The Origins of DIT
• Nothing ‘new’!

• Draws on the psychoanalytic competence framework (Lemma, Roth and Pilling, 2008) [www.ucl.ac.uk/CORE]

• We expect you will find much that is familiar adapted to a brief format for delivery within NHS context
PSYCHOANALYTIC/DYNAMIC COMPETENCES FRAMEWORK (LEMA, ROTH AND PILLING, 2008)
AN ABILITY TO MAINTAIN AN
‘ANALYTIC ATTITUDE’ IS THE OVERARCHING
COMPETENCE IN DIT

• The ‘analytic stance’ is characterised by interest in, and receptiveness to, the patient’s unconscious communications and to the unfolding of the transference
IMPLICATIONS OF CONTEXT FOR TREATMENT

• Cannot take strategies from long-term psychotherapy and apply them to unselected group of patients

• Need more structure for brief psychoanalytic psychotherapy
Module 1

Orientation to the DIT Model
RATIONALE FOR DIT

• DIT is a brief (16 sessions) psychodynamically and interpersonally oriented intervention

• Designed on the basis of Expert Reference Group work on clinical competencies which worked on identifying key components drawn from manualised psychoanalytic/dynamic therapies

• Now offered at Step 3 within IAPT. NICE guidelines for depression state that brief psychodynamic therapy can be considered for depressed patients
INTERPERSONAL FOCUS OF DIT

• Focus on patient’s relationships, internal and external, as they relate to problem(s) in current life, causing symptoms of depression and/or anxiety

• Interpersonal focus shared with several other modalities, e.g. IPT

• Unlike IPT, which does not address internalised object relationships, DIT focuses on the activation in the present of one internalised, often unconscious, object relationship
DYNAMIC FOCUS OF DIT

- Concerned with helping patient understand the interplay between external and internal reality as it relates to a problematic relational pattern

- Addresses a non-conscious realm of experience, which again distinguishes DIT from IPT, and aligns it with other psychodynamic models
WHAT ABOUT SYMPTOMS?

- Presenting symptoms of anxiety and depression are understood to be responses to interpersonal difficulties/ perceived threats to attachment (loss/separation) and hence also as threats to the self.

- Perceived threats can both result from, and cause, difficulties in thinking clearly and realistically (mentalising) - not only about the external world but also the internal world.
THEORETICAL INFLUENCES ON DIT

- Object Relations Theory
- Interpersonal Psychoanalysis
- Mentalisation
- Attachment Theory
COMMONALITIES WITH OTHER ANALYTIC/DYNAMIC APPROACHES

• Impact of early childhood on adult functioning

• Internal and external forces form our perception of ourselves in relation to others

• Existence of unconscious realm of experience that is a motivating force
• Unconscious projective and introjective processes underpin subjective experience of relationships

• Ubiquity of the transference, by which patients respond to others and the therapist, according to developmental models that have not been updated or challenged
• Sullivan believed that humans strive to minimise insecurity; interpersonal behaviours can be understood as attempts to avoid anxiety or establish/maintain self-esteem

• In therapy, Sullivan encouraged the therapist to establish ‘interpersonal security’ through an engaged, active stance (this is carefully attended to in DIT)
• Sullivan advocated a ‘detailed enquiry’ into the patient’s interpersonal world (this informs the active, detailed assessment of interpersonal functioning in DIT)

• Sullivan was interested in ‘current interpersonal experience’ (the primary focus in DIT)

• Psychotherapy provides an opportunity for ‘facilitating interpersonal learning’ (one of the main aims in DIT)
Module 2

Core Features and Strategies
TIME-LIMITED (16 SESSIONS)

- Structure: 3 phases
- Initial phase: engagement, exploration and formulation (sessions 1-4)
- Middle phase (sessions 5-12)
- Ending phase (sessions 13-16)
THERAPEUTIC STANCE

• Supportive stance which does not undermine the patient's autonomy
• Involved, empathic manner
• Aim to work collaboratively with the patient from the outset
• 'Not knowing'
• Being active, encouraging change
INTERPERSONAL-AFFECTIVE FOCUS – ‘IPAF’

- Identify recurring configuration(s) of 'self-other' representations and affect linking the two particular to the patient – ‘ideographic’

- The IPAF provides the ‘spine’ of the work in the middle phase

- Goals are related to the IPAF being worked on
WHAT IS AN ‘IPAF’?

• In DIT unconscious conflict is understood as resulting from a clash between particular ‘self and object’ representations - resulting in a recurring interpersonal pattern and expectation of self and others (Kernberg, 1980)

• IPAF is dynamic – it can be reversed e.g. when painful feelings of worthlessness are projected on to the Other and Self takes up the critical position
1. A **self-representation** (e.g. a demanding infant)
2. An **object representation** (e.g. a rejecting mother)
3. An **affect linking** the two (e.g. terror)
4. The **defensive function** of this configuration
   (e.g. avoidance of own aggression)
FOCUS ON THE PATIENT'S MIND

• Consistent focus on the patient's mental states (beliefs, feelings, wishes and thoughts)

• Genuine curiosity about the patient’s mental states through actively enquiring about interpersonal processes and their connection with the client's mental states

• Working through the IPAF involves enhancing the patient's awareness of how his behaviour is driven by mental states

• The therapist aims to make ‘explicit’ what has effectively become ‘procedural’
HERE-AND-NOW FOCUS

- Focus on what the patient is currently feeling in the session

- Focus on exploration of current difficulties in the patient’s life rather than establishing links to childhood origins

- Active use of the patient-therapist relationship to help the patient explore the IPAF in the here and now
Listen for the "cautionary tale" (Ogden, 1992) in the interpersonal narratives and share this with patient

What beliefs does it suggest about relationships? (e.g. intimacy is always painful)

Link this to anxieties about the therapy and the IPAF, where appropriate
DEFENSIVE FUNCTION OF THE IPAF

• In addition to the use of defences against painful affect, the IPAF itself can be seen as serving a defensive function

• The patient usually has an unconscious investment in keeping the IPAF in place

• Part of sharing the formulation includes sharing your understanding of the protective function the IPAF serves:
  
  • what does the IPAF defend the patient against knowing about him/herself?
DEFENSIVE FUNCTION OF IPAF CON.

- IPAF can rid the patient of unwanted parts of the Self that are lodged (projected) in the other

- The work of DIT involves taking back unwanted parts of the Self and reintegrating these into the self-perception

- This can lead to a more empowered and functional self, where aggression can be harnessed constructively to assert needs and for self-protection
HOW CAN FOCUS ON ONE PATTERN AMONGST SEVERAL BE OF HELP?

• “Lifetime burning in every moment’ (T. S. Eliot)

• Focus is on helping the patient to establish/consolidate a ‘mentalising’ process for approaching relationship difficulties: the focus is the means to this end
• **Defensive Function of IPAF:** defend against knowledge of own rage and contempt of the other (reversal)
• **Defence Against the Affect:** self-denigration, placatory behaviour
• **Cost of Defence:** uncomfortable in relationships, tendency to conflict in different settings
IPAFS RELATING TO DEPRESSION OFTEN CENTRE AROUND TWO TYPES – BLATT

- **Introjective**: where the self feels **unlovable** and **worthless** with the object anticipated to be **humiliating/punishing**

- **Anaclitic**: where the self often feels **unloved** and **helpless** with the object is anticipated to be **abandoning/inaccessible**
In order to select a focus, the therapist will be guided by several considerations:

- ‘Temporal’ contiguity with onset and maintenance of depressive symptoms

- ‘Thematic’ contiguity, i.e. helping the patient make sense of their experience during episodes of depression
• ‘Affectively’ meaningful, i.e. this an emotionally significant issue and not peripheral

• Validity of the IPAF is supported by a ‘goodness of fit’ with the patient’s patterns evident through the INs

• IPAF is recurring and manifest across a number of the relationship domains
CASE STUDY
Module 3

The Initial Phase
SETTING THE CONTRACT

• The verbal contract should emphasise:
  
  • the affective-interpersonal context and the rationale
  
  • the short-term duration: 16 (50min, once weekly) sessions
  
  • the problem area that will be targeted
  
  • the crisis management plan, where appropriate
  
  • the agreement for session-by-session outcome monitoring
INITIAL PHASE - STRATEGIES

• Identify patient's 'interpersonal map' – detailed picture of significant relationships and their connection to presenting problems

• Use 'attachment self-descriptions' to characterize basic attachment style

• Focus on interpersonal circumstances and significant life events – preceding onset of depression/anxiety
INITIAL PHASE - AIMS

• ‘Engagement’ – establishing the therapeutic relationship

• ‘Exploration’ of patient’s symptoms/concerns (including risk factors) with an emphasis on the origins and psychological meaning of the symptoms

• ‘Formulation’ and finding a focal area of work
• Start with exploring current significant relationships

• Explore relationships across a variety of settings

• Explore the affect aroused by significant relationship

• Aim in eliciting INs is to establish:

  • The **form** of a relationship
  • The **key processes** employed in maintaining it
  • If it has **changed over time**
  • How it **relates to problems** (e.g. makes depression worse)
• Explore any relationships which are exceptional

  Have you felt understood by anyone in your life?

  Do you feel differently in any relationships?

• Useful questions

  Does anything like this happen anywhere else?”

  Does this happen with anyone else?”

  Who is the most important person in your life right now?
ATTACHMENT DESCRIPTORS
(BARTHOLOMEW AND HOROWITZ)

• “It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me”
  (secure)

• “I am uncomfortable getting close to others. I want emotionally close relationships but I find it difficult to trust others completely, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others”
  (fearful)
• “I want to be completely emotionally intimate with others but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships but sometimes worry that others don't value me as much as I value them” (preoccupied)

• “I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me” (dismissive)
<table>
<thead>
<tr>
<th>Style</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>like me</td>
<td>like me</td>
<td>like me</td>
</tr>
<tr>
<td>Style A</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Style B</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Style C</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Style D</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Module 4

The Middle Phase
AIMS OF THE MIDDLE PHASE

• Concentrated effort to stay focused on the agreed IPAF

• Prioritise working on current significant relationships to the patient that demonstrate the activation of the IPAF, including the transference

• Stimulate patient's capacity to think about and understand his thoughts and feelings, and how these underpin behaviour and patterns of relating that seem strange or self-defeating
• Help the patient identify areas of difficulty in relationships

• Help the patient understand his characteristic ways of managing areas of difficulty (defences) and point out the 'cost' of these strategies

• Attend to the patient's affective state and to the therapeutic relationship

• Help the patient practice the skill of recognising internal states (feelings, thoughts, wishes) and connecting these to the events of the week and to the IPAF
As we listen to the patient's INs we are thinking about:

- Who does what to whom? This involves identifying perceived intentions (benign and/or malign) towards the self or of the self towards others

- Who feels what towards whom? This involves identifying the main affects present in the narrative

- How do we feel as we listen? This involves identifying our countertransference (e.g. do we feel swamped, seduced or excited by the story?)
• MIDDLE PHASE

- General exploration of the problem
- Focusing on the patient’s state of mind and activation of the IPAF
- Focusing on alternative ways of understanding the patient’s and other people’s states of mind
- Supporting attempts at new behaviour in relationships

General exploration of the problem

- Focusing on the patient’s state of mind and activation of the IPAF
- Focusing on alternative ways of understanding the patient’s and other people’s states of mind
- Supporting attempts at new behaviour in relationships
- General exploration of the problem
When to Use Mentalisation Techniques in DIT

In DIT, we employ mentalising techniques when the patient’s - and our own - mentalising breaks down

Non-mentalising is a common feature of depression

• e.g.: it’s all worthless; I’m a failure; it’s a chemical imbalance in my brain so therapy can’t help

The following slides will help you recognise non-mentalising, both in your countertransference and in the patient’s presentation.
Characteristic types of non-mentalising include:

**Psychic-Equivalence**

feelings = reality

In Psychic Equivalence, there is great **certainty** and **concrete expression** of feeling: what I feel is real

  e.g.: “She hates me - I know it!”; “I know I am worthless”

Typical countertransference: **irritation** and **exasperation**
Characteristic types of non-mentalising include:

**Pseudo-Mentalising/Hypermentalising**

mind decoupling

This is pretend mode - patient appears to be ‘doing therapy’ but we find it hard to follow them. It’s like **spinning wheels** in the sand – lot of effort but no results. Mind is decoupled from reality

Typical countertransference: **boredom, feeling sleepy**
In teleological mode, **actions alone** express intentions:
e.g.: “it won’t end unless you do something”

Typical countertransference - wanting to **do** something; being the **rescuer**
MENTALISING INTERVENTIONS

• Aim to support a therapeutic process in which the mind of the patient becomes the focus of the treatment

• Not the content, but the process of understanding, feeling and experiencing at the heart of this intervention
MENTALISING INTERVENTIONS

- Inquisitive or ‘not-knowing’ stance

- Mental states are opaque: the therapist can have no more idea of what is in the patient’s mind than the patient himself

- The focus is on affect. Interventions are simple, always focusing on mind rather than behaviour and on current affect and experience
The mentalising therapeutic stance should illustrate ...

- Humility deriving from a sense of ‘not-knowing’
- Taking time to identify difference in perspectives
- Accepting different perspectives
WHY SHOULD WE FOCUS ON AFFECT?

• Emotional expression is related to treatment outcome, regardless of treatment approach
  • Psychodynamic psychotherapy
  • CBT
  • Experiential therapy

• Example of PT treatment
  • Focus on affect is strongly related to treatment outcome: effect size $r = .30$
  • At least as important as the therapeutic relationship!
ATTACHMENT STYLE AND MENTALISING EMOTIONS

DEACTIVATING:
focus on cognition to neglect of affect

Cognition

HYPERACTIVATING:
focus on affect to the neglect of cognition

Affect
TYPICAL SEQUENCE: INQUISITIVE STANCE

• Affect recognition
• Affect amplification (with deactivating patients)
• Affect differentiation
• Relating affect to interpersonal relationships and the IPAF in particular
• Pointing out the “emotional cost” of the defensive function of this configuration
WORKING WITH DEFENCES
WORKING WITH DEFENCES

- Accept the patient's style of relating and respect the defensive needs that may underlie particular interpersonal styles.

- Focus on helping the patient understand ‘why’ and ‘how’ they protect themselves from particular painful feelings/states of mind.

- Highlight the 'costs' of their defences by pointing out the impact on patient's own capacities and relationships.
STRATEGIES FOR EXPLORING DEFENCES

Acceptance of the NEED for defences

The COSTS of defences

The HOW of defences

The WHY of defences
Primary aim of a transference interpretation is not to arrive at an insight but to engage the patient in the process of making sense of how his mind works.

A transference interpretation begins by validating the patient's experience (by describing it as a legitimate response).
• The therapist works jointly with the patient to clarify and explore the transference feelings evoked

• If the therapist has somehow contributed to this, experienced through an enactment, this also needs exploration

• Therapist and patient finally arrive at an interpretation which pulls together these different components
CRITERIA FOR INTERPRETING THE TRANSFERRENCE IN DIT

• When it enhances the exploration of the IPAF

• When making a link between the transference and an external relationship adds immediacy and validity

• When the patient finds it difficult to report INs (or is very isolated) and hence what transpires between the patient and therapist is the most ‘live’ material available
• When the therapist considers that the IN reported by the patient is being used to create emotional distance from the IPAF and an interpretation about what is going on in the here-and-now serves to refocus the patient

• When there is resistance to the work of therapy
VIDEO CLIP 5

- Self: Side-lined
- Other: rejecting, preferring others

Affect: Anxious, placating
Defensive Function of IPAF:
• defend against being rejected by giving the other all the power and decision-making

Defence Against Affect:
• Cares for others (people-pleaser); avoidant; self-denigrating

Cost of Defence:
• Denies own needs even further; overly focused on others to the neglect of self
Module 5

The Ending Phase
ENDING PHASE: STRATEGIES

• Systematically draw attention to, and address, the patient's feelings, unconscious fantasies and anxieties about the ending of the therapy

• Respond to the indications of regression near the end of treatment (e.g. a symptomatic deterioration) by linking this with the feelings and fantasies associated with endings
• Help the patient review the therapy as a whole
  • e.g. whether they have achieved their goals

• Write a 'good-bye' letter which reviews the original agreed formulation, and what progress has been made in working on the issues identified then

• Help the patient express gratitude and/or disappointment, as appropriate
THE GOOD-BYE LETTER

- The therapist drafts a 'letter', familiar and accessible to the patient, that:
  - Refers clearly to the IPAF
  - Is a 'realistic' account
  - Includes reference to how the patient *managed* to overcome his difficulties
  - Is *offered* to the patient at - or near - the beginning of the 13th session
• Is about a page long, or less, with no jargon using the patient's words, or using examples that have been worked on

• Is read with the patient who is invited to suggest changes/elaborations

• The final draft is handed to the patient once the changes have been made
The Good-Bye Letter

Self: Side-lined

Other: Rejecting, preferring others

Affect: Anxious, placating
SUMMARY OF DIT

• Identify an interpersonal problem of great subjective significance associated with specific relational-emotional focus

• Work with the patient collaboratively to create an increasingly mentalistic picture of the problem
• Encourage the patient to explore the possibility of alternative ways of feeling and thinking
  • (‘playing with a new internal and external reality’)

• Ensure the therapeutic process (of change in self) is reflected on

• Present a summary of the work for the person to hold onto for relapse prevention
SUPERVISED PRACTICE

- 2 patients
- Weekly supervision
- All sessions taped
- 3 sessions for case 1 are rated using DIT rating scale – see appendix
- At least 1 session (and up to 3) from case 2
- 3000 word case study (integration of theory and practice)
- See manual and website for more information
The Manual

brief dynamic interpersonal therapy

A CLINICIAN’S GUIDE