The IPTF Framework in Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



The IPTF Framework in Practice

The practice's staged integrative framework: four modalities, one treatment logic.

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

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

Revision 8. 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 is the course in our library that teaches the practice's own clinical method: the Integrative Phase Treatment Framework, the staged model developed and used at Talking Therapies UK, which organises cognitive behavioural, psychodynamic, systemic and humanistic work into one coherent treatment logic rather than an improvised blend.

The first module teaches the framework itself: why phased treatment respects how change actually unfolds, what each phase is for, and how four modalities contribute distinct instruments to a single arc, stabilising and engaging before deepening, deepening before consolidating. You will then learn assessment and phase placement: reading where a client's difficulty and resources sit, and starting treatment where the client is rather than where the model begins. The second module runs the treatment: phase-appropriate technique selection, managing the transitions where treatments most often falter, and consolidation that makes gains survivable beyond the final session.

Substantial written lessons with key points and case-based practice tasks, supported by a study tutor familiar with the material. Ten hours of CPD with around nine months of access, a final assessment, and a personalised certificate on passing. Essential preparation for clinicians working within, or alongside, the practice's framework.

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

- Apply the IPTF stage by stage, from engagement and stabilisation through formulation-led change work
- Build integrative formulations that specify what is offered when, and why
- Blend cognitive-behavioural, relational and experiential methods without incoherence
- Use outcome and alliance feedback to steer the integration in real time
- Manage transitions between ways of working inside one therapy without losing the thread
- Articulate the IPTF rationale to clients, supervisors and colleagues clearly

PART 1

Foundations and Phasing in the IPTF Framework

This module covers the core treatment logic, assessment, phase placement, and integration of modalities within the IPTF framework.

CHAPTER 1

Why phases: the IPTF treatment logic

The Integrative Psychotherapy Treatment Framework (IPTF) rests on a single organising claim: the success or failure of any therapeutic element is determined primarily by its timing in relation to the client's current capacity for affect regulation, relational engagement and cognitive flexibility. This claim is not a novel invention but a synthesis of observations that have accumulated across the major schools of psychotherapy. Linehan (1993) demonstrated that dialectical behaviour therapy (DBT) skills are ineffective when taught to a client whose physiological arousal remains above the window of tolerance; Barlow (2002) showed that exposure techniques can exacerbate anxiety if the client has not first mastered anxiety management strategies; and Beck et al. (1979) found that cognitive restructuring loses potency when the client is overwhelmed by emotional flooding. The IPTF therefore proposes that most treatment failures are not the result of an inherently flawed technique but of a mismatch between the technique and the client's moment-to-moment readiness to receive it. This is the logic of phase-based treatment: each phase supplies the prerequisite capacities for the next, and the therapist's task is to match intervention to capacity rather than to a pre-determined protocol.

The framework delineates three broad movements that together constitute a complete therapeutic arc. The first movement, which we may refer to as the regulation phase, is concerned with establishing safety, stabilising affect, and expanding the client's capacity to tolerate emotional intensity. In this phase the therapeutic alliance is forged, the crisis economy is calmed, and the client learns concrete skills that increase their ability to stay within a functional window of tolerance. The importance of this phase cannot be overstated: neurobiological research on the stress response (McEwen, 1998) shows that when the limbic system is hyper-aroused, higher-order cortical processes such as reflective thinking and memory consolidation are impaired. Consequently, any attempt to engage in deep relational or cognitive work while the client remains in a state of dysregulation is likely to be experienced as overwhelming, leading to avoidance, dropout, or iatrogenic worsening of symptoms.

The second movement, the relational-pattern phase, builds directly upon the capacities cultivated in the regulation phase. Here the therapist and client explore the core relational schemas, attachment patterns and cognitive belief systems that maintain the presenting problem. The work is conducted both through the therapeutic relationship itself – employing techniques such as transference interpretation, rupture-repair, and the exploration of internalised object relations – and through structured methods that bring these patterns into conscious awareness, such as functional analysis, schema-focused questioning and behavioural experiments. The aim of this phase is not merely to manage symptoms but to transform the underlying patterns that generate them. Evidence from psychodynamic research (Shedler, 2010) indicates that when patients have sufficient affect regulation, insight into relational dynamics predicts long-term symptom reduction, whereas insight without regulation tends to be fleeting.

The third movement, consolidation, is the phase in which the gains achieved in the relational-pattern work are translated into the client's everyday life. This phase involves the attribution of change to specific mechanisms, the careful negotiation of endings, and the preparation for potential relapse. It also incorporates the values-directed action that characterises acceptance and commitment therapy (ACT). By aligning newly formed patterns with personally meaningful goals, the client is able to sustain change beyond the confines of the therapeutic setting. Relapse prevention strategies, such as the development of a personal crisis plan and the rehearsal of coping skills in imagined future scenarios, are integral to this phase. The literature on long-term outcomes (Kazdin, 2000) consistently shows that interventions that include a dedicated consolidation stage have lower rates of relapse compared with those that terminate abruptly after symptom reduction.

Four well-established modalities provide the primary technical resources for each of the three movements, and the IPTF specifies precisely when each modality's strengths are most appropriate. The regulation technologies of DBT – including mindfulness, distress tolerance, emotion regulation skills and chain analysis – are deployed in the first phase because they have been empirically validated for expanding the window of tolerance (Linehan, 1993). The relational depth of psychodynamic work – transference, counter-transference, and the exploration of internalised relational representations – is most potent in the second phase, where the client's affect regulation permits the safe examination of deep-seated relational

patterns (Fonagy & Target, 1997). The appraisal precision of cognitive-behavioural therapy – formulation, hypothesis testing, behavioural experiments and cognitive restructuring – is woven throughout the relational-pattern phase, sharpening the identification and modification of maladaptive beliefs (Beck, 1976). Finally, the values-directed action of ACT – willingness, committed action, and experiential acceptance – drives the consolidation phase, ensuring that the client's new patterns are anchored in lived experience and aligned with personal values (Hayes, Strosahl & Wilson, 1999).

Why does the IPTF favour a phase-based approach rather than a menu of techniques that can be applied at any time? The answer lies in the hierarchical nature of human change. Capacities are prerequisite, not parallel. An unregulated nervous system does not simply "record" new information; it re-records it in a way that reinforces existing dysregulation (Porges, 2011). Likewise, an alliance that has not yet been securely established cannot sustain the therapeutic risk required for deep relational confrontation; the client will interpret challenge as threat, consuming the limited emotional bandwidth that could otherwise be allocated to insight. Finally, pattern work that has not been adequately examined cannot be reliably translated into large-scale behavioural change; committed action taken on the basis of an unexamined pattern merely reproduces the pattern in a new context. The phase sequence is therefore not bureaucratic red-tape but the architecture of how humans actually change, as demonstrated by longitudinal studies of psychotherapy process (Shedler, 2010; Hayes et al., 2006).

To illustrate the logic of the IPTF in practice, consider the case of Maya, a 34-year-old woman who presented with chronic depression, recurrent self-harm, and a history of multiple unsuccessful treatment attempts. Maya's prior experiences included a brief course of CBT that focused on thought challenging, a psychodynamic therapy that explored early childhood trauma, and a mindfulness-based stress reduction programme that she attended for eight weeks. Each of these interventions terminated after a few months, and Maya reported that the CBT "never stuck", the psychodynamic work "opened everything and couldn't close it", and the mindfulness classes "made her feel more anxious". A careful formulation using the IPTF revealed a common error: interventions were introduced before Maya had achieved sufficient affect regulation.

In the regulation phase, the therapist began by establishing a strong therapeutic alliance, validating Maya's experience of chronic dysregulation, and introducing DBT skills tailored to her immediate needs. Over the course of eight weeks, Maya learned to identify early warning signs of emotional escalation, practised paced breathing and progressive muscle relaxation, and engaged in daily mindfulness exercises that were brief enough to be tolerable within her limited tolerance window. The therapist also conducted chain analyses of recent self-harm episodes, revealing that each episode was precipitated by a rapid rise in physiological arousal that Maya could not articulate verbally. By the end of the regulation phase, Maya's PHQ-9 score had fallen from 18 to 12, and her GAD-7 score from 15 to 9, indicating a measurable reduction in symptom severity and an expanded capacity to tolerate affect.

Having secured this regulatory foundation, the therapist moved into the relational-pattern phase. Using the therapeutic relationship as a laboratory, the therapist gently explored Maya's attachment history, noting a recurrent pattern of "emotional abandonment" that manifested in both her adult relationships and her internal self-talk. Through a series of transference-focused interventions, the therapist highlighted how Maya's expectation of rejection was being reenacted in the therapy room, and together they examined the origins of this expectation in her early caregiving experiences. Concurrently, CBT techniques were employed to test the validity of Maya's core belief "I am unlovable". Behavioural experiments involved Maya arranging a low-stakes social interaction with a trusted friend, followed by a structured reflection on the outcome. Over twelve weeks, Maya's belief system shifted, as evidenced by a reduction in the conviction rating of the belief from 90% to 45%, and her ability to tolerate relational discomfort increased.

The final consolidation phase integrated the values-directed action of ACT. Maya identified "being present for her younger sister" as a core value, and the therapist supported her in committing to a weekly phone call with her sister, despite lingering fears of rejection. The therapist also helped Maya develop a relapse prevention plan that incorporated the DBT distress tolerance skills she had mastered, the cognitive restructuring techniques she had practised, and a values-guided action checklist to guide future decisions. Over the subsequent six months, Maya reported sustained improvements: her PHQ-9 remained in the low range (scores of 6-8), she had

not engaged in self-harm for nine months, and she described a renewed sense of agency in her relationships. The case demonstrates that the IPTF's phase logic – regulation first, relational-pattern work second, consolidation third – allowed each modality to be deployed at the point where its evidence-based strengths could be most effective.

The IPTF's synthesis of four modalities does not imply a superficial stitching together of disparate techniques. Rather, it recognises that each therapeutic tradition has solved a particular segment of the treatment problem with a high degree of empirical precision. DBT offers a robust set of regulation technologies that have been shown to increase the window of tolerance in borderline personality disorder (Linehan, 1993). Psychodynamic work provides a nuanced understanding of internalised relational representations that can be accessed safely once regulation is in place (Fonagy & Target, 1997). CBT contributes a systematic method for hypothesis testing and belief revision that sharpens the focus of pattern work (Beck, 1976). ACT contributes a values-centred action framework that ensures that change is not merely internal but is expressed in the client's lived environment (Hayes et al., 1999). By ordering these strengths according to the client's evolving capacities, the IPTF creates a coherent therapeutic arc that mirrors the natural progression of human change.

In practice, the therapist using the IPTF must remain vigilant to the client's moment-to-moment capacity. This requires ongoing assessment of affect regulation (through measures such as the Difficulties in Emotion Regulation Scale), relational engagement (through alliance ratings such as the Working Alliance Inventory), and cognitive flexibility (through thought-record adherence and belief conviction ratings). When any of these indicators suggest that the client is approaching the limits of their current capacity, the therapist may need to pause pattern work, reinforce regulation skills, or revisit previously consolidated actions. This dynamic responsiveness is the hallmark of phase-based treatment and distinguishes it from static protocol-driven approaches.

The IPTF also offers a language for interdisciplinary collaboration. Because each phase aligns with a particular modality's evidence base, clinicians from different theoretical backgrounds can contribute their expertise without compromising the overall treatment logic. For example, a DBT-trained clinician may lead the regulation phase, a psychodynamic analyst may

co-facilitate the relational-pattern phase, and a CBT practitioner may supervise the formulation and experimentation components throughout. This collaborative model not only enriches the therapeutic experience for the client but also fosters professional development across modalities, reflecting the integrative spirit of contemporary mental health practice.

In summary, the IPTF's phase logic is grounded in a robust body of empirical research that demonstrates the necessity of matching therapeutic interventions to the client's current capacity for regulation, relational engagement and cognitive processing. By sequencing work through regulation, relational-pattern, and consolidation phases, and by drawing on the complementary strengths of DBT, psychodynamic therapy, CBT and ACT, the framework provides a comprehensive roadmap for effective, durable change. The case of Maya illustrates how this logic operates in a real-world context, turning previous treatment failures into a coherent narrative of progressive capacity building. The ultimate wager of the IPTF is simple yet profound: most treatment failure is not a failure of technique, but a failure of timing. By honouring the temporal architecture of human change, clinicians can deliver interventions that not only alleviate symptoms but also transform the underlying patterns that give rise to them, ensuring that the client's journey from crisis to consolidation is both safe and sustainable.

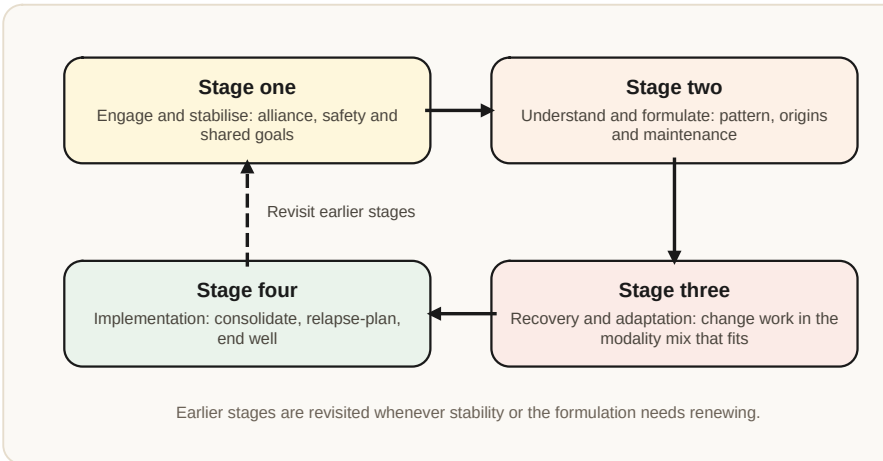


FIGURE 1.1 The IPTF pathway at a glance

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

- Timing decides whether elements take: hence phases
- Sequence: regulation, relational and pattern work, consolidation
- Four modalities supply strengths on the framework's schedule

PRACTICE TASK

From your own experience, name one technique you have seen fail by timing and the phase in which it would have taken.

CHAPTER 2

Assessment and phase placement

The IPTF Framework in Practice rests on a single, decisive clinical question: at which phase of the integrative pathway does the client's present capacity most reliably sit? This question supersedes diagnostic taxonomy, symptom counts, or even the client's own narrative about what they believe they need. The answer emerges from a systematic capacity assessment that interrogates three interlocking domains – regulation, relational, and reflective – each of which is grounded in a robust evidence base and operationalised through observable, behavioural markers rather than abstract self-report. The practitioner at the intermediate level is required to move beyond the seductive clarity of diagnostic labels and instead cultivate a finely tuned sense of the client's functional capacities, reading them directly from the therapeutic encounter and from the client's lived history.

Regulation capacity refers to the client's ability to maintain, regain, or re-establish a functional affective equilibrium when confronted with emotional load. The theoretical underpinnings draw heavily on Porges' Polyvagal Theory, which distinguishes between ventral vagal social engagement, sympathetic mobilisation, and dorsal vagal shutdown as hierarchical response systems. Individuals who can flexibly shift between emotional states under stress are more likely to benefit from higher-order therapeutic interventions. In practice, the assessor first gathers a detailed chronology of the client's worst weeks, noting the intensity, duration, and precipitants of dysregulation. Questions such as "What does a typical crisis look like for you?" and "How do you usually bring yourself back to a place where you can think clearly?" are paired with behavioural observations made in the assessment room. A client who becomes visibly distressed when a mildly challenging question is posed, yet is able to re-ground through a brief grounding exercise or a supportive therapeutic presence, demonstrates a nascent but functional regulation capacity that is not captured by static questionnaires such as the PHQ-9 or GAD-7. Conversely, a client who dissociates mid-sentence, exhibits a flat affect, or relies on rehearsed emotional distance signals a more profound regulatory collapse, suggesting that the regulation domain is not yet reliable enough to support the demands

of later phases.

Relational capacity concerns the client's ability to sustain a therapeutic alliance that can bear the weight of emotional work. This domain is informed by attachment theory, particularly the work of Bowlby (1982) and Ainsworth (1978), as well as contemporary models of mentalisation such as Fonagy's Reflective Functioning framework. The assessor examines the client's relational history for evidence of at least one dyadic relationship that has survived honest conflict and sustained mutuality. In the room, micro-tests are embedded throughout the assessment: the practitioner may offer a gentle clarification, pose a mild challenge, or simply sit with a moment of apparent misunderstanding. The client's response – whether they seek repair, withdraw, become defensive, or display curiosity – provides a live index of relational capacity. A client who, when gently challenged, leans in, asks "What do you mean?" and then reflects on the therapist's point, demonstrates an alliance that can accommodate the interpersonal stressors inherent in later phases. In contrast, a client who reacts to the same challenge with abrupt termination of the session, overt hostility, or a pattern of blaming the therapist, reveals a relational capacity that is fragile and would be jeopardised by the interpersonal demands of pattern-focused work.

Reflective capacity is the ability to observe one's own internal patterns, mental states, and behavioural sequences without collapsing into overwhelm or denial. This capacity is closely aligned with the construct of mentalisation, as articulated by Fonagy, Target, and Gergely (2002), and with the concept of metacognition described by Lysaker and Lysaker (2008). The assessor tests reflective capacity directly by offering a tentative pattern observation and watching the client's reaction. For example, after listening to a client's narrative about recurrent interpersonal conflict, the therapist might say, "I'm noticing that when you feel criticised, you tend to withdraw and then later feel angry about the distance that has grown." A client who responds with curiosity, elaborates with examples, or even respectfully disagrees, is demonstrating the ability to hold a mental representation of their own pattern while remaining emotionally regulated. By contrast, a client who reacts with bafflement, immediate compliance without elaboration, or a shutdown marked by shame and silence indicates that reflective work must be deferred until the foundational capacities of regulation and relational safety are more securely established.

The IPTF placement rule is therefore simple yet profound: treatment commences at the earliest phase whose capacities are not yet reliable. This rule is not a suggestion but a clinical imperative, because each subsequent phase builds upon the skills and stability cultivated in the preceding one. The framework delineates three primary phases – Phase One (Regulation and Alliance), Phase Two (Skills and Psychoeducation), and Phase Three (Pattern and Narrative Work). A client whose regulation capacity is unreliable but whose relational and reflective capacities are relatively intact would be placed in Phase One, focusing on stabilisation, grounding techniques, and alliance strengthening. Once regulation is consistently demonstrated, the client can progress to Phase Two, where evidence-based skills such as emotion-focused coping, interpersonal effectiveness (drawn from DBT), and cognitive restructuring are introduced. Only when the client reliably regulates affect, maintains a collaborative alliance, and can reflect on patterns without collapse does Phase Three become appropriate, allowing for deep exploration of core schemas, attachment narratives, and systemic patterns.

Misplacement in either direction carries significant therapeutic cost. Starting too deep – for instance, launching directly into pattern work with a client whose regulation capacity is fragile – reproduces the classic overwhelm cascade described by Linehan (1993) and Barlow (2002). The client experiences a flood of affect that they cannot contain, leading to a rapid escalation of distress, potential dissociation, and ultimately dropout. The client may internalise the experience as evidence that therapy is harmful, reinforcing maladaptive beliefs about interpersonal safety. This scenario is the most common failure with complex presentations, and it is a placement error, not a client failure. Conversely, starting too shallow – such as confining a well-regulated, psychologically minded client to Phase One skills training – can be experienced as patronising. The client perceives the therapy as remedial, the alliance erodes through subtle disengagement, and the client may terminate treatment before any substantive work occurs. Both trajectories waste therapeutic resources and erode the credibility of the practitioner.

The IPTF manual provides a structured protocol for capacity assessment, including a series of probes for each domain, decision-making algorithms, and a scoring matrix that translates observed behaviours into phase placement recommendations. The central skill cultivated through this protocol is honest capacity reading, which supersedes diagnostic labelling.

Two clients with identical DSM-5 diagnoses may be placed in entirely different phases because their functional capacities differ. The following worked example illustrates how the assessment unfolds in practice, how the three capacities are evaluated, and how the placement decision is derived.

Amir, a 34-year-old man, presents with a referral stating “recurrent depression, query personality factors.” In the intake interview, Amir describes volatile weeks marked by intense anger after minor disagreements, followed by heavy drinking to “numb the feeling.” He reports that no romantic or platonic relationship has survived a period of honest disagreement; friends tend to drift away after he becomes “too intense.” When asked to recount a recent conflict, Amir’s voice rises, his hands tremble, and he begins to pace the room. Mid-story, he abruptly stops, looks away, and his gaze narrows as he reports feeling “like the world is closing in.” The therapist offers a brief grounding exercise, inviting Amir to notice the texture of the chair beneath him. Amir complies, his breathing steadies, and he is able to continue the narrative, albeit with a noticeable reduction in affective intensity. The therapist then offers a tentative pattern observation: “It sounds like when you feel criticised, you tend to become angry, then you use alcohol to escape the feeling, which often leads to more conflict.” Amir’s reaction is a prolonged silence lasting thirty seconds, followed by a statement, “I don’t know what you mean.” He does not elaborate, does not ask for clarification, and appears to withdraw further. In this moment, the three capacity domains are coded as follows: regulation – partial (the grounding exercise demonstrates a capacity to re-ground, but the initial escalation and dissociative pause indicate unreliability); relational – fragile (the client’s history of relationships that cannot survive disagreement, and the in-session withdrawal when challenged, suggest a tenuous alliance); reflective – absent (the lack of engagement with the pattern observation and the prolonged silence indicate an inability to hold a mental representation of the pattern without collapse). According to the IPTF placement rule, the earliest unreliable phase is Phase One. The therapist therefore plans a series of sessions focused on affect regulation (e.g., paced breathing, grounding, safe-space visualisation), alliance repair (consistent therapist presence, validation of Amir’s experience, collaborative goal-setting), and gentle reflective exercises that remain within the client’s regulatory window. Pattern work is deferred until Amir demonstrates consistent regulation across at least three consecutive sessions.

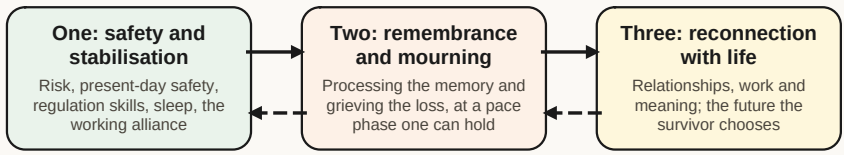
In contrast, Joan, a 42-year-old woman, also referred for “recurrent depression, query personality factors,” presents a markedly different profile. Joan describes a stable career, long-standing friendships dating back to university, and a supportive partner who has weathered several disagreements. She reports that her depressive episodes are characterised by low mood and anhedonia but are generally contained; she can attend work, maintain routines, and engage in self-care. During the assessment, when the therapist offers the same tentative pattern observation – “I’m noticing that when you feel criticised, you tend to withdraw and then later feel angry about the distance that has grown” – Joan’s eyes light up. She replies, “God, yes, my mother did exactly that with me,” and proceeds to give three concrete examples from childhood, adolescence, and her current relationship. Her affect remains steady, she asks clarifying questions, and she integrates the observation into her narrative. The capacity coding for Joan is regulation – reliable (she remains emotionally stable throughout the interview), relational – robust (her history includes multiple relationships that have survived honest conflict), reflective – present (she engages with the pattern observation, elaborates, and demonstrates metacognitive insight). Consequently, the earliest unreliable phase is Phase Three, and the therapist can commence pattern and narrative work from the first session, using interventions such as schema-focused imagery, attachment-focused dialogue, and narrative restructuring. Skills training from Phase Two is not required as a prerequisite, because Joan’s capacities already support the higher-order work.

These two vignettes illustrate the core premise of the IPTF Framework: capacity, not diagnosis, drives phase placement. The practitioner’s role is to conduct a disciplined, evidence-informed assessment that yields a clear picture of where the client stands across regulation, relational, and reflective domains. The assessment protocol includes a timeline of affective episodes, a relational map highlighting surviving bonds, and a series of in-session micro-tests that probe each capacity. The decision matrix translates observed behaviours into a placement recommendation, which is then communicated transparently to the client, framing therapy as a collaborative journey through progressively deeper phases rather than a static treatment label.

The IPTF Framework also emphasises the dynamic nature of capacity. Placement is not a one-off decision; it is revisited regularly as the client’s

abilities evolve. A client who begins in Phase One may, after several weeks of successful regulation work, demonstrate sufficient relational safety to move into Phase Two, where skills such as emotion-focused coping and interpersonal effectiveness are introduced. Likewise, a client who progresses through Phase Two may, once reflective capacity consolidates, be ready for Phase Three's deep pattern work. The therapist therefore maintains a continuous capacity monitoring sheet, noting any regression or advancement, and adjusts the therapeutic focus accordingly. This iterative approach aligns with the transdiagnostic perspective advocated by McHugh and Otto (2012), which recognises that functional capacities cut across diagnostic categories and that therapeutic progress is best understood as a trajectory of capacity development.

In summary, the assessment and phase placement lesson within the IPTF Framework in Practice equips the intermediate practitioner with a rigorous, evidence-based methodology for discerning the client's functional capacities across regulation, relational, and reflective domains. By anchoring placement decisions in observable behaviour and lived history, rather than in diagnostic labels or client preferences, the practitioner safeguards against the twin perils of over- and under-placement. The framework's structured protocol, grounded in seminal models such as Polyvagal Theory, attachment theory, and mentalisation, provides a clear pathway from initial assessment to phase-appropriate intervention, ensuring that therapy proceeds at a pace that matches the client's capacity to engage, learn, and transform. The worked examples of Amir and Joan demonstrate how the same diagnostic label can lead to divergent therapeutic trajectories when capacity assessment is applied faithfully. This capacity-centred approach is the heart of the IPTF Framework, and mastering it is the essential craft that underpins successful integrative therapy across the full spectrum of client presentations.



Stepping back a phase is a clinical decision, not a setback.

The phase is decided by present stability, never by elapsed time or session count.

Herman (1992); consistent with NICE NG116 (2018)

FIGURE 2.1 The three-phase model of trauma work

Herman's phases organise trauma treatment across every modality: safety and stabilisation first, processing only on a foundation that can hold it, and reconnection as the phase in which the gains become a life. The arrows run both ways deliberately: returning to stabilisation when processing destabilises is the model working, not the treatment failing.

Points worth keeping

- Assess capacity: regulation, relational, reflective
- Enter at the earliest unreliable phase
- Misplacement costs both ways; capacity beats label

PRACTICE TASK

For two contrasting (anonymised or constructed) clients, state the entry phase you would choose and the capacity evidence for each.