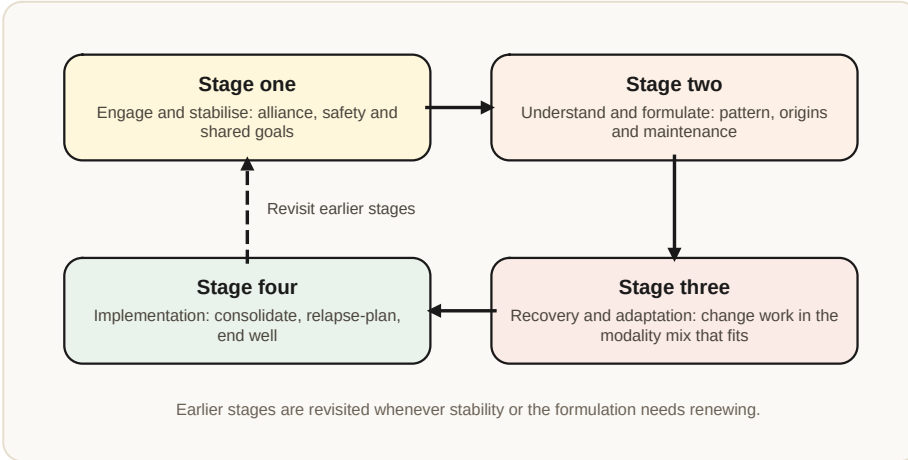


FIGURE 1.1 The IPTF pathway at a glance
The integrative pathway taught across the IPTF courses moves through four broad stages: engaging and stabilising, understanding and formulating, working for recovery and adaptation, and implementing gains so they hold in everyday life. Progress is cyclical rather than strictly sequential; earlier stages are revisited whenever the work requires it.

Points worth keeping

- Aims: safety, stability, alliance, skills
- The target hierarchy: life-threatening, therapy-interfering, stability-interfering
- Group skills training plus individual therapy
- What Stage One deliberately does not attempt

PRACTICE TASK

Write the Stage One target hierarchy with one example at each level.

CHAPTER 2

The skills curriculum and the individual component

In the first stage of the Integrative Psychotherapy Treatment Framework (IPTF), the therapeutic architecture is deliberately constructed as a dual-track system that weaves together a group-based curriculum with a parallel individual component. This design is not an incidental feature but a theoretically grounded strategy that draws on the evidence base of trauma-informed group work (Herman, 1992; Cloitre et al., 2011) and the well-established benefits of individual formulation in cognitive-behavioural trauma treatment (Ehlers & Clark, 2000). The overarching aim of Stage One is stabilisation and safety, and every element of the curriculum is calibrated to serve that purpose. The facilitator, therefore, assumes a central coordinating role, ensuring that the group arc progresses with fidelity while the individual sessions reinforce and contextualise the skills being taught.

The group curriculum follows a tightly sequenced arc that can be described as orientation, teaching, practice, and homework. Orientation is the inaugural encounter in which the facilitator establishes the therapeutic contract, outlines the ground rules, and co-creates a safety framework with the participants. This phase is informed by the principles of psychological safety articulated by Edmondson (1999) and the trauma-sensitive guidelines of the National Institute for Health and Care Excellence (NICE, 2023). The facilitator must explicitly negotiate confidentiality, the handling of disclosures, and the use of distress signals, thereby embedding a predictable structure that mitigates the hyper-vigilance often observed in trauma survivors.

Teaching follows orientation and consists of a concise, didactic presentation of the stage's skills model, which gives the group a shared language to discuss and rehearse skills such as grounding, goal-setting, regulation and assertiveness. The facilitator's task during teaching is to balance fidelity to the manual with responsiveness to the group's emergent needs, employing adult learning principles (Knowles, 1980) and the Socratic method to encourage reflective dialogue. Evidence from meta-analyses of skills-based group interventions (Kazdin, 2003) underscores the importance of clear,

repetitive instruction to promote skill acquisition.

Pactice is the experiential core of each session. After the conceptual exposition, participants are invited to role-play, engage in behavioural rehearsals, or complete in-session worksheets that operationalise the target skill. The facilitator must create a “safe container” that allows for error-making without judgement, a stance that aligns with the compassion-focused framework of Gilbert (2010). Real-time feedback is provided, and the facilitator models the skill themselves when appropriate, thereby reinforcing the therapeutic alliance and modelling adaptive interpersonal behaviour.

Homework consolidates learning beyond the group room. Participants are assigned concrete tasks that mirror the skill practised during the session, such as completing a diary entry, conducting a brief behavioural experiment, or using a coping card. The facilitator reviews homework at the start of the subsequent session, offering validation for successes and collaborative problem-solving for barriers. This cyclical loop of instruction, rehearsal, and reinforcement is supported by the learning theory of spaced repetition (Karpicke & Roediger, 2008), which has been shown to enhance retention of therapeutic skills.

Parallel to the group work, the individual component functions as a laboratory in which the abstract concepts of the curriculum are anchored to the client’s lived experience. The cornerstone of this component is the systematic diary review. Clients are instructed to maintain a daily log that records interpersonal events, emotional responses, physiological cues, and any use of the skills introduced in the group. The diary serves a dual purpose: it provides the therapist with granular data for formulation, and it encourages the client to adopt a reflective stance that is associated with reduced symptom severity (Kuyken et al., 2016). The facilitator reviews the diary at the start of each individual session, highlighting patterns that correspond with the current group focus.

Behavioural chain analysis, a technique originally popularised within cognitive-behavioural therapy for borderline personality disorder (Linehan, 1993) and later adapted for trauma work (Ehlers & Clark, 2000), is employed to dissect the sequence of antecedents, thoughts, emotions, and behaviours that culminate in a distressing interpersonal episode. In the IPTF context, the chain analysis is reframed to emphasise interpersonal triggers and the role

of safety-related beliefs. The facilitator guides the client through a step-by-step reconstruction: identifying the trigger, articulating the automatic appraisal, noting the emotional surge, describing the behavioural response, and pinpointing the point at which a skill could have been inserted. This granular mapping is essential for pinpointing skill gaps and for planning targeted interventions.

Skills strengthening is the third pillar of the individual component. After the chain analysis, the facilitator collaborates with the client to generate a concrete, personalised plan that integrates the relevant skill. This plan is recorded in the client's diary as a "skill-use intention" for the upcoming week. The facilitator then monitors adherence, providing reinforcement for successful implementation and troubleshooting for any obstacles. The iterative nature of this process aligns with the principles of mastery learning, whereby repeated practice leads to competence (Bloom, 1968).

Maintaining alignment between the group and individual strands is a dynamic, ongoing responsibility of the facilitator. The alignment is achieved when the content of the individual session directly reflects the skill focus of the group session. For example, if the group is concentrating on assertiveness, the facilitator will deliberately select diary entries that illustrate assertive challenges, conduct chain analyses that expose missed assertive opportunities, and co-construct assertiveness plans for the client to trial before the next group meeting. This synchrony prevents the fragmentation that can arise when group learning is perceived as abstract or disconnected from daily life, a phenomenon documented in the trauma literature as "skill dissociation" (van der Kolk, 2014).

The facilitator's tasks, therefore, encompass both macro-level orchestration of the curriculum arc and micro-level attunement to each client's experiential reality. At the macro level, the facilitator must monitor the progression of the group through the orientation-teaching-practice-homework cycle, ensuring that each session builds logically upon the previous one and that the pacing respects the group's collective readiness. At the micro level, the facilitator must conduct diary reviews, guide chain analyses, and facilitate skills strengthening with precision, always linking back to the group's current focus. This dual responsibility requires a high degree of reflective practice, as described by Schön (1983), and a commitment to ongoing supervision to safeguard fidelity.

A concrete worked example illustrates how these principles coalesce in practice. Emily, a 34-year-old woman referred for complex trauma stemming from childhood abuse, joins the IPTF group at the outset of Stage One. In the orientation session, the facilitator establishes the safety contract, introduces the PHQ-9 and GAD-7 as routine outcome measures, and explains the skills model. Emily is assigned the homework of completing a daily diary that captures interpersonal interactions, emotional intensity (rated on a 0-10 scale), and any use of the grounding skill introduced in the first teaching segment.

During the second group session, the focus shifts to regulation. The facilitator delivers a concise lecture on the neurobiological underpinnings of emotional dysregulation, referencing the work of Porges (1995) on the polyvagal theory, and demonstrates a paced-breathing exercise. Participants then practice the breathing technique in pairs, receiving feedback on timing and sensation. For homework, Emily is instructed to employ the breathing exercise whenever she notices a physiological cue of rising anxiety, and to record the outcome in her diary.

In Emily's subsequent individual session, the facilitator begins by reviewing her diary entries. One entry details a confrontation with her sister at a family dinner, where Emily reported a physiological cue of a racing heart (8/10) and an automatic thought that "I will be judged if I speak up." The facilitator guides Emily through a chain analysis: the trigger (sister's criticism), the automatic appraisal ("I am being judged"), the emotional surge (anxiety), the behavioural response (silence), and the missed opportunity for regulation. Together, they identify the point at which the paced-breathing skill could have been inserted, noting that Emily had not yet recognised the cue in the moment.

The facilitator then collaborates with Emily to formulate a concrete skill-use intention: "When I notice my heart racing, I will pause, take three slow breaths, and then state, 'I need a moment to process this.'" This plan is written into Emily's diary as a skill-use intention for the upcoming week. The facilitator also introduces a brief exposure exercise, asking Emily to rehearse the statement in a role-play scenario, thereby strengthening the skill through immediate practice. At the end of the session, the facilitator checks that Emily's next group homework will involve reporting on the use of the breathing technique, ensuring that the individual work feeds directly back

into the group curriculum.

When the group reconvenes for the third session, the facilitator reviews the collective homework, noting that several participants, including Emily, reported successful use of the breathing technique. The facilitator validates these successes, highlights common challenges, and transitions to the next skill, assertiveness. The alignment is evident: the individual work on regulation has primed the group for assertiveness training, as emotional regulation is a prerequisite for effective assertive communication (Linehan, 1993). Emily's diary entry from the previous week is referenced, illustrating how the regulation skill facilitated a more confident response in a subsequent interpersonal encounter. This seamless integration reinforces the therapeutic narrative that skills are cumulative and interdependent.

Throughout Stage One, the facilitator continuously monitors outcome measures such as the PHQ-9 and GAD-7, noting any clinically significant reductions that may signal emerging stability. These quantitative markers are triangulated with qualitative data from diary reviews and chain analyses, providing a comprehensive picture of progress. The facilitator also engages in reflective supervision, discussing any deviations from the curriculum arc and strategising corrective actions, thereby upholding the integrity of the IPTF model.

In summary, the skills curriculum and the individual component of Stage One operate as interlocking strands of a single therapeutic rope. The curriculum arc—orientation, teaching, practice, homework—offers a structured pathway for skill acquisition, while the individual component—diary review, chain analysis, skills strengthening—grounds those skills in the client's lived reality. The facilitator's role is to steward both strands, ensuring that each session of the group is mirrored by a corresponding focus in the individual work, and that the client's diary serves as the conduit through which theory becomes practice. By maintaining this alignment, the IPTF programme fosters a coherent, safety-oriented environment that supports stabilisation, reduces trauma-related symptomatology, and lays the foundation for the deeper relational work that follows in later stages of the programme.

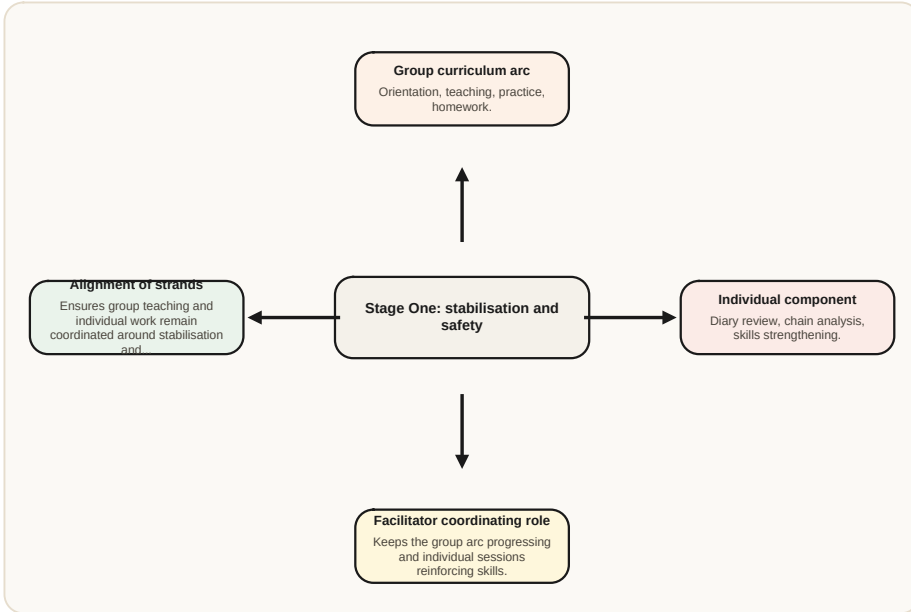


FIGURE 2.1 The dual-track Stage One system

This hub shows the dual-track system at the heart of Stage One. The facilitator coordinates the group arc and the individual component to keep both strands aligned toward stabilisation and safety.

Points worth keeping

- The curriculum arc and facilitator tasks
- Running the group: orientation, teaching, practice, homework
- The individual component: diary review, chain analysis, skills strengthening
- Keeping group and individual strands aligned

PRACTICE TASK

Plan the opening ten minutes of a Stage One group session.