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Dynamic Interpersonal Therapy (DIT)

Developing a New Psychodynamic Intervention for the Treatment of Depression[1]

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This paper outlines the development of a manualised, brief (16 session) psychodynamic intervention – Dynamic Interpersonal Therapy (DIT)[3] - for the treatment of depression. DIT is based on a distillation of the evidence-based brief psychoanalytic/psychodynamic treatments pooled together from manualised approaches that were reviewed as part of the competence framework for psychological therapies first commissioned in the UK by the Department of Health. This paper will begin with a description of the methodology underpinning the competence framework followed by an overview of the model, its relevance to depression, and finally its strategies and techniques, which are illustrated through a case study.

The origins of DIT

"When I feel depressed" a patient said, "I feel that I am wading through quicksand. I hate it and fear it but it is me. Inside and outside me. When I am depressed that is all that I am". This comment captures vividly the complexity of depression: it is a disabling condition and yet the relationship an individual may have with it – that is, its function in the patient's psychic economy – may make the patient fearful of change and hence resistant to being helped.

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[1] DIT has been adopted as the 'prototype' brief psychodynamic treatment option for depression with the Improving Access to Psychological Therapies UK programme.

[2] This development has resulted from a collaboration between the Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre

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[3] DIT is easily confused with Interpersonal Therapy (IPT) since both therapies are interpersonal in their focus. However, IPT is *not* a psychodynamic therapy and this is reflected in the competences required to deliver it (Lemma, Roth and Pilling, 2010), which are quite different to the psychoanalytic competences required to deliver DIT.

Alongside the complexity of depression, a simplistic approach has prevailed at the level of service provision within the public health sector in the UK (and elsewhere) where the current emphasis on evidence-based practice has privileged Cognitive Behaviour Therapy (CBT) as the treatment of choice for depression (NICE guideline, 2009). This 'one size fits all' approach to treatment has strongly marginalised psychoanalytic interventions. The superiority of CBT in this respect has been rightly questioned, not because it is not helpful to many depressed patients - it evidently is - but because it is not helpful to *all* depressed patients[4].

The culture of evidence-based practice can be in some ways the 'enemy', as it were, of psychoanalytic practice. However, as well as posing a serious threat it has, in fact, helpfully focused our attention not only on the importance of systematically evaluating what we do so as to monitor the quality of what we offer to patients, but also on the thorny question of therapists' competence: how we define it, hone it and assess it. In the UK, for example, the Department of Health has invested in the development of competences for a range of psychological therapies, including psychoanalytic psychotherapy, as the basis for the development of National Occupational Standards (NOS) for the practice of psychological therapies. The origins of DIT lie in several models of brief psychoanalytic work, drawn together in this work on competences.

The Psychoanalytic/dynamic Competences Framework (Lemma et al., 2008)[5] describes a model of psychoanalytic/psychodynamic skills based on empirical evidence of efficacy. It indicates the various areas of activity that, taken together, represent what has been proven in research studies to produce good clinical outcomes.

This work began by identifying those psychoanalytic/psychodynamic approaches with the strongest claims for evidence of efficacy, based on the outcome in controlled trials where a manual was available. In order to determine which studies to select, the reviews of psychological therapies conducted by Roth and Fonagy (2005), were combined with the trial and systematic review database held at the Centre for Outcomes, Research and Effectiveness, as part of scoping work for the National Institute for Health and Clinical Excellence (NICE). From the combined lists (in conjunction with an Expert Reference Group comprising senior clinicians and researchers representative of different analytic traditions) clinical trials of appropriate quality for inclusion in the framework were identified and the manuals used in these studies were located. Only trials where a manual could be accessed were included. These manuals were then studied carefully with a focus on what the therapists were expected to do. This

[4] In the UK, the Improving Access to Psychological Therapies Programme (IAPT), has committed itself to an expansion in the range of psychological interventions on offer to patients, beyond just CBT. This now includes DIT.

[5] The full list of competences can be accessed at www.ucl.ac.uk/CORE

qualitative analysis provided the basis for the articulation of the core, specific and meta-competences required to practice psychoanalytic psychotherapy. These competences, where possible, were peer-reviewed by the originators of the manuals and also by an Expert Reference Group. To supplement these manuals several widely-cited texts that explicate psychoanalytic terminology and provide clear descriptions of how these concepts translate into clinical practice, were also consulted (e.g. Bateman et al. 2000; Etchegoyen 1999; Greenson 1967; Lemma 2003).

Because research trials monitor therapist interventions through audio or video recordings that are then rated, we know that therapists in these trials adhered to the manual. This gives some confidence that if an approach is followed as set out in the manual, which has been associated with substantial clinical improvements in research trials, there should be good outcomes for future patients also. Readers of this journal may find this approach clinically naïve and/or irrelevant; it is addressed at a public health scene dominated by brief, empirically-supported treatments judged by cost-effectiveness. The current culture is also driven by the wish to reduce poor quality practice with unmonitored bad outcomes for patients, a concern that we all presumably share.

The core techniques and strategies underpinning DIT thus reflect the competences found to characterize models of psychoanalytic psychotherapy which have been tested and shown to be effective. DIT deliberately uses methods taken from manualised dynamic therapies, and those who have developed other brief dynamic models (such as those in the current issue) will find many familiar strategies and techniques in DIT[6].

An approach that failed to contextualise theoretically what the therapist is aiming to do and why would be very limited; we have therefore embedded DIT in a range of psychoanalytic ideas that we consider to be highly relevant to understanding depression and its impact on an individual's internal and external worlds. This may give enough common ground to make the model of interest to psychoanalytic psychotherapists with a range of trainings; in particular we draw on object relations theory, attachment theory and Sullivan's interpersonal psychoanalysis (Lemma, Target and Fonagy, 2011b).

As with other brief psychodynamically oriented approaches, in DIT the guiding principles are rooted in the broader psychoanalytic framework that emphasises: (i) the impact of early childhood experiences on adult functioning, with particular attention to adult attachment processes and the significance of mental models of relationships; (ii) the internal and external forces that shape the mind and therefore inform our perception of ourselves in relationships with others; (iii) the existence of an unconscious realm of experience that is a motivating force; (iv) the unconscious projective and introjective

[6] The theories underpinning the manuals we consulted (see Lemma et al, 2008) have greatly influenced the development and elaboration of the current protocol.

processes that underpin the subjective experience of relationships, and (v) the ubiquity of the transference, by which patients respond to others, and to the therapist, according to developmental models that have not been updated or challenged.

The Psychodynamic Model for Depression in DIT

DIT formulates depression as including characteristic, repeated experiences of self and other across relationships, underpinned by a specific, relevant unconscious conflict. This maintains and illuminates the apparently self-defeating pattern, and makes it hard to change. The symptoms reflect unconscious responses to perceived threats to attachments (loss/separation) and to the survival and acceptability of the self. The unconscious conflict creates underlying instability of representation of self, other and affect, and temporary relationship problems disorganize the sense of security within the attachment system. This in turn generates a range of distortions in thinking and feelings typical of the depressive process. In the therapy a focus is maintained on this emotional 'crisis' through an elaboration of the thoughts, feelings and expectations (conscious and unconscious) most characteristic of the particular patient, and relevant to his[7] depression, as these emerge in the context of the therapeutic relationship. This focus is formulated explicitly, individually and collaboratively between therapist and patient. Through the focused exploration of the transference relationship the patient is helped to develop of a better understanding of his reactions to subjective threats. Making implicit anxieties and concerns explicit by improving the patient's ability to reflect on his own and other's thoughts and feelings, in turn, enhances the patient's ability to understand and rethink current relationship threats and challenges.

Structure of DIT

Although we conceptualise DIT as unfolding over three broad phases - an engagement and assessment phase (session 1-4), a middle phase (sessions 5-12) and an ending phase (sessions 13-16)- and we make some suggestions about the kinds of interventions that may be helpful in each of these, the therapist's *flexibility* in delivering this therapy is considered to be the sine qua non of good clinical practice. A therapist armed with knowledge of therapeutic strategies and techniques without understanding the psychodynamic model is not likely to be a competent therapist.

We regard our manualised approach as a 'guide' to treatment whose aim is to describe the principles of therapy in general terms consistent with the model advocated. A fundamental competence when practising DIT is indeed the ability to adapt the approach to whom the patient is (i.e. the filtering impact of personality structure on the experience of symptoms of depression or anxiety), and where in his mind, and in his external world, the patient finds himself at any given point in time during the course of a therapy. Understanding these highly idiosyncratic variables will determine how best to

[7] For clarity and economy, the patient will be referred to as 'he'.

intervene, and this may well entail going 'off-manual'. Having the manual in mind supports clarity and consistency in applying the model but also discipline in clinical decision making: it forces us to think explicitly about why we may decide to do something other than what is advocated in the manual.

The initial phase: formulating the Interpersonal-Affective Focus (IPAF)

The primary task of the initial phase, which organises DIT's therapeutic thrust, is to identify typically one dominant and recurring unconscious interpersonal pattern that is meaningfully connected with the onset and/or maintenance of the depressive symptoms (the IPAF). We understand this pattern as underpinned by a particular representation of self-in-relation-to-an-other that characterises the patient's style of relating, and that leads to difficulties and disappointments in his relationships because of the way in which it organises his interpersonal behaviour. These representations are typically linked to a particular affect(s) and defensive manouevres. In this respect, Kernberg's (1985) integration of object relations theory with ego psychology in the theoretical frame of Transference Focused Psychotherapy (Clarkin et al., 2006) is very close to the heart of DIT's theoretical basis and way of formulating a focus for the intervention. However, DIT is not only much briefer, but also draws on other techniques (e.g. enhancement of mentalizing, and interpretation beyond the transference).

Given the brevity of the therapy, the focus is on a core segment of the patient's experience of relating that is closely connected with the presenting symptom(s). Past experiences, while clearly informing current functioning and internal object-relations, are explored in the initial phase as the basis for the formulation the IPAF, but they are not the major focus of the therapy overall. They are included in the formulation shared with the patient so as to meaningfully frame his current difficulties in the context of his lived experience over time, but it is the current difficulties which the therapist then prioritises.

The therapist strives to establish from narratives across the patient's main relationships, the main repetitive pattern of expectations, key processes employed in maintaining it (including compromises with unconscious wishes and anxieties), if it has changed over time, and how it relates to current problems (e.g. makes depression worse by spoiling close relationships).

An important source of information that supports the formulation of the IPAF lies in the evolving transference relationship. The therapist is encouraged to listen for 'cautionary tales' (Ogden, 1992); that is, the patient's unconscious anxieties about developing a relationship with the therapist that will reflect particular expectations of himself and of other people. The anxieties are typically communicated through the interpersonal narratives that the patient brings. The quality of the phantasies the patient has about the therapist is vitally important to the viability and outcome of DIT. The patients most difficult to help in time-limited therapy are those with persecutory phantasies that

shape virtually all aspects of their mind, relating to the world with phantasies organised around controlling, tormenting or rejecting the object before they then run the risk of becoming the victim of phantasised retaliatory attacks. More typically the patient's anxieties will reflect the belief that relationships will inevitably become painful, disappointing, unreliable, overly sexualised, etc.

Many patients, but by no means all, arrive for the consultation looking for an authoritative person to relieve the distress. The underlying initial transference may therefore be to a powerful, omniscient parental figure. This may set up a conflict between the wish for, and fear of, a dependent relationship, establishing the therapeutic relationship as unequal in the patient's mind and potentially fostering regression. DIT tries actively to recognise and address such conflicts in the work while supporting the patient in being a collaborator (rather than becoming a passive recipient or victim of the phantasied parental therapist).

Being able to accurately identify these threatening undercurrents and convey understanding of them to the patient draws his attention in an immediate way to his anxieties. It also allows the therapist to give the patient an experience of the kind of reflection that will take place within the therapy whilst testing out the patient's capacity to make use of it. It is helpful and containing for the patient if the therapist is able to articulate these anxieties early on, so that they can then be incorporated into the formulation of the IPAF - sometimes the representation of self and other that underpins the cautionary tale becomes the essence of the IPAF, which is explicitly discussed with the patient as the basis for the rest of the work. Formulation in DIT uses some of the psychoanalytic model and technique, but happens much earlier, and with a much narrower focus, than we would generally expect in long-term psychotherapy.

The Middle Phase

The IPAF guides the therapist's interventions during the middle phase of the therapy (sessions 5-12). During this phase the therapist helps the patient to stay focused on, and work through, the IPAF. The therapist makes use of the transference to help the patient to explore the IPAF as it becomes live in the therapeutic encounter.

Transference interpretations are used in a more circumscribed manner than in longer-term analytic therapies. They are primarily aimed to help the patient recognise the implicit representations of himself and others that underpin his problematic relationship patterns. The therapist actively encourages the patient to discuss and explore his perceptions of, and feelings about, the therapist and how he thinks the therapist may feel or think about him. The aim is to help the patient explore the IPAF in his relationship to the therapist, making links and drawing parallels between his subjective experience with others outside the therapy (past and present, *but especially with current people in the patient's life*) and with the therapist.

In DIT the primary aim of a transference interpretation is not to impart a particular new insight; rather the goal is to engage the patient in the process of noticing and making

sense of how his mind works. Using what happens in the transference provides, in our view, the most immediate and often most striking way of doing this. In addition to the use of a transference interpretation in enhancing the exploration of the IPAF, it may be made to help the overall working alliance (e.g. if there seems to be a danger that the patient will drop out of therapy because of a transference fantasy that the therapist wants to get rid of him; this may or may not be part of the chosen IPAF).

An important aspect of working through the IPAF involves helping the patient to identify the often unconscious 'investment' in maintaining a particular self-other representation. The patient may, for example, complain that he feels belittled by others whom he experiences as haughtily superior, and yet he repeatedly recruits into his world people who treat him in this way. He may become able to see that one of the 'pay-offs' is that this way he remains the victim of other's criticism and he can sidestep owning his own arrogance and responsibility.

Working with defences can be thought of as consisting of four interlinked strategies that build on each other: a) the acceptance of the need for some defences, b) the exploration of the 'how' of defences (i.e the patient's characteristic defensive strategies), c) the exploration of the 'why' of defences (i.e. the function of defences), and finally d) the 'costs' of defences (see Figure 6.4) (Greenson, 1967). The overall aim is to help the patient to reflect on behaviours and feelings that give rise to, perpetuate or exacerbate the core, painful interpersonal pattern identified by the IPAF.

The exploration of defences is closely linked to the exploration of the patient's affect. Here we are primarily interested in helping the patient to become aware of several facets of his emotional life, namely a) those affects that need to be kept in check by defences, b) those affects that function as defences; that is, affects that protect the individual from feeling other emotional states, and c) how particular affects are managed or discharged (e.g. through self-harm or substance abuse).

The Ending Phase

The last four sessions (13-16) are devoted to helping the patient explore the affective experience and unconscious meaning of ending the therapy, to review progress and to help him to anticipate future difficulties/vulnerabilities. Particular attention is devoted to identifying the unconscious fantasies that are evoked by the anticipated separation from the therapist.

A central, organising strategy in the Ending Phase involves the therapist writing a "goodbye letter" to the patient. This is an important feature of Cognitive Analytic Therapy (CAT) (Ryle, 1990; 2004) and we have directly borrowed the idea from this model. In our view, a written overview of the formulation and work done can be very helpful in the work of ending the therapy, and may even help to prevent relapse (the latter requires testing). Unlike in CAT, however, the DIT therapist only writes a letter near the end, and this letter is actively discussed and worked on with the patient. Our

experience is that through considering and adding to this description of the work, many patients make fuller use of it and deepen their understanding.

Why a letter? There are a number of reasons why we consider this to be an important adjunct. From a practical point of view a 'goodbye letter' provides a helpful way of punctuating the beginning of the Ending Phase and provides a tangible focus for the joint evaluation of the therapy. In a brief therapy, where the pace and rate of learning for the patient is inevitably faster than in longer term psychodynamic therapy, the scope for consolidating gains is correspondingly more limited. The letter provides a record of the therapeutic work that the patient can refer to and reconsider once the therapy is over.

For many patients, as Ryle (2004) recognised, the letter is also important because it has the quality of permanence (Hamill, Reid and Reynolds, 2008). The letter may have symbolic value where the patient's own narrative is characterised by the impermanence of his attachments. The letter may thus be said to provide some kind of reassurance at the point of separation - a kind of transitional object that may contribute to the internalisation of a benign attachment figure (Ingrassia, 2003). It gives the patient something to take away as a memento of the work and to remind him of the understanding gained if he has later difficult periods, or simply misses the relationship with the therapist.

Of course, such letters might bypass the working through of the pain of separation. Whilst this possibility needs to be borne in mind and taken up in the transference with the patient where appropriate, in our experience, if the patient's affective experience of ending is addressed directly, the letter aids in working through separation rather than avoiding it.

Moreover the clinical experience across many DIT cases is that these letters provoke strong affects, sometimes an intensification of the sense of loss, and are often experienced by the patient as supportive and challenging in equal measure. The letter squarely focuses them on a realistic appraisal of the therapy, what they have gained but also on what it has *not* been possible to achieve; that is, they do not sidestep the reality of disappointment. For the therapist, too, the act of writing the letter can be powerful, thought-provoking and challenging, clarifying for the therapist as well what has been understood, what could not be achieved and how to support the patient in continuing to understand himself. The discipline of reflecting on the work to arrive at a succinct yet affectively meaningful and powerful account of the therapy and its impact on the patient can sometimes alert the therapist to countertransference experiences that she can then take back to the therapy and explore with the patient.

Here-and-now focus

DIT maintains a focus on the patient's interpersonal functioning in the 'here-and-now' of his current life and of the therapeutic session. The 'here-and-now' focus is central to DIT and denotes three related activities:

Firstly, it refers to the focus on what the patient is *currently* feeling in the session. This requires careful tracking of the patient's emotional state during the session, so as to communicate an understanding of this to the patient in order to help him to recognise his feelings as his own, differentiate feelings from actions, and allow discussion of the connections between feelings and actions, which facilitates self-understanding and awareness of motivations attributed to others (e.g. I missed last week's session because when I feel anxious I want to avoid being with you– because I think you find me boring and hopeless).

Secondly, it refers to a primary focus on the exploration of *current* difficulties in the patient's life rather than in trying to establish links to the childhood origins of these difficulties. This way the patient can be helped to feel he is working on difficulties that are live and current and over which he can effect a degree of change.

Thirdly, and related to the above points, it refers to the active use of the patient-therapist relationship to help the patient to explore the IPAF in the immediacy of the transference relationship.

Focus on the patient's mind

A distinguishing feature of DIT (compared for example to CBT) is that it approaches the exploration of problematic interpersonal patterns not by addressing the patient's behaviour, but through its consistent focus on mental states (beliefs, feelings, wishes and thoughts) in themselves and in others. A primary aim is to provide the patient with an experience of being with another person who is interested in *thinking with* the patient about what distresses him so as to stimulate the patient's own capacity for reflecting on his own experience. This is the collaborative stance the DIT therapist must establish with her patient. It contrasts with an expert stance, in which the therapist knows, and imparts authoritative interpretations, which the patient is not necessarily expected to understand.

Throughout DIT a consistent effort is made to encourage and support the patient to make psychological sense of what is happening in his own mind, others' minds and in important interactions. The goal is not simply to work on an unconscious conflict; rather the aim is primarily to use the patient's reports of his interpersonal experiences as a way of helping him to develop his own capacity for thinking and feeling his experience. This focus is fundamental to DIT and it informs technique in so far as the helpfulness of the therapist's interventions (e.g. the interpretation of transference) is evaluated against the criterion of whether they help to stimulate the patient's capacity to reflect on their own subjective experience in relation to that of others, within the stress of a problematic relationship.

The DIT therapist is particularly interested in making explicit what has effectively become procedural (sometime dynamically unconscious but sometimes simply habitual and unnoticed), so that the patient is then better able to effect change in how he manages his relationships. Working through the IPAF therefore involves enhancing the patient's awareness of how his behaviour is driven by mental states, focusing on what the patient think and feels right now. The patient's experience is explored in the relational realm, not just the intrapsychic.

Therapeutic stance

The DIT therapist adopts an involved, empathic manner. The aim is to work collaboratively with the patient from the outset, especially in arriving at a formulation that provides a meaningful focus for the patient. The therapist is explicit about her understanding of the patient's problems, openly discussing and checking out the formulation with the patient, and jointly elaborating it in their formulation statement. The aim is to create the opportunity for the patient to actively participate in agreeing and understanding a focus for the work.

The therapist is receptive to the patient's feedback. If the patient questions the therapist's understanding, or her perception of the treatment, the therapist responds non-defensively, providing a clear account of how she has arrived at her understanding, while considering a modification based on the patient's comments. The aim is to be as transparent as possible whilst being attuned to, and working with, the patient's need, where it arises, to control the therapist through projective processes.

The therapist strives to adopt a 'not knowing' but curious stance that prioritises the joint exploration of the patient's mental states as they relate to the identified interpersonal process that has been agreed as the focus of the therapy. Interpretations of deep unconscious material are generally less helpful in this brief model than the support of the patient's own capacity to stand back from his own immediate experience in order to be able to reflect on it.

Although the basic stance is a psychoanalytic one, rooted in an interest in the patient's unconscious communications, and in making use of the transference, the brevity of the treatment requires more activity on the part of the therapist.

Techniques

In DIT the therapist intervenes to generate, clarify and elaborate interpersonally relevant information. A key intervention is to help the patient stay focused on the agreed IPAF. All the techniques used support this core aim of helping the patient to better understand what is happening for him, in his mind, when things go wrong in his relationships, including how the IPAF is enacted in the therapeutic relationship. To this end DIT draws liberally on supportive and expressive techniques whilst also sometimes using more directive techniques to support change within a brief time-frame.

No therapy can occur without some *supportive* techniques: support and empathy are necessary components of all therapies and the therapeutic skills of reflective listening and accurate empathy are a fundamental aspect of DIT. This does not mean that the therapist agrees with everything the patient says. Confrontation or challenge is an equally important aspect of DIT.

Because DIT is used with patients whose depression ranges from mild to severe, and may sometimes be co-morbid with Axis II disorders, the therapist needs to titrate the level of supportive interventions offered to a given patient. The less impaired patient, with a higher level of pre-morbid interpersonal functioning, is more likely to make greater use of expressive techniques without requiring more supportive interventions to bolster defences and support his day-to-day functioning. The ability to apply the model flexibly and to balance supportive and expressive techniques is therefore essential.

The *expressive* techniques used in DIT will be familiar to all analytically trained clinicians: clarification, confrontation and interpretation. Particular emphasis is placed on identifying and helping the patient to reflect on unverbalised feelings. As with all analytic approaches, the therapist considers the possible meaning of her own emotional reactions to the patient as a basis for facilitating this exploration.

As in any analytic therapy, the therapist will make judicious use of silence so as to allow the emergence of the patient's flow of associations and communications. As noted above, the DIT therapist is far more active than when practising longer term analytic therapy, guided by DIT's focus on helping the patient to actively start working on his difficulties within the brief time frame of the therapy.

This greater activity does not usually involve giving advice, but it requires that the therapist is alert to any deviations from the agreed focus so as to re-direct the patient back to the focus. It also requires that the therapist explicitly supports the patient's attempts to change. To this extent some *directive* techniques may be used during the middle phase of treatment. Such interventions include more freely asking questions to clarify the patient's experience and active encouragement to try out different ways of approaching a conflict with another person, but stopping short of suggesting 'homework'. These non-specific directives appear to have a subtle structuring impact on the patient's perspective on his experience.

In deploying active techniques in DIT, the therapist is alert to the meaning that the more directive stance may acquire for the patient in light of the IPAF. For example, an anxious patient for whom separation is felt to be terrifying may well be very compliant with the therapist's suggestions, because non-compliance is felt to be a threat to the relationship. Yet, in spite of the therapist's support and encouragement, little change occurs for this patient. In such an instance, the DIT therapist would be attuned to the unconscious meaning that may be latent in the patient's wish to please the therapist

and would actively address this with the patient, linking it to the identified IPAF and the lack of progress in the therapy.

The use of outcome monitoring measures

One of the features of this protocol, partly dictated by its use within UK IAPT services, is the inclusion of session-by-session outcome monitoring – a demand that is unfamiliar to many psychoanalytic therapists. As a part of DIT in the NHS context, patients complete brief questionnaires at the start of each session. Although this practice is often anticipated to be intrusive to the therapeutic process, in our experience this is typically an intrusion felt more acutely by the therapist than the patient.

This monitoring, as well as providing both patient and therapist with another form of feedback on how the patient is feeling week-to-week, also often brings to the fore areas of 'stuckness' or resistance. Once the therapist is acculturated to the routine of outcome monitoring, the 'use' made of the questionnaires by the patient becomes grist to the therapeutic mill and is integrated into the therapeutic process. For example, one patient reported significant improvement in the sessions, yet her scores on the questionnaires for symptoms remained very high. When this discrepancy was taken up by the therapist it made it possible to understand, at the level of the transference, the patient's wish to 'punish' the therapist and deprive her of evidence she might share with others that the therapy was of help - an enactment of the grievance the patient harboured towards her mother.

Case illustration

Marc, a man in his mid twenties, was referred by his GP after he was signed off work for two consecutive weeks due to stress at work with his boss. Marc explained that he had never taken to his boss because he was 'loud' and 'brash'. A few months prior to being signed off work by his GP, Marc had felt particularly humiliated by his boss after he was openly critical of one of Marc's reports in front of other colleagues. At the time, Marc had barely spoken, feeling himself immediately to be 'stupid'. Subsequently, he felt that everyone viewed him differently and he found it increasingly hard to even look people in the eye when he was at work. He ruminated over this exchange in his mind and the more he did so the more angry he became. He spoke about the 'injustice' of it all as he was hard working and diligent.

As Marc spoke about his difficulties, the therapist (AL) became aware that he was having a particular impact on her: she felt she was being recruited into siding with Marc against the boss who had become the personification of evil. The therapist made a mental note of this, but said nothing at this stage. This feeling nevertheless grew stronger as he described in more detail his relationship with his younger brother.

Marc was the eldest of two. His father died unexpectedly of a heart attack when he was five years old. Following his death, his mother appeared to have sunk into a very depressed state of mind from which she never fully emerged. Marc still lived at home

with his mother while his younger brother left home to move in with his girlfriend. He felt that his brother had acted selfishly, leaving home just when Marc had taken up his new job and their mother had become more severely depressed. Consequently, Marc had felt that the burden of care for his mother had fallen on him, as he felt it had always done since his father's death.

The description of his brother bore an uncanny similarity to Marc's hated boss. His brother was described as loud, unthinking and selfish. They had never been close, and he reluctantly acknowledged that his brother was very successful in life. He spontaneously recounted that as they were only eighteen months apart, they shared many friends together and went to the same school, but that he felt he was always in his shadow because of his more outgoing personality. When the therapist invited him to elaborate on this Marc gave a very detailed account of his brother's superior physical achievements. In this respect he thought that his brother had taken after their father who had been an excellent runner in his time. He added somewhat pointedly that his brother had been fortunate to inherit his father's height and strength whereas he had followed in the maternal footsteps: his mother's family was described as a family of 'clever thinkers prone to depression'.

Marc said he did not really feel that he knew his father except through his mother's 'rose-tinted glasses'. He had grown up hearing what an impressive character he had been, and he mentioned twice the way his mother referred to the father's 'stature' both concretely, as he had indeed been tall and strong, and because of his standing in the world of work. As he spoke he conveyed a sense of hopelessness about his own capacity to be impressive, and the therapist reflected this back to him.

By the end of session 2 the therapist had become conscious of a pattern in the room: whenever she tried to be empathic or made some observation, Marc either appeared to ignore it or typically replied that 'it was *not quite* like that'. The therapist began to feel that she was being carefully scrutinised and duly criticised, as if in the room the roles had been reversed: it was now Marc who was in some way criticising her reports, just as he reported his boss had done to him.

In session 3 the therapist explored further the circumstances around the time when Marc's brother left home. It became clear that the onset of a more insidious state of depression dated back to that time, and that it had been further aggravated by the more recent incident at work. It emerged that the mother had felt bereft by the brother's decision to move away from the family home. She appeared to have been stuck in an unresolved grief reaction following the death of her husband, which was fuelled with new impetus by the departure of her younger son. All this appeared to have deeply angered Marc, who had seemingly always felt in the shadow of his father and brother's greater stature in his mother's eyes. The incident at work had been the final blow for him as he had somehow always managed to reassure himself of his superior intellect as a defence against his deep-rooted conviction that he was simply not good

enough for his mother. To be attacked publicly, as he saw it, for producing a bad report, reduced his intellectual stature and he felt profoundly humiliated and exposed to the critical eyes of others. His anxiety indeed had a distinctly paranoid flavour. His basic response to this interpersonal scenario was one of passive aggression, where he said nothing, withdrew into himself and internally remained locked in a grievance against the other person. His most profound grievance was towards the parental couple in his mind by whom he felt painfully excluded.

In approaching a possible focus, the therapist began by summarising the way in which Marc had conveyed to her his longstanding experience of not having any stature in his mother's eyes, and that this characterised more generally his expectation of how other people viewed him. She acknowledged the importance to him of his intellectual pursuits as a way of reassuring himself and others that he did have substance and stature in his own right. Consequently work had been overvalued such that it had not only pulled him away from developing relationships, but it had also made him highly sensitive to any slight to his intellect.

The therapist spoke with Marc about the heavy burden of having to bear not just the meaning for him of the early loss of his father, but perhaps even more significantly to have to nurse his mother through her ongoing sense of loss, which he could never assuage. He seemed to feel that he had lived in the shadow of his father and brother, both of whom had managed to escape the fate of the 'clever thinkers prone to depression', leaving him feeling as if was forever lagging behind them in some fundamental way, which nothing could change. At the same time he had to take care of a mother who both needed him, but also made him feel second best.

Marc replied by emphasising that in the intellectual domain he had always shone, but that somehow this was never really valued, even though he had always thought that his mother, herself an academic, prized intelligence. The therapist observed that he seemed to have always been very preoccupied with what his mother was looking for, and that he felt confused about what she valued and admired. His whole life in a way had been devoted to getting it right for his mother rather than for himself.

She then wondered with him as to whether now that they were negotiating what to work on in therapy, he might be similarly preoccupied with what he imagined the therapist would prize. This appeared to resonate with Marc, who observed how anxious he had felt each time he had come for the session. He then reported a dream he had the night before the third session in which he had been jeered at by a group of adolescents. In the dream he wanted to shout back, but no words came out. As we explored this dream, Marc was able to elaborate on his experience of feeling castrated and his struggle to find his own voice. The therapist acknowledged his fear of being humiliated by her and made to feel small and how difficult he might find it to let her know about his anxieties.

By this stage the therapist felt confident enough to propose a possible IPAF. She suggested that a recurring experience for Marc in his relationships was to feel that he was small, lacking in stature, insufficient, while the other person was more typically felt to be either explicitly humiliating and rejecting (as he had felt his boss had been recently), or they were more implicitly humiliating (as he felt his mother had been, leaving him feeling that he could never live up to his father's/brother's stature). His only option seemed to be to follow on in the maternal family tradition of 'clever thinkers prone to depression'. Distressing though this was, the therapist suggested that this way at least Marc comforted himself with a likeness to his mother, which he felt only he shared with her, and thus gave him some 'stature', but at considerable cost.

As the therapy progressed Marc's identification with the critical object could be addressed more directly. He was gradually able to reflect on how he also took up the position of being the critical one in his own mind and subjected the other to harsh scrutiny. This was very apparent in the transference and was actively worked on through the transference relationship.

For example, a characteristic pattern that had already been apparent in the early sessions was Marc's tendency to somehow diminish what the therapist offered him. The therapist continued to feel under scrutiny. In session 8 Marc responded to an interpretation about his tendency to sideline himself (and thereby make himself 'small') as a way of averting the possibility of being humiliated with a long silence, which the therapist experienced as very tense, as if her every word was being carefully studied. When Marc eventually resumed speaking he did not make any direct reference to what the therapist had said. Instead he recounted an incident whereby he had offered help to a friend who had been struggling with writing a report. He had been struck by the friend's reluctance to take his advice and he had got very angry with him, feeling he had wasted his time. The therapist engaged Marc in elaborating a bit further his state of mind in relation to this friend before she shared a transference interpretation. (This is characteristic of the process of working through in DIT whereby the emphasis is placed on actively helping the patient to mentalise their experience before sharing the therapist's understanding of the transference.)

Marc responded by saying that he enjoyed helping others because it made him feel he had some 'worth'. When his colleague appeared to reject his help, he felt belittled and enraged. At this point the therapist wondered whether Marc might also struggle with accepting her input, as 'being helped' could be experienced by him as a humiliation that demonstrated his lack of 'worth'. Marc was thoughtful and said he often felt like not coming for his sessions, but he had not really understood this threat as a factor. The therapist elaborated that there were two threats that he might want to avoid by not coming: he did not want to be confronted with his need for help (which he experienced as a humiliating confirmation of his 'smallness') and he feared that if he came and then rejected the help the therapist might retaliate by getting angry with him, just as he had felt incensed by his colleague's apparent rejection of his help.

The subsequent sessions provided further similar opportunities for exploring the IPAF, in all its nuances, both in the transference and in the patient's current relationships, not least that with his mother. Marc gradually developed a clearer sense of his own voice, taking more responsibility for his anger and how critical he could be of others. He accepted an invitation by his boss to discuss a return to work, which offered Marc an opportunity to approach the exchange with his boss with less defensiveness. This meeting, and Marc's expectations of how his boss would relate to him, were explored in depth in the sessions leading up to it in order to support new ways of being in a relationship charged with anticipated humiliation.

In session 13 the therapist gave Marc a draft of the goodbye letter. At first he responded in a rather unemotional way, pointing out a few typological mistakes but not making any other comments. This provided fertile ground for revisiting the IPAF, which appeared to have been mobilized with renewed vigour by the prospect of ending. The letter, as it turned out, left him feeling 'discharged'. The therapist linked this to how the ending left Marc feeling 'small' in relation to his fantasized rivals who would have more stature in the therapist's mind and who would replace him, while he was handed a measly letter and discharged. The last four sessions revisited this theme and helped to consolidate the gains made, which also led to Marc wanting to put in the letter both how he had struggled with the ending, and how it had helped him to notice more clearly the rage he carried inside. By this stage the letter felt like a more genuinely collaborative piece of work, that captured both the gains Marc had made and the struggles he experienced until the very end in this brief, yet very intense, therapeutic encounter.

Overview of studies

DIT is a relatively new protocol, based on models with some research evidence but not itself researched until very recently. We have successfully piloted the protocol in a primary care context with consecutively referred, depressed patients who were offered 16 sessions of DIT, as a basis for planning a larger scale RCT. In the pilot, DIT was associated with a significant reduction in reported symptoms in all but 1 case, to below clinical levels in 70% of the patients. (Lemma, Target, Fonagy, 2011a).

This preliminary study also demonstrated that this model was easy to grasp in a three-day training and to implement by clinicians who had not undergone full psychoanalytic training, but who were experienced at offering once weekly psychodynamic therapy in the NHS. Feedback from both therapists and patients involved in the pilot study contributed to further refinement of the protocol and the training: a four day training, followed by weekly supervision of two video or audio-taped cases. This training module looks promising in its potential for helping dynamically oriented clinicians to achieve good results if they follow five relatively simple strategic steps in the course of a brief therapeutic engagement: (i) Identify an attachment related problem with a specific relational emotional focus rooted in dynamic conflict, that is felt by the patient to be currently making them feel depressed; (ii) Work with the patient collaboratively to

create an increasingly mentalistic picture of interpersonal issues raised by the problem; (iii) Encourage the patient to explore the possibility of alternative ways of feeling and thinking ('playing with a new internal and external reality'), actively using the transference relationship to bring to the fore the patient's characteristic ways of relating ; (iv) Ensure the therapeutic process (of change in self) is reflected on; (v) Near the end of treatment present to the patient a written summary of the collaboratively created view of the person and the selected area of unconscious conflict, for him to hold on to, to reduce the risk of relapse (known to be very likely in clinical depression).

The qualitative data obtained from the patients also suggested that the approach was felt to be congenial and relevant to their presenting concerns.

A larger scale study is now underway, which will benchmark the effectiveness of DIT in three community based psychological therapies services. In order to begin to find out if DIT could be an effective treatment for depression we will compare the outcomes of patients receiving DIT with those of patients on a 16 week enhanced waiting list for therapy. These studies will help prepare the way for a larger RCT comparing DIT and CBT.

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