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To cite this article: Angela Douglas, Nicky Ablett-Tate & Nicola Chadd (2016) Dynamic interpersonal therapy in an NHS tertiary level specialist psychotherapy service, Psychoanalytic Psychotherapy, 30:3, 223-239, DOI: 10.1080/02668734.2016.1198415

To link to this article: http://dx.doi.org/10.1080/02668734.2016.1198415

Published online: 28 Sep 2016.
Dynamic interpersonal therapy in an NHS tertiary level specialist psychotherapy service

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(Received 4 March 2016; accepted 29 May 2016)

We describe the introduction of dynamic interpersonal psychotherapy (DIT) into an National Health Service (NHS) tertiary psychoanalytic specialist psychotherapy service. Training in DIT began as our contribution to Improving Access to Psychological Therapies and primary care services, supporting the training and supervision of their DIT practitioners. We then discovered DIT could be a valuable treatment within our own tertiary NHS service for patients with complex presentations. Currently fighting for survival, like many NHS psychoanalytic psychotherapy services nationally, we have adopted a manual-guided, psychoanalytically based therapy to broaden our tertiary clinical psychoanalytic service and accommodate trends in mental health service provision, whilst protecting the quality and integrity of our psychotherapy. DIT helped us continue providing relevant and beneficial psychoanalytic and psychodynamic services to individual patients despite limitations of the financially challenged NHS, NICE guidelines and Payment by Results. We outline the progress and outcomes for patients with complex mental health presentations, include individual case discussion and our experience of using the DIT approach within a traditionally longer term psychoanalytic psychotherapy service.

Keywords: dynamic interpersonal therapy; NHS tertiary service; NHS specialist psychotherapy service; psychodynamic psychotherapy; psychoanalytic psychotherapy; payment by results

The NHS specialist psychotherapy service

Tees, Esk & Wear Valleys NHS foundation trust specialist psychotherapy service (SPS) is a small multidisciplinary trust-wide team of nine part-time staff – clinical and counselling psychologists, adult psychotherapists and a medical psychotherapist, all trained and registered or in training in psychoanalytic and/or group analytic psychotherapies. We are based at two localities in the trust and provide individual and group psychoanalytic psychotherapy, supervision and training in psychodynamic and psychoanalytic approaches across the trust. We are one of several psychotherapy services established in adult mental health (AMH) following the psychotherapy review recommendations of the Department of Health.

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From 2004 this promised growth turned to cuts, particularly after the phased introduction of Improving Access to Psychological Therapies (IAPT) services after the Layard report (Layard, 2006). We are despondent about the future of psychoanalytic and psychodynamic psychotherapy in the National Health Service (NHS). Like many services, our main task has been retaining sufficient resources to continue to provide our service. This requires constant increase in productivity and efficiency and supportive management and organisational relationships. For commissioning we continually defend psychoanalytic psychotherapy’s poor representation in NICE guidelines, the National Institute for Health and Care Excellence guidance and quality standards for the delivery of healthcare in the United Kingdom (2016, https://www.nice.org.uk/about).

Our patients present with severe and enduring depression, anxiety, bipolar disorder and a range of personality disorders, some diagnosed, some not. We accept patients assignable to NHS Mental Health Clusters of 6, 7 or 8 for complexity and severity (Department of Health Mental Health Clustering Tool V3.0 2013) defined by the Payment by Results (PbR) system of the Department of Health (Department of Health, Mental Health Payment By Results Guidance for 2013/2014). PbR is the transparent rules-based payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs. The complexity is determined using the Mental Health Clustering Tool (Department of Health, 2013). The majority have already had one or more previous therapies, usually cognitive behavioural therapy (CBT), interpersonal therapy (IPT) or eye movement desensitisation and reprocessing (EMDR), and may have responded well but found that problems return and they need more than these therapies to equip them to deal with the underlying interpersonal relationship issues and unconscious factors. Others are identified as not being suitable for those therapies or have not responded to them in the past. Referrals are made by IAPT teams, secondary care access teams, primary care psychological services, affective disorders teams and other specialist, secondary and primary NHS services, occasionally GPs. This broad access to referrers ensures that patients do not have to experience repeated assessments at all stages of stepped care before referral to this service. The SPS service sits within the AMH directorate in this NHS trust and complies with the waiting list target, currently 4 weeks from initial referral to appointment. To ensure the service does not develop a waiting list, all referral enquiries are screened initially over the phone. Of those screened, we find that only 50–60% will need to engage in psychoanalytic and psychodynamic psychotherapy. We are a specialist service employing psychotherapists with substantial clinical and psychotherapeutic experience often the last stop for patients who have had other therapies or not benefitted from other treatments. They have not had the space to understand what in-depth psychodynamic or psychoanalytic psychotherapy entails. We offer up to six consultations to enable engaging in psychoanalytic therapy or to resolve previous therapeutic ending issues or grievance whilst aiming to avoid raising false hopes and repeating an experience of ineffective psychotherapy. SPS psychotherapists act as ‘lead professionals’ for their patients’ general mental healthcare, completing
Why introduce DIT into a tertiary psychotherapy service?

This was never the intention. We aimed to support the development of dynamic interpersonal psychotherapy (DIT) in local IAPT services, being inspired by the work of Lemma, Target, and Fonagy (2010) in introducing a manual-based protocol for the treatment of mild to moderate depression. Our local IAPT teams lacked staff with the requisite knowledge and skills in psychodynamic and psychoanalytic psychotherapy to undertake DIT training (see DIT website: http://www.d-i-t.org/about.php) The training requires evidence of a previous course of study of psychoanalytic theory underpinning psychodynamic psychotherapy, one year of personal psychodynamic/psychoanalytic psychotherapy, 150 h of supervised psychodynamic practice and current registration with one of the HCPC, BACP, BPC or UKCP registration bodies. Our local IAPT services wanted to be up to date with the range of evidence-based treatments for depression now being recommended, DIT being one. The solution was SPS staff training and providing the IAPT DIT service and supervising suitable IAPT DIT staff when they could be appointed. In 2011 all psychoanalytic psychotherapists offering individual psychotherapy in SPS agreed to train in DIT to enable this development. On the training course, we learned how Lemma and colleagues (Lemma, Target, & Fonagy, 2011) had already introduced this therapy protocol in NHS settings across London NHS Trusts, training therapists to implement it in IAPT services nationally (e.g. Gelman, McKay, & Marks, 2010; Wright & Abrahams, 2015). By 2015 all SPS individual psychoanalytic psychotherapists had trained in DIT to practitioner accreditation and three to supervisor level. In 2014 SPS began supervising two IAPT high intensity therapists training in DIT within the trust.

What is DIT?

DIT is a Department of Health approved brief psychotherapy (Department of Health, 2011), recommended as a talking treatment for depression within IAPT teams. It is a 16-session analytically based psychotherapy protocol that focuses upon the interpersonal narrative of the patient in the service of making sense of long-held disruptive relational patterns (Lemma et al., 2011). Designed specifically to treat depression and anxiety, it conceptualises such mood disorders as primarily relational in origin (Lemma et al., 2010). Whilst not excluding some sense of the patient’s history, it concentrates on the here and now and makes use of transference phenomena to facilitate the work. Developed by Lemma et al. (2010), the psychotherapist is an active proponent of the approach which addresses the unconscious mind of the patient at the level of a pre-conscious state of awareness. Patient and therapist develop an explicit statement of an ‘interpersonal affective
focus’ (IPAF) as part of the work. This encapsulates the patient’s sense of self and other and his or her affective state in relation to both elements. The IPAF is established, developed and explored throughout the initial, middle and ending phases which structure the work. It is the IPAF which is central to the DIT approach; it provides a clear focus for the course of the therapy and is unique to DIT within the context of short-term psychoanalytic and psychodynamic approaches. It provides a means of narrowing down the formulation and a signpost to support the therapeutic work ahead. But it is not rigid and can be reworked by therapist and patient during the early middle phase as needed. As the psychotherapy progresses in the middle phase, the affective focus becomes a powerful tool in recognising and working through the defensive structures maintaining the interpersonal dynamic of the IPAF. Patient and psychotherapist become allies in defining and exploring its conscious and unconscious territory.

All of this is ensconced in an atmosphere of curiosity; the therapist’s curiosity about the patient’s mind and the patient’s curiosity about their own mind in relation to themselves and others. The emphasis is upon mentalisation, a reflective process of thinking about one’s thoughts, memories and relational experiences. The therapist might use mentalisation-focused interventions to drive forward the patient’s capacity to understand psychological motives in their relationships, including that with their therapist.

A goodbye letter, produced at session 13 by the psychotherapist in discussion with the patient, allows some evaluation of the therapy and is designed to support the work of the ending. It represents a tool of the ending phase which can be used to facilitate a review of the work done and aid the working through of the patient’s approaching separation from the psychotherapist (Lemma et al., 2010).

Introducing DIT within SPS tertiary service provision

Unfortunately, establishing a specific DIT referral stream from IAPT for our own training proved impractical. We found some IAPT teams unable to refer patients they would normally treat with CBT, IPT or EMDR, instead referring cases to us that were identified as untreatable within IAPT because of complexity or severity. This and the need, as always, to explore ways of seeing more patients, led us to consider how to use DIT for our own patients, mindful of the need to protect their interests at all times, and determined not to sacrifice the quality and integrity of our psychotherapy service. DIT is specifically designed for depression and most of our patients had diagnoses that included depression. We doubted the value of introducing further short-term psychodynamic psychotherapy for the majority of SPS patients, given that most shorter term psychotherapies are not recommended for complex problems and diagnoses or enduring conditions, despite their good outcome evidence (Abbass et al., 2014). DIT is no exception. Studies such as those by Gelman et al. (2010) and Wright and Abrahams (2015) report good
outcomes for DIT in primary care and IAPT services, but we knew of none reporting DIT being used in tertiary services.

**Clinical outcomes for DIT in SPS**

The outcome data reported on is a clinical audit of our work, not research. We could not ethically impose research designs on our day-to-day service, e.g. randomised controlled samples, and would not have pursued using DIT, where it interfered with the usual anticipated progress of patients. We did not have resources to provide external data collection. We have simply begun collecting routine clinical outcome data, including DIT outcome measures used by services piloting DIT. Our pre- and post-measures include the CORE-OM (Clinical Outcomes in Routine Evaluation, Evans et al., 2000), used by other psychotherapy services, and the PHQ-9 depression measure (Patient Health Questionnaire-9, Kroenke, Spitzer, & Williams, 2001), GAD-7 (Generalised Anxiety Disorder-7, Spitzer, Kroenke, Williams, & Lowe, 2006) and Schwartz-10 general outcome measure (Blais et al., 1999), used by some primary care and IAPT services and recommended by DIT supervisors whilst we were training. Our session by session measures include the PHQ-9, GAD-7 and Schwartz-10. Choosing these measures allows our DIT results to be compared informally with DIT results in IAPT and primary care services as well as with other AMH psychotherapy services and other psychotherapies in this service. Apart from pre- and post-scores, which are collected anonymously in the waiting room, we have deliberately integrated the weekly session-by-session measures into the psychotherapy process to inform the interaction between therapist and patient and enable unconscious processes related to the data to be recognised and voiced. The service asks all patients to complete an anonymised open-ended end of therapy feedback questionnaire describing their therapeutic experience, including benefits and unhelpful aspects to capture more detailed patient feedback. These measures are not reported here as they require detailed qualitative analysis.

**Results – patient sample**

Results are reported for a sample of 28 patients, 10 male, 18 female, age range from 26 to 76 years, mean age 44.8 years, ethnicity 27 white British, 1 ‘mixed other’, all have a single or co-morbid diagnosis of severe depression. All patients have had varying diagnoses in previous contact with services and were considered as complex affective or personality disorders, excluding borderline personality, with histories of serious developmental trauma, and interpersonal difficulties. Referrers generally prefer to focus on the NHS cluster as previously described. The clusters assigned to this sample were all 6 (Non-Psychotic Disorder of Over-Valued Ideas) and 7 (Enduring Non-Psychotic Disorders (High Disability) with one patient clustered as 11 (Ongoing Recurrent Psychosis (Low Symptoms), 90% clustered at 6 or 7.
Results on PHQ-9, GAD-7 and Schwartz-10 questionnaires for 28 DIT cases

PHQ-9 scores

A paired-samples *t*-test was conducted to compare responses of the PHQ-9 questionnaire before and after undergoing DIT. There was a significant difference between pre-DIT (M = 13.89, SD = 6.75) and post-DIT (M = 8.90, SD = 7.13); $t(28) = 3.05, p = .005$. The means and standard deviations are shown in Table 1 and Figure 1.

Table 1. Means and standard deviations of pre- and post-PHQ-9 scores.

<table>
<thead>
<tr>
<th>Time</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-therapy</td>
<td>14.06</td>
<td>7.15</td>
</tr>
<tr>
<td>Post-therapy</td>
<td>9.5</td>
<td>6.85</td>
</tr>
</tbody>
</table>

Note: The mean score reflects response to the PHQ-9 questionnaire before and after therapy.

Figure 1. Means and standard deviations of pre- and post-PHQ-9 scores.

GAD-7 scores

A paired-samples *t*-test was conducted to compare responses of the GAD-7 questionnaire before and after undergoing DIT. There was a significant difference in scores before DIT (M = 12.83, SD = 5.58) and after DIT (M = 7.78, SD = 5.71); $t(28) = 3.58, p = .001$. The means and standard deviations are shown in Table 2 and Figure 2.

Table 2. Means and standard deviations of pre- and post-GAD-7 scores.

<table>
<thead>
<tr>
<th>Time</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-therapy</td>
<td>12.61</td>
<td>5.35</td>
</tr>
<tr>
<td>Post-therapy</td>
<td>8.42</td>
<td>5.71</td>
</tr>
</tbody>
</table>

Note: The mean score reflects response to the GAD-7 questionnaire before and after therapy.
A paired-samples \( t \)-test was conducted to compare responses of the Schwartz-10 questionnaire before and after undergoing DIT. There was a significant difference in scores before DIT (\( M = 19.59, SD = 10.31 \)) and after DIT (\( M = 31.17, SD = 15.82 \)); \( t (28) = -4.06, p = .000 \). The means and standard deviations are shown in Table 3 and Figure 3.

Table 3. Means and standard deviations of pre- and post-Schwartz-10 scores.

<table>
<thead>
<tr>
<th>Time</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-therapy</td>
<td>19.44</td>
<td>12.19</td>
</tr>
<tr>
<td>Post-therapy</td>
<td>29.33</td>
<td>15.48</td>
</tr>
</tbody>
</table>

Note: The mean score reflects response to the Schwartz-10 questionnaire before and after therapy.

Figure 2. Means and standard deviations of pre- and post-GAD-7 scores.

Figure 3. Means and standard deviations of pre- and post-Schwartz-10 scores.
CORE-OM scores (17 patients)

A paired-samples \( t \)-test was conducted to compare responses on the CORE-OM questionnaire before and after undergoing DIT. There was a significant difference in scores before DIT (\( M = 73.22, SD = 24.22 \)) compared with after DIT (\( M = 42.27, SD = 7.59 \)); \( t(17) = 4.83, p < .05 \). The means and standard deviations are shown in Table 4 and Figure 4.

Table 4. Means and standard deviations of pre- and post-CORE-OM scores.

<table>
<thead>
<tr>
<th>Time</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-therapy</td>
<td>73.22</td>
<td>24.22</td>
</tr>
<tr>
<td>Post-therapy</td>
<td>42.27</td>
<td>7.59</td>
</tr>
</tbody>
</table>

Note: The mean score reflects response to the CORE-OM questionnaire before and after therapy.

Discussion of outcome scores

Twenty-four of 28 patients showed a significant improvement on all outcome scores. On PHQ-9 and GAD-7, 12 patients showed a change in scores from severe, above cut-off for clinical cases, to mild or below the cut-off for clinical cases. This improvement in depression and anxiety was also reflected in the more general improvement measured by the Schwartz-10. We only have CORE-OM scores for 17 of the 28 patients, due to data collection issues, but these, too, show significant improvement. These initial results for a short-term psychodynamic therapy are encouraging given that the criteria for treatment in this service is that individuals have a long-standing history of mental health disorders requiring treatment, sometimes over 10 years in various out-patient and in-patient services. We have not collected follow-up data routinely, but where it has been collected, individuals’ improved scores have been maintained at 3–6 month post-therapy ending assessments.
From this sample of (28) patients in SPS offered DIT over the first three years of the project, we can report that our initial analysis of the DIT data in comparison with our long-term psychoanalytic psychotherapy data is encouraging and suggests we may potentially use DIT in this service for some patients we would previously have assumed could only benefit from longer term psychoanalytic or psychodynamic psychotherapy. Considering possible therapist bias in the outcomes, the authors consider this an unlikely influence as most of the psychotherapists were sceptical about the value of a shorter term approach and would still be wary of offering DIT to the majority of patients referred, whatever pressures arise from limited resources. Each psychotherapist had a maximum of two DIT cases at any one time, 10–15% of an individual caseload for part-time and full-time staff, apart from one psychotherapist who had three–five cases, 30–50% of her caseload, at any one time. All were patients for whom depression and anxiety had been highlighted as the reason for referral but whose overall diagnoses were mixed, complex and severe. The numbers seen reflect each therapists’ confidence in and judgement of likely suitability of the approach for patients, not any planned research protocol.

When examining individual progress of patients on their scores over the sessions, we found variations in how patients used the measures. Further input from the psychotherapists concerned suggests these variations relate to both intrapsychic and transference issues in the psychotherapy. For two patients the psychotherapist considered this indicated their strong defence against being seen as vulnerable or needy, linking to their IPAF’s. In DIT each had worked on underlying unconscious self-representations that were about an inner belief that they were too needy, weak or vulnerable and had adopted strong, capable and self-reliant self-representations supported by defensive behaviours of never seeking help and always relating as the giver or supporter of others. The initial scores on the measures could have reflected the need to always appear to cope, particularly in the family, for fear of the consequences. Each of these patients showed slight initial worsening of scores on their weekly measures as the IPAF, maintaining defences and underlying feelings were explored. Weekly scores improved as the impact of uncovering repressed feelings lessened but the scores could not improve greatly given the initial scores. Other individuals rated themselves at the severe end on all measures throughout most of the psychotherapy, even though they reported marked improvement in their mood, well-being and general mental state at the end. The psychotherapist attempted to explore this with these patients, considering what may be the unconscious factors maintaining this discrepancy between self-report and the outcome measures. Factors such as needing to maintain a specific self-representation in relating to others, an unexpressed negative transference towards the psychotherapist or towards the whole process of completing self-rating scales or the need to maintain an ‘illness’ in the eyes of society for fear of losing financial or emotional support were considered. One patient confided her fear of losing her benefits and the very real threat of poverty if she provided ‘written evidence’ that she feared could be accessed by other agencies. This
potential distortion of patient ratings suggests assessment measures need to include open-ended patient feedback and psychotherapist ratings and feedback as well as patient-rated questionnaires.

Our outcome measures were useful in evaluating our service but the battery of outcome measures we use needs refinement. We can compare our routine patient rated clinical outcomes with similar measures used by IAPT and primary care but need to consider the suitability of these measures for our patient population. Other outcome measures, e.g. the Inventory of Interpersonal Problems (IIP-32, Barkham, Hardy, & Startup, 1996) may allow us to focus on the interpersonal aims of psychodynamic psychotherapy in comparing our findings with similar services and with other psychotherapies focussed on interpersonal difficulties. We wonder whether the IIP may have potential in assisting the process of defining an interpersonal focus for patients with complex presentations.

**Using DIT across a range of complex diagnostic presentations**

In our experience, patients with complex and enduring mental health problems do not present with a single clear diagnosis of depression. Our DIT sample was no exception. In one patient, for example, depressed mood and anxiety were not the core problem at the heart of the presentation, despite being a consequence and leading to a diagnosis of depression. This patient described severely low moods and high anxiety that had brought her into psychiatric services in response to experiences of depersonalisation and dissociation that left her feeling unreal and disconnected from the world. Determining the IPAF was crucial in enabling her to identify the unconscious feelings that necessitated a depersonalised defence and its active maintenance within the interpersonal pattern of her relationships. The psychotherapist considered that in a less active, less focused approach this patient would have been overwhelmed by anxiety and demanding of direction and interpretation from the psychotherapist rather than finding her own capacity to analyse her self-representation, feelings and relationships.

Another example of a core underlying problem that was not depression but resulted in severe depressed mood was a patient who presented with resistant PTSD symptoms and recent suicidal behaviour. He had received the usual psychological therapeutic treatments for PTSD, including CBT and EMDR, but remained overwhelmed by depression and sudden impulses to take his life. The decision to offer DIT was not an easy one in view of the suicidal risk and it was essential to involve an AMH community team during his psychotherapy. In formulating the IPAF, however, it became clear that his suicidal acts were all on impulse and in response to feelings and thoughts that were central to a self-representation of being unworthy to live that had developed through early developmental emotional deprivation as well as recent trauma. This emerged in interpersonal relationships and had guided his identity as a protector of others, whom he unconsciously considered more worthy to live than he himself. Working with this IPAF led to a major shift in his depression and increasing satisfaction in interpersonal relationships.
Identifying patients who cannot benefit from DIT

In a few cases, DIT had disappointing outcomes. Two patients showed no improvement at all and considered themselves to be no better or even worse than at the start of DIT. The psychotherapist had experienced both of these patients as well motivated and keen to use the model but had not realised until further in the therapy how fixed their belief was that DIT psychotherapy would be inadequate. These patients analysed themselves psychologically, reflected and related well to the psychotherapist yet had a habitual experience of nothing making any difference to how they felt, no matter how well they understood their chosen IPAF and they felt unable to put their insights into action unless their awful feelings could be removed first. Both wondered during the course of the DIT whether they could benefit from hypnotherapy. The individual presentations and underlying pathology were different. Patient A, a male, had a predominately intellectualising defensive pattern and an extreme sensitivity to any silence on the therapist’s part or any possibility that the therapist was not understanding or recognising his pain. It was a severely narcissistic presentation. He felt the psychotherapist was well meaning but unable to help him effectively. The psychotherapist felt impotent in the face of this and frustrated that she had somehow thought that he could benefit from DIT. Patient B was female. Her previously undisclosed severe ruminative thinking and obsessional behaviour emerged as her depressive symptoms improved. These were the underlying difficulties leading to the depression and they soon overwhelmed her capacity to focus on interpersonal relationships. The severe underlying narcissistic and obsessional difficulties that became evident in these patients may have contributed to the strong desire for a ‘magic cure’ that did not involve stirring up overwhelming mental anguish. These two cases suggest that rigidity of underlying defences may be a contra-indication for short-term treatment. Fortunately, such outcomes are less than 10% of the sample. Sharing information on cases that prove unsuccessful could help determine which complex cases may not respond to DIT, assisting assessment.

This failure to enable patients to experience change is common to all psychotherapies. Such examples illustrate how DIT is not a ‘one therapy for all’ approach and will, as with any other psychological therapy protocol, have little to offer individuals who need to retain their defensive patterns as the best solution when faced with the overwhelming internal disruption that can accompany psychological change.

Clinical examples

We present here two clinical examples in greater detail to illustrate some of the vicissitudes of using DIT within a tertiary level SPS.
**Patient D**

Patient D, a 42-year-old male, had pre therapy Gad-7 and PHQ-9 scores at the severe end of the spectrum for depression and anxiety and showed a range of traits consistent with avoidant personality disorder. He came into therapy under immense pressure in relation to his job. He had stopped working following a distressing fallout with a manager that he saw as bullying and authoritarian. He suffered crippling anxiety and had not responded successfully to CBT previously. He adopted an intensely avoidant position with his wife, remaining terrified of her seeing his weakness and then losing respect for him. His strategy of managing such situations was to become withdrawn and incommunicative, often drinking copious amounts with friends at the pub, becoming disorderly and on occasion leaving the family home for days at a time. This caused stress in his marriage and took him away from the care of his one years old daughter.

His father left the family home when he was six years old and he was left with his mother and a younger brother. He remembered much violence and arguments in the time before his father’s departure. From that point onwards he experienced protracted states of panic at times of significant change or loss.

His IPAF, developed through his realisation that his relationship with father was revisited through his relationship with the manager, was about a perception of others persecuting him and a perception of himself as alone and misunderstood. His dreams repeatedly brought to the surface his murderous feelings and he found himself fighting (usually the manager/father) again and again to the point of killing the other and then suffering paroxysms of crippling guilt. Much of the DIT therapy was about helping him to make contact with his rage through use of the IPAF and finding ways for him to be legitimately angry with his situation rather than murderous. This was to the effect that his anxiety and depression symptoms decreased dramatically by the end of the sessions. A turning point for him was being made redundant and instead of collapsing both functionally and internally, as might have been anticipated at the beginning of therapy, he found himself in a more senior position in a different company. This was a role where he could feel more in charge, but one that supported him socially and in his family life. Slowly he found ways of letting his wife know about some of his internal struggles and he reduced his drinking behaviour. This was a man with lifelong difficulties with anxiety and debilitating depression who had found a way of making sense of his difficulties and using his life opportunities to his advantage.

He missed a number of sessions towards the end of the work (as his new job began) and there was some exploration of how he wanted his job to replace the difficulties of the ending phase. It was felt that he could not have tolerated a longer term therapy since it threatened to keep him in a state of dependence which felt too threatening to him and it encouraged a level of regression that might have deprived him of any level of functionality; DIT represented a way of offering something active which had the capacity still to capture his complexity within the context of his individual personal history.
**Patient N**

This case is one where DIT was not a sufficient treatment on its own but the psychoanalytic psychotherapist considered it had enabled treatment for a patient where an intensive psychoanalytic approach would have left the patient unable to recover or develop further. Mrs N’s difficulties were of a chronicity and complexity that on the face of it made DIT a less than obvious choice of treatment. Levels of risk were high, she had had the recent involvement of the crisis team, and there were ongoing concerns of suicide. Nevertheless, she was highly motivated, having identified during the course of a brief CBT that she felt stuck in a repeated pattern of relating to others which left her feeling miserable and depleted. The IPAF we identified for psychotherapy was of a disappointing and unlovable self, beholden to a demanding and reproachful other. An ever-giving position defensively masked a deeper anger and resentment, feelings which produced such guilt that she could only deny her needs even further in an effort to assuage these unacceptable feelings and avoid rejection. Her IPAF served to defend against knowing and expressing her angry feelings; her only escape from this impossible dynamic was complete withdrawal or collapse.

The pattern she wished to change was thus one in which self and other were linked more by guilt, fear and excessive demands than by love. Through DIT psychotherapy Mrs N was able to find a less extreme version of self and other which made room for give and take, where accepting responsibility did not mean overwhelming guilt, where saying no did not risk certain rejection and where showing love did not preclude setting limits. The result was a subtle change in relationships, which began to be more equal and more rewarding. Her scores on the PHQ-9, GAD-7 and Schwartz-10 outcome measures showed a significant decrease in anxiety and depression and a significant increase in general well-being.

Mrs N was offered DIT because of her wish to actively tackle her difficulties. This short-term approach was also chosen with the thought that too intensive a therapy might be more destabilising than helpful, and precipitate further collapse. In the event, the crisis team did need to be involved during the therapy due to acute external pressures. Whilst this greatly troubled the psychotherapist about the possible inappropriateness of the approach, it proved to represent a turning point. The second half of therapy saw the patient’s emerging capacity for greater equality in relationships, reflecting a growing ability to mentalise in contrast to her previously unquestioned assumptions about self and other. At the end of her therapy Mrs N was realistic about what she had gained and the changes she had made, seeing them as the beginnings of more lasting change, but recognising there was more work to be done. With DIT laying the groundwork, she went on to do well in the containing framework of group analytic psychotherapy.
The personal impact of DIT on the psychoanalytic psychotherapist

DIT is a protocol based on a manual and as such represents a shift change for any psychoanalytic psychotherapist used to providing long-term psychotherapy. It dictates a time frame and specific methods and techniques that are akin to but not the same as a long-term, or other short-term psychoanalytic psychotherapies. The main learning for all of us with DIT was to do with being guided by a manual whilst maintaining the capacity to respond to the uniqueness of an individual’s internal world and the free associative nature of the psychoanalytic method of psychotherapy. The psychotherapist has to learn to focus on a defined IPAF, interpersonal affective focus, as well as the usual attention to unconscious defences, transference and countertransference, inter- and intra-psychic processes. The agreed IPAF, although a product of the patient and psychotherapists initial explorations of past and present difficulties, delineates the territory in the ensuing psychotherapy, so that the psychotherapist, as much as the patient, limits her/his desire to follow other issues or needs that may present in the material and the dialogue. This can initially inhibit the psychotherapists capacity to think freely in the process until s/he is familiar with the DIT model and able to integrate ‘the old’ with ‘the new’ psychoanalytic approaches. It can be a frustrating and disturbing journey.

Most of us found introducing outcome measures at every session somewhat alien and feared that this would interfere with the analytic frame. However, as mentioned earlier, we found, like Gelman et al. (2010), that the measures could become part of the frame and a focus for exploration and interpretation by commenting, for instance, on discrepancies between what is reported in the measures and how the patient presents in-session.

The goodbye letter, collaboratively produced for the last four sessions of the work, could feel equally challenging, especially during early stages of training in DIT, when its tools were experienced as so different from the traditional methods of a psychoanalytic approach. It became clear though that this too could be incorporated into the analytic frame. The patient who lost her goodbye letter, for instance, and waited until the final session before she could admit this, could then be helped to explore this and disclose her expectation of disappointing the therapist or others. Similarly, where separation and ending is a critical aspect of the psychotherapy, we found that some patients experienced the goodbye letter as a kind of transitional object, (Winnicott, 1971), grateful to have a reminder of what they had achieved and the relationship they had experienced in psychotherapy.

We all experienced a kind of disturbance in our professional identity. We had to become familiar with a more active approach and find a way to be explicit with the patient in supporting their efforts. As Lemma et al. (2010) say, the DIT approach involves a process of being active within a context for the search for meaning and focusing upon the patient’s mind, not their behaviour. The aim is to stimulate the patient’s capacity for reflection upon themselves and their circumstances and foster a collaborative stance as might be used in more active therapeutic models. Most of us found that this aspect of the work became easier with practice and with an experience of seeing more patients for DIT.
In addition, the shift to the time-limited nature of the DIT model had the effect of creating a pressure on the psychotherapist which influenced the pace of the work, and disturbed the stance of the therapist, initially raising anxieties, frustrations and uncertainties about the likely outcome of the approach.

**Conclusion – DIT in an NHS tertiary specialist psychotherapy service (SPS)**

Our findings concern the kind of complex, disturbed patient group typical of an NHS tertiary SPS. This group is different from that reported on in the Gelman study, which used DIT within a primary care setting and excluded patients with severe personality disturbance, unstable living conditions and those deemed unable to manage an ending. We too made decisions about who would be offered DIT on the basis of either limiting the degree of overall disturbance and personality pathology or offsetting this factor with what was assessed as potentially good ego-strength and motivation to use a short-term approach. We hoped this limited the potential for serious decompensation with an active short-term psychodynamic approach. However, by the nature of our referred patient group, we made deliberate decisions to introduce DIT to a patient group diagnosed with recurrent and long-term depression and displaying many co-morbid difficulties, such as chronic and generalised anxiety disorders, chronic and severe trauma symptoms and moderate to severe levels of personality disorder, excluding borderline personality disorder. Our outcomes suggest that, if managed carefully, we can further explore how DIT may be used successfully within this patient group, alongside careful monitoring of risk and severity of psychopathology and factors influencing poor outcomes. Our cases so far have been limited to 16 sessions, but this may need extending when applied to more entrenched problems. Three patients seen for DIT as part of this project were referred on for further work within the service, group analytic psychotherapy. The group psychotherapists considered these patients would not have been willing or able to engage with this kind of work without the preparatory work of DIT. This may indicate the potential of DIT as a stimulator for change which can be further progressed with a psychotherapy that emphasises unconscious processes and an interpersonal approach involving collaboration with others rather than intensive long-term individual psychoanalytic psychotherapy.

A formalised, brief psychotherapy might be seen as a doomsayer to the intensive, long-term psychotherapy traditionally offered by a psychoanalytic psychotherapy service. These results do not indicate that the majority of our patients using psychoanalytic psychotherapy can be considered as suitable for DIT. Rather, we suggest that services like ours, treating a wide range of complex mental health conditions including depression, may consider offering this DIT protocol for some patients, without the need for longer term psychotherapy. We think a range of shorter term psychoanalytic, mentalisation-based therapy (Bateman & Fonagy, 2006) and shorter term group analytic psychotherapies (Karterud, 2015;
Lorentzen, 2014; Lorentzen, Ruud, Fjeldstad, & Hoglend, 2013) would be necessary for the range of complex problems in such services. Another question posed is whether DIT could be a means of improving the capacity of some patients to use a psychoanalytic or psychodynamic approach who might otherwise not be able to engage. We have learned that we need to refine how we select patients for shorter term psychotherapy and that we need to further refine outcome measures to assist with this as well as evaluate outcome. Additionally, DIT has taught us the need to consistently provide routine outcome clinical data to support the continued commissioning of both our short-term and our long-term psychoanalytic psychotherapy. We have previously relied on our good relationships with managers and our reputation as a service with both referrers and patients using our service. Increasingly their voice is outweighed by commissioners quoting Nice Guidelines and expecting rigorous evidence of the effectiveness of our work. We are greatly encouraged by the increase in research investigating the outcome of psychodynamic and psychoanalytic psychotherapy, e.g. the Tavistock Adult Depression Study, (Fonagy et al., 2015). In order to protect service provision meanwhile and in the future, we suggest that psychoanalytic psychotherapy services operating outside of IAPT need to use means of evaluation that compare favourably with IAPT systems and integrate with NHS AMH service requirements. Pragmatically, DIT is an invaluable addition to what we offer patients in psychoanalytic psychotherapies, in a world where psychoanalytic psychotherapy has to adapt to retain its place as an NHS treatment. We hope it is an example of innovative mental healthcare that opens possibilities for further creative work to the benefit of patients and service provision in the future.

**Acknowledgements**

Thank you to Kate Surgeoner, Lesley Kendrick and Joanne Brooks for participating as DIT psychotherapists. For the collection and analysis of data, we thank Rebecca Tinkler, Julie Freeman, Emma Limon, Lauren Gibson and Fiona Parker. For encouragement and supervision and comments on this paper, we thank Anne McKay, Deborah Abrahams and Maxine Dennis. Finally, we thank senior managers, executives and head of AMH psychology, Malcolm Bass, for their commitment to maintaining high-quality psychoanalytic and psychodynamic psychotherapy services for patients using mental health services.

**Disclosure statement**

No potential conflict of interest was reported by the authors.

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