The Development of a Brief Psychodynamic Intervention (Dynamic Interpersonal Therapy) and Its Application to Depression: A Pilot Study

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This paper describes a protocol for a brief psychodynamic intervention (Dynamic Interpersonal Therapy; DIT) for use with depressed patients and a pilot study set out to test its acceptability and compatibility with session-by-session monitoring as a prelude to a future randomized controlled trial. Sixteen consecutively referred, depressed patients (aged 20-53) were offered 16 sessions of DIT. Patient outcomes were collected pre-post, and on a session-by-session basis, using the PHQ-9 and GAD-7. Therapist and supervision feedback indicates that this structured psychodynamic treatment could be effectively taught, and that the key competences involved were acquired and demonstrated in the clinical work supervised. Patients found the treatment acceptable and relevant to their problems. The treatment appeared compatible with session-by-session monitoring of symptoms of anxiety and depression. DIT was associated with a significant reduction in reported symptoms in all but one case, to below clinical levels in 70% of the patients. Random regression models revealed highly significant linear and quadratic components, confirming the decrease in reported symptom severity but cautioning about slight increase in symptoms around the ending phase of the treatment. The results suggest that DIT is promising in its acceptability and effectiveness with an unselected group of primary care patients, and is easily acquired by psychodynamically trained clinicians.

Depression is a common and disabling condition that is associated with considerable morbidity and carries a significant risk of mortality through suicide (Ustun et al., 2004). The pervasiveness and the disabling and refractory nature of depressive disorder make the identification of effective treatment protocols a high priority for Western health care systems.

In 2009, the UK National Institute for Clinical Excellence (NICE) reviewed the original Clinical Guideline for the management and treatment of adults with a primary diagnosis of depression. In this most recent
revision, the Guideline (CG90) suggests that for patients with depression who decline other treatment modalities, the clinician can consider brief psychodynamic psychotherapy, and hence it has now been recommended as one of the therapeutic approaches provided through the Improving Access to Psychological Therapies (IAPT) initiative in England. This initiative has also placed an emphasis on identifying the competences required to deliver effective interventions (Roth & Pilling, 2008). The Psychodynamic Competences Framework (Lemma, Roth, & Pilling, 2008) describes the model of psychodynamic competences based on empirical evidence of efficacy. A qualitative analysis of several treatment manuals used in the controlled trials that provided the best evidence for the efficacy of psychodynamic therapy (see Roth & Fonagy, 2005; Fonagy, 2010) formed the basis for the articulation of the core, specific, and meta-competences required to practice psychodynamic psychotherapy (see Lemma, Roth & Pilling, 2008).

THE DEVELOPMENT OF DYNAMIC INTERPERSONAL THERAPY (DIT)

The core techniques and strategies underpinning DIT reflect the competence framework that emerged from this systematic review of manuals used in outcome studies. DIT thus deliberately uses methods taken from across the board of dynamic therapies, and we would therefore expect those who have been involved in the development of other brief dynamic models to find many familiar strategies and techniques in DIT.

DIT is a time-limited (16 sessions) intervention (Lemma, Target, & Fonagy, in press). The assumptions informing this protocol were similar to those that underpin other brief dynamically oriented approaches: (a) that behavior is unconsciously determined, (b) that internal and external influences shape thoughts and feelings and therefore inform our perception of ourselves in relationships with others, (c) that adult interpersonal strategies and ways of relating are generated by childhood experience, particularly within the family, (d) that unconscious processes, including defenses and identifications (projective and introjective processes), underpin the subjective experience of relationships, (e) that thinking about behavior and emotional experience in terms of mental states has significant therapeutic effects, and (f) that therapy should focus on the patient’s current relationships, including the relationship with the therapist.

DIT’s starting point is the common clinical observation that patients who present as depressed invariably also present with difficulties and distress about their relationships. The presenting symptoms of depression are reformulated as responses to interpersonal difficulties/perceived threats to attachments (loss/separation) and hence also to the self. It is hypothesized that these perceived threats can both result from, and cause, difficulties in thinking clearly and realistically, not only about the external world, but also about the internal world, one’s own thoughts, feelings, and experiences with others. It is assumed that improving the patient’s ability to reflect on their own and others’ thoughts and feelings will improve their ability to understand and cope with current attachment-related interpersonal threats and challenges. The DIT therapist reframes the patient’s symptoms of depression as manifestations of a relational disturbance, which the patient cannot understand, or understands in a maladaptive way, attributing unlikely or unhelpful motivations to himself and others.

DIT consists of three phases, each with specific aims and strategies. The primary task of the initial phase (sessions 1-4) is to identify one dominant and recurring unconscious interpersonal pattern, the interpersonal-affective focus (IPAF), which is assumed to be central to the onset and/or maintenance of the depressive symptoms. This pattern is underpinned by a particular representation of self-in-relation-to-an-other that char-
acterizes the patient’s interpersonal style and leads to difficulties in his relationships. These representations are typically linked to particular affect(s) and defensive maneuvers. Affects are understood to be responses to the activation of a specific self-other representation in the patient’s mind. This particular way of formulating derives from Kernberg’s (1980) distinctive integration of object relations theory with ego psychology, which is very close to the heart of the theoretical basis of the recommended treatment protocol presented here. For example, an IPAF might focus on a self-representation as “a loser” in relation to an object by whom the individual feels humiliated. This particular configuration might then arouse a wish for revenge, as well as give rise to various defensive strategies to reverse the representation of self and other and thereby triumph over the felt-to-be humiliating object.

While past experiences clearly inform current functioning and internal object-relations, they are not the major focus of DIT. Rather, given the brief nature of the therapy, the focus is on a core segment of the patient’s interpersonal functioning that is closely connected with the presenting symptom(s).

The IPAF guides the therapist’s interventions during the middle phase of the therapy (sessions 5-12), which aims to help the patient work through the IPAF. This phase involves (a) maintaining a systematic focus on the agreed IPAF, by prioritizing work on current significant relationships that demonstrate the activation of the IPAF and focusing on the therapeutic relationship as a live example of the IPAF in action; (b) helping the patient practice the skill of recognizing internal states (feelings, thoughts, wishes etc.) and connecting them to the week’s events and to the identified IPAF.

The last four sessions (13-16) are devoted to helping the patient explore the affective experience and conscious and unconscious meaning of ending the therapy, reviewing progress, and helping him to anticipate future difficulties/vulnerabilities.

**Pilot Study**

In order to assess whether the DIT protocol could be used by experienced clinicians, we carried out a two-day training followed by close supervision of the treatment of consecutively recruited cases representative of community-based psychotherapy practice. The trainees were four senior, psychodynamically oriented clinical psychologists and one counselor, all with at least five years of experience since qualification. All were employed by the National Health Service in a London borough characterized by high levels of deprivation and ethnic diversity.

The therapists were trained in DIT as a group by two of the originators (AL and MT). They received 16 hours of skills training based on a draft version of the manualized protocol, followed by weekly 1½ hour group supervision sessions with one of the trainers (AL) over one year. The training was a mixture of didactic and practical/experiential, with a particular focus on helping trainees to formulate an IPAF and use it in the subsequent work. Participants were asked to provide verbal and written feedback at the end of the training, and their verbal feedback as they progressed through the supervision was noted by the supervisor. They all reported finding the theoretical approach accessible and relevant, and they were comfortable with the practical approach outlined. They did, however, express some initial concern about the possible impact of combining this dynamic clinical technique with the introduction of session-by-session outcome monitoring, which was becoming a routine assessment procedure in their service.

**Participants**

The participants (n = 16) were all referred to a primary care psychology service in Inner London, with depression as their main presenting complaint. All patients had
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depression as a primary complaint and 38% were co-morbid with an anxiety disorder as assessed through the clinical interview. All 16 referrals came from primary care doctors. Patients were then routinely assessed by a senior clinician who established study criteria and determined suitability for the service. Exclusion criteria were diagnosis of psychosis; current substance misuse of such severity as to prevent them from working with a therapist (e.g., incapable drunk/stoned for substantial parts of the day); dementia; and significant suicide risk. Of the 16 patients, 11 were female and 5 were male. The age of the patients ranged from 20 to 53, with a mean age of 34.3 years. Ethnic monitoring data showed that 43.7% identified themselves as White British, 18.7% as White European, 18.7% as Mixed Race, 12.5% as Latin American, and 6.2% as Asian. A total of 43% of the patients reported at least one prior contact with mental health services, and 25% reported a history of self-harm and/or suicide attempts. The self-reported length of psychological problems, assessed through the routine questions asked by the clinician at interview, ranged from 18 months to 12 years.

All of the patients were offered 16 weekly sessions of DIT, each lasting 50 minutes. Demographic and outcome data were collected on both completers \( n = 14 \) and early terminators \( n = 2 \). Of the latter two, one had been referred with relatively mild levels of depression and felt she no longer needed help after the first four sessions. The other was considered unsuitable for a brief intervention after the first two sessions and was referred to tertiary care services.

**Measures**

The measures utilized were those currently in use for these services: the PHQ-9 (Kroenke et al., 2001) and the GAD-7 (Spitzer et al., 2006). These are brief, symptom-oriented reports covering symptoms of depression and anxiety, respectively, based on DSM criteria for Major Depression and Generalised Anxiety Disorder. They were administered weekly at the beginning of each session. Patients were told that the therapy would be evaluated through measures given by the therapist at each session; all patients agreed to this.

Although DIT is not a symptom-focused therapy, adherence to this rigorous assessment schedule was very good, with a mean return rate of 94% for those completing treatment. The two patients who dropped out of the study contributed forms for each session attended (2 and 4, respectively).

Treatment acceptability was assessed with an anonymous treatment satisfaction questionnaire in use by the clinical service, which asked the patient four open-ended questions: what they had found most helpful, what they had found least helpful over the 16 sessions; what changes they had observed in their life since completing the therapy; and how they had experienced the weekly outcome monitoring. The questionnaire was handed out by the therapist at the last session and returned by mail (70% of patients submitted the report).

**Data Analysis**

Clinical caseness was determined through the cut-off score for mild depression and anxiety as assessed through the PHQ-9 and GAD-7, respectively.

All data, including early dropout data, were analyzed using a random regression model. Because of the small sample size, we did not impute missing data, and we used the last value carried forward method to estimate data for non-completers. STATA version 11 XTREG procedure was used to generate mixed effects linear and quadratic growth curve models for the PHQ-9 and GAD-7, both normally distributed variables in this sample. The coefficients below are the beta weights for mean differences between patients (intercept), linear and quadratic effects of time using robust standard errors to
provide conservative estimates of statistical significance. Mixed effects models and general estimating equations use all available data.

The qualitative data were analyzed using thematic analysis.

RESULTS

Pre-Post Measures

The mean PHQ score at the beginning of treatment was 12.0; this declined to a mean of 5.25 at the end of treatment ($d = 1.19$, 95% CI: 0.41 to 1.91). This is close to the threshold for clinical caseness (a score of 5 is the cutoff score for mild depression (Kroenke et al., 2001). At the beginning of treatment no cases scored below 6, while at termination 69% of cases ($n = 10$) scored 5 or below. The mean GAD score declined from 10.3 at the start of treatment to 4.4 at the end ($d = 1.34$, 95% CI: 0.54 to 2.07); a score of 5 indicates the cutoff point for mild levels of anxiety and 75% of the sample scored below that value. Mean scores by session are shown in Figure 1. On both variables, the steepest decline of mean scores was between session 1 and session 3.

Change Across Sessions

The best-fitting model for the decline of PHQ scores, included both a linear and a quadratic component for time, which was a reasonable fit overall (Wald $\chi^2 = 57.2$, $p < .0001$). The correlation between intercept and time was positive but not significant ($r = .36$, 95% CI: -0.42 to 0.83). The coefficient for linear decline indicated a 1 point decrease per session on the measure ($\beta = -1.03$; 95% CI -1.4 to -.71; $z = 6.27$, $p < .0001$). The coefficient for quadratic slope was also signifi-
cant, with a positive coefficient suggesting a rapid initial decline but also a slight tendency for increase in symptom scores in the last few sessions of the treatment ($\beta = .04; 95\% \text{ CI } .02 \text{ to } .06; z = 4.42, p < .001$).

The results for the GAD were quite similar. The best-fitting model, including both a linear and a quadratic component for time, was again a reasonable fit. The mixed effects regression model was highly significant ($\text{Wald } X^2 = 41.14, p < .0001$). The correlation between intercept and time was small and negative ($r = -0.04, 95\% \text{ CI: } -0.61 \text{ to } 0.56$). The linear decline in GAD scores was about a 0.9 point decrease per session ($\beta = -.89; 95\% \text{ CI } -1.2 \text{ to } -.57; z = 3.75, p < .0001$). The coefficient for quadratic slope was again significant, with a positive coefficient suggesting a rapid initial decline but also a slight tendency for increase in symptom scores in the last few sessions of the treatment ($\beta = .03; 95\% \text{ CI } .02 \text{ to } .05; z = 3.75, p < .001$).

Qualitative Data

The qualitative data suggest that all the patients who completed the questionnaire ($n = 10$) valued the interpersonal-affective emphasis of the therapy, and their perceived positive outcomes consistently reflected interpersonal gains. A thematic analysis of the data highlighted two consistent themes in response to the question of what had been most helpful about the therapy: “identifying patterns,” especially ones that were felt to sabotage relationships ($n = 5$), and ‘focus on feelings’ in their relationships ($n = 6$). In response to the question of what positive changes they had observed in their lives since the therapy, the central theme coalesced around the experience of the therapy as an aid to helping them to feel more confident in their relationships ($n = 6$), with a few patients also noting that they were better able to “manage interpersonal conflict” ($n = 4$). Although the patients themselves did not make this link, it was striking that 50% made explicit reference to how they now felt able to “manage negative feelings,” suggesting perhaps that through helping them recognize and express negative affect the therapy helped them feel better equipped to manage conflict in their relationships. Importantly, none of the patients reported finding anything unhelpful. The therapists regularly provided feedback about their experiences using this protocol to their supervisor, who kept notes of all their comments. This feedback led to the refinement of the training and of the protocol.

DISCUSSION

Preliminary Evidence for the Effectiveness of DIT

The intent of this pilot investigation was not formally to assess the effectiveness of DIT, but to examine the feasibility of the protocol in the context of primary care services in England, which uses session-by-session outcome monitoring as part of the quality assurance standards. From this preliminary examination, DIT appears to be a relatively effective intervention for mild to moderate depression. Despite the obvious limitations of this study due to the very small sample size, the data suggest that DIT was associated with a significant reduction in reported symptoms in all but one case, to below clinical levels in 70% of the patients. The pre-post effect sizes are comparable to those obtained in larger studies (Knekt et al., 2008; Driesen et al., 2007) and meta-analyses (Driesen et al., 2010; Abbass et al., 2007; Leichsenring et al., 2004) of short-term psychodynamic psychotherapy. The improvements observed were, on average, quite rapid, although the inter-subject variation in patterns of improvement was quite marked. It is also not unusual to observe that the greatest change occurs after the first few sessions of treatment (Cailhol et al., 2009; Segal et al., 2003). Random regression models
revealed highly significant quadratic as well as linear effects, confirming the significance of the decrease in reported symptom severity, but also cautioning about slight increase in symptoms around the ending phase of the treatment. This may be accounted for by the particular emphasis placed by the DIT therapist on the affective experience of ending that heightens the patient’s awareness of feelings of loss and distress in the last phase of the therapy. Analysis of the followup data in the future is required to evaluate the meaning of this trend.

Implications for Feasibility Based on Patients’ and Therapists’ Reports

The qualitative data were very encouraging. First, the protocol was felt to be helpful by patients and therapists alike. The rationale for the therapy had face validity across a range of patients from diverse socioeconomic and ethnic backgrounds. All the patients who completed the therapy found it helpful and relevant to their problems, as also indicated by the quantitative data. Although this may say more about the therapists than it does about the model, if the model was not acceptable, it might have been shown to be problematic despite the therapists.

Second, the therapists’ and patients’ experience of collecting outcome data was also encouraging. Despite the initial concerns about how such monitoring would interfere with the therapeutic process, weekly routine outcome monitoring was sensitively and usefully integrated within the therapy without this compromising the process.

Third, the chosen pilot site is representative of many public health services, and hence the implementation of this protocol was exposed to the stresses and strains that are common in such settings—and yet it fared well. This study was located in a very deprived, multi-ethnic Inner London borough. Patients were consecutive primary care referrals not selected for psychodynamic treatment on the basis of suitability. Their feedback along with the naturalistic setting of the pilot thus suggest that DIT may be useful in other routine clinical settings where a brief, focused model is applicable, and perhaps also for other common disorders, such as anxiety, dysthymia, and adjustment disorders.

Fourth, the close alignment of this protocol to the competences required to deliver effective psychodynamic therapy makes it possible to clearly specify the pre-entry training requirements and the training curriculum itself. This protocol can thus contribute to the development of more evidence-based systems for monitoring the quality of services by setting out the competences that therapists could be expected to adhere to.

Finally, the therapists’ unanimous positive reports and enthusiastic espousal of the protocol suggest that it is easy to grasp and implement for clinicians who are reasonably experienced at offering once weekly psychodynamic therapy in a public health service setting without having to undergo intensive psychoanalytic training. Feedback from both therapists and patients has contributed to further refinement of the protocol, and to an extension of the training to 32 hours (i.e., four days), with the main increase being in the time given to experiential learning. It nevertheless remains a relatively brief training that looks promising in its potential for helping dynamically oriented clinicians to achieve good results.

In summary, although no definite conclusions regarding the effectiveness of DIT can be drawn from this study given the size of the sample, this pilot nevertheless provides the basis for developing the methodology for a larger scale randomized controlled trial to test the effectiveness of DIT with depressed patients.
REFERENCES


