Advanced IPTF: Recovery, Adaptation and Implementation

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced IPTF: Recovery, Adaptation and Implementation

Stage Three, specialist adaptations, and building an IPTF service

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Advanced IPTF: Recovery, Adaptation and Implementation course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 5. 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.

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How to use this manual

This advanced course completes the Integrative Psychotherapy Framework (IPTF) pathway, designed for experienced practitioners and service leads seeking to master the nuances of Stage Three, specialist adaptations, and service implementation. You will engage in a comprehensive exploration of functional recovery and identity, learning how to facilitate a life reclaimed through the restoration of vocation, meaningful relationships, and a coherent sense of self. The curriculum also addresses the critical skill of ending treatment well, ensuring clients are equipped with robust relapse prevention strategies and the ability to navigate booster sessions and planned discharge with confidence.

Moving beyond the core model, you will acquire the expertise to flex the framework with fidelity across diverse and complex settings. This includes navigating the specific demands of forensic environments and the Offender Personality Disorder pathway, as well as tailoring interventions for neurodivergent populations and those with ADHD. You will also examine the application of IPTF in primary care and stepped care models, alongside developmental adaptations for adolescents and young adults. Finally, the course provides a strategic overview of implementation, guiding you through the transition from manual to service. You will develop competence through structured training and supervision, learn to monitor fidelity and outcomes, and engage with the ongoing research agenda to ensure your practice remains evidence-based and effective.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 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

- Lead stage-three recovery and adaptation work across modalities with complex presentations
- Run stage-four implementation: consolidation, relapse planning and endings that hold
- Adapt the pathway for personality-organised difficulty and chronic relational trauma
- Manage long treatments' arcs: plateaus, regressions and renegotiated goals
- Embed the framework in a service: supervision, audit and fidelity without rigidity
- Evaluate outcomes across an IPTF caseload and feed the learning back into practice

PART 1

Part 1: Aims, delivery and the community interface

Lessons 1 to 5 of the course.

CHAPTER 1

Aims, delivery and the community interface

Stage three of the Advanced IPTF: Recovery, Adaptation and Implementation marks a decisive shift from the intensive, symptom-focused work of the earlier phases to a broader, life-centred agenda. In this phase the therapist's primary purpose is threefold: to consolidate functional recovery, to facilitate the emergence of an identity that is no longer defined by the disorder, and to nurture sustainable connections with the wider community. The theoretical underpinning of these aims draws on a constellation of evidence-based models. The recovery paradigm articulated by Anthony (1993) insists that recovery is a deeply personal, non-linear process that is defined by the individual's own values and life goals rather than by diagnostic remission alone. Self-Determination Theory (Deci & Ryan, 2000) supplies a mechanistic explanation for why autonomy, competence and relatedness are essential ingredients of lasting change, while Social Identity Theory (Tajfel & Turner, 1979) clarifies how belonging to valued groups can reshape self-concept and promote resilience. Relapse Prevention, as formulated by Marlatt and Gordon (1985), provides a practical framework for maintaining gains through the identification of high-risk situations and the development of coping repertoires that are rehearsed in the real world. Finally, the principles of Recovery-Oriented Care championed by the UK Department of Health (2009) and operationalised in tools such as the Mental Health Recovery Star remind clinicians that therapeutic success must be measured against the person's own definition of a meaningful life.

The delivery of stage three is deliberately lighter in intensity. Whereas the first two stages typically involve weekly or fortnightly sessions of 50 minutes, the third stage often adopts a schedule of bi-monthly or even monthly meetings, supplemented by brief telephone or email check-ins. This spacing is not a concession to therapist convenience; rather, it is a strategic intervention. Longer intervals between sessions are intended to encourage clients to experiment with skills in naturalistic settings, to experience the consequences of their actions, and to develop a sense of agency that is difficult to cultivate under the protective umbrella of frequent contact. The

therapist's stance correspondingly changes from that of a primary caregiver to a consultant or "recovery coach". The therapist offers guidance, monitors progress, and intervenes selectively when risk thresholds are crossed, but the day-to-day responsibility for applying therapeutic tools rests with the client.

A central construct in this phase is the Community Interface – the point at which the client's internal therapeutic work meets the external social world. The concept is rooted in the recovery capital model (Cloud and Granfield, 2008), which describes the social, physical, human and cultural resources that can be mobilised to support recovery. Personal recovery capital includes skills, hope and self-efficacy; social capital comprises supportive relationships and networks; community capital encompasses access to housing, education, employment, and culturally relevant services. The therapist's role is to help the client map these resources, identify gaps, and co-construct a plan for bridging them. This process is inherently pragmatic: it may involve navigating the complexities of local authority housing allocations, liaising with vocational rehabilitation services, or supporting the client in accessing peer-support groups that align with their identity.

The evidence base for a community-oriented approach is robust. A systematic review and narrative synthesis by Leamy and colleagues (2011) identified connectedness, which includes being part of the community, as one of five processes of personal recovery. This underscores the necessity of extending therapeutic influence beyond the consulting room.

In practice, the therapist must balance two complementary imperatives. First, the therapist must validate the client's own definition of recovery. This may involve exploring what a "good day" looks like for the client, how they would like to be seen by others, and what activities would confer a sense of purpose. Second, the therapist must translate these personal aspirations into concrete, measurable steps that can be pursued in the community. The use of goal-setting frameworks such as SMART (Specific, Measurable, Achievable, Relevant, Time-bound) or the Goal-Setting Theory of Locke and Latham (1990) provides a shared language for this translation.

The following worked example illustrates how these principles can be operationalised with a client who presents with chronic depression, elevated PHQ-9 scores, and marked social isolation.

John is a 42-year-old man who has been in treatment for the past 18 months. His initial PHQ-9 score was 18, and despite a modest reduction to 12 after stage two, he continues to report pervasive low mood, anhedonia, and a sense that he no longer belongs to any social group. John's GAD-7 score remains at 11, indicating persistent anxiety about social interactions. In stage three, the therapist begins by inviting John to articulate his own vision of recovery. John says, "I want to feel like I'm part of something again – maybe a local football club or a book club – and I want to be able to go to my daughter's school events without feeling like a burden."

The therapist first acknowledges the legitimacy of this vision, linking it to the recovery principle that "the person defines recovery". The therapist then introduces the concept of recovery capital, asking John to identify existing resources. John mentions that he still has a modest savings buffer, a supportive sister who lives nearby, and a basic level of computer literacy. He also notes that he has a longstanding interest in photography, though he has not pursued it for several years.

Next, the therapist and John co-construct a stepped plan. The first step is to re-engage with photography as a gateway to social connection. They set a SMART goal: "By the end of the next four weeks, John will attend one free photography workshop at the community centre and will share at least two of his photographs on the centre's online forum." The therapist explains that this goal satisfies the competence component of Self-Determination Theory and offers a low-stakes environment for practising social interaction, thereby addressing John's social isolation.

To support the goal, the therapist helps John draft an email to the community centre, role-plays the phone call to confirm the workshop details, and reviews potential anxiety-management strategies drawn from Cognitive-Behavioural Therapy (e.g., thought-recording, exposure hierarchy). The therapist also arranges a brief check-in via text message after the workshop to reinforce effort and to troubleshoot any barriers that arise.

Simultaneously, the therapist assists John in mapping out a longer-term objective related to his daughter's school events. Using the Goal-Setting Theory framework, they set a target of "attending at least two school performances in the next three months, and volunteering to help with the school's annual fundraiser". The therapist connects John with a parent liaison officer at the school, providing a contact email and offering to

accompany John on an introductory call if needed. This step not only expands John's social network but also aligns with the identity reconstruction aim – moving from the role of "patient" to "parent-volunteer".

Throughout the month, John attends the photography workshop, shares his images, and receives positive feedback from peers. He reports a modest reduction in his PHQ-9 score to 9 and a GAD-7 drop to 8. More importantly, he describes feeling "more like myself" and expresses pride in having taken the initiative to contact the community centre. When the therapist meets John after six weeks, the session is brief – 30 minutes – and focuses on consolidating these gains. The therapist invites John to reflect on what worked, what felt challenging, and how he might sustain the momentum. John identifies that the structured email template the therapist provided was crucial, and he requests a similar template for contacting the school.

In the final session of this stage, the therapist and John review the broader recovery plan. They note that John now has two active community engagements, a renewed sense of competence, and a clearer sense of identity that incorporates his roles as photographer, father, and community member. The therapist reinforces the principle that the therapist's role is now consultative, encouraging John to seek out additional opportunities (e.g., a local photography exhibition) independently, while reminding him that the therapist remains available for brief check-ins should anxiety spikes occur.

The case of John exemplifies how the three aims of stage three – functional recovery, identity reconstruction, and connection – can be woven together through a lighter delivery schedule and a purposeful community interface. By anchoring therapeutic work in the client's own definition of a good life, by employing evidence-based goal-setting and relapse-prevention strategies, and by actively mobilising personal and community recovery capital, the therapist helps bridge the gap between clinical improvement and everyday functioning.

In summary, the advanced IPTF model regards the third stage not as a winding down of therapy but as a strategic hand-over of responsibility to the client, supported by a scaffold of community resources. The therapist's expertise is exercised in three interlocking domains: (1) validating and co-creating a personally meaningful recovery narrative; (2) designing a delivery schedule that maximises autonomy while maintaining safety; and

(3) acting as a conduit between the client and the external systems that constitute the community interface. When these elements are integrated with fidelity to the evidence base – from Self-Determination Theory to Relapse Prevention – the likelihood of sustained functional recovery and a resilient, enriched identity is markedly enhanced.

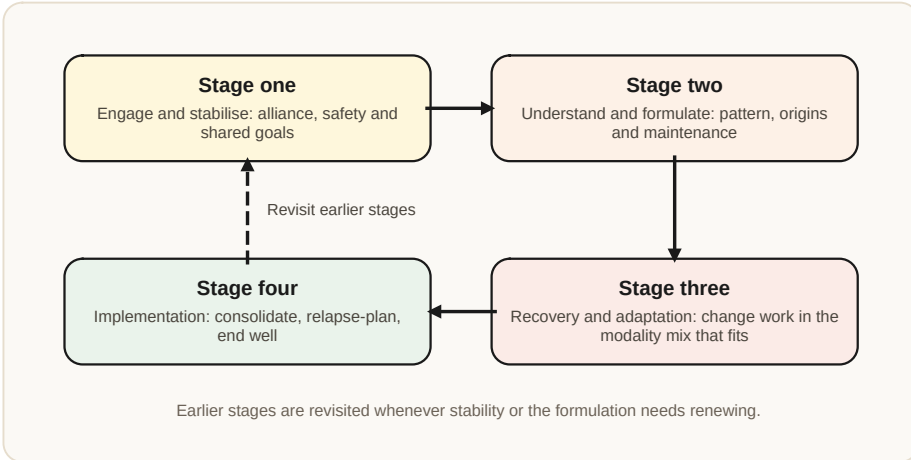


FIGURE 1.1 The IPTF pathway at a glance
The integrative pathway taught across the IPTF courses moves through four broad stages: engaging and stabilising, understanding and formulating, working for recovery and adaptation, and implementing gains so they hold in everyday life. Progress is cyclical rather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

Points worth keeping

- Aims: function, identity, connection
- Lighter delivery and longer intervals
- The community interface
- Recovery defined by the person's life

PRACTICE TASK

List three community interfaces in your setting and the Stage Three work with each.

CHAPTER 2

Vocation, relationships, identity and ending well

The framework's treatment of vocational recovery begins from an evidence-based conviction: work, in the broad sense that includes education, training, volunteering and caregiving, is not a reward that waits for recovery but a vehicle of it, and the manual therefore makes graduated vocational engagement clinical work, planned in sessions and processed in them. Graduated means what it says. The sequence runs from structure, any regular commitment that gives the week bones, through voluntary or protected roles where stakes are rehearsable, to open education and employment, with each step chosen for its learning value rather than its status. The clinical content is the meeting of the person's patterns with occupational reality: the perfectionism that makes every shift a trial, the rejection sensitivity that converts feedback into catastrophe, the interpersonal templates that recruit workplace casts into family dramas, the shame narratives that whisper fraud at every threshold. Sessions prepare each step, rehearse its predictable collisions, and debrief the actual events, and the framework is explicit that a lost job worked through in treatment is worth more than a protected placement that taught nothing. Where services exist, the manual endorses individual placement and support principles, rapid engagement with real work and in-work support, over lengthy pre-vocational preparation, whose evidence is thin and whose hidden message, that the person is not yet fit for reality, the framework regards as anti-therapeutic.

Social recovery is handled with the same deliberateness, because the relational learning of Stages One and Two consolidates only in relationships the service does not provide. The stage plans the person's relational field: mapping who is actually in the life, which relationships nourish and which re-run the old patterns, where new connection could plausibly grow, and then treating each real relationship event, the friendship attempted, the boundary set with a parent, the conflict survived or fled, as session material of the first importance. The framework names the specific dangers of this territory: the person whose only intimacies have been clinical, for whom friendship's

unstructured mutuality is genuinely unmapped; the gravitational pull of old networks organised around crisis, use or exploitation; the loneliness that follows outgrowing one's former relationships before new ones exist, which the manual identifies as a high-risk interval and instructs clinicians to name in advance. Family work in Stage Three, where undertaken, shifts from psychoeducation towards renegotiation, the person returning to the family system as someone changed, and the system's pressure to restore the old equilibrium is anticipated as a matter of course.

Identity consolidation, the third strand, is the stage's quiet centrepiece: the deliberate construction of a self-story in which the person is more than a patient. Years of services confer an identity, competent at being ill, fluent in clinical language, known by professionals, and its loss, however desired, is a real bereavement that the framework requires be worked rather than skipped. The work is narrative and practical at once: the life story retold in sessions until difficulty becomes chapter rather than title; roles accumulated in the world, student, colleague, friend, teammate, volunteer, each a platform outside the patient position from which the person can be seen, by others and eventually by themselves, as someone else; and the future given content, plans made in the grammar of a person expecting to have one. The manual marks the checkpoints of consolidation, the person who no longer opens conversations with their diagnosis, who misses an appointment for a genuinely better reason, who speaks of the treatment in the past tense, and instructs the clinician to greet these not as disengagement but as the outcome arriving.

The four strands are braided in practice rather than sequential, and the manual instructs services to schedule them so: a vocational step generates relational material, workmates, tutors, the first colleague conflict; relational movement feeds identity, each new role another sentence in the non-patient story; and the approaching ending tests all three, since the person who has built a week, a network and a self-story meets the separation with resources the entry assessment could not have imagined. The clinician's discipline across the braid is restraint in the right places: to let the college enrolment be the person's achievement rather than the service's outcome; to allow a friendship to fail without converting it into a treatment emergency; to hear the first missed session with pleasure. The framework gives this restraint a name, dignity of risk, borrowed from the recovery movement and meant exactly: the right to attempt, to fail, and to own both, is what the person was

denied by illness and often by services, and its restoration is Stage Three's deepest intervention.

Ending well is the strand that binds the others, because in personality difficulty the ending is never administrative: it is the framework's last and largest exposure, a separation conducted with the very templates the treatment has been revising, and the manual therefore ends treatment deliberately, through relapse prevention, boosters and planned discharge. Relapse prevention is built as a personal document in the person's own words: early-warning signature, the specific situations that load the old patterns, what has worked, who does what when the signature appears, written by the person as author rather than the clinician as prescriber. Boosters are scheduled, not contingent, fixed check-ins at lengthening intervals after discharge, three, six, twelve months, so that returning carries no failure meaning and the ending is a taper rather than a cliff. Planned discharge itself is given a phase: the date set collaboratively and held against the predictable late storm of returning symptoms, which the framework, like the dynamic tradition it borrows from, reads aloud as the ending being felt rather than the treatment failing; the gains reviewed honestly beside what remains unfinished; the relationship itself reviewed, including what the person made of the clinician and survived in them; and the door left explicitly ajar, with re-referral routes named, because the message that closure must be total is one more abandonment template, and the framework declines to run it. A person discharged this way leaves with a life under construction, a manual they wrote themselves, and an experience, often the first, of an important relationship that ended on purpose, well; and the remaining lessons of this course turn to the settings, forensic, neurodivergent, primary care and adolescent, where the framework must bend without breaking.

Going deeper: disclosure, repair and the last session.

Three practical territories inside this lesson's arc deserve their own tools. Disclosure at work is the vocational module's hardest recurring decision, and the framework refuses a blanket answer in favour of a decision procedure: what would disclosure buy (adjustments, protection, honesty with a trusted manager), what could it cost (career ceiling, changed treatment by colleagues), who actually needs to know, and what is the minimum accurate account that serves the purpose. People rehearse the chosen account in

session until it is theirs, including the boundaried version ('I had a period of ill health; it is managed') that most situations warrant. The right to not disclose is stated as clearly as the right to disclose; recovery includes owning the story's distribution rights.

Relationship work divides into repair and construction, and the division matters because they need different courage. Repair addresses relationships damaged during the ill years: an adult child re-approached, a friendship where amends are owed. The framework borrows the honest-accounting stance, acknowledge specifically, without either grovelling or litigating the past, and accept that repair is invited, not owed. Construction addresses the thinner, harder territory of new connection in adult life, where the schema forecasts run strongest precisely because no shared history compensates; the consolidation-experiment method continues here, one small vulnerability at a time, with the diary still quietly running. Identity work threads both: the narrative exercises (the life told as a survivor's account rather than a symptom log, the values inventory, the deliberate cultivation of roles that have nothing to do with services) are how 'person in recovery' stops being the identity and becomes one fact among several.

The ending itself is rehearsed, not merely scheduled. The final sessions review the whole arc in the person's own telling, name what the relationship has been and what its ending honestly costs, and complete the maintenance manual: early-warning signature, first-response plan, re-entry route with its non-shameful framing in writing. Many services offer a planned booster at three or six months and an open, criteria-defined door thereafter. The last session's business is the framework keeping its first promise: that this relationship, unlike the ones that built the difficulties, would end on purpose, in daylight, with the person holding the pen.

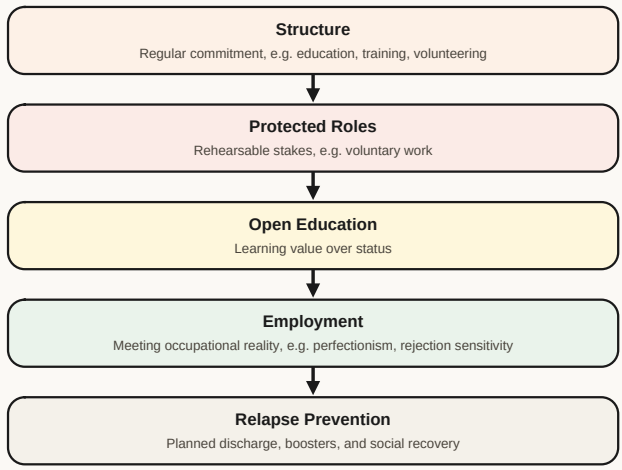


FIGURE 2.1 Vocational Recovery

The lesson outlines a framework for vocational recovery, focusing on graduated engagement and social recovery. It emphasizes the importance of work as a vehicle for recovery, rather than a reward for it.

Points worth keeping

- Graduated vocational engagement
- Social recovery and relationships
- Identity beyond the patient role
- Relapse prevention, boosters, planned discharge

PRACTICE TASK

Draft a four-step graduated engagement plan for a client returning to part-time study.