Dynamic Interpersonal Therapy (DIT): Providing a focus for time-limited psychodynamic work in the National Health Service
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Dynamic Interpersonal Therapy (DIT): Providing a focus for time-limited psychodynamic work in the National Health Service

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In this paper we outline the experience of our involvement as clinicians in a pilot feasibility study of a new brief psychoanalytically-based protocol – Dynamic Interpersonal Therapy [DIT] (see also Lemma, Target, & Fonagy, this issue). We discuss how the DIT model has helped us to integrate more coherently the brief psychoanalytically-based work we have been doing in the London Borough of Tower Hamlets, an area of ethnic diversity and high levels of deprivation. We describe the experience of using standardized outcome measures in a brief psychoanalytic therapy. We also include some case studies of clinical work undertaken using the DIT model.

Keywords: brief therapy; psychodynamic; DIT; IAPT; research in clinical practice

Background to the provision of psychological therapies in primary care in the National Health Service

The provision of psychological therapies in primary care within the National Health Service (NHS) has undergone significant change in recent years. Like other parts of the NHS, psychology service provision has been substantially affected by demands for accountability, both in terms of cost effectiveness and measurement of clinical outcome. The Tower Hamlets Primary Care Psychology and Counselling Team has also recently integrated an Increasing Access to Psychological Therapies (IAPT) service into the existing model of service provision, which has increased the focus on demonstrable clinical outcomes in short-term psychological therapies.

The IAPT programme was introduced by the Department of Health (DOH, 2007) three years ago. It is based upon the premise that common mental health problems (depression and anxiety) are a significant drain on public health resources and the social welfare system (Layard, 2006). IAPT proposes that the provision of psychological therapies with an established evidence base, as outlined in the Department of Health National Institute for Clinical Excellence (NICE)
guidelines, should be increased within primary care, where patients with common mental health disorders initially present.

One of the conditions of the IAPT programme is to measure outcome for all patients at every session, using a defined minimum data set (IAPT Outcomes Toolkit, 2008). In addition, targets of waiting times for assessment and treatment are clearly delineated. The requirement by IAPT for evidence-based psychological interventions has meant that cognitive behaviour therapy (CBT) is the dominant theoretical structure, although recent developments may allow for greater choice of therapies. Therapists trained in CBT treatment protocols constitute a significant proportion of those delivering psychological therapies within primary care.

**Primary care psychological therapy service provision**

In the Tower Hamlets Primary Care Psychology and Counselling Service, we are referred patients from all backgrounds and with any number of presenting difficulties. As a programme, the brief of IAPT is to provide psychological therapies for patients with mild to moderate anxiety and depression who do not have sufficient access to psychological therapies via their General Practitioner (GP). IAPT offers a ‘stepped care’ approach, with the highest level of IAPT service provision being CBT treatment protocols for anxiety and depressive disorders, delivered by CBT therapists. Within our service, however, a substantial proportion of the referrals are more complex than the mild to moderate anxiety and depression which IAPT was set up to address. Patients typically present with co-morbidity, risk of suicide, long-standing interpersonal difficulties, economic instability (e.g. homelessness, unemployment), difficulties using the help they are offered, a history of violence against others, domestic violence, and other forms of risk. In June 2010, 37% of those who had entered treatment at all levels of the service were in the moderate-severe to severe range of depression. Patients with more severe or more complex presentations are often offered a short CBT intervention and then ‘stepped up’ and out of the IAPT service to an experienced psychologist or counsellor, or may be ‘stepped up’ immediately.

Developments within the field of clinical psychology in the NHS, have meant that CBT has established dominance in clinical training and in service provision. This has been boosted greatly by the IAPT programme (Roth & Pilling, 2007). In many clinical services multiple approaches are used and appreciated (Moorey, 2010) and it is hardly a new observation that patients in a public healthcare system may benefit from a variety of therapeutic approaches, each with different ways of understanding and addressing the multi-faceted and layered difficulties with which most patients present (Moorey, 2010). However, in reality a more hegemonic CBT discourse has become dominant.

Those using and promoting CBT within the NHS have been proactive in meeting the needs of a public health service. CBT has responded appropriately to demands for a published and empirical evidence base.1 In contrast, despite a long
history of providing psychological input in the NHS, psychodynamic practitioners and institutions have, in many ways, failed to respond adequately to those same requirements. Thus, it may be suggested that while CBT has engaged with the demands of an evidence-based public health service psychoanalytic academic and research institutions have been slow in providing evidence of efficacy using empirical methods (Lemma & Patrick, 2010). Some psychoanalytic institutions may be perceived by others in the profession as having secluded themselves (Cooper & Lousada, 2010) and, in some ways, acted out a phantasy of timelessness and the use of retreat. Furthermore psychoanalytic approaches have been criticized for failing to adapt clinical work to provide brief, cost effective interventions suitable for a diverse range of patients.

In this climate psychodynamically interested practitioners working in the NHS have been feeling less secure and valued. This has not been helped by the instruction within the NICE guidelines for depression that short-term psychodynamic therapy only be offered to patients who decline other types of therapy with an explicit discussion with the patient ‘of the uncertainty of the effectiveness of ... psychotherapy in treating depression’ (NICE, 2009).

One important response to the current marginalization of psychoanalytic interventions has been a greater investment in research by psychoanalytic practitioners and researchers. It is beyond the scope of this paper to review this literature but it is nevertheless worth noting that more recently some brief psychoanalytically-based models have established reliable evidence bases via randomized controlled trials (RCTs), for example, Mentalisation Based Therapy (Bateman & Fonagy, 2006), Panic Focused Psychoanalytic Psychotherapy (Milrod, Busch, Cooper, & Shapiro, 1997) and Intensive Short-Term Dynamic Psychotherapy (ISTDP) for personality disorders (Abbass, Sheldon, Gyra, & Kalpin, 2008). Compared to trials of CBT, many have relatively small samples and are clouded by various confounding factors (Holmes, 2010). Nevertheless, first steps have been taken and lessons are being learnt with the result that newcomers are able to align themselves, albeit modestly, with an empirical ancestry.

An inner city psychological therapy service meets DIT

We are a group of five clinical psychologists and counsellors who are part of a wider team that has been providing psychological services in primary care in the NHS in Tower Hamlets for 30 years. Our service offers a variety of theoretical approaches (some outside the IAPT service), including CBT, Systemic work with families and individuals, Cognitive Analytic Therapy (CAT), Interpersonal Therapy (IPT) and psychodynamic practice. Senior members of this team have been trained in psychoanalytic theory and clinical practice.

Some of us have also received various levels of training in a CBT approach or, through necessity or interest, set out to learn about it. We would be the first to acknowledge that it is an approach which has great value for many patients and
many presenting difficulties. However, it is also no panacea and fails to address many of the complexities of human relationships — and one of the strengths of a psychodynamic approach is that it does. Consequently we became increasingly dismayed by clinical psychology trainees on placement in our service who were receiving only a handful of lectures in a psychodynamic approach during their three-year training.

Within our particular NHS context we often felt that psychodynamic work was dismissed as irrelevant. We felt that this dismissal came from two fronts: those who observe that it does not have the evidence base of CBT, and those who, also, or instead, feel that psychodynamic work cannot be helpful in a short-term, once-a-week, setting, whether practiced by psychoanalytic psychotherapists or other clinicians without that particular specialist training.

Since we work in a clinically diverse environment, and with patients from differing backgrounds, the psychodynamic ‘mini team’ has, for a number of years, been examining our model of working and looking for models of brief psychodynamic work that have an evidence base and that will help us to work effectively with our patients in our particular context. We have thus been considering the different short-term psychodynamic therapy models, looking for something that would address our needs and those of the patients within our service.

In 2008, with fortuitous good timing, we heard about Dynamic Interpersonal Therapy [DIT] (Lemma, Target, & Fonagy, in preparation {a}). The DIT team were looking for a group of clinicians to pilot their new protocol, and we were very interested in developing our skills in a form of structured brief psychodynamic therapy. We were pleased that DIT was explicitly addressing outcome research and building an evidence base for psychodynamic work in the NHS and we were interested to see how this model would fare if tested using the same measures used to evaluate treatment outcomes in an IAPT service.

We received three days of training in DIT in January 2009 and agreed to pilot the approach within our service. We each started off using the approach with one (later, two or three) of our patients, taken from the waiting list without pre-selection, unless there was a specific reason to exclude them.

We had weekly group supervision with one of the DIT team. At the first appointment we administered the IAPT minimum data set (PHQ-9 for depression, GAD-7 for anxiety symptoms, Work and Social Adjustment Scale [WSAS]), and at each session thereafter we administered the PHQ-9 and GAD-7. The DIT team added a self-description of attachment style. At the final appointment the whole battery was administered, with the addition of a more qualitative assessment questionnaire compiled by ourselves. The weekly questionnaires took 10 minutes to complete for the first and last sessions, and five minutes in the session for the weekly measures.

Towards the end of our pilot study we were delighted when DIT was granted a tender to be included as an IAPT intervention, which paves the way for a randomized controlled trial, which, if successful, offers the hope of DIT being included as a treatment for depression in the NICE guidelines.
What is DIT?2

DIT is a brief (16 sessions), manualized, focused psychodynamic intervention for depression. It formulates the symptoms of depression as responses to interpersonal difficulties which pose threats to the attachment system and thus also to the self. DIT incorporates object relations theory, attachment theory and the theory of mentalization.

The DIT intervention is centred round a focused interpersonal formulation (the Interpersonal Affective Focus or IPAF) which combines a central representation of self in relation to an object representation and linked by a particular affect. DIT works with the unconscious and utilizes the transference as a central aspect of treatment. The focus during a DIT intervention is on the patient’s mind in relation to self and others, rather than his or her behaviour.

DIT differs from a traditional psychodynamic psychotherapy approach in being time limited and specifically focused. Furthermore, the therapist adopts a fairly active stance, combining interpretations of unconscious content (unconscious content which is accessible enough to a patient that they are able to hear, absorb and use such an interpretation within a brief therapy), supportive comments and sometimes directive interventions (such as suggesting that a patient try something different between appointments). Although reference may be made to historical events, DIT has a determined here-and-now focus.

DIT is divided into three distinct phases of work (initial, middle, end), each with defined aims and strategies. The beginning stage focuses on engagement and formulating an interpersonal focus. The middle phase has the aim of working through the mutually agreed, interpersonal focal area in relation to the patient’s presenting difficulties. The final phase of a DIT intervention involves enabling the patient to explore conflicts related to loss and separation, as well as reviewing what has been achieved and planning for the future. An important component of the end phase is the end of therapy letter – a summary of the IPAF, of progress made and of areas which may need further work (further detail on DIT may be obtained from the the DIT manual, Lemma et al., in preparation {a}).

How does DIT differ from other brief psychodynamic approaches?
The team who developed DIT explicitly acknowledge that DIT makes no claims to being a new therapy as such, but that it draws upon aspects of other brief dynamic models, especially those that have an evidence base (Lemma, Target, & Fonagy, [in this issue]). DIT therefore reflects the findings of the competency framework (Lemma, Roth, & Pilling, 2008). DIT also has a focus on addressing depression and the dynamic aspects incorporated in DIT specifically address depressive phenomena.

Despite being a composite model which openly utilizes aspects of other brief dynamic models, DIT also deviates from aspects of some brief models. Messner and Warren (1995) describe two broad models of brief psychodynamic psychotherapy: the drive/structural model (Coughlin Della Selva, 1996; Davanloo,
Who might not be suitable for DIT?

A number of factors guided our decision as to whether or not someone would be suitable for DIT. Level of disturbance was one of them, although we tried the model with some patients who were more disturbed and they were able to use the help offered and manage the ending. One key deciding factor was whether we thought the patient would be able manage an ending which, due to the brief nature of the work, is introduced after only a few sessions.

We also found that it was advisable not to pursue DIT work with patients who are struggling with some of the following difficulties: current high levels of instability (homelessness, severe current substance abuse); evidence of a significant difficulty in using help; an attachment history with multiple separations and losses and indications of a severe personality disorder. Patients with these difficulties were offered more supportive work (e.g. IPT or CBT) or referred on for longer-term psychotherapy. Several patients were referred on to NHS or private psychotherapy after their DIT sessions, and rather than this being a sign of the weakness of the model, we understood it to be a sign of its efficacy in engaging some patients in taking their difficulties in relating seriously enough to recognize their need for a substantial amount of further help.

What was it like for us to use DIT in our clinical NHS work?

In many ways, the DIT approach was familiar to us, utilizing concepts that we had been using in our work previously – such as object relations and attachment theory. Having, over the years, found ways to adapt a psychodynamic approach to short-term work, we were all very conscious of the need for a focus. What DIT really helped us with was in focusing the focus – having some way to think in a structured and theoretical way about the direction of our interventions. It highlighted to us how easy it is, confronted with the many facets of a patient’s difficulties and complex history, to fail to use the limited number of sessions to address one focus which would make a difference in the short time available. What we liked about the DIT approach was the way in which we were encouraged to spend the first part of the therapeutic encounter working really hard to find the right formula and words, which would become the central focus of the therapy – the IPAF. As well as the account of the distress the patient brings, and the details of
their history, the fundamental relational tool at our disposal, that is, understanding how the relationship between ourselves and the patient was being perceived and used, was an important part of developing and working through the IPAF.

Working within the NHS context, many of us had, for years, been using techniques and approaches that we were perhaps rather reluctant to acknowledge to our psychodynamic colleagues working in longer term or private settings. DIT provided us with permission to be directive sometimes, supportive at others and active in the room.

**Using outcome measures**

Our pilot study included the administration of IAPT outcome measures at every session. Our experience of using the IAPT minimum data set was itself interesting. Our initial concern, like that of many psychodynamically-inclined practitioners who are concerned with the therapeutic relationship, was that it may be compromising to this relationship. What we found, however, was that, used sensitively, the measures could be woven into an attuned relational context. Most but not all the patients could see their value (see below).

We found it informative to track the scores over the course of our work with individual patients, noticing that scores on the PHQ 9 and GAD 7 tended to rise around breaks from the therapy – something that any clinician working in the context of the transference relationship would expect. Furthermore, we noticed that scores seemed to drop quite significantly within the first one to three appointments, as patients felt listened to and that their problems were being taken seriously. Frequently, however, scores then rose again as difficult issues were tackled and patients had to surrender their fantasy of a magical solution. This was usually followed by improvements and then frequently a rise in scores again as the ending of therapy was confronted.

The majority of the patients in the pilot study made clinically and statistically significant improvement on measures of depression and anxiety (Lemma, Target, & Fonagy, this issue and in press). A small percentage did not improve dramatically, as measured by the questionnaires. This was not a great surprise to us – in any therapy work, the definition of a good outcome or a helpful piece of work with a patient depends on the patient you are working with. Sometimes in primary care what we are doing is giving people the first experience of being with someone who is trying to work with them to see if together they can understand that person’s experience and begin to help them to change. Some patients may use the sessions to show the therapist that no one can help and the task here would be to help them see what they do when anyone tries to help them and that they may need help with this destructive problem. For some, the level of complexity may mean that 16 sessions is not going to shift their depression or anxiety a great deal, but it may help them to begin to see the extent of their problem and enable them to pursue and make use of help in the future. For some patients we may have failed to find the right focus or the right words to describe an important aspect of the patient’s relational context in the
IPAF. We may also, for many possible reasons, not have understood adequately what the patient was communicating to us session by session and/or not responded in ways most useful or digestible to the patient. In relation to those patients whose scores did not improve with a DIT intervention, further research is needed to clarify the limitations of DIT and which type of patients are likely to not experience symptom relief (although they may feel helped) from this particular brief model.

We felt at times that there was a discrepancy between what our patients were telling us and what they wrote on the questionnaires. In calls for standardized screening tools and outcome measures this discrepancy has been described as reflecting our patients’ wish to please us, with the implication that the scores on standardized questionnaires are a more accurate picture of therapeutic outcome than a patient’s reported subjective experience. This may, indeed, be the case in some situations but our clinical experience tells us that it is not always the case and that standardized questionnaires simply cannot capture the complexity of human process. This is not to say that we should not use them, but simply that we should broaden our perspective and listen on multiple levels. Some of our patients, for example, requested that they mark half points on the questionnaires as they felt frustrated by the fact that the given categories did not capture their experience. In our qualitative questionnaire at the end of treatment we asked our patients how they had found completing the questionnaires at the beginning of every appointment. Figure 1 gives some of the comments made on this questionnaire.

We had experiences also of the questionnaires alerting us and our patients to important interpersonal dynamics. One patient came in one week and marked many of the questions with zero. On handing the questionnaire to the therapist she commented that she had been thinking how reluctant she is to commit to extreme scores, particularly those that suggest improvement. This insight matched a central aspect of the formulation and enabled us to elaborate on her interactions with others.

The ‘goodbye’ letter

Some of us had realized the value in brief work, used by CBT and CAT, of providing written documents for patients to use as part of the therapy which the patient can access, like a transitional object (Winnicott, 1953) between sessions or after the end of therapy. A central aspect of the DIT model in the ending phase,

- I found it quite frustrating … it didn’t feel that they adequately assessed my experience
- The categories weren’t specific or clear enough
- It was a helpful way of summing up the week
- Helpful to be able to assess a pattern over time, but I’m not sure it’s helpful to focus too much on any of the detail
- They are by definition limited in their applicability

Figure 1. Feedback on use of IAPT questionnaires.
which to those of us unfamiliar with CAT and CBT work, felt different at first, involves writing a letter to the patient summarizing the focus/formulation, the progress made, as well as areas that may need further work.

Almost all of our patients responded positively to this letter. One patient reported ‘reading it 20 times’ on the weekend after receiving it, and another, who was travelling overseas for an extended period, expressed how reassured she felt to be taking it with her. Our feeling was that the letter functions as a way for both patient and therapist to consolidate the often quite complex work covered over a fairly limited time. Like a transitional object (Winnicott, 1953) it appears to give patients a bridge between being helped and helping themselves. As therapists, we all found that writing the letter helped us to think clearly about what we had achieved with our patients and what further work, if any, we would recommend.

Outcomes of the pilot study
Overall we saw 16 patients, but as this was a feasibility pilot study, the sample is too small to draw any firm conclusions. The majority of the patients showed a statistically significant improvement on the PHQ-9 and GAD-7, but a slight deterioration in symptoms towards the ending phase was also noted (Lemma, Target, & Fonagy, in press). It remains unclear whether this finding implies a weakness in the DIT model or whether it is a predictable outcome based upon the centrality of attachment and separation that underlies the DIT model.

Using the IAPT measures to investigate outcome in this study also raises the question of whether variations in outcome as indicated by these measures reflects limitations of the DIT protocol, or whether it reflects on the limitations of measuring outcome using these two particular screening tools (PHQ-9 and GAD-7). Within our broader IAPT service, we have noticed that low scores on these measures do not always predict the level of subjective suffering, interpersonal difficulty or level of disturbance. We have also become aware that some patients will make progress in ways that are not adequately captured by the IAPT minimum data set. Others may have the subjective experience of having improved significantly while their scores on questionnaires do not reflect this change. Some patients may show progress on the questionnaires, but not move out of ‘caseness’ as defined by IAPT. These will always be issues in using measures on large numbers of patients in a diverse setting, and one way to address it may be to use a wider range of measures which might provide more sensitive data. On the other hand, there is sometimes virtue in simplicity, and the use of the IAPT minimum data set did allow us to integrate the outcomes from the DIT pilot seamlessly into the data from the rest of the service, and, perhaps at a later stage, even compare it with outcomes from other modalities.

Patient feedback
In addition to the ‘hard’ data captured in the IAPT measures, patients completed qualitative feedback questionnaires where we asked a range of questions about
how the therapy had helped them. Figure 2 shows some of the comments provided on these questionnaires.

What is gratifying about this feedback is the level of interpersonal development and improvement.

- I got a better understanding of me as a person and why I feel as I do. I thought I did understand my problem, but I didn’t
- I am more open in my relationships
- I am more accepting of my negative feelings
- I feel I am more in the real world now. I feel more realistic, I feel I am having a real honest relationship with … [my partner] which is the first time I have ever had that. I’m accepting the wide range of emotions that make up a real relationship.
- My relationships with people have improved – I am more open with others
- I have more positive views of myself
- I am more willing to be noticed by others

Figure 2. Comments from feedback questionnaires.

Clinical examples

Below are two case studies to illustrate our use of the IPAF and the way in which this central focus shapes the clinical work.

Nazma

Nazma is a 34-year-old woman who was referred by her GP to primary care psychology for help with recurrent feelings of depression. She is married and works for a publishing company. Nazma describes growing up in a family in which love was expressed as criticism and Nazma had little sense of her stories and achievements being noticed and celebrated. She described herself as being ‘closed’ and not revealing herself emotionally. She felt that she did not fit in to her social group as a child, and was not helped to do so by her parents. Nazma described the trigger for her current depressive episode as based on feeling criticized by a colleague.

In the initial stages of the therapy, an IPAF was agreed upon as follows: in her relationships she typically felt herself to be undesirable in relation to an object experienced as depriving. The activation, in her mind, of this pattern left her feeling very angry. She protected herself by keeping others at a distance both physically and emotionally. For example, Nazma was able to recognize, in the second session, that she had avoided talking about feelings in the initial session, and had presented the therapist with a series of ‘facts’.

Nazma’s defensive barriers against relating, and the way in which these linked with the self-object representation outlined in the IPAF, were explored in the transference. For example, in the second session, Nazma told the therapist how
anxious she had felt coming to her session and how unsettled she had felt after her first appointment. The therapist explored with Nazma how hard it was for her to be in the room with another person who was truly focused on her – who was not depriving her and was not treating her as, in some way, undesirable. During a silence in the initial stages of the therapy, Nazma became distressed and the therapist helped her to look at her conviction that the therapist was having negative thoughts about her, rather than thinking about her with interest and a wish to help her.

The middle stages of the therapy focused upon the ways in which the barriers that Nazma established between self and other functioned both to deprive self and other. For instance, in exploring an incident in which she had felt criticized at work, it was noticed how she failed to hear or acknowledge positive feedback, thus depriving herself of hearing good things from others. It also became evident that she could be her own worst critic, thus treating herself as undesirable and depriving herself of the right to a positive sense of herself. Over time, Nazma started to notice that she herself could be very critical of others and deprive them of praise. This was apparent in the transference: Nazma started a session in the middle phase of therapy by saying that she had been thinking how reluctant she was to score zero on the IAPT minimum data set questionnaires (PHQ-9 and GAD-7) and she was able then to think about how she deprived the therapist of feeling that she was helping Nazma.

Over the course of therapy, Nazma was able to start to acknowledge some feelings of closeness with the therapist. She also reported being more emotionally open with others, particularly her husband and a close friend. She noticed that this made her feel closer to others and that she was spending more time interacting with them. In small ways, she started to allow herself to be more noticeable to others by, for example, wearing an item of jewellery that drew compliments from colleagues. Nazma’s scores on the PHQ-9 and the GAD 7 reduced significantly over the course of therapy.

Grace

Grace had first come to see the therapist some years prior to the most recent contact, when she had separated from a ‘boring, uncommunicative’ husband she had married in haste in her early twenties, mostly to get out of her overcrowded family home. She had decided to go back to him because of her three children, and because it would please her father. She had another child, who was the symbol of the family reuniting.

Six years later, prompted by the tragic death of her youngest child, Grace asked to see the same therapist again. At the time she was struggling with this loss and she also wanted help with re-bonding with her older children and her husband, as over the months of the youngest child’s illness, Grace had spent a lot of time in hospital. It also emerged that during the period of her bereavement, she felt cut off from her husband, and had fantasies of finding another, perfect, relationship in which there would be continual closeness, excitement and love. These fantasies made her feel very guilty.
The key distress in the first session was guilt around the fantasy of a perfect love outside the boring family, and the patient had gone as far as telephoning an old boyfriend to see if the old excitement could be rekindled. It was hard to follow her narrative, and the therapist felt herself losing track of people, family members and most particularly of the dead child and the living children. The struggle to get some focus in the assessment sessions became the focus itself, and Grace agreed with palpable relief, that she wanted to find a focus.

When Grace was very young her family had moved to the UK. Her mother both worked very hard to help to support the family, and had had several children in rapid succession. Consequently, Grace, as the eldest, had, in a sense, ‘lost’ her parents’ attention very young. Squabbling with her siblings and vying with them for approval from her parents emerged as more important than attending to her own children. The family of origin operated towards each other with total indifference to any boundary shift that might have been created by marriages, in-laws, children, jobs: they expected instant attention from each other, and any request for a chore/favour/lift or shopping from a sibling or parent was immediately responded to, while spouses and children were left in second place.

This excited over-responsiveness to demands covered up knowing that they all felt that there was not enough, and that they were in competition with each other for what little there was. The constant push and pull was exhausting. The children then experienced demanding and withholding parents in their turn.

An angry neediness coloured all Grace’s relationships, with her children often getting to see her drained and irritable, reluctant to pay attention. In a paradoxical way, her youngest child’s illness and hospitalization gave Grace the first experience of really spending time with, and caring for, one person in her family, with real devotion. Inevitably, he was idealized as the perfect child. After his unexpected death, she retreated defensively into longing for a perfect ‘other’ – not her tired, hard-working, taciturn husband, or her sad, needy children – to fill up the emptiness of the void now left.

The IPAF that was eventually agreed centred on a self-representation as an eternally needy and ‘un-fillable’ child, relating to another perceived as demanding and withholding. It was challenging, however, to help her to stay focused on this: her characteristic over-activity and excitement were ways of not thinking about the linking affect, which was her fear of being left out, and anger at being made to feel thus afraid.

Her fear of being left out and not kept in mind was also immediately manifest in the transference: in spite of a six-year gap in the therapy she resumed in the first session as if there had not been any gap to the current sessions. When this was explored with her it became clearer that to acknowledge separateness would mean a terrifying confrontation with a withholding other and her insatiable need.

In the 16 sessions, Grace worked really hard to think about what it would mean for her to relinquish her longing for excited and competitive relating, and focus instead on the more mundane and painful aspects of relating to her real family, and, in the transference, to her real and disappointing therapist. Abandoning the
fantasy relationship with the therapist, and facing the limits of what was really available to her (e.g. 16 sessions was not very long, but at least it was something real and available to her) allowed her to be both desperately sad about the very tragic loss of her child, and to engage with new energy with the children who were alive. She could be angry about what she did not and could not have, but was also now able to imagine that people could be angry with her in turn.

Grace made significant moves forward in her capacity to test out the creative possibilities of living within the boundaries of her real life. The youngest children, who had had a parent each in their bed at night since their brother was ill, went back to their own beds, and the parents came together in theirs. She put together a memory box for her dead son, and allowed the other children to have ‘his’ space in the cupboards. She spoke to the children about their loss, and refused extended family requests so as to be able to take them to and from school herself, so that she could be more in touch with the details of their lives. She found to her delight that her sisters and parents grumbled but didn’t cast her out. She started studying again when the children were at school and was able to enjoy the novel experience of being alone with herself.

Unsurprisingly, given the IPAF, ending the 16 sessions was difficult. Her scores on the anxiety and depression scales, which had come down substantially over the sessions, went up again in the last two sessions. She was upset, cross, anxious about regressing again and came late to two of the last four sessions. She found it hard to tell the therapist how upset she was at losing her again, but seemed to actually enjoy ‘getting it off her chest’ when she tried. Her progress in what she called ‘focusing’ on her family and her own life, acknowledging her own resources rather than looking out for something tantalizing from a fantasy other, really pleased her.

When completing the outcome measures she initially almost ignored them, talking as soon as she entered the room, sitting down to fill them in and becoming distracted by a particular question and going off with a story about what a neighbour or sibling had said to her that week. Helping her to focus on them as a task was part of helping her to notice how hard she found it to focus on any one strand of thought. However, Grace did start to get curious about what they showed about her changing mental state.

At the end of the therapy she found it helpful to get a letter, and said that she would keep it to read again. More than questionnaires and letters, however, what DIT offered in contrast to the period of therapy she had received six years earlier, was the IPAF – a lens through which all other therapy material could be brought into focus. This was particularly helpful for Grace; and was experienced as very helpful by the therapist too.

Does DIT offer a focus for short-term psychodynamic therapy on the NHS?
We make no claim that DIT is the only short-term psychodynamic therapy that works, or that it is the most effective. We found, however, that it is effective, in
the outcome terms suggested by IAPT, as a treatment for depression and as an alternative to CBT and IPT.

We appreciate the help it provides us with in focusing brief psychodynamic work in the NHS context and the way in which it gives us a structure which ‘fitted’ with the work we were already doing. The weekly supervision with a highly skilled clinician was appreciated during the pilot phase, but in subsequent months a peer supervision group with monthly external input has been sufficient. DIT gives us a common language to describe the focus of our work in supervision.

Furthermore, in a climate where the discourse of outcome and clinical effectiveness runs alongside that of theoretical understanding, it was satisfying to be part of a project speaking both discourses and starting to show that a brief psychodynamic way of working can hold its own amongst the other brief therapeutic approaches.

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Notes

1. The cognitive behavioural evidence base underlying IAPT is based upon randomized controlled trials (RCT) in which the patient sample to be studied is carefully chosen to exclude the complicating variables which are so familiar to clinicians in a public health care setting. This introduces the debate of whether the result a therapy achieves in a clinical trial can adequately predict the result a therapy achieves in routine clinical practice (the effectiveness/efficacy debate) (Roth & Fonagy, 2005). This debate and its implications are beyond the scope of this paper. It is included here to introduce recognition of critiques of RCTs as the only way to indicate that a particular therapy approach is clinically useful and effective.

2. This paper provides a deliberately brief description of DIT, as the model is fully described in the paper by Lemma, Target, and Fonagy (in this issue).

3. All clinical case material has been anonymized and identifying information disguised and/or consent has been granted to use anonymized case material.

References


 Lemma, A., Target, M., & Fonagy, P. (in press {b}). *The development and pilot evaluation of a brief psychodynamic therapy (Dynamic Interpersonal Therapy) for depression*. Psychiatry: Interpersonal and Biological Processes.


