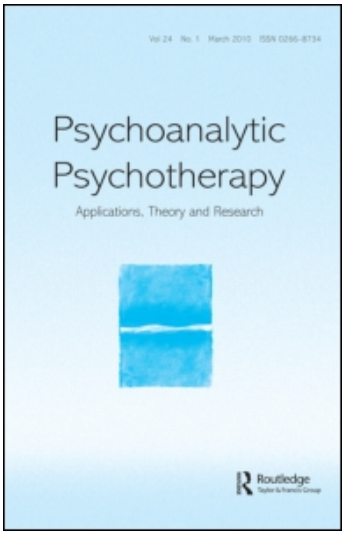

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The development of a brief psychodynamic protocol for depression: Dynamic Interpersonal Therapy (DIT)

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This paper outlines the development of a manualized, brief (16-session) psychodynamic intervention – Dynamic Interpersonal Therapy (DIT)[1] – for the treatment of depression. DIT is based on a distillation of the evidence-based brief psychoanalytic/psychodynamic treatments pooled together from manualized approaches that were reviewed as part of the competence framework for psychological therapies first commissioned by Skills for Health. DIT has now been selected as the brief psychodynamic protocol that will be provided nationally in the UK as part of the IAPT programme. This paper will first describe the methodology underpinning the competence framework followed by an overview of the model, its relevance to depression, and finally its strategies and techniques.

Keywords: depression; brief psychodynamic therapy; dynamic interpersonal therapy; competences framework; IAPT; primary care

'Depression', a patient said, 'feels like wearing a beautifully embroidered black veil. I know I can't see things clearly through it, but I don't know that I could reveal myself to the world without it'. 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.

Depression is both a common and often complex condition that typically manifests early in life: 40% of depressed people experience a first episode by the age of 20 years (Eaton et al., 2008). It interferes with social and occupational functioning, it is associated with considerable morbidity and carries a significant risk of mortality through suicide (Ustun, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004). Incomplete recovery and relapse are all too common. Following the first episode of major depression, people will go on to have at least one more episode (Kupfer, 1991) and the risk of further relapse rises sharply to 70% and 90% after the second and third episodes, respectively (Kupfer, 1991).

Its aetiology is not fully understood, but is likely to be over-determined by psychological, social and biological processes (Fonagy, 2010; Goldberg, 2009;

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Malhi et al., 2009; Taylor, 2009). It is also common for depressed people to have a co-morbid psychiatric diagnosis (e.g. anxiety, various personality disorders) (Kessler et al., 2003; Moffitt et al., 2007). Patients meeting criteria for a major depressive disorder are nine times more likely than chance to meet criteria for other conditions (Angst & Dobler-Mikola, 1985). Some 50%–90% of patients with Axis I conditions also meet criteria for other Axis I or Axis II conditions (Westen, Novotny, & Thompson-Brenner, 2004).

Alongside the evident complexity of depression, an apparently simplistic approach has prevailed at the level of service provision within the public health sector where the current emphasis on evidence-based practice has privileged CBT as the treatment of choice for depression. This 'one size fits all' approach to treatment has strongly marginalized psychoanalytic interventions. The superiority of CBT in this respect has been rightly questioned, not because it is not helpful to many depressed patients, as it evidently is, but because it is not helpful to *all* depressed patients. RCTs show that, as with all available treatments, a substantial minority of patients do not benefit sufficiently (around 50% responding adequately across treatments, with half of those losing gains over the following year, e.g. Roth & Fonagy, 2005). No single treatment has the answer for everybody and a variety of approaches with some evidence of effectiveness should continue to be available.

Several publications have focused on the effectiveness of psychoanalytic approaches for depressed patients and have criticized the hegemony of CBT in this respect (Gabbard, Gunderson, & Fonagy, 2004; Leichsenring, Rabung, & Leibing, 2004; Abbas et al., 2006). Even so, the all too frequent conflation of an under-developed evidence base for psychoanalytic interventions with a 'weak' treatment prevails in the minds of those commissioning services. We will not rehearse these tensions here. Moreover, this external context is slowly showing signs of some change: in the UK, the Improving Access to Psychological Therapies Programme, has now committed itself to an expansion in the range of psychological interventions on offer to patients beyond just CBT. This will now include DIT.

The culture of evidence-based practice may be felt to be the 'enemy', as it were, of psychoanalytic practice, but as well as posing a 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 competencies 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 this work. Before describing the model itself, and its relevance specifically for depressed patients, we will therefore briefly outline the competence framework that underpins the development of DIT. This paper is not clinical in its emphasis as this is covered by Gelman et al. (this issue), who describe their experience of implementing the model in their service.

The rationale for developing DIT

The Improving Access to Psychological Therapies (IAPT) programme in the UK, which was launched in May 2007 (Department of Health, 2007), provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies. The CBT competence model was specifically developed to be a 'prototype' for articulating the competences associated with other psychological therapies (Roth & Pilling, 2008). The Psychoanalytic/dynamic Competences Framework (Lemma et al., 2008),[2] which followed, describes a model of psychoanalytic/psychodynamic competences based on empirical evidence of efficacy. It indicates the various areas of activity that, taken together, represent what has been proven to be good clinical practice.

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 qualitative analysis provided the basis for the articulation of the core, specific and meta-competences required to practice psychoanalytic psychotherapy (Figure 1). 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 (Bateman, Brown, & Pedder, 2000; Etchegoyen, 1999; Greenson, 1967; Lemma, 2003).

Since research trials monitor therapist performance through audio or video recordings that are then rated, we can be assured that therapists in these trials adhered to the manual. This makes it possible to be reasonably confident that if procedures are 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.

The core techniques and strategies underpinning DIT reflect the competences found to characterize models of psychoanalytic psychotherapy which have been shown to be effective (Figure 1). In other words DIT is based on a distillation of the evidence-based brief psychoanalytic/psychodynamic treatments, pooled from the manualized approaches that were reviewed as part of this project. DIT deliberately uses methods taken from across the board of dynamic therapies and we would

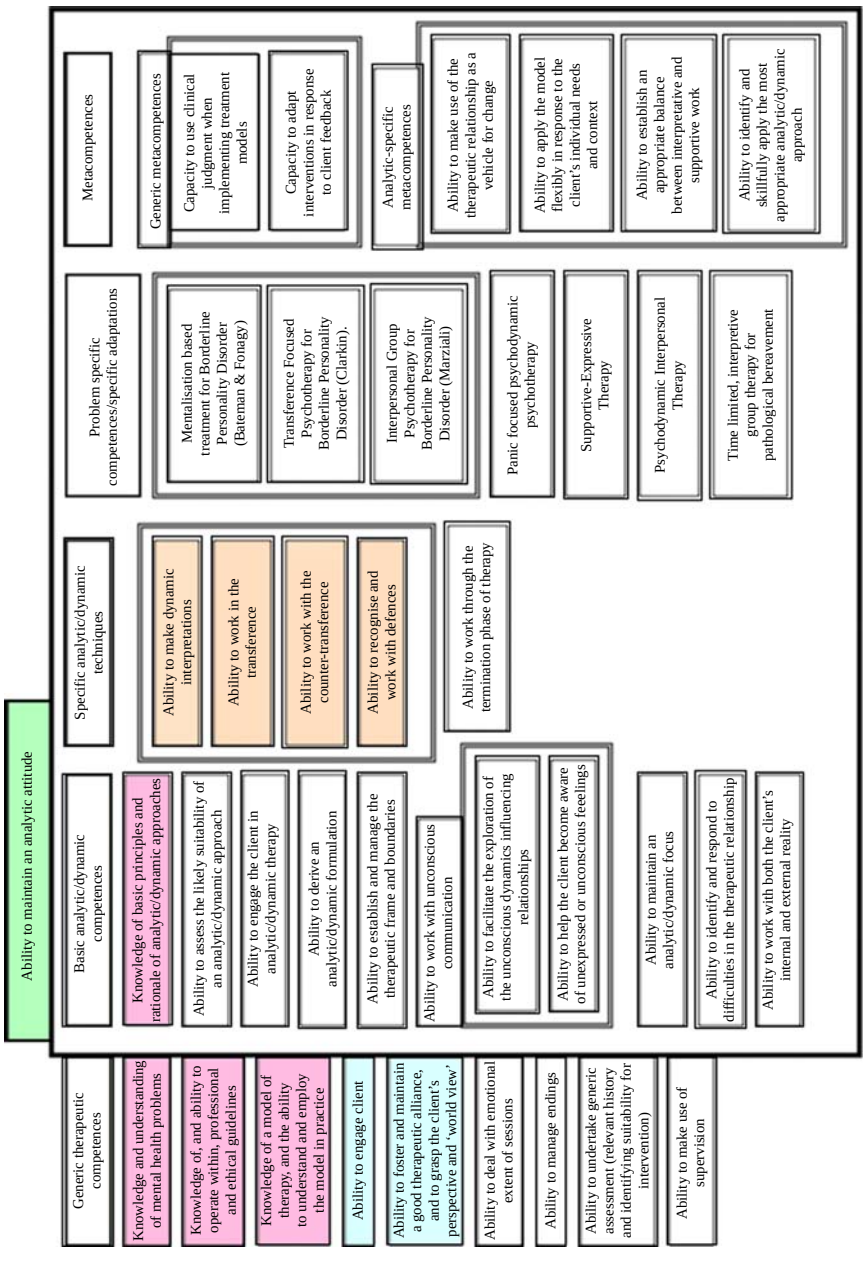

Figure 1. The map of psychoanalytic/dynamic competences

therefore expect those who have been involved in the development of other brief dynamic models to find many familiar strategies and techniques in DIT.

New wine in an old bottle?

We are short of neither psychodynamic protocols nor acronyms. In developing DIT (Lemma, Target, & Fonagy, In press) we did not wish to add to an already long list, and yet our experience as clinicians, trainers and researchers persuaded us that the competence framework provided an opportunity to develop a protocol that integrated core, shared analytic principles and techniques grounded in the extant evidence base, and that would thus carry some external or empirical credibility when applied with a specific focus on depression.

Keeping the training burden to a minimum was one of the guiding principles for the development of this protocol. The different 'versions' of brief psychodynamic therapy models that were examined as part of the development of the competence framework suggested that a variety of complex procedures are necessary to address the difficulties of specific patient populations, for example, borderline patients. However, many of these techniques, such as focusing primarily – even if not exclusively – on the transference relationship (e.g. Kernberg's Transference Focused Psychotherapy, Clarkin, Yeomans, & Kernberg, 2006), seemed too specialized for DIT. Nevertheless, the theories underpinning the manuals we consulted have greatly influenced the development and elaboration of the current protocol.

DIT was developed for pragmatic reasons so that clinicians with a psychoanalytic/dynamic psychotherapy or counselling training can readily acquire the specific priorities and competences associated with time-limited therapeutic work (defined as 16 sessions in this model). This is a protocol that we have successfully piloted 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. DIT was associated with a significant reduction in reported symptoms in all but one case, to below clinical levels in 70% of the patients (Lemma, Target, & Fonagy, In press).

Feedback from both therapists and patients involved in the pilot study (see Gelman et al., this issue) has contributed to further refinement of the protocol. A four-day training, followed by weekly supervision of two video or audiotaped cases, 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: (1) Identify an attachment-related problem with a specific relational emotional focus, that is felt by the patient to be currently making them feel depressed; (2) Work with the patient collaboratively to create an increasingly mentalized picture of interpersonal issues raised by the problem; (3) 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; (4) Ensure the therapeutic process (of change in self) is reflected on;

(5) Near the end of treatment present the client with a written summary of the collaboratively created view of the person and the selected area of unconscious conflict, for him to hold onto, to reduce the risk of relapse (known to be very likely in clinical depression). The clinicians involved in the pilot study demonstrated that these steps can be readily learned and applied by clinicians irrespective of the particular dynamic orientation of their original training.

Although the techniques and strategies used in DIT reflect the findings of the broad competence framework for psychoanalytic psychotherapy, an approach that failed to contextualize theoretically what the therapist is aiming to do and why would be very limited. Consequently we have 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, and which may give enough common ground to make the model of interest to psychoanalytic psychotherapists with a range of trainings; in particular we drew on attachment theory, object relations theory and Sullivan's interpersonal psychoanalysis.

Several core assumptions thus underpin DIT: (1) The social origins and nature of individual subjectivity; (2) The importance of attachments as the building blocks of the mind, and as the context for developing crucial social cognitive capacities; (3) The impact of internalized, unconscious 'self' and 'other' representations on current interpersonal functioning; (4) The importance of the capacity to mentalize experience without which the individual is more vulnerable to developmentally earlier modes of experiencing internal reality which, in turn, undermine the capacity to resolve interpersonal difficulties.

As with other brief psychodynamically-oriented approaches, in DIT the overarching principles are rooted in the broader psychoanalytic framework that emphasizes: (1) The impact of early childhood experiences on adult functioning, with particular attention to adult attachment processes and the significance of mental models of relationships; (2) The internal and external forces that shape the mind and therefore inform our perception of ourselves in relationships with others; (3) The existence of an unconscious realm of experience that is a motivating force; (4) The unconscious projective and introjective processes that underpin the subjective experience of relationships, and (5) 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.

Why DIT for depression?

DIT formulates the presenting symptoms of depression as responses to interpersonal difficulties/perceived threats to attachments (loss/separation) and hence also as threats to the self. DIT conceptualizes depression in terms of an underlying temporary disorganization of the attachment system caused by current relationship problems, which 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 and feelings

(conscious and unconscious) most characteristic of the particular patient, and relevant to his[3] depression, as these emerge in the context of the therapeutic relationship. Through the focused exploration of the transference relationship the patient is helped to develop a better understanding of his subjective reactions to threats. Making implicit anxieties and concerns explicit through improving the patient's ability to reflect on his own and other's thoughts and feelings, in turn enhances the patient's ability to cope with current attachment-related interpersonal threats and challenges.

DIT's starting point is rooted in the common clinical observation that patients who present as depressed invariably also present with difficulties and distress about their relationships. Although the patient may well experience his problem as 'I cannot sleep and concentrate' the DIT therapist reframes the symptoms of depression as a manifestation of a relational disturbance, which the patient cannot understand, or understands in a maladaptive way, attributing to himself and others motivations that are unlikely or unhelpful. Once the patient is helped to make some changes in the way he approaches his relationship difficulties, depressive symptoms are typically alleviated.

There are many features of depression that suggest that a dynamically-oriented approach focusing on interpersonal issues is likely to be effective in addressing symptoms of major depression. Interpersonal problems are marked in severe depression and evident even in mild or moderate depression (Luyten, Corveleyn, & Blatt, 2005), driven not only by the potential of depressed mood to elicit negative responses from others, but also by those with depression being inclined to select and generate interpersonal scenarios with the propensity to evoke distress, such as conflicted interactions leading to social exclusion and rejection (Kiesler, 1983; Lewinsohn, Mischel, Chaplin, & Barton, 1980).

The recent work of psychoanalytic researchers Sidney Blatt and Patrick Luyten demonstrates that not only is vulnerability to depression associated with the unconscious generation of interpersonal stress, but interpersonal factors explain much current data on the outcomes of treatments of depression (S.J. Blatt, Zuroff, Hawley, & Auerbach, In press; Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006). There is increasing agreement in the field that the interpersonal aspects of depression should be given comparable weight to the normally highlighted intrapersonal dimensions (Hammen, 2005).

While the literature on distorted information processing in depression largely speaks to distortions of conscious cognition in depressed individuals (Beck, Rush, Shaw, & Emery, 1979; Kyte & Goodyer, 2008) some concepts in this literature, such as the dominance of a hopeless, helpless attributional style (Abramson, Seligman, & Teasdale, 1978) echo classical psychoanalytic writings which link these observations to unconscious projective and introjective processes (Engel & Schmale, 1967).

DIT as an approach specifically alights on apparent dysfunctions in interpersonal cognition concerned with an individual's distorted and inadequate understanding of others' thoughts and feelings (that is, mentalization). The focus

of DIT on mentalization is consistent with recently-accumulating data demonstrating Theory of Mind deficits in patients with unipolar and bipolar depressive disorders (Y. Inoue, Tonooka, Yamada, & Kanba, 2004; Y. Inoue, Yamada, & Kanba, 2006; Kerr, Dunbar, & Bentall, 2003; L. Lee, Harkness, Sabbagh, & Jacobson, 2005; Montag et al., In press).

Measures of mentalizing in the attachment context also yield indications of a deficit associated with depression (Fischer-Kern et al., 2008; Fonagy et al., 1996; Müller, Kaufhold, Overbeck, & Grabhorn, 2006). This is important as DIT assumes failures of self and other understanding in depression to be strongly tied to particular self-other interaction patterns evolved from childhood experiences, real or fantasized (see section below on the Interpersonal Affective Focus).

DIT has a dual focus on interpersonal and affective issues. The affective issues of greatest relevance centre on attachment related concerns. Insecurely attached individuals are more likely to have more frequent depressive episodes, residual symptoms, use more pharmacotherapy and to be impaired in their social functioning (Conradi & de Jonge, 2009).

There is a substantial body of work linking vulnerability to depression to insecure attachment (Bifulco, Moran, Ball, & Bernazzani, 2002; Bifulco, Moran, Ball, & Lillie, 2002; Grunebaum et al., In press; A. Lee & Hankin, 2009). Blatt's theory of depression identifies two classes of attachment history-based cognitive-affective schemata most likely to be found in depression: interpersonal dependency and excessive self-criticism (Blatt, 2008; Blatt & Luyten, 2009) linked to preoccupied and avoidant patterns of attachment, respectively (Blatt & Luyten, 2009).

For decades, evidence has been accumulating linking childhood adversity, likely to disrupt attachment, to adult vulnerability for depression (Brown & Harris, 1978, 1989). The association is increasingly well understood in terms of the effects of attachment experiences on the stress system (Heim, Newport, Mletzko, Miller, & Nemeroff, 2008) and the moderation of the impact of later stressful experiences by acquiring a secure state of mind in relation to attachment history (Bakermans-Kranenburg, Van Ijzendoorn, Mesman, Alink, & Juffer, 2008).

Attachment experiences also link mentalizing and depression (Heim et al., 2008; Luyten, Mayes, Fonagy, & Van Houdenhove, 2009). A reduced capacity to think about mental states may be related to personal histories (e.g. trauma) but may also be a secondary consequence of disordered mood (Luyten & Fonagy, In press). Indications of a failure of mentalizing are not hard to find. There is a re-emergence of a pre-reflective, physical self-experience in place of a psychological self-experience (Fonagy & Target, 2000). Psychological experience is felt to be far too real, with a common equation between psychological and physical pain and emotional and physical exhaustion (Van Houdenhove & Luyten, 2008). A state of 'hyperembodiment' ensues, in which subjective experiences are primarily felt to be physical in nature. Worries can feel like genuine weights on one's shoulders, and the criticism of others threatens the sense of integrity of the embodied self. The therapeutic task is the elaboration of the psychological nature of the state that is felt to compress the body

rather than being available for consideration and reappraisal as a belief or a thought. The lack of drive, which is at the heart of depression, is similarly seen as a regressive embodiment of disempowering thought.

Similarly, the intensity of worries about the future, and the overpowering nature of self-blame associated with past experience, imply an underlying loss of symbolic perspective, where thought gains inappropriate, concrete strength by being awarded the same status as physical reality. In the absence of a capacity to reflect on experience, self-questioning turns into an irresolvable and interminable persecutory attack upon the self-representation.

In the formulation of depression advanced in support of DIT, distortions of cognitions are considered indications of pseudo-mentalizing (also referred to as 'hypermentalizing'). Here the patient's description of the mental states of others or his own mental state reflects an apparent thoughtfulness, but this lacks some essential features of genuine mentalization; it is a partial understanding, containing some truth but is excessively detailed and often repetitive. Characteristics include a sense of certainty about mental states, including the unrealistic assumption that one can directly know someone else's mind, and limiting what is attributed to the other's mental state to ideas and themes that reinforce the individual's existing perspective, which however painful and self-destructive, is held on to for powerful unconscious reasons.

A genuine capacity to reflect on one's own experience should thus not be confused with hypermentalization, nor with rumination. Whereas rumination leads to exacerbations of depressive cognitions, effective self-reflection normally leads to lifting of depressed mood (Allen, Fonagy, & Bateman, 2008). This assumption is borne out by studies showing a distinction between reflection and brooding, with the former being related to improved mood, the latter with greater depression and suicidal ideation.

Core features of DIT

The DIT therapist has two aims: (1) to help the patient to understand the connection between his presenting symptoms and what is happening in his relationships by identifying a core, unconscious, repetitive pattern of relating that becomes the focus of the therapy; (2) to encourage the patient's capacity to reflect on his own states of mind and so enhance his ability to manage interpersonal difficulties. DIT primarily targets the capacity to think about and understand changes in mood symptoms and interpersonal functioning. It addresses character problems in a very limited way, and does not aim to go beyond those most clearly linked to the maintenance of depression.

This model, along with the majority of brief psychodynamic models, can be conceptualized as consisting of three phases: an engagement/assessment phase (sessions 1–4), a middle phase (sessions 5–12) and an ending phase (sessions 13–16), each one with its own distinctive strategies. The primary task of the initial phase, which organizes DIT's therapeutic thrust, then follows, which 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. We understand this pattern to be underpinned by a particular representation of self-in-relation-to-an-other that characterizes the patient's interpersonal style and that leads to difficulties in his relationships because it organizes interpersonal behaviour. These representations are typically linked to particular affect(s) and defensive manouevres. Affects are understood to be responses to the activation, in the patient's mind, of a specific self-other representation. Kernberg's (1980) integration of object relations theory with ego psychology in the theoretical frame of TFP (Clarkin et al., 2006) is very close to the heart of DIT's theoretical basis and way of formulating a focus for the intervention.

Past experiences, while clearly informing current functioning and internal object-relations, are not the major focus of DIT. 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 they are not a central component of the therapeutic process. Rather, given the brief nature of the therapy, the focus is on a core segment of the patients' interpersonal functioning that is closely connected with the presenting symptom(s). The therapist identifies the most important current and past relationships but does so with emphasis on the present. The relationships brought to the assessment are characterized according to considerations born of attachment theory primarily as a heuristic device. The therapist strives to establish the form of a relationship, the key processes employed in maintaining it, if it has changed over time, and how it relates to problems (e.g. makes depression worse).

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, and to try out new, more adaptive ways of resolving their interpersonal difficulties. 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 last four sessions (13–16) are devoted to helping the patient to explore the affective experience and unconscious meaning of ending the therapy, to review progress and to help him to anticipate future difficulties/vulnerabilities.

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.

First, 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 recognize 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. when I feel anxious I want to avoid being with you – missed last week's session – because I think you find me boring and hopeless).

Second, 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.

Third, 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 is that it approaches the exploration of problematic interpersonal patterns not by addressing the patient's behaviour, but through its consistent focus on the patient's 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 what we label the collaborative stance the DIT therapist must establish with her patient. 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, in the context of a problematic interpersonal relationship.

The DIT therapist is particularly interested in making explicit what has effectively become procedural 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. The aim is to review the experience related to the IPAF as much in the current moment as possible – what the patient feels right now. The patient's phenomenal experience is explored in the relational realm, not just the intrapersonal.

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, unambiguous account of how she has arrived at her understanding. The aim is to be as transparent as possible while 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 prioritizes 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 avoided in favour of the facilitation and 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. This is especially so at the start of the therapy because the aim is to engage the patient quickly and to actively support change in the first few sessions.

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, that is, 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 while also making judicious use of 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.

As 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 unverbalized 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 would be the case in any analytic therapy, the therapist will make judicious use of silence so as to allow the emergence of the patient's uninterrupted flow of associations and communications. However, given the brevity of the treatment, 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 are used during the middle phase of treatment. These techniques may well be less familiar to analytically trained therapists, since analytic approaches typically proscribe these more active interventions. In DIT, 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. They are considered to have a subtle structuring impact on the patient's perspective on his experience.

The way directive techniques are deployed in DIT is nevertheless framed in the context of a good understanding of the meaning that the therapist's 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 direction, 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 very attuned to the unconscious meaning that may be latent in the patient's wish to please the therapist and would actively take this up with the patient, linking it to the identified IPAF and the lack of progress in the therapy.

Working in the transference

Transference interpretations are used to support the aim of helping the patient to identify the implicit representations about himself and others that underpin his problematic interpersonal patterns (i.e. the IPAF). 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 to 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 (and vice versa).

In DIT the primary aim of a transference interpretation is not to arrive at an insight; rather the goal is to engage the patient in the process of making sense of how his mind works. Using what happens in the transference provides the most immediate way of doing this.

A transference interpretation begins by validating the patient's experience, that is, by accepting it as a legitimate response (e.g. when I reminded you that we only have five sessions left, you felt very abandoned). The therapist then works jointly with the patient to clarify and explore the transference feelings that have been evoked to elaborate the experience (e.g. is the patient perhaps disappointed AND angry?). If the therapist has somehow contributed to this experience through an enactment this needs exploration too. This is important because an important aspect of working in the transference is to model a capacity for reflecting on what happens in relationships, which involves acknowledging mistakes or misunderstandings. Finally, all this exploration allows the therapist and patient to arrive at an interpretation that pulls together all these different components.

By virtue of the brief nature of the therapy, transference interpretations are used in a more circumscribed manner than in longer-term analytic therapies. A transference interpretation is primarily made because it enhances the exploration of the IPAF, or when needed 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).

The use of outcome monitoring measures

Therapists are encouraged to administer measures at the start of each session (this is required in the IAPT context). Although this practice may be felt to be intrusive to the therapeutic process, this is typically an intrusion felt more acutely by the therapist than the patient. 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. For example, one patient reported significant improvement in the sessions, yet her scores on the questionnaires 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.

Conclusion

In this paper we have reviewed the methodology underpinning the development of a brief psychodynamic protocol for the treatment of depression. DIT is not a new approach; rather, it reflects our attempt to integrate the empirically-supported aspects of psychodynamic therapy into a coherent model that is relatively easy to acquire by professionals already trained in psychodynamic

therapy or counselling, and that can be delivered within a public health sector setting. Attachment theory provides an integrating theoretical, evidence-based framework and heuristic device, linking deficits in mentalization to the conceptual understanding of depression and its treatment.

The initial and very preliminary pilot study we carried out demonstrated that this model was easy to grasp and implement by clinicians who had not undergone an intensive analytic training, but who were experienced at offering once-weekly psychodynamic therapy in the NHS. The qualitative data obtained from the patients also suggested that the approach was felt to be congenial and relevant to their presenting concerns. The very small sample size and lack of any randomization do not permit us to draw any firm conclusions about DIT's effectiveness at this stage. A large scale RCT will be required to determine the value of this particular application of psychoanalytic ideas to the treatment of depression.

Notes

1. 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, & Pilling, 2008), which are quite different to the psychoanalytic competences required to deliver DIT.
2. The full list of competences can be accessed at www.ucl.ac.uk/CORE
3. For clarity and economy, the patient will be referred to as 'he'.

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