DYNAMIC INTERPERSONAL THERAPY: WORKING WITH PERCEPTIONS OF THE SELF AND OTHER

DEBORAH ABRAHAMS OUTLINES THE CONTRIBUTION OF SHORT-TERM PSYCHODYNAMIC WORK TO IAPT SERVICES

WHAT IS DYNAMIC INTERPERSONAL THERAPY?

Dynamic interpersonal therapy (DIT) is a brief model of psychodynamic psychotherapy that was developed by Alessandra Lemma, Peter Fonagy and Mary Target in 2010.[1] It arose in response to the Improving Access to Psychological Therapies (IAPT) initiative, in order to ensure that a psychoanalytically informed model would be offered alongside CBT, as one of the non-CBT approved treatments for depression. However, IAPT's annual workforce surveys indicate acute gaps in the DIT workforce nationally, with DIT representing less than one per cent of the overall number of referrals seen for treatment.[2–5] The importance of patient choice in accessing psychological therapies is widely recognised: over 50 per cent of patients do not move into recovery with CBT, as shown by the annual IAPT reports.[3] Surveys of patients and IAPT leads have demonstrated strong demand for DIT in order to improve therapy uptake, completion and recovery rates through increased patient choice, as well as improved staff retention through opportunities for professional development and greater work satisfaction.[6] Research found that the way in which some local areas have interpreted and implemented IAPT has actually led to a reduction in both choice and access to psychological therapies.[5,7] A survey carried out by Mind showed that only eight per cent of patients were given a full choice of IAPT therapies. Those patients who had a choice were three times more likely to be happy with their treatment than those who did not get the choice they wanted. In addition, people who were offered a full choice of therapy were five times more likely to report that therapy helped them back to work than those who were not.[8]

The DIT model draws on a systematic review of clinical competencies in psychoanalytic and psychodynamic models of psychotherapy.[9] As such, DIT is underpinned by a strong evidence base. Those who attend the DIT training often find many familiar points of reference with the model; this is to be expected, since it is a distillation of best practice in brief psychotherapy approaches.

I have always had an interest in brief models of psychotherapy with children, families and adults, and was attracted to this new development while I was working as a clinical psychologist and psychotherapist in the Camden and Islington NHS Foundation Trust IAPT and psychodynamic psychotherapy services. I was part of the first DIT training cohort in 2010 and I continue to use DIT in both my NHS work and private practice. I find it a containing and meaningful structure within which to approach brief work, both for practitioners and patients. Although DIT was designed as a treatment for depression, it also has a strong effect size with anxiety symptoms.[10] This is understandable because DIT formulates depression as a threat to the patient's attachment system, which is accompanied by an increase in anxiety. DIT allows the practitioner to work trans-diagnostically and to consider the interpersonal implications of the difficulties the patient is facing.

STRUCTURED BRIEF WORK

DIT is informed by theories of object relations, attachment, mentalising and interpersonal psychoanalysis. It has three phases. During the initial phase, which lasts for around four sessions, the therapist maps the patient's interpersonal world and collaborates with the patient in trying to identify a repeated pattern of relating that is linked to the presenting difficulties. During the middle phase (sessions five to 12) the therapist works explicitly with the patient around this agreed focus, encouraging change and taking up inevitable resistance to change. The ending phase is heralded by a goodbye letter in session 13, and the last four sessions bring the work to an end.

THE INTERPERSONAL AND AFFECTIVE FOCUS

At the heart of DIT is the 'interpersonal and affective focus' (IPAF): how the patient perceives others in relation to a self-perception, and the affect that links these two experiences. For example, the patient may see themselves as unwanted and experience others as rejecting, which leaves him/her anxious, with less conscious feelings of rage. The pattern is ideographic to each patient and draws on the patient's imagery and experiences. The more powerful the descriptors, the more impactful the IPAF will be. A patient's imagery or significant catchphrases often capture a multifaceted experience of self or other in an evocative way that goes beyond our usual repertoire of descriptors. Self-descriptors such as 'on the shelf', 'slug' or 'street rat' are more affect-laden than 'out of sight' or 'unacceptable'.

Unlike other types of psychotherapy, in DIT we communicate this formulation directly to our patients and negotiate a shared focus for the work. This is part of the collaborative approach adopted in DIT, a stance that is more supportive than would be the case in longer-term work. We then invite our patients to consider how they want to work towards change over the course of the remaining sessions. This can be a novel approach for some longer-term psychotherapists, who are not used to agreeing goals with patients or helping patients to articulate explicit expectations for therapy.

At all times, DIT is informed by the clinician's psychoanalytic stance. This means that we are on the lookout for our patients' resistances and defence mechanisms that may get in the way of making changes, both consciously and unconsciously. We might also take up the way the patient has an investment in keeping these patterns going, despite their stated wish for change. Part of the work is understanding the patient's coping strategies and the cost to the patient of maintaining them. However, we remain respectful of the patient's defences: given this is brief work, we are not intending to dismantle these.

Often, therapists become intimidated by the process of identifying an IPAF and find it difficult to settle on one pattern among several. However, it is helpful to consider this as a starting point, rather than an end point, for therapy. We continue to refine and polish the formulation as the work progresses and as new material emerges. The focus of the work should reflect the presenting difficulties, as well as making sense of past relationship struggles. The IPAF should be generalisable to more than one relational and temporal domain for it to have credibility. By this, I mean that the focus of the work should have its origins in the patient's childhood and be repeated in the present, so that the pattern makes sense of several different areas of the patient's life and is emotionally meaningful.

The IPAF is also a means to an end. We know that in depression, patients are often unable to mentalise flexibly. Mentalising is the ability to keep mind in mind, to see ourselves from the outside and others from the inside. The IPAF usually represents a troublesome and fixed way of viewing self and other, one that has developed out of difficult, even traumatic life experiences. Although it is painful, it is familiar to reinstate this pattern in uncertain interpersonal situations. By having an awareness of this repetition and considering ways of stepping outside this pattern, we are facilitating our patient's capacity to mentalise more flexibly. This results in greater reflective capacity and enhanced emotional regulation.

So what does DIT and the formulation look like? Given how personal the IPAF usually is, it is difficult to protect patient confidentiality when providing examples. For the purposes of this article, I have therefore amalgamated several different patient details in the following case studies.

CASE STUDY ONE: PETER

Peter came to see me for long-standing depression at his GP's request. He was the youngest son of a family of four and felt that his birth was an afterthought. His mother was often exhausted and unable to attend to his needs. Not only was she juggling two or three part-time jobs at any one time to make ends meet, but she was also consumed with worry about his sister, who had a life-threatening medical condition. Peter learned to keep himself in the background. He was afraid of overloading his mother's already stretched resources. He spoke painfully about times when he was left out of family trips. Despite feeling a deep sense of unfairness, he was unable to directly voice his complaints, becoming increasingly withdrawn and quiet. He drifted into a marriage but never felt that his wife truly wanted to be with him. When she announced that she was leaving him for someone she had met through the Internet, he felt a familiar sense of unfairness and resentment. He came forward for help when his mother developed dementia and he took on the role of being her full-time carer, moving back into the family home. He felt trapped and unable to have a life of his own. His siblings were not pulling their weight, happy to leave the lion's share of the care to him.

The focus for the work that we settled on was a sense of himself as 'an unimportant afterthought' and of others treating him in a dismissive manner that could even feel exploitative. This left him with feelings of hopelessness and resentment. It was more difficult to get hold of the resentment because, in many ways, this pattern protected him from the knowledge of his own aggression by locating it firmly in others.

Part of the reason for sharing the formulation with the patient is to help them to understand the defensive function of the IPAF and how it serves to protect them from parts of the self that are difficult to know about and are often projected into others. When identifying the affect that links the self and other representations, we are aware that the patient is more conscious of some affects than others. In sharing the pattern, we titrate how much we feel the patient can manage to hear. In brief work, we are largely working with conscious and pre-conscious levels of awareness. However, in the course of the work, deeper layers of understanding often emerge.

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Peter found it useful to have this pattern made explicit to him and together we identified that he would like to work on the goals of being more visible and less of a 'wallflower'. We saw that there were ways in which he contributed to maintaining this pattern by retreating into the background and being avoidant. We could link this to his fearful avoidant attachment style. This is actively addressed in DIT when we ask patients to rate themselves on the Bartholomew and Horowitz relationship scale, which measures adult attachment styles.[11]

I am often surprised at the level of change that patients are able to manage in the course of the 16 weeks of DIT. Peter began to question his certainty about feeling solely responsible for his mother. It was transforming for him to be able to step outside this pattern and mentalise more flexibly about himself in relation to others. It freed him up to put his needs forward more clearly to his siblings and, to his surprise, they were able to step forward and cover for him. This allowed him to return to aspects of his life that he had put on hold. Indeed, the impetus for change was the realisation that he was waiting for his mother to die before he felt he had a right to resume his own life.

MIDDLE PHASE OF DIT

In the middle phase of DIT, the clinician adopts a more open approach to the sessions, listening to the narratives the patient brings and to what emerges in the dynamics between patient and therapist, so an idea of who is doing what to whom can be explored and clarified. I find the middle sessions of DIT to be the most similar to 'therapy as usual'. However, there is also a danger that we slide back into our familiar ways of being. The IPAF is the spine of the middle phase of the work. By repeatedly referring to it and continuing to refine it, we are more likely to remain on model. We are also able to work with our patient's unconscious processes in the middle phase. We will take up the defences the patient uses more actively, pointing out the cost of these defences in the hope of mobilising some change, while still respecting the need for those defences. After all, this is brief work and we are not expecting to radically change our patients' defence systems in 16 weeks.

We will also address the way the transference is activated in relation to the IPAF. In the case of Peter, I often found myself pulled into being controlling, even pushy, in response to his elusiveness in therapy and his hopelessness that anything could be different. It was useful to name this in the room and understand both how this might happen and his contribution to keeping others engaged with him in this way. The therapeutic relationship can become a very powerful part of the mutative experience in DIT. I have found this way of working in the transference is often experienced as less persecutory by patients, perhaps because we already have agreement about the focus of the work and because the transference is used judiciously to illuminate that focus.

ENDINGS IN BRIEF WORK

In brief work, the ending is present from the beginning of therapy and we work actively with this throughout the 16 weeks. When we get to session 12, we prepare our patients for a 'goodbye letter', summarising the work. The therapist drafts this letter for the 13th session.

Patients have a range of fantasies about the meaning of both the letter and the ending. We work very actively with those fantasies and try to put words around the particular sense our patients make of the ending. How does the ending tie in with their childhood experiences? Do they feel replaced by another, more worthy, patient? Do they feel we have grown bored of them and are discarding them?

Sharing the goodbye letter is often an evocative and charged experience. My first DIT patient burst into tears as I was about to read the letter to her. What emerged when we explored her reaction was her fear that I would whitewash her struggles. Her relief at reading the letter was palpable, as she realised that I acknowledged her struggles and the areas she still needed to work on.

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The letter does several things: it is a summary of the patient's background and referral, which informed the IPAF; it sets out the IPAF, the pattern we have worked on throughout the therapy, as well as detailing the various coping strategies the patient has employed in the face of it; and it points out what happened over the course of therapy, the changes the patient was able to achieve, and the remaining unfinished business. With 12 sessions behind us, we may be able to anticipate the effect of the upcoming ending or events in our patient's life that may be worrying for them. The letter also addresses the impact of this pattern on the therapeutic relationship. The letter is presented as a draft so we can continue to collaborate around its content as we conclude therapy. It is important that patients feel they can contribute towards it, so that it functions as a record of their experience and a transitional object to consolidate the work and assist with relapse prevention.

CASE STUDY TWO: ALIYA

Aliya came to see me for DIT because she was depressed after being diagnosed with breast cancer in her early 50s. She grew up in Pakistan as the youngest and only daughter in a family of five. She said that being female was never valued in her family; her brothers received preferential treatment. She came to the UK through an arranged marriage and although she hoped her partner would have more progressive views, she was disillusioned at finding herself in a similar situation to her family of origin. She was unable to have children and felt distanced from other women in her community, feeling she had failed as a wife. She found refuge in her work as a bookkeeper; however, since becoming unwell, she had had to take time off work and no longer felt validated there. She was aware of a growing sense of anger, particularly towards her husband and, on one occasion, she admitted that she had lashed out at him physically.

We identified the focus of our work together as the way Aliya experienced herself as 'second best' and expected others to be critical of her, resulting in feelings of anger and shame. We also saw how the pattern could reverse itself: Aliya would be the critical one, judgmental of others and furious at the way they were treating her. At its most extreme, this happened when she became violent towards her husband and it resulted in her feeling even more worthless. Taking up this reversal is part of the dynamic focus of DIT; it involves taking back the aspects of the self that are disowned and projected onto others. Some patients cycle through the IPAF, repeatedly switching from the self to other experience. Since this is an object relationship, we can also expect to find an internalised IPAF at play, and occasionally we may explore the way the patient can, in the example of Aliya, treat a vulnerable, second-best part of themselves with criticism and derision. Ultimately, DIT is an interpersonal therapy and we work in the domain of here-and-now relationships; the patient's early experiences are embedded in the IPAF. In this brief approach, we do not routinely make interpretations linking to the past.

With Aliya, we recognised the way she expected to find in me a critical, belittling therapist. She thought I would tell her it was all her fault and that she was getting things wrong in her marriage and her life. This critical voice chimed with both her parents during her childhood, as well as her husband, mother-in-law and one of her employers in the present. It was a real struggle for Aliya to concede that change was possible and for us to agree a goal for our work together. Over time, she was able to find some relief in identifying and exploring these patterns and the sense of being a waste of time. During therapy, Aliya's sense of being always 'second-best' began to fade. We were also able to consider the way her difficulties interacted with her husband, and she began to have a different appreciation of his point of view. As the work came to an end, there was a brief resurgence in her low mood and anxiety, something we often find because the ending reactivates attachment anxieties. Yet, with the help of the IPAF, we were able to make sense of this and her fears about being left behind.

WHO MIGHT BENEFIT FROM DIT?

I find it useful to have DIT as one of the approaches to consider when seeing new patients. Not everyone can make use of longer-term psychotherapy. Some patients benefit from the more active, circumscribed and supportive stance that DIT offers, as well as the focus on mentalising. Therapists, too, may find it useful to work in short-term treatments alongside open-ended cases, particularly those therapists who are moving towards retirement and have a time-limit in their minds. I have always found brief work a refreshing reminder of the resilience and creative capacities of patients. Sometimes, we can join patients on their journey for a

short while and help them identify a core, repeated interpersonal pattern that is holding them back. This can allow them to move forward in a more constructive way. Occasionally, people require more help, and in those cases, I feel more confident that, after completing DIT, they can make good use of psychodynamic work.

WHO CAN TRAIN IN DIT?

The current DIT training is designed for those people who have already demonstrated the psychodynamic/analytic competencies, as evidenced by a minimum of a year of personal therapy, 150 hours of supervised practice of psychodynamic therapy and a course in psychoanalytic theory. It is a five-day training programme that leads to supervised practice of two cases. There is a new proposal to make DIT accessible to a wider audience, including counsellors, psychological therapists and third-year psychology trainees, and to open up the entry criteria that have served as a barrier to eligibility for DIT training. We anticipate that Health Education England will adopt this extended DIT training, which will teach and develop core DIT competences, so that DIT is better represented in IAPT services and patients have a greater choice of therapy. IAPT services are facing ever-increasing pressure to meet performance targets, leading to a privileging of numbers over quality and treatment choice. It is clear that DIT's 16-session model poses certain challenges in this environment. However, the current approach of restricting IAPT services to even shorter-term work represents a false economy, often resulting in a 'revolving door' service. I believe that a more substantial one-off investment in 16 sessions of DIT represents a more cost-efficient and effective treatment over the longer term. ■

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READER RESPONSE

The author would welcome feedback on this article. To contact her, please email deborah.abrahams@icloud.com or DAbrahams@tavi-port.nhs.uk

Details of DIT training dates can be found on the Anna Freud National Centre website (www.annafreud.org), as well as the DIT website (www.d-i-t.org).