Curriculum for High Intensity Brief Dynamic Interpersonal Therapy (DIT)

CONTINUING PROFESSIONAL DEVELOPMENT FOR QUALIFIED THERAPISTS DELIVERING HIGH INTENSITY INTERVENTIONS

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Professor Alessandra Lemma
Director
Psychological Therapies Development Unit
Tavistock and Portman NHS Foundation Trust
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1. Introduction

1.1. Background

Brief Dynamic Interpersonal Therapy (DIT) is the brief psychodynamic therapy model offered at Step 3 within IAPT. The National Institute for Health and Clinical Excellence (NICE) guidelines for depression state that brief psychodynamic therapy is one option that can be considered for depressed patients either when the patient has not responded to CBT interventions, or where the patient actively opts for a psychodynamic approach.

DIT was explicitly developed out of the Psychoanalytic/dynamic Competences Framework (Lemma et al., 2008) that provided the basis for the National Occupational Standards (NOS). It is consequently drawn from those psychoanalytic/dynamic approaches with the strongest empirical evidence for efficacy, based on the outcome of controlled trials. It is specifically designed to address presenting symptoms of depression and for delivery within the context of modern public health care provision in an IAPT service.

1.2 What is DIT?

DIT is a time-limited (16 sessions) psychodynamic intervention that draws on expressive, supportive and mentalising techniques (Lemma, Target and Fonagy, in press). The assumptions informing this protocol are similar to those that underpin other brief dynamically oriented approaches: (a) that behaviour 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 behaviour and emotional experience in terms of mental states has significant therapeutic effects, (f) that therapy should focus on the patient's current relationships, including the relationship with the therapist.

1.3 Course Accreditation

All courses need to be accredited by the British Psychoanalytic Council.

1.4 Training selection criteria

The training programme for DIT provides psychoanalytically/dynamically trained practitioners with a structure within which to conduct a time limited (16 sessions), manualized psychodynamic therapy. It is intended as a CPD course to hone the skills of already established psychodynamic practitioners so as to enable them to deliver an effective brief psychodynamic intervention for the treatment of depression.
Courses for high-intensity DIT therapists will aim to provide a post-qualification ‘top-up’ training to practitioners who meet the following pre-entry criteria:

1. They have undertaken a course of study that includes knowledge about psychoanalytic developmental theory and the theory underpinning the rationale for psychodynamic interventions.

2. They will have undertaken a minimum of one year of personal psychoanalytic/psychodynamic psychotherapy or counselling.

3. They will have undertaken a minimum of 150 hours of supervised psychodynamic practice.

4. They will be HPC, BAPC, BPC or UKCP registered.

5. They will have obtained a minimum of two years’ post-qualification experience in an NHS or voluntary setting with depressed patients and those presenting with other mental health problems.

1.5 Training structure

The training programme comprises two components:

1. A five-day full time course that covers in detail the DIT protocol and its delivery within an IAPT service context.

2. Weekly supervised practice with two depressed patients using the DIT protocol.

1.6 Cultural competence and equality

The course objective to acquire cultural competence aligns with statutory duties under the Equality Act 2010, requiring public authorities who exercise public functions and organisations carrying out public functions on behalf of a public authority, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations between people of shared protected characteristics and those who do not. Achieving cultural competence is a lifelong learning process. Cultural competence for high-intensity DIT therapists will aim to develop the student’s ability to recognise their own reaction to people who are perceived to be different and values and belief about the issue of difference (cultural competence module). The assessment criteria will include

- Definition of culture, related values and factors effecting culture e.g. age, disability, marital status, ethnicity, parental status, sexual orientation, gender, education, language, socio-economic status, and religion or belief.

- Raise awareness of the student’s reaction to people who are different and the implications of these reactions during sessions.
• To develop ability to take responsibility for responses and actions taken with people who are different or are perceived to be different

• To develop ability to accept ambiguity of not knowing what to expect or what to do initially during an inter-cultural situation.

• Risk taking in order to communicate effectively with people from diverse cultures.

• Work effectively with interpreters, establishing ways of working together and considering clinical implications.

1.7 Course training staff

1.5.1 Requirements for running a training programme

DIT training can be provided by suitably qualified DIT practitioners under the overall course leadership of an approved DIT trainer.

In order to become a DIT trainer the individual will have successfully completed the following:

1. Practitioner level qualification in DIT as specified by British Psychoanalytic Council (BPC), the accrediting body.

2. Supervisor level accreditation, which involves successfully completing a further 2 supervised cases.

3. A six-month period as a supervisor with monthly consultations on the supervision with an accredited DIT supervisor.

4. Shadowing a full five-day course with an established trainer.
1.5.2 Requirements for becoming an accredited supervisor

In order to become a supervisor the individual will have successfully completed the practitioner level qualification in DIT as specified by British Psychoanalytic Council (BPC), the accrediting body, and successfully completing a further 2 supervised cases, followed by a six-month period as a supervisor with monthly consultations on the supervision with an accredited DIT supervisor.

2. Course aims and objectives

The course assumes an established core psychodynamic theoretical knowledge base, with a particular focus on object relations theory, attachment theory and interpersonal psychoanalysis. These theoretical influences are therefore only briefly reviewed in the five day course, providing a ‘refresher’ of the relevant psychodynamic theories informing the DIT protocol as well as their relevance to the understanding of depression more specifically.

The greater emphasis of the course will be on providing practical skills training to support the development of psychodynamic techniques applied within a brief psychodynamic format.

The course will aim to equip students to practice as competent, independent DIT practitioners in accordance with the British Psychoanalytic Council’s (BPC) outlines for good practice. The BPC is the accrediting body for this course.

The training programme, including the period of supervised clinical practice, will provide opportunities for students to develop and demonstrate knowledge, understanding and skills as follows:

1. Techniques relevant to working in a focused manner with a depressed patient in a psychodynamic framework.

2. An understanding of the nature of depression both generically (e.g. symptomatic profile, prevalence), and more specifically within a psychoanalytic framework.

At the end of the training programme students will be able to:

1. Demonstrate knowledge of the principles of DIT for the treatment depression.

2. Use the DIT formulation model to link the onset of depressive symptoms to an unconscious, repetitive interpersonal-affective pattern (the IPAF).

3. Share the formulation openly with the patient, explain the model and negotiate a treatment plan with them.

4. Use the formulation to guide the therapy and remain focused

5. Integrate session-by-session outcome monitoring within the parameters of a
psychodynamic intervention.

6. Demonstrate an ability to adapt DIT flexibly so as to meet the individual needs of the patient where required.

3. Training outline and trajectory

The training programme consists of several components and assessment points, as follows:

1. Attendance at a five day full time training course.

2. Competence role-play: At the end of the five days students will be invited to undertake a videotaped role play with an actor role-playing a depressed patient. The role-play vignette will be scripted with a relatively mild to moderately depressed patient in mind.

During this role-play students will have to evidence:

a. An aptitude for identifying relational and affective themes from the patient’s material: the aim is to ensure that the student can pick up on themes but there is no requirement to evidence a capacity to formulate.

b. A capacity to articulate and share with the patient these relational and affective themes in a clear and coherent manner so as to test their relevance to understanding the patient’s current predicament

c. Demonstrate the DIT therapeutic stance.

The above criteria will be clearly specified at the outset so that students are clear about what is expected of them. Ideally the trainers will either demonstrate these skills in a live role-play at some point over the five days or will show the students a DVD exemplifying these skills/aptitudes so as to provide the students with an indication of what is required.

3. Each role play will last fifteen minutes and is rated according to the 3 criteria above each scored on a 5 point scale where 1 (=not all evidenced) and 5 (=very evidenced). In order to proceed students will score no less than 3 on all three criteria.

4. If the student passes the role-play they can then proceed to the practice component of the training.

5. If the student fails the role play they will be given detailed feedback about the reasons for this and given the opportunity to do another role-play some months later, if they so wish. Meanwhile they will be encouraged to reflect on the feedback with their own supervisor in their workplace and to identify areas of competence they may need to attend to if they wish to pursue DIT training in future.
6. The supervised practice component will involve seeing two depressed patients under weekly supervision. Each patient will be seen for sixteen sessions of weekly DIT. All therapy sessions will be audio or videotaped. In the first case three tapes will be randomly selected and rated according to the DIT rating scale. For the second case, assuming that a student is progressing well in the training, one tape will be selected for rating. Where there are concerns about the student’s progress an additional two tapes may be requested and rated.

7. Upon successful completion of the clinical casework the student will need to submit a 3000 word case study, which should evidence a capacity to integrate theory and practice through giving an account of work with one of the two training cases.

8. The student will then submit a portfolio confirming successful completion of their supervised practice, along with successful completion of the case study, and evidence that they meet all the pre-entry requirements. All requirements will need to be successfully completed before the portfolio can be submitted to the BPC for eventual accreditation as a BPC-approved DIT practitioner.

4. Course structure

They will be run as a five-day full time course. The curriculum outlined below relates specifically to the five day taught course, but the overall training programme also includes the supervised clinical practice component.

It is anticipated that students will attend the five-day course over one week. Immersion in the model in this concentrated manner is advised. The particular organisation of the training days will vary, but we recommend that the emphasis of the course is placed on explaining the rationale for the protocol, its relevance to depressed patients seen in an IAPT context, and skills practice, with less time overall allocated to theory. This is because the pre-entry training requirements stipulate grounding in psychodynamic theory and hence we are assuming students will have already acquired the background theory through their previous diploma level training in psychodynamic psychotherapy or counselling.

Training providers will need to liaise closely with commissioners and local IAPT managers to ensure that students will be given the required time to undertake the two supervised clinical cases.

Students on the course will be expected to see a minimum of two patients, both of them over sixteen sessions each. In addition they will be expected to:

a) attend a weekly supervision, or individual supervision, for the duration of their supervised clinical practice

b) submit formal audio/videotaped sessions giving due consideration to data protection policies.
5. Learning and teaching strategy

Without wishing to be overly prescriptive the teaching strategy, which will vary to a degree depending on the training provider, should incorporate the following:

1. Experiential and skill-based group work over the five-day course so as to provide students with the opportunity to practice particular features of the DIT protocol, which require some adaptation of a more classical psychoanalytic technique.

2. Small case discussion groups to support the student’s practice in formulating using the DIT model.

3. Skill-based competency will be supported through small group work and role-plays during the five day course, and the opportunity to observe videos of DIT sessions providing examples of ‘on-model’ and ‘off-model’ interventions.

4. During the five day course there should be opportunities for small groups to benefit from being observed by one of the trainers whilst role-playing so that direct feedback can be given.

5. Ongoing clinical supervision for two cases by members of the training team all of whom will be DIT supervisors.

6. Self-directed study to support the written assignment.

6. Assessment

Throughout the training programme a range of self-assessment and other formal assessment procedures will be used:

1. Prior to coming on the course students will be invited to fill out the DIT self-assessment tool (link to tool).

2. A videotaped 15 minute role-play with an actor at the end of the five-day course to assess aptitude for the DIT model.

3. A minimum of four taped DIT sessions from the supervised caseload, which will be rated by the supervisor, will need to be ‘passed’. Where there are concerns about a student’s progress an additional two tapes may be required from the second case. The rating scale is in Appendix 2. The students’ tapes need to be considered developmentally such that there is no expectation that the early tapes should demonstrate a high level of adherence to all the items. Rather, the aim is to ensure that by tapes 3 and 4 the ratings will be in the range of at least 4 and above.

4. If the student fails one case, they are given the opportunity to see another case. If this latter also fails the course Director will meet with the student to discuss this
and assess, along with the supervisor’s feedback, whether the student should be encouraged to resubmit another case or whether the training would be best discontinued.

5. A case study of approximately 3000 words, evidencing a capacity to integrate theory and practice using one of the two supervised cases.

7. Competences

All the competences outlined in this document are integral to the delivery of the DIT protocol, and reflect both the overarching psychodynamic competence framework and the more specific adaptations of this framework for DIT. Please refer to Lemma et al. (2008, 2010) for detailed information about the competence frameworks.

The pre-entry training requirements have been set at a level commensurate with the basic and specific competences as set out in the psychodynamic framework. The expectation therefore is that students will fulfill these competences before they embark on the DIT training.

By the end of the five-day course students will demonstrate additional competence in the following knowledge and applied domains related to the delivery of DIT specifically:

- Knowledge of the developmental model underpinning the understanding of depression
- Knowledge of the aims and focus of the DIT protocol
- Knowledge of DIT’s treatment strategy
- Ability to adopt the DIT therapeutic stance
- Ability to assess the quality and patterning of the client’s current and past interpersonal functioning
- Ability to engage the client in DIT

By the end of the period of supervised practice students will demonstrate competence in the following applied domains:

- Ability to independently formulate an interpersonal-affective focus (IPAF)
- Ability to help the client identify their aims for the therapy
- Ability to work to the agreed focus
- Ability to focus the content of interventions
- Ability to work collaboratively with the client towards an understanding of the transference experience
- Ability to support the client’s mentalising stance in relation to the IPAF
- Ability to encourage interpersonal change
- Ability to explore the unconscious and affective experience of ending
- Ability to work with difference (cultural competence)

8. Descriptions of individual modules and their link to the competences
The five-day course comprises 7 modules that are closely linked to the psychodynamic competences framework (Lemma, Roth and Pilling, 2011 – see appendix 1) and for DIT specifically (www.ucl.ac.uk/clinical-psychology/CORE). These need to be considered alongside the generic competences framework that underpins all psychological therapies (www.ucl.ac.uk/clinical-psychology/CORE).

As a protocol DIT draws on expressive, supportive and mentalising techniques all of which will be addressed over the five-day course. However it is important for the trainers to keep in mind that activities in all domains of DIT competence need to be carried out in the context of an overarching competence: the ability to approach all aspects of the interaction with the client, and of the management of the therapeutic setting, with an “analytic attitude”. The analytic attitude describes the therapist’s ‘position’ or state of mind in relation to the therapeutic task. This stance is characterised by a receptiveness to the client’s unconscious communications and to the unfolding of the transference. This competence therefore is one that needs to evidenced throughout.

The suggested sequence of teaching over the five days is as follows:

**Day 1**

Day 1 ideally covers Modules 1 – 3. The focus is primarily on reviewing the theory underpinning the DIT model as well as more specific psychoanalytic theory pertaining to an understanding of depression.

It is also important to set out the overall DIT model, its rationale and aims, so that the students can begin to reflect on the distinctive emphasis of the DIT model in relation to the patient's presentation.

**Day 2**

Day 2 should aim to focus particularly on the initial stage of DIT (Module 4), giving students ample time to practice eliciting interpersonal narratives and articulating emergent affective and relational themes. IT should also cover the use of session-by – session outcome monitoring allowing space for reflection on this feature of DIT, which not uncommonly elicits some concerns amongst psychodynamic clinicians.

**Day 3**

Day 3 focuses specifically on the DIT formulation model (Module 4), and invites students to bring their own cases to formulate using DIT and practicing this through a role-play sharing the DIT formulation with the patient, setting goals and explaining the model.
Day 4

Day 4 provides further opportunities to reflect on formulation and then moves on to specifically consider the middle phase of the work, reviewing the various techniques that DIT draws on, with a particular emphasis on mentalising techniques (Module 5). Students are invited to role play a patient who arrives at the session with a very recent interpersonal incident that is distressing to them and the therapist is encouraged to use mentalising techniques to engage the patient in thinking about their mental states as well as those of other in this incident.

Day 5

Day 5 focuses on the ending phase (Module 6) and assessing suitability for the DIT model, and on the implementation of DIT within and IAPT service, with teaching specifically aimed at reviewing NICE guidance, pharmacotherapy, and outcome monitoring (Module 7).

Individual module objectives

A more detailed breakdown of each module’s objectives now follows. This is supported by a PP slideshow that covers the essential components of the protocol (excluding theory and IAPT specific slides).

The slides provide a skeleton outline of the essential learning points. They are directly based on the treatment manual developed by Lemma, Target and Fonagy (in press, 2011). Trainers will need to add additional slides to complement this package as they see fit, but especially for Module 3, which aims to give a theoretical overview of DIT’s origins. Here trainers are encouraged to refer to the suggested references in the Curriculum Guide and to structure the theoretical overview accordingly. For Module 7, trainers should refer to the generic IAPT slides.
Module 1: Orientation to DIT Model

Teaching objectives: Module 1

- To provide an account of the development of DIT and its rationale
- To review the competence framework that underpins the practice of DIT
- To contextualise DIT in relation to other dynamic/analytic approaches
- To provide opportunities for students to discuss their anxieties in relation to learning a new, manualised form of brief dynamic therapy and the perceived threats this may be felt to pose to the integrity of an analytic/dynamic way of working
- To provide a succinct theoretical overview of the psychoanalytic ideas underpinning the model:
  - Attachment theory
  - Object relations theory
  - Harry Stack Sullivan’s ‘interpersonal psychoanalysis’

This module refers to the following competences:

1. Knowledge of the developmental model underpinning the understanding of depression (see appendix 3)
Teaching objectives continued …

- To use the theoretical overview to foreground some of DIT’s key features and their relationship to depression, namely:
  - DIT is rooted in the assumption of:
    - the social origins and nature of individual subjectivity
    - the importance of attachments and that threats to attachments can lead to depressive reactions.
    - the importance of the capacity to mentalise experience without which the patient is more vulnerable to developmentally primitive modes of experiencing internal reality
  - Past relationships are understood to contribute to current difficulties through the activation of internalised representations of self and others that may trigger and/or maintain depressive symptoms.
  - The core aims in DIT are to:
    - help the patient to think about their depressive symptoms in relation to what is happening in their relationships now (including the relationship with the therapist).
    - systematically focus on the patient’s state of mind, not on their behaviour, and on their affects in the here-and-now of the session or recent past, not on the interpretation of unconscious or distal events.

This module refers to the following competences:

1. **Knowledge of the developmental model underpinning the understanding of depression**
Module 2: Core features and strategies

Teaching objectives: Module 2

- To outline the core features of DIT (at this stage the aim is to give an overview without getting into the detail, for example, of the IPAF)
- To outline the tri-phasic structure of DIT and how each phase relies on the implementation of particular strategies that drive the therapeutic process and aim to keep the therapist and patient focused.
- To clarify that even though DIT encourages in between session ‘work’ to change interpersonal patterns this is supported through a sensitive, but active exploration of the patient’s mental states, not his behaviour.
- To clarify what is meant by working in the ‘here-and-now’ within DIT: although DIT does make use of the transference, and to this extent works in the classical analytic sense of ‘here-and-now’, it also distinguishes itself from some dynamic/analytic approaches to the extent that there is an explicit emphasis on an exploration of current difficulties that the patient is actively encouraged to try to resolve.
- To outline the core techniques used in DIT (supportive, expressive and mentalising) all of which aim to help the patient to understand what is happening in his mind when things go wrong in relationships.
- To link the techniques to the aims of the therapy, that is, that the therapist may deploy a range of techniques so as to generate, clarify and elaborate interpersonally relevant information.
- To engage students in thinking about the demands and adaptations required to working within a time-limited frame.

(NB: It is not necessary to cover the techniques in detail at this stage as they will be covered more thoroughly when reviewing the work of the middle phase)

This module refers to the following competences:

2. Knowledge of the aims and focus of treatment
3. Knowledge of the treatment strategy
4. Therapeutic stance
Module 3: About depression

Teaching objectives: Module 3

• To review key facts about depression and highlight its complexity

• To review relevant psychodynamic formulations about depression

This module refers to the following competences:

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<td>1. Knowledge of the developmental model underpinning the understanding of depression</td>
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Module 4: The Initial Phase

Teaching objectives: Module 4

• To outline the core aims and strategies of the initial phase. This will involve covering the following areas:
  o How to engage the patient
  o Assessment
  o Eliciting interpersonal narratives
  o Listening out for cautionary tales
  o Developing an interpersonal map
  o Identifying attachment styles and using the attachment questionnaires
  o Formulating an interpersonal-affective focus
  o Negotiating the contract
  o Negotiating outcome monitoring and how to meaningfully integrate this into the therapeutic process

• This module blends didactic and practice components to allow students to experiment with the model using role plays, specifically to practice:
  o eliciting interpersonal narratives
  o formulating an IPAF
  o explaining the model to the patient

This module refers to the following competences:

6. Ability to assess the quality and patterning of the client’s current and past interpersonal functioning and formulate a focus

7. Ability to engage the client in DIT

8. Ability to help the client identify their aims for the therapy, ability to work to the agreed focus

13. Ability to integrate routine outcome monitoring into the therapeutic process

16. Ability to work with difference (cultural competence)
Module 5: The Middle Phase

Teaching objectives: Module 5

- To outline the aims and strategies of the middle phase. This will include covering the following areas:
  - sequence of movement in the middle phase
  - tracking the IPAF and how to stay focused
  - use of expressive, directive and mentalising techniques
  - focusing on affect
  - working with defences and resistance
  - working in the transference
  - using the countertransference
  - managing difficulties in the therapeutic relationship

This module refers to the following competences:

9. Ability to focus on the content of interventions
10. Ability to work collaboratively with the client towards an understanding of the transference experience
11. Ability to support the client’s mentalising stance in relation to the IPAF
12. Ability to encourage interpersonal change
Module 6: The Ending Phase

Teaching objectives

- To outline the aims and strategies of the ending phase. This will include covering the following areas:
  - How to prepare the patient for ending
  - Interpreting the unconscious meaning of endings
  - Managing ‘Acting out’
  - How to write a good-bye letter and how to use this to initiate the process of addressing the end of therapy

This module refers to the following competences:

14. Ability to explore the unconscious and affective experience of ending
Module 7: Assessing suitability

Teaching objectives: Module 7

• To review suitability criteria for DIT and selection of cases for the supervised practice

• To provide information and space for reflection about IAPT services, NICE guidance for the treatment of depression, pharmacotherapy and the place of DIT within the stepped model of care. This module should include:
  o Assessment of risk
  o Review of the NICE guidelines for depression and the place of DIT within a stepped care model of care
  o The role of medication
  o Overview of IAPT services and their philosophy of care:
    • Stepped Care, referral criteria and self-referral, triage and assessment
    • Low and High Intensity Interventions; medication
    • Roles: Psychological Wellbeing Practitioners, High Intensity Therapists, GP Leads, Employment advisors
    • Supervision and case management
    • Risk and safe-guarding policies
    • Return to work
    • Choice and personalisation
    • Diversity of providers

This module refers to the following competences:

a. Knowledge of depression

b. Ability to assess and manage risk of self-harm

c. Ability to use measures to guide therapy and to monitor outcomes
Monitoring and evaluation

• Session by session monitoring of outcomes
• Prescribed measures
• Data protection issues
• Number of sessions
• Stepping up and stepping down
• When to complete/discontinue treatment based on amount of change in clinical outcomes
• Key Performance Indicators

Modalities based on NICE Guidance

• CBT
• Counselling for Depression
• Couple Therapy for Depression
• DIT
• IPT

Long term sustainability

• Realising the Benefits policy guidance
• Role of SHAs and PCTs
• Equity of access
• Tailoring to special populations and communities
• Workforce planning for the psychological workforce in the future
Bibliography

Essential reading


Recommended reading relevant to DIT


Recommended reading relevant to IAPT and generic competences

CCAWI website,
www.lincoln.ac.uk/ccawi/publications/Ten%20Essential%20Shared%20Capabilities.pdf


Ethnicity Online. Useful web resources and good practice guidelines at www.ethnicityonline.net/resources.htm


HM Government Office for Disability Issues:
http://www.officefordisability.gov.uk/index.php

MIND information on different community groups:
http://www.mind.org.uk/help/people_groups_and_communities/


Royal National Institute for the Blind at http://www.rnib.org.uk/Pages/Home.aspx


Appendix 1

The Psychodynamic Competences Framework

[Diagram showing various competencies and their relationships, including: Ability to maintain an analytic attitude, General therapeutic competencies, Specific analytic/dynamic competencies, Problem specific competencies/specific adaptations, Meta-competences, etc.]

- Ability to make dynamic interpretations
- Ability to work in the transference
- Ability to work with the counter-transference
- Ability to recognise and work with defences
- Ability to work through the termination phase of therapy
- Ability to make use of the therapeutic relationship as a vehicle for change
- Ability to apply the model flexibly in response to the client’s individual needs and context
- Ability to establish an appropriate balance between interpretative and supportive work
- Ability to identify and skillfully apply the most appropriate analytic/dynamic approach

[Further details on specific competencies and their descriptions are also present in the diagram, such as knowledge and understanding of mental health problems, ability to engage the client in analytic/dynamic therapy, ability to establish and manage the therapeutic frame and boundaries, etc.]
Appendix 2

DIT-Session Rating Form

Therapist: ............................................
Session .............................................

Client ID: ...........................................  Rater: ..................................................

Instructions: Using the scale provided below, please rate how characteristic each statement was of the therapy session. For each item, please write the scale rating number on the blank line provided.

Scale:

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<tbody>
<tr>
<td><strong>Not at all characteristic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Highly characteristic</strong></td>
</tr>
</tbody>
</table>

(1) The therapist works collaboratively with the patient to formulate and agree an IPAF _____ *(initial sessions only)*

(2) The therapist encourages the exploration of feelings _____

(3) The therapist focuses on the patient’s mind rather than his behaviour _____ (links interpersonal processes with patient’s mental states)

(4) The therapist focuses discussion on the agreed IPAF _____

(5) The therapist focuses on the exploration of interpersonal events _____

(6) The therapist help the patient to discover what he *currently* feels and how this relates to current and past interpersonal experiences _____

(7) The therapist helps the patient to make connections between symptoms and interpersonal events _____
(8) The therapist maintains an active, supportive stance to encourage the patient to try out new ways of resolving their interpersonal difficulties in-between sessions ______

(9) The therapist gives explicit advice or direct suggestions to the patient ______

(10) The therapist actively initiates the topics of discussion and therapeutic activities ______

(11) The therapist links the patient’s current feelings or perceptions to experiences of the past ______

(12) The therapist focuses attention on similarities among the patient’s relationships repeated over time, settings, or people ______

(13) The therapist focuses discussion on the patient’s irrational or illogical belief systems ______

(14) The therapist focuses discussion on the relationship between the therapist and patient in order to further the exploration of the IPAF ______

(15) The therapist encourages the patient to experience and express feelings in the session ______

(16) The therapist addresses the patient’s avoidance of important topics and shifts in mood ______

(17) The therapist explains the rationale behind his or her technique or approach to treatment ______

(18) The therapist suggests alternative ways to understand experiences or events not previously recognized by the patient ______

(19) The therapist identifies recurrent patterns in the patient’s actions, feelings and experiences ______

(20) The therapist provides the patient with information and facts about his or her current symptoms, disorder, or treatment ______

(21) The therapist allows the patient to initiate the discussion of significant issues, events, and experiences ______

(22) The therapist teaches the patient specific techniques for coping with symptoms ______
The therapist encourages discussion of patient’s wishes, fantasies, dreams, or early childhood memories (positive or negative) ____

The therapist interacts with the patient in a didactic manner ____

Ending phase sessions only

The therapist facilitates the expression of the patient’s anxieties and fantasies about ending ____

The therapist helps the patient to review work that has been accomplished ____

The therapist engages the patient in anticipating future difficulties/areas of vulnerability ____

<table>
<thead>
<tr>
<th>1. Not at all characteristic</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6. Highly characteristic</th>
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Appendix 3

Brief Dynamic Interpersonal Therapy for Depression (DIT)

This section describes the knowledge and skills required to carry out Dynamic Interpersonal Therapy.

It is not a ‘stand-alone’ description of technique, and should be read as part of the psychoanalytic/ psychodynamic competence framework.

Effective delivery of this approach depends on the integration of this competence list with the knowledge and skills set out in the other domains of the psychoanalytic/ psychodynamic competence framework.


Knowledge

0. General

An ability to draw on knowledge of the psychological and interpersonal difficulties experienced by clients with a diagnosis of depression

1. Knowledge of the developmental model underpinning the understanding of depression

| An ability to draw on knowledge that DIT is grounded in attachment theory (including models of mentalisation), object relations theory and interpersonal psychoanalysis |
| An ability to draw on knowledge of attachment-based and object relational models of depression |

2. Knowledge of the aims and focus of treatment

| An ability to draw on knowledge that DIT aims to help the client: |
| understand the connection between their presenting symptoms and significant difficulties in their relationships, by working with them to identify a core, unconscious, repetitive pattern of relating (and making this the focus of the therapy) |
| develop a capacity to mentalise |

| An ability to draw on knowledge that the primary aim of DIT is to enhance the client’s interpersonal functioning and their capacity to think about and relate, |
changes in their mood to mental states (conscious and non-conscious)

<table>
<thead>
<tr>
<th>An ability to draw on knowledge that DIT systematically focuses on:</th>
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<tbody>
<tr>
<td>a circumscribed interpersonal and affective focus (IPAF) that is linked with the onset and/or maintenance of symptoms</td>
</tr>
<tr>
<td>the client’s state of mind, rather than their behaviour)</td>
</tr>
<tr>
<td>the client’s experience in the here-and-now of the session or recent past, rather than the interpretation of distal events</td>
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</tbody>
</table>

### 3. Knowledge of the treatment strategy

<table>
<thead>
<tr>
<th>An ability to draw on knowledge that the three main phases of the treatment have distinct aims:</th>
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<tbody>
<tr>
<td>an <em>initial</em> phase that aims to assess the quality and patterning of relationships, past and present, as the basis for identifying a dominant, recurring, unconscious interpersonal and affective pattern (IPAF) that will become the focus of the therapy</td>
</tr>
<tr>
<td>a <em>middle</em> phase that focuses on helping the client to elaborate and work on the IPAF</td>
</tr>
<tr>
<td>an <em>ending</em> phase that focuses on helping the client to reflect on the affective experience of ending and so prepare for ending and plan for the future</td>
</tr>
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</table>

| An ability to draw on knowledge that DIT makes active use of the client-therapist relationship to explore the IPAF |
| An ability to draw on knowledge that DIT makes use of expressive, supportive and directive techniques to support the aims of the treatment |

### Interventions

#### 4. Therapeutic stance

| An ability to establish and maintain an involved, empathic relationship with the client: |
| An ability to establish and sustain an active, collaborative stance |
| An ability to adopt a ‘not knowing’, curious stance when exploring the client’s mental states, to communicate a genuine attempt to find out about their mental experience |

#### 5. Ability to assess the severity of the client’s depression

| An ability to assess the client’s overall functioning to arrive at a diagnosis of depression |
| An ability to assess level of risk: |
| An ability to involve relevant professional networks to support the therapy where appropriate |
6. Ability to assess the quality and patterning of the client’s current and past interpersonal functioning and formulate a focus

| An ability to generate, clarify and elaborate narratives about relationships |
| An ability to draw the client’s attention to repetitive patterns in their relationships |
| An ability to identify one dominant repetitive interpersonal pattern that is connected to the onset/maintenance of the depression and that will become the focus of the therapy (the Interpersonal Affective Focus – IPAF) |
| An ability actively to reflect on, and make use of, the transference relationship, and the therapist’s countertransference, to arrive at the formulation of the IPAF |

7. Ability to engage the client in DIT

| An ability to communicate with the client in a direct, transparent manner that invites them to provide feedback on the formulation and process of therapy: |
| An ability to respond to requests by the client for clarification in a direct and clear manner that models a self-reflective stance that is open to correction |
| An ability to offer a “trial interpretation” in order to: |
| make use of client’s response to the interpretation in order to elaborate the evolving formulation |
| assess the client’s capacity to make use of such interventions |
| An ability to engage the client in formulating the focus of the work by: |
| tentatively sharing an understanding of how their presenting symptoms/problems may be connected with unconscious feelings and interpersonal conflicts. |
| actively soliciting the client’s response to the formulation and engaging reflection on their emotional reaction to it |
| modifying the formulation in line with new understanding developed with the client. |
| An ability to introduce the client to the rationale and aims of DIT through the use of ‘live’ material in the session (e.g. by drawing the client’s attention to recurring interpersonal dynamics as they describe themselves and their relationships) |
| an ability to personalise the introduction of the model by linking it to the client’s own history, current symptoms and interpersonal experiences |

8. Ability to help the client identify their aims for the therapy

| An ability to identify and agree with the client therapeutic goals that are meaningfully connected with the agreed IPAF |
| An ability to help the client to be realistic about what can be achieved within a brief time frame: |
| an ability to respond to any feelings the client has about areas it may not be possible to work on |

Ability to work to the agreed focus

| An ability to elicit interpersonal narratives and to track the agreed IPAF as it |
emerges in the narrative(s) as the basis for any interpretation

<table>
<thead>
<tr>
<th>Ability to maintain a focus on current significant relationships that demonstrate the activation of the IPAF and its relationship to depression:</th>
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<tbody>
<tr>
<td>an ability to take a stance of curiosity about interpersonal scenarios (e.g. asking questions and clarifications as necessary, to bring into focus an interpersonal exchange so as to highlight a salient repetitive pattern).</td>
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<table>
<thead>
<tr>
<th>Ability to maintain a focus on the agreed IPAF by:</th>
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<tbody>
<tr>
<td>identifying areas of difficulty in the client’s relationships that relate to the IPAF</td>
</tr>
<tr>
<td>understanding the client’s characteristic ways of managing areas of difficulty in their relationships and to point out the ‘cost’ of these strategies</td>
</tr>
<tr>
<td>inviting reflection on the unconscious assumptions behind feelings and thoughts when in a relationship in order to highlight the way these assumptions perpetuate or exacerbate interpersonal difficulties</td>
</tr>
<tr>
<td>drawing the client’s attention to their affective state in the session</td>
</tr>
<tr>
<td>attending to the therapeutic relationship in order to draw the client’s attention to moments when the relationship between therapist and client reflects the activation of the agreed IPAF</td>
</tr>
<tr>
<td>helping the client practise the skill of recognising internal states (feelings and thoughts) as they relate to the IPAF</td>
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</table>

9. Ability to focus the content of interventions

<table>
<thead>
<tr>
<th>Ability to focus on the client’s mind, not on their behaviour:</th>
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<tbody>
<tr>
<td>an ability to follow shifts and changes in the client’s understanding of their own and others’ thoughts and feelings</td>
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<table>
<thead>
<tr>
<th>Ability to focus on the client’s affects (primarily in relation to the here-and-now of the session and their current circumstances)</th>
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<table>
<thead>
<tr>
<th>Ability to focus on current relationships, including the relationship with the therapist</th>
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10. Ability to work collaboratively with the client towards an understanding of the transference experience

<table>
<thead>
<tr>
<th>Ability to help the client to be curious about what is happening in the therapeutic relationship</th>
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<table>
<thead>
<tr>
<th>Ability to identify and respond to enactments/ruptures in the therapeutic relationship:</th>
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<tbody>
<tr>
<td>an ability to respond non-defensively to the client’s experience of the therapist</td>
</tr>
<tr>
<td>an ability to use clarification and elaboration to elicit a detailed picture of what has transpired between client and therapist</td>
</tr>
<tr>
<td>an ability to monitor countertransference and to work to regain a reflective stance after an enactment</td>
</tr>
<tr>
<td>an ability to acknowledge and explore openly with the client any enactments on the part of the therapist:</td>
</tr>
<tr>
<td>an ability to communicate the therapist’s perspective about the impasse</td>
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</table>
or rupture

An ability to monitor and engage with the client’s response to an interpretation

### 11. Ability to support the client’s mentalising stance in relation to the IPAF

| An ability to use clarification and elaboration to gather a detailed picture of the feelings associated with a specific behavioural sequence related to the IPAF |
| An ability to help the client make connections between actions and feelings |
| An ability to help the client develop curiosity about their motivations |
| An ability for the therapist to share their perspective so as to help the client to consider an alternative experience of the same event |
| An ability to help the client shift the focus from non-mentalising interaction with the therapist towards an exploration of current feelings and thoughts (as manifested in the client-therapist interaction, or in recent experiences outside the therapy room) |

### 12. Ability to encourage interpersonal change

| An ability to balance helping the client to explore the IPAF and supporting them to make use of their understanding of the IPAF to change current relationship patterns that are linked with the onset and/or maintenance of depression |
| An ability to monitor and respond to the client’s experience of the therapist’s more active stance |

### 13. Ability to integrate routine outcome monitoring into the therapeutic process

| An ability to engage the client in reflecting on their responses to the questionnaires: |
| An ability to respond to the client’s use of the questionnaires in the context of the evolving transference relationship |
| An ability to use and interpret weekly questionnaire data in order to track progress, and to guide any changes to the intervention indicated by this data (e.g. in response to evidence of a deterioration in levels of depression) |

### 14. Ability to explore the unconscious and affective experience of ending

| An ability to assess the client’s sensitivity to separation so as to ensure that the meaning of the ending is worked on from the outset |
| An ability systematically to draw attention to, and explore, the client’s feelings, unconscious fantasies and anxieties about the ending of therapy. |
| An ability to recognise and respond to indications of regression near the end of treatment (e.g. a symptomatic deterioration) by linking this with the feelings and fantasies associated with endings. |
| An ability to help the client to review the therapy as a whole (e.g. whether they have achieved their aims): |
| An ability to help the client express disappointment where appropriate |
| An ability to respond non-defensively to the client’s feedback about the therapy |
15. **Ability to work with difference (cultural competence)**

- An ability to draw on knowledge that the term ‘difference’ refers to the individualised impact of background, lifestyle, beliefs or religious practices.
- An ability to draw on knowledge that the demographic groups included in discussion of ‘difference’ are usually those who are potentially subject to disadvantage and/or discrimination, and it is this potential for disadvantage that makes it important to focus on this area.
- An ability to draw on knowledge that clients will often be a member of more than one “group” (for example, a gay man with disabilities, or an older adult from a minority ethnic community), and that as such, the implications of different combinations of difference needs to be held in mind by therapists.
- An ability to maintain an awareness of the potential significance for practice of social and cultural difference across a range of domains, but including:
  - age
  - ethnicity (including nationality and ethnic origin)
  - class
  - religion or belief
  - gender
  - disability
  - gender reassignment
  - sexual orientation

- For all clients with whom the therapist works, an ability to draw on knowledge of the relevance and potential impact of social and cultural difference on the effectiveness and acceptability of an intervention.
- Where clients from a specific minority culture or group are regularly seen within a service, an ability to draw on knowledge of that culture or area of difference.
- An ability to draw on knowledge of cultural issues which commonly restrict or reduce access to interventions e.g.
  - language
  - marginalisation
  - mistrust of statutory services
o lack of knowledge about how to access services
o different cultural concepts, understanding and attitudes about mental health which affect views about help-seeking, treatment and care
o stigma, shame and/or fear associated with mental health problems (which makes it likely that help-seeking is delayed until/unless problems become more severe
o stigma or shame and/or fear associated with being diagnosed with a mental health disorder
o preferences for gaining support via community contacts/contexts rather than through ‘conventional’ referral routes (such as the GP)

• An ability for therapists of all cultural backgrounds to draw on an awareness of their own group membership and values and how these may influence their perceptions of the client, the client's problem, and the therapy relationship

• An ability to take an active interest in the cultural background of clients, and hence to demonstrate a willingness to learn about the client’s cultural perspective(s) and world view

• An ability to work collaboratively with the client in order to develop an understanding of their culture and world view, and the implications of any culturally-specific customs or expectations, for:
  o the therapeutic relationship
  o the ways in which problems are described and presented by the client
• An ability to apply this knowledge in order to identify and formulate problems, and intervene in a manner that is culturally sensitive, culturally consistent and relevant
• An ability to apply this knowledge in a manner that is sensitive to the ways in which individual clients interpret their own culture (and hence recognises the risk of culture-related stereotyping)

• An ability to take an active and explicit interest in the client's experience of difference:
  • to help the client to discuss and reflect on their experience of difference
  • to identify whether and how this experience has shaped the development and maintenance of the client’s presenting problems

  • An ability to discuss with the client the ways in which individual and family relationships are represented in their culture (e.g. notions of the self, models of individuality and personal or
collective responsibility), and to consider the implications for organisation and delivery of therapy

- An ability to ensure that standardised assessments/measures are employed and interpreted in a manner which is culturally-sensitive e.g.:
  - if the measure is not available in the client’s first language, an ability to take into account the implications of this when interpreting results
  - if a bespoke translation is attempted, an ability to cross-check the translation to ensure that the meaning is not inadvertently changed
  - if standardisation data (norms) is not available for the demographic group of which the client is a member, an ability explicitly to reflect this issue in the interpretation of results

- An ability to draw on knowledge of the conceptual and empirical research-base which informs thinking about the impact of cultural competence on the efficacy of psychological interventions

- Where there is evidence that social and cultural difference is likely to impact on the accessibility of an intervention, an ability to make appropriate adjustments to the therapy and/or the manner in which therapy is delivered, with the aim of maximising its potential benefit to the client
- An ability to draw on knowledge that culturally-adapted treatments should be judiciously applied, and are warranted:
  - if evidence exists that a particular clinical problem encountered by a client is influenced by membership of a given community
  - if there is evidence that clients from a given community respond poorly to certain evidence-based approaches

- Where the therapist does not share the same language as clients, an ability to identify appropriate strategies to ensure and enable the client’s full participation in the therapy

- where an interpreter/advocate is employed, an ability to draw on knowledge of the strategies which need to be in place for an interpreter/advocate to work effectively and in the interests of the client