12/11/2021 Stockholm

Patrick Luyten

University of Leuven, Belgium

University College London, UK

I so wish I could be there with you…

- DIT background
- DIT principles and strategies
- Modifications of DIT
- Empirical research on DIT

Team

- **Psychoanalysis Unit London** (UK): Alessandra Lemma, Mary Hepworth, Peter Fonagy, Deborah Abrahams
- **Psychoanalysis Unit Leuven & PraxisP (Belgium)**: Patrick Luyten, Saskia Malcorps
- **Viersprong Institute (The Netherlands)**: Sarah Campens, Kees Kooiman, Maaike Smits

DIT: Background

- Lemma, A., Target, M., & Fonagy, P. (2011). *Dynamic Interpersonal Therapy. London: Oxford University Press.*
- Lemma, A., Target, M., & Fonagy, P. (2011). The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: A pilot study. *Psychiatry: Interpersonal and Biological Processes.*
- Luyten, P., Van Houdenhove, B., Lemma, A., Target, M., & Fonagy, P. (2012). A mentalization-based approach to the understanding and treatment of functional somatic disorders. Psychoanalytic Psychotherapy, 26, 121-140.

DIT Background

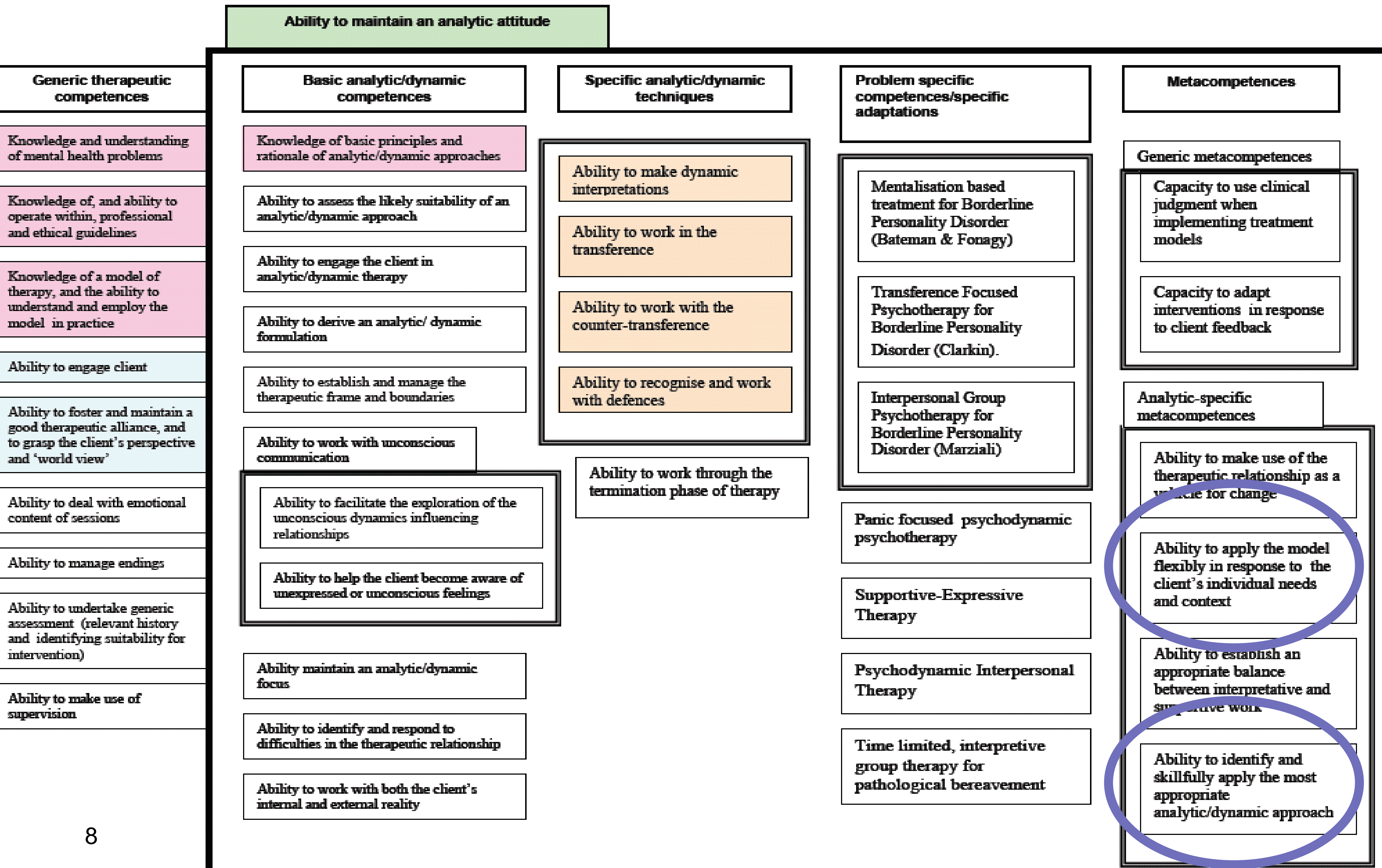
- First developed as a **brief manualized psychodynamic intervention** (DIT) for **depression** in the context of the Improving Access to Psychological Therapies (**IAPT**) in the United Kingdom
- The core techniques and strategies of DIT are based on a **competence framework** that emerged from a systematic review of manuals of brief psychodynamic therapies that have been empirically investigated
- DIT thus represents a **distillation of evidence-based brief psychodynamic treatment models**

DIT is an integrative treatment

- Based on **competences** framework
- Effective competences in evidence-based psychodynamic treatments for depression
- Framed within an **attachment/mentalizing** approach to ensure three C's
  - Coherence
  - Continuity
  - Consistency

https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks

Psychoanalytic/dynamic Competences Framework (Lemma, Roth and Pilling, 2008)



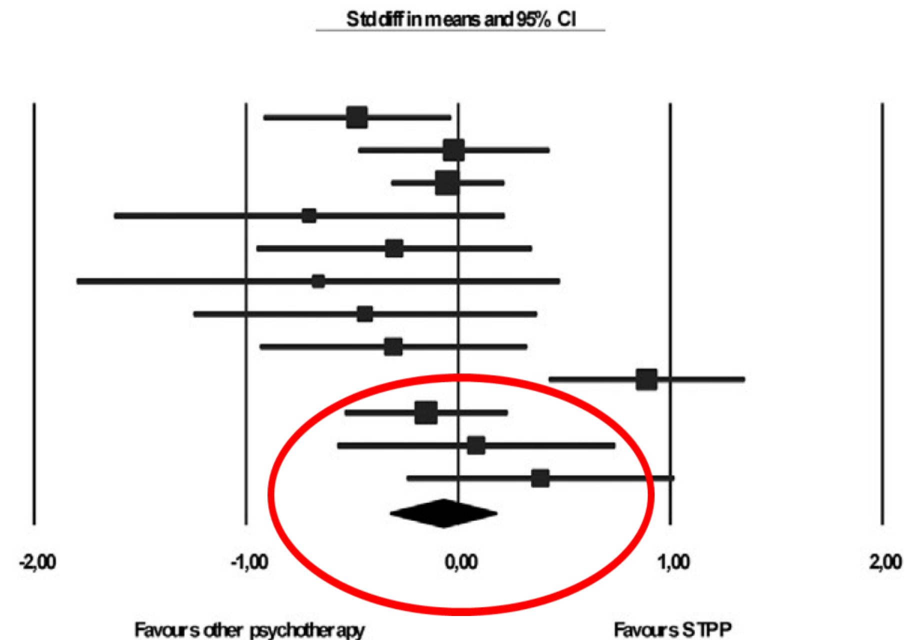
The “Dodo Bird Verdict” in depression

Short-term psychodynamic therapy for depression
META-ANALYSIS

N=54 studies, totaling 3,946 patients

No significant differences found between brief PDT and other therapies at post-treatment (d = -0.14)

No significant differences found between brief PDT and other therapies at follow-up (d = -0.06)

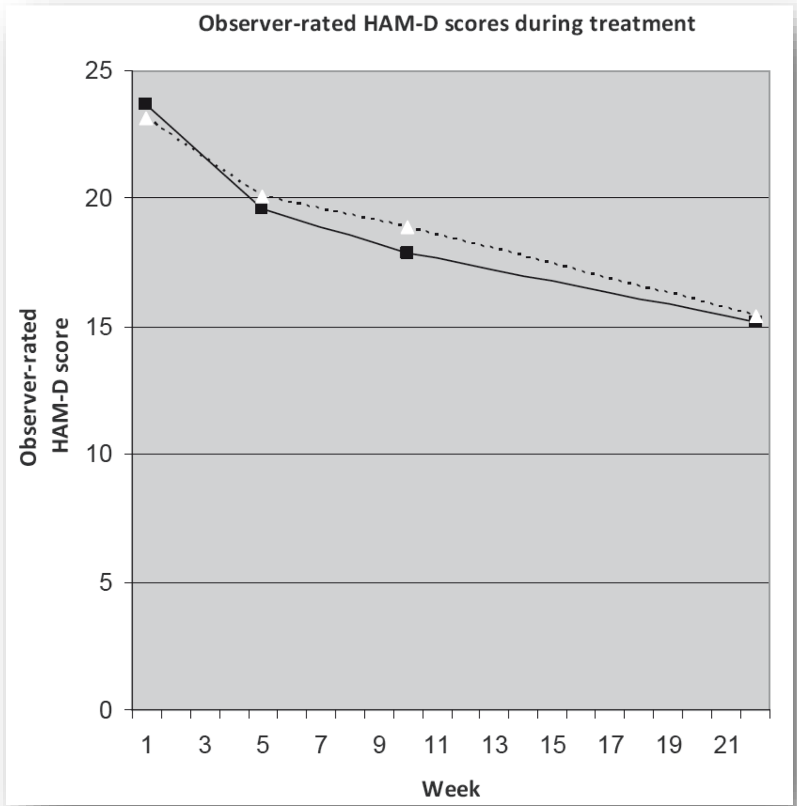


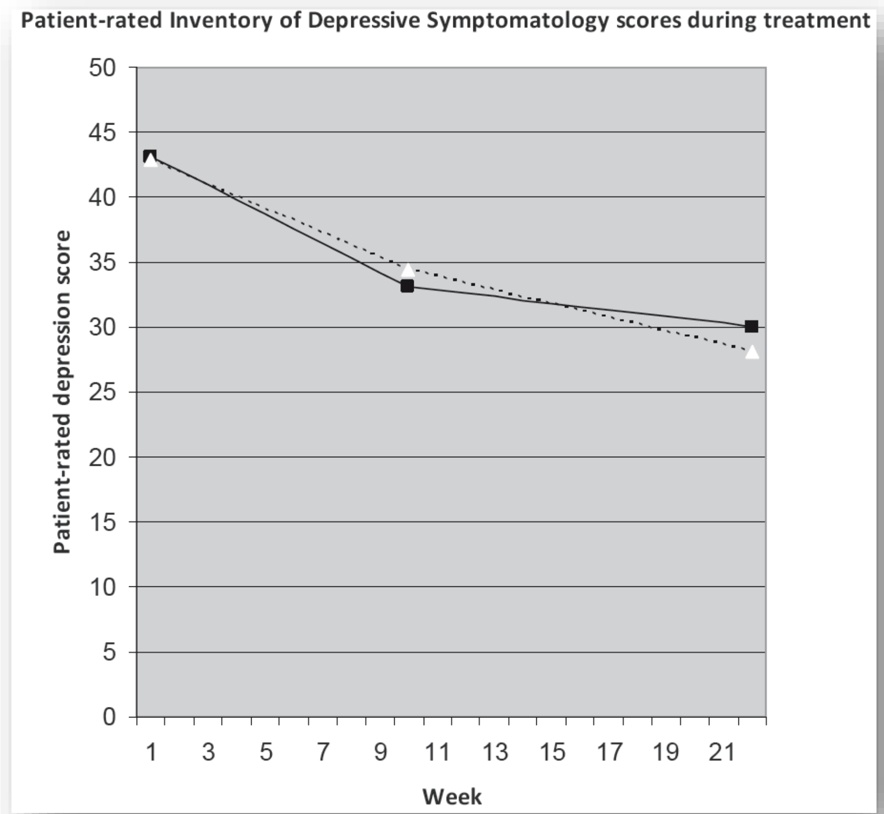
Driessen, E., Hegelmaier, L. M., Abbass, A. A., Barber, J. P., Dekker, J. J., Van, H. L., . . . Cuijpers, P. (2015). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update. *Clinical Psychology Review, 42*, 1-15.

CBT vs. PDT for Major Depression (N=341)

- **CBT**
  - **16 individual sessions**
  - **Manualised (Molenaar et al., 2009)**
  - **N= 164**

- **Psychodynamic Therapy**
  - **16 individual sesisons**
  - **Manualised (de Jonghe, 2005)**
  - **N=177**





Driessen, E., Van, H. L., Don, F. J., Peen, J., Kool, S., Westra, D., . . . Dekker, J. J. (2013). The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: a randomized clinical trial. *American Journal of Psychiatry, 170*(9), 1041-1050. doi: 10.1176/appi.ajp.2013.12070899

DIT principles and strategies

Flexible approach

- Combines mental process and mental representation focus
  - **Mental process**: focus on impairments in mentalizing or reflective functioning
  - **Mental representation**: focus on identifying and working through a repetitive interpersonal pattern associated with onset and persistence of symptoms

  = **Interpersonal Affective Focus (IPAF)**

Lemma, A., Target, M., & Fonagy, P. (2011). *Dynamic Interpersonal Therapy. London: Oxford University Press.*
Lemma, A., Target, M., & Fonagy, P. (2011). The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: A pilot study. *Psychiatry: Interpersonal and Biological Processes.*

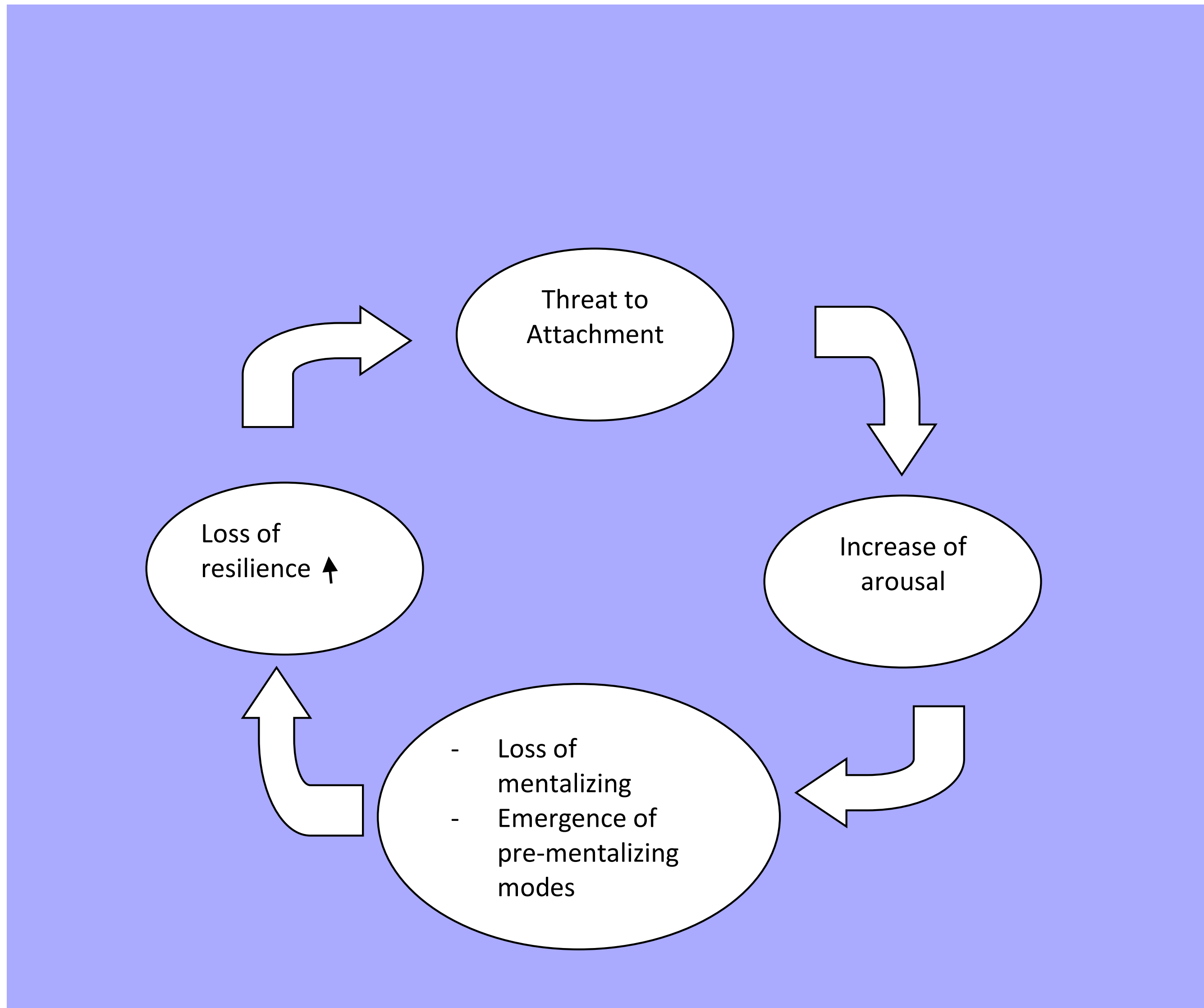
Basic assumptions

- DIT assumptions:
  - Symptoms are related to **threats to attachment system** and thus to the **self**
  - Symptoms reflect, in part, impairments in stress/affect regulation associated with **secondary attachment strategies** and resulting **mentalizing impairments**

Lemma, A., Target, M., & Fonagy, P. (2011). *Dynamic Interpersonal Therapy. London: Oxford University Press.*
Lemma, A., Target, M., & Fonagy, P. (2011). The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: A pilot study. *Psychiatry: Interpersonal and Biological Processes.*

Stress/threat and the attachment system

Adverse Emotional Experience



A simple version of the mentalizing model of depression and resilience

Structure: 3 phases

- Initial phase: Engagement/validation, assessment and formulation (sessions 1-4)

- Middle phase (sessions 5-12): working through

- Ending phase (sessions 13-16): empowerment

Therapeutic Stance

- Positive, supportive stance that does not undermine the patient's autonomy
- Involved, empathic manner
- Aim is to work collaboratively with the patient from the outset
- Inquisitive, not knowing stance
- Judicious disclosure of the therapist's thoughts and feelings in order to 'normalise' experience
- Active stance encouraging change

- Reassurance
- Support
- Accurate empathy

- Clarification
- Confrontation
- Interpretation

- To re-direct patient back on to the focus
- To encourage patient to try out new ways of relating
- Only limited advice giving (eg. if patient is suicidal)
- Patient’s experience of therapist’s active stance is explored

- Stop, stand, and explore
- Stop and rewind
- Stop and stand

Initial phase aims

- Engagement
- Exploration of patient’s symptoms/concerns (including risk factors) with an emphasis on the origins and psychological meaning of the symptoms
- Formulation of focal area of work

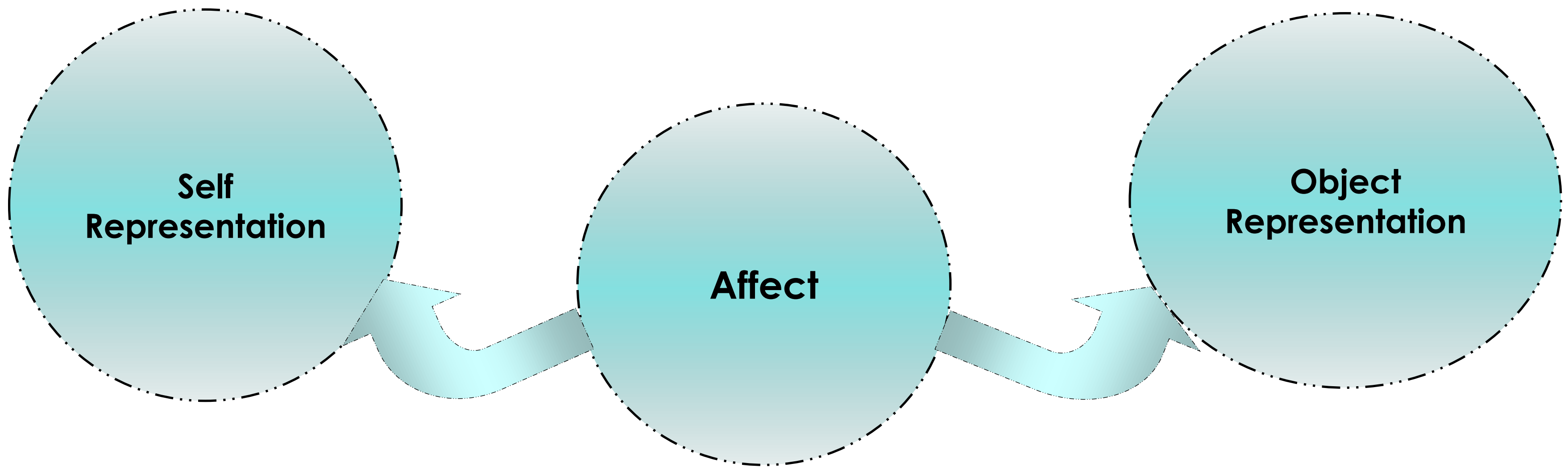
Initial phase: strategies

- Identify patient's **'interpersonal map'** (detailed picture of the patient's significant relationships and their connection with presenting problems)
- Use **attachment self-descriptions** to characterise basic attachment style
- **Focus on interpersonal circumstances** and significant life events preceding onset of depression/anxiety

Initial phase: strategies

- Assessment of patient's current and past interpersonal functioning to identify recurring interpersonal patterns that inform the patient's experience of his relationships
- Discuss and agree with the patient the formulation, treatment rationale and goals
- Joint identification and formulation of Interpersonal Affective Focus (IPAF)

IPAF dimensions



1. A self-representation (eg. Demanding but neglected, misunderstood, unloved)

2. An object representation (eg. Rejecting others)

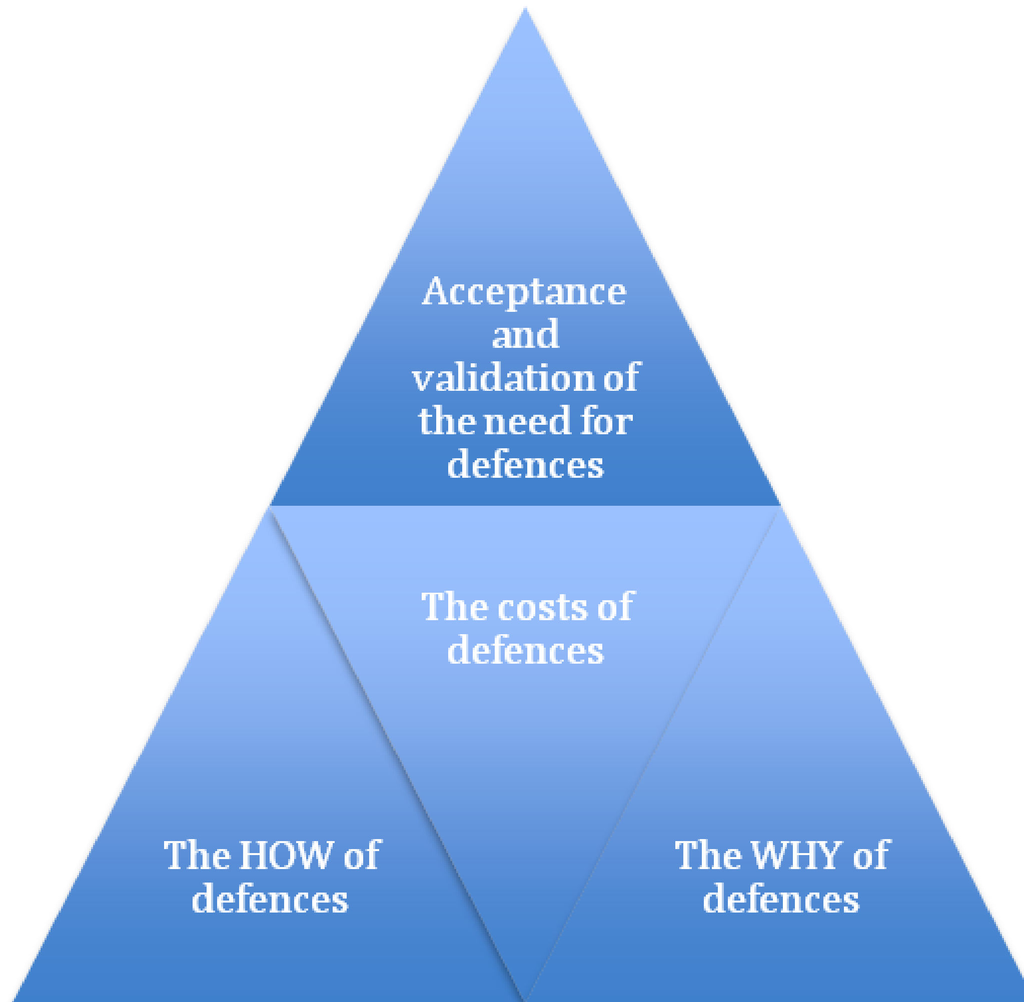
3. An affect linking the two (eg. Helplessness)

4. The defensive function of this configuration (eg. avoidance of own aggression)

Middle phase

- **Working through** of IPAF
- Focus on **recognizing** and **changing** core repetitive interpersonal pattern by recognizing this pattern as an **understandable adaptation strategy** which, unfortunately, has increasingly become associated with a very **high emotional cost**

Strategies for exploring the cost of not mentalizing



Ending phase

- 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 (eg. a symptomatic deterioration) by linking this with the feelings and fantasies associated with endings

- Help the patient review the therapy as a whole
  (eg. whether they have achieved their aims)

The good-bye letter

- The therapist drafts a 'letter', written in terms familiar and accessible to the patient. The letter:
  - refers clearly to the IPAF that has been the focus of the work
  - is a 'realistic' account of the work
  - 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 offered to the patient who is invited to suggest changes/elaborations
- The final draft is handed to the patient once the changes have been made

Adaptations of the DIT Model

Adaptations

- Initially developed for depression (and anxiety)
- Online self-help and blended care
- DIT complex care: patients with more entrenched personality problems
- Functional somatic disorders
- PTSD
- Young adults (Landström, Levander, & Philips, 2019)

Spectrum of interventions

Number of sessions

0 8 16 26 40

DIT functional somatic disorders Adaptations to the DIT model

- Greater emphasis on
  - **validation** and **normalization**
  - fostering **embodied mentalizing** through **micro-slicing** of (interpersonal) experiences
  - **Differences** in **attachment style** and their impact on somatic symptoms and impairments in (embodied) mentalizing

Luyten, P., & Fonagy, P. (2020). Psychodynamic Psychotherapy for Patients With Functional Somatic Disorders and the Road to Recovery. *American Journal of Psychotherapy, 73,* 125-130. doi: 10.1176/appi.psychotherapy.20200010
Luyten, P., De Meulemeester, C., & Fonagy, P. (2019). Psychodynamic therapy in patients with somatic symptom disorder. In D. Kealy & J. S. Ogrodniczuk (Eds.), *Contemporary psychodynamic psychotherapy: Evolving clinical practice* (pp. 191-206). Philadelphia, PA: Academic Press.

Embodied mentalizing

- Our capacity for mentalizing, as all our psychological functioning, is to a large extent **rooted in** and **shaped by** our body:
  - rooted in the body (eg feeling high or down)
  - shaped by the body (eg avoiding another person's gaze, response to shame is hiding)

Problems with embodied mentalizing in FSDs

- **Recognizing** emotions ('I feel bad', 'I feel tense')
- **Ownership of emotions** (rapid infection by others' emotions versus disowning emotions)
- Ability to **reflect** on and **modulate** emotions
- Ability to **share** emotions in appropriate ways ('Showing emotions is a sign of weakness' versus opening up emotionally to strangers)

Using the inquisitive, not knowing stance to micro-slice experiences

- **R**ecognizing emotions
- **A**mplifying emotions
- **D**ifferentiating emotions
- **L**inking emotions to interpersonal relationships and dynamic formulation of the patient
- Pointing out the "**E**motional cost" of problems with (embodied) mentalizing to foster change

RADLE

Luyten, P., & Fonagy, P. (2020). Psychodynamic Psychotherapy for Patients With Functional Somatic Disorders and the Road to Recovery. *American Journal of Psychotherapy, 73,* 125-130. doi: 10.1176/appi.psychotherapy.20200010
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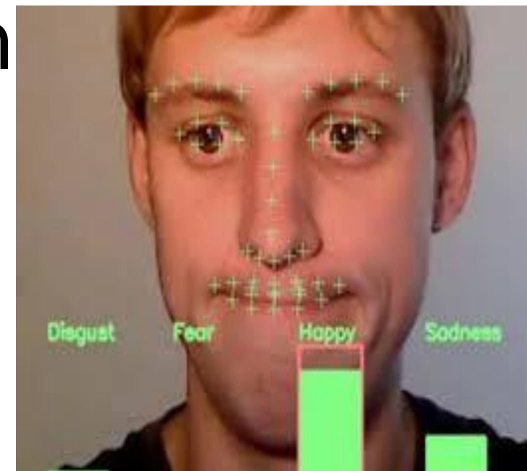
Somatic markers of inner mental states

Facial markers	Frowning, blinking fast, scowling, smiling, blushing, crying
Voice	Speaking very loudly/quietly, stuttering, sudden changes in pitch of voice, quavering voice
Specific bodily markers	Hand clenching, headaches, tension in shoulders/neck/arms/legs/chest, sighing, sweating, vomiting, fainting, dizziness, restless legs, psychogenic non-epileptic seizures, pseudo-paralyses
Body posture	Leaning back/forward, making oneself seem bigger/smaller

Luyten, P., De Meulemeester, C., & Fonagy, P. (2019). Psychodynamic therapy in patients with somatic symptom disorder. In D. Kealy & J. S. Ogrodniczuk (Eds.), *Contemporary psychodynamic psychotherapy: Evolving clinical practice* (pp. 191-206). Philadelphia, PA: Academic Press.

Recognizing Emotions

- From physical sensations or proto-emotions (eg tense, nervous) to felt emotions that can be labeled (cognition) and felt (affective)
- Labeling emotions through marked mirroring is key intervention



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Amplifying Emotions

- Because emotional states are typically not mentalized, and thus felt and not felt at the same time, we need to amplify them

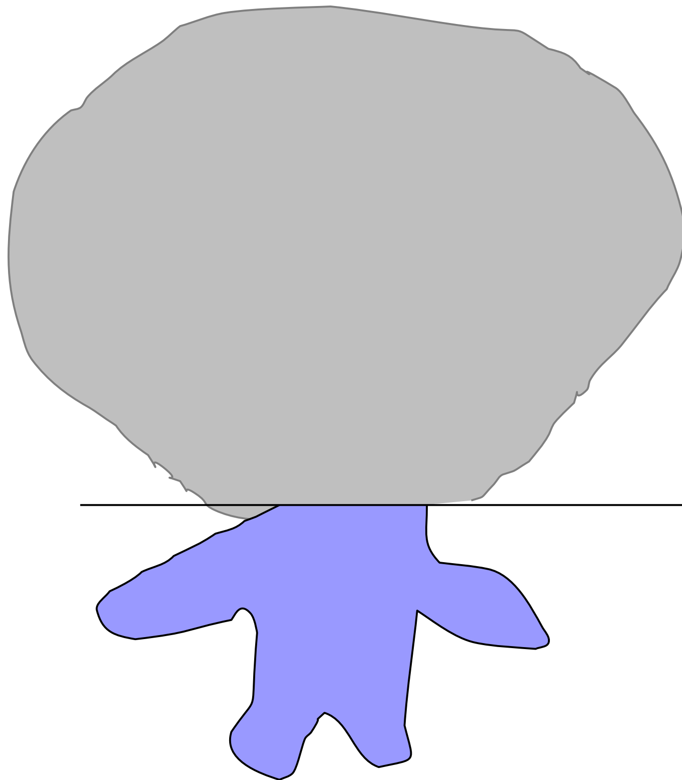
Differentiating Emotions

- Embodied states of mind typically involve multiple emotional states

Attachment style and mentalizing emotions

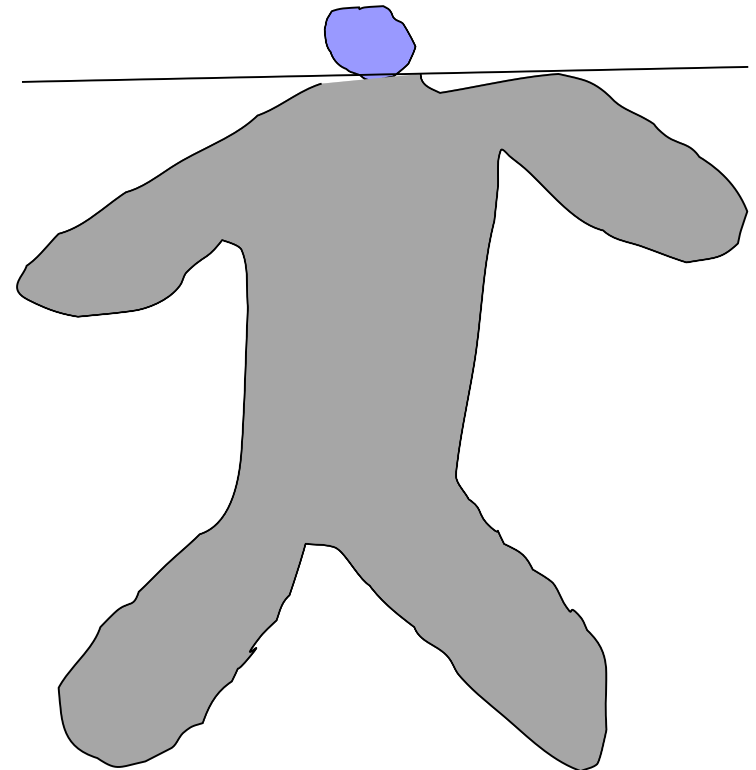
Deactivating

focus on cognition to neglect of affect

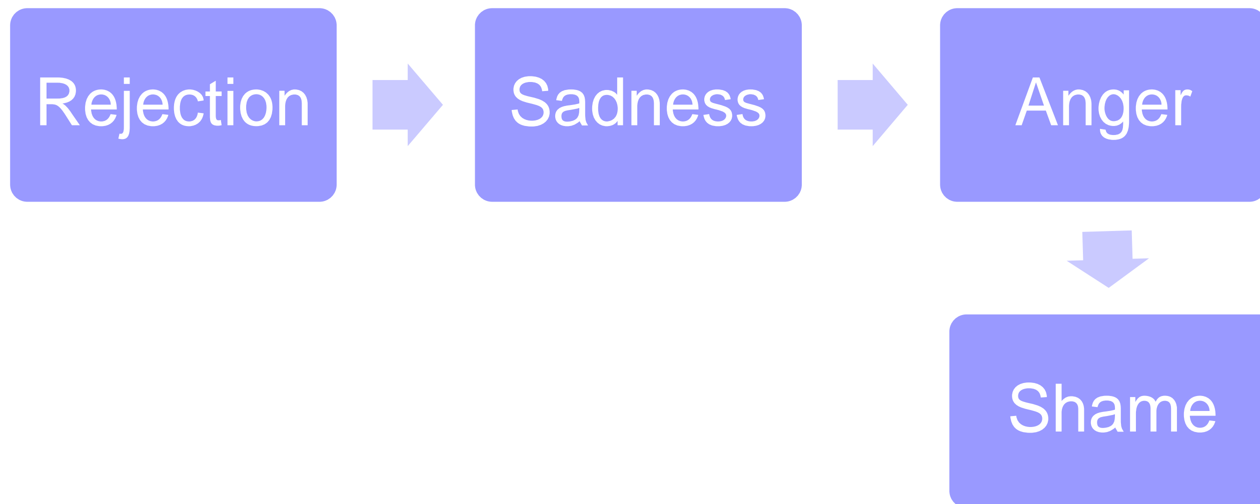


Hyperactivating

focus on affect to the neglect of cognition



Linking emotions and linking emotions to the patient's core dynamics



DIT-Complex Care

- **Adaptation of brief DIT** for depression and anxiety for patients with more entrenched patterns of relating to self and others
- **Modifications**
  - Greater focus on problems with epistemic trust and salutogenesis: **epistemic petrification**
  - Greater focus on Relationship Interfering Behaviors (**RIBs**): mid-term letter
  - **Extended treatment**: 26 sessions

Rao, A. S., Lemma, A., Fonagy, P., Sosnowska, M., Constantinou, M. P., Fijak-Koch, M., & Gelberg, G. (2019). Development of dynamic interpersonal therapy in complex care (DITCC): a pilot study. *Psychoanalytic Psychotherapy, 33*, 77-98. doi: 10.1080/02668734.2019.1622147

Structure of programme
20 weekly, 6 bi-weekly sessions

- **Phase 1. the set-up phase**: 6 weekly sessions primarily concerned with establishing a working alliance and enhancing the 'therapy readiness' of the client.
- **Phase 2. the insight phase**: 14 weekly sessions.
  - Initial sessions are devoted to the development of the IPAF and setting goals (maximum 3 sessions)
  - The remaining 11 middle phase sessions to working through the IPAF paying close attention to the RIBs
- **Phase 3. the work-through phase:** 6 bi-weekly sessions focused on implementing changes as per the agreed goals and pays attention the affective experience of greater challenge to translate insight into interpersonal change and eventual ending

Phase 1. Engagement

- **Central tasks**:
  - Engaging the patient
  - Recovery of mentalizing
  - Identifying and exploring maladaptive interpersonal cycles (potential RIBs)

Phase 2. Insight phase (7-20)

- **Central tasks**:
  - Validation and recognition of IPAF
  - Working through IPAF
  - Fostering change
- **Mid-term letter**: ‘Taking stock and moving on’ at session 16
  - Gains
  - RIBs
  - Goals for phase 3

Phase 3. Working through and ending

- **Central tasks**:
  - Actively supporting the patient in making changes
  - Focus on RIBs
  - ‘good-bye’ letter at session 25

Empirical research

Empirical research on DIT

- Pilot (feasibility) trials
- Superiority and Feasibility RCT
- Ongoing non-inferiority trial comparing blended DIT to face-to-face DIT and CBT
- Process-outcome research
- Qualitative research

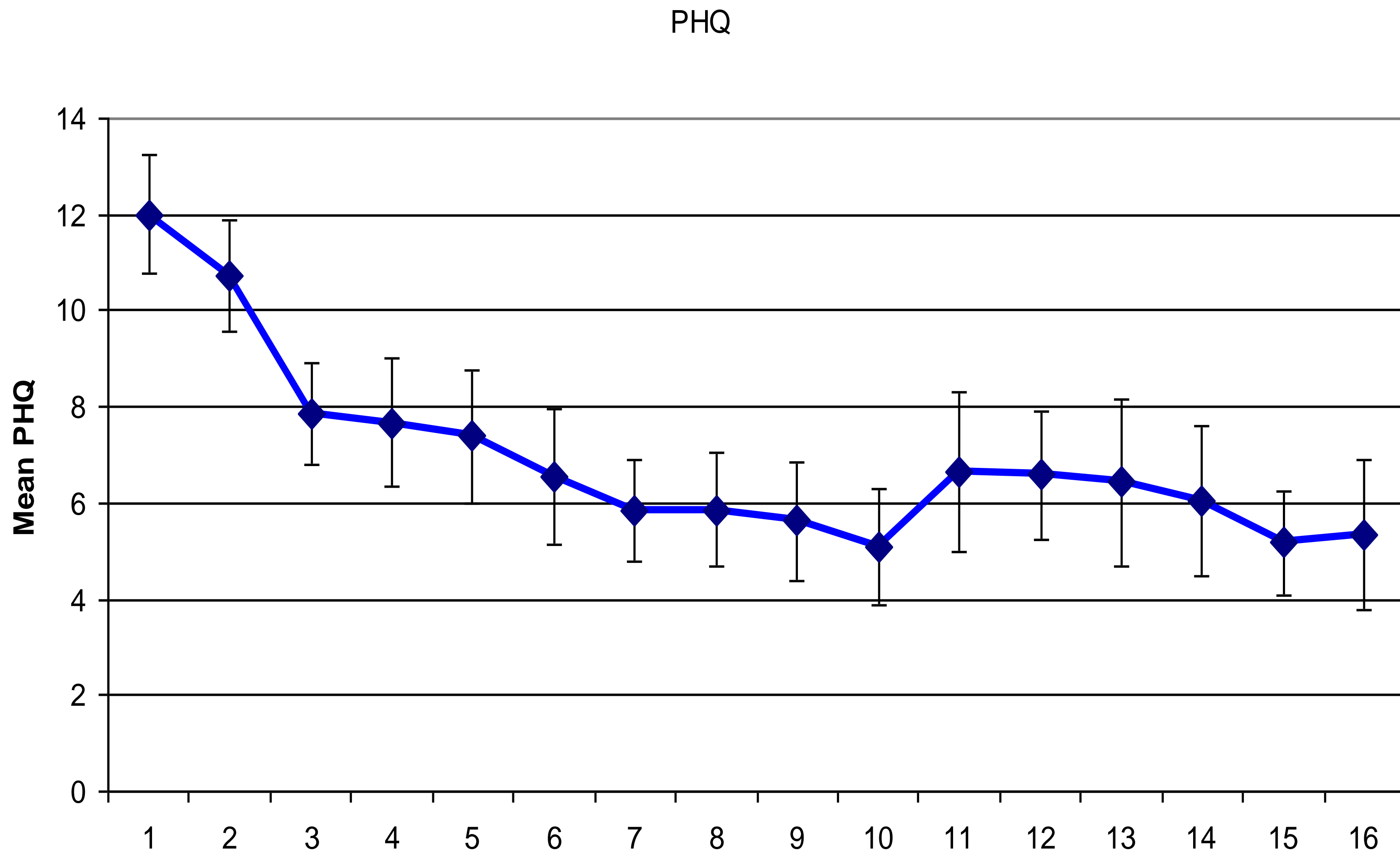
Pilot study DIT for depression

- Consecutive referrals meeting IAPT criteria
  - Anyone aged over 16 suffering with depression or an anxiety disorder (Generalised Anxiety Disorder, Panic Disorder, Post Traumatic Stress Disorder, Social Anxiety Disorder, Obsessional Compulsive Disorder, Phobias)
  - Referral is by a health professional, or self referral (this has been shown to be safe and beneficial, and helps deliver the service to patients who prefer not to use primary care)
  - Patients should not have alcohol or drug problems of such severity as to prevent them working with a therapist (ie not be incapably drunk/ stoned for substantial parts of the day)
- 16 patients recruited and treated for 16 sessions of supervised DIT

Lemma, A., Target, M., & Fonagy, P. (2011). The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: A pilot study. *Psychiatry, 74*(1), 41-48. doi: 10.1521/psyc.2011.74.1.41

Mean decline in PHQ scores

70% met criteria for remission



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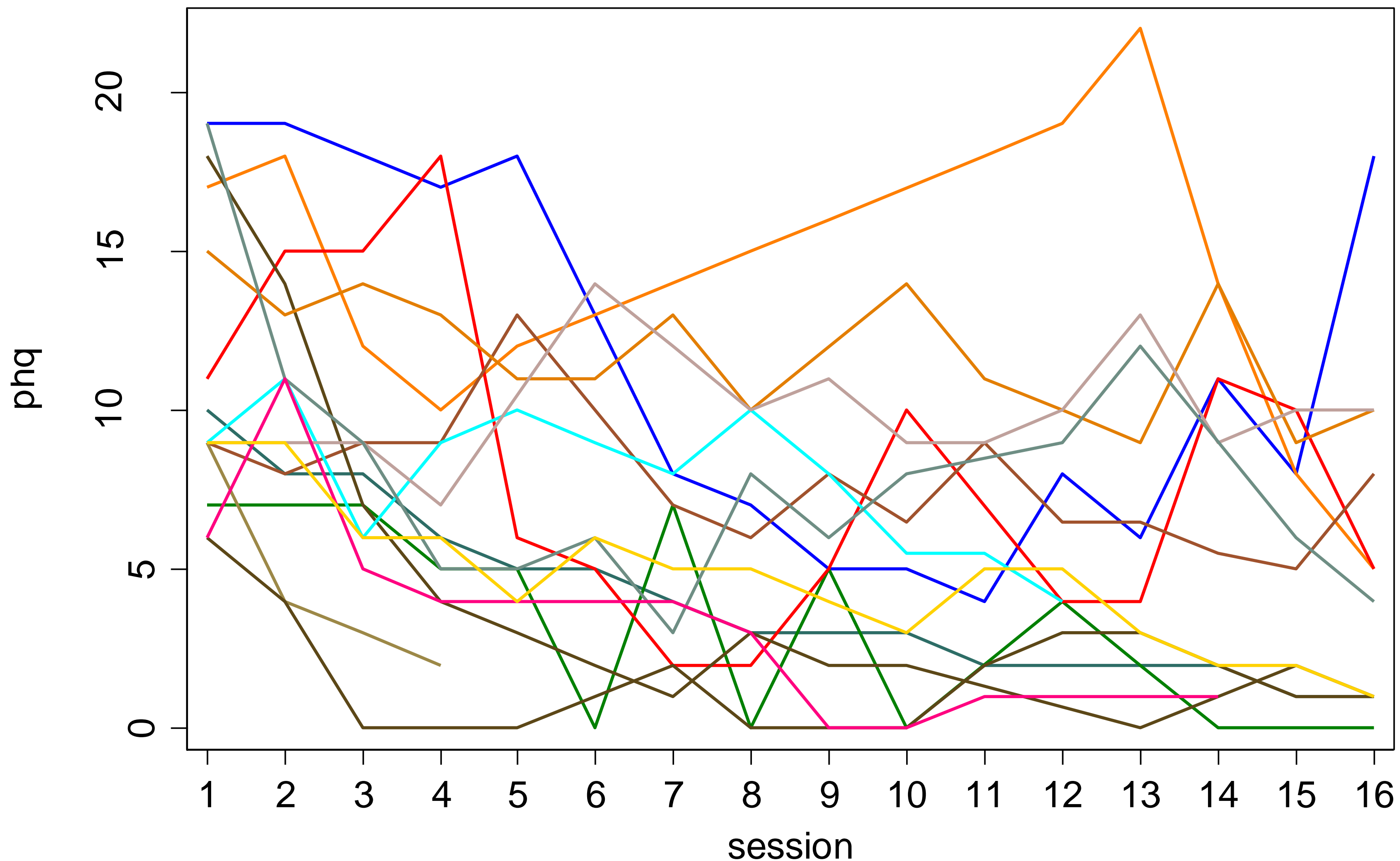
Individual patterns of PHQ scores over 16 sessions (n=16)



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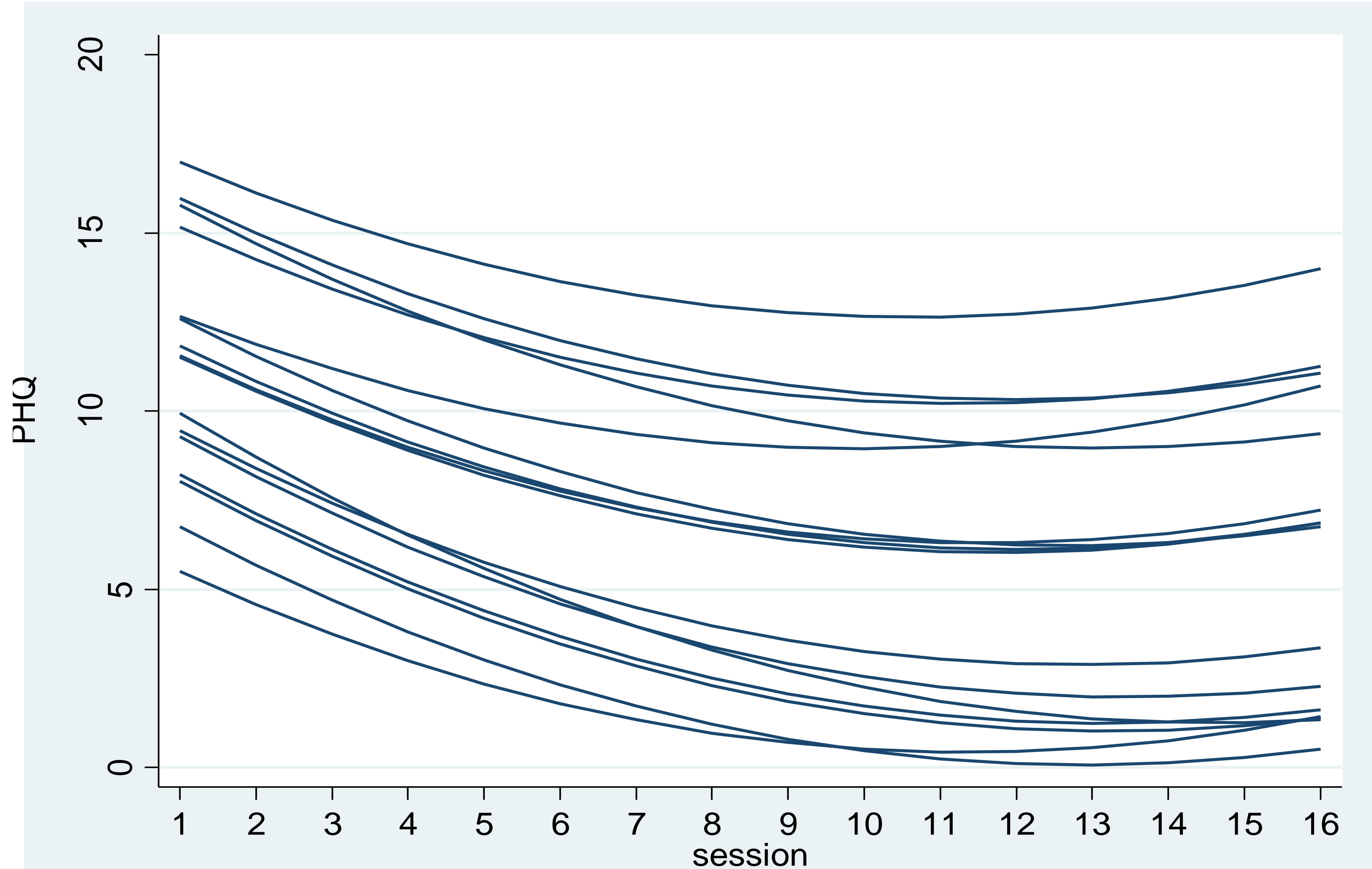
Random Intercept and Random Slope Model of PHQ Data (n=16)

LR test vs. linear regression: $chibar^2(01)$ = 148.72, Prob >= $chibar^2$ = 0.0000



log likelihood χ^2=543.8, Session: β(linear)= -1.15, 95% CI: -1.51 -.79 z=-6.20 $p<0.000$,
β(quadratic)= .05, 95% CI: .03 .07 z=4.45 $p<0.000$

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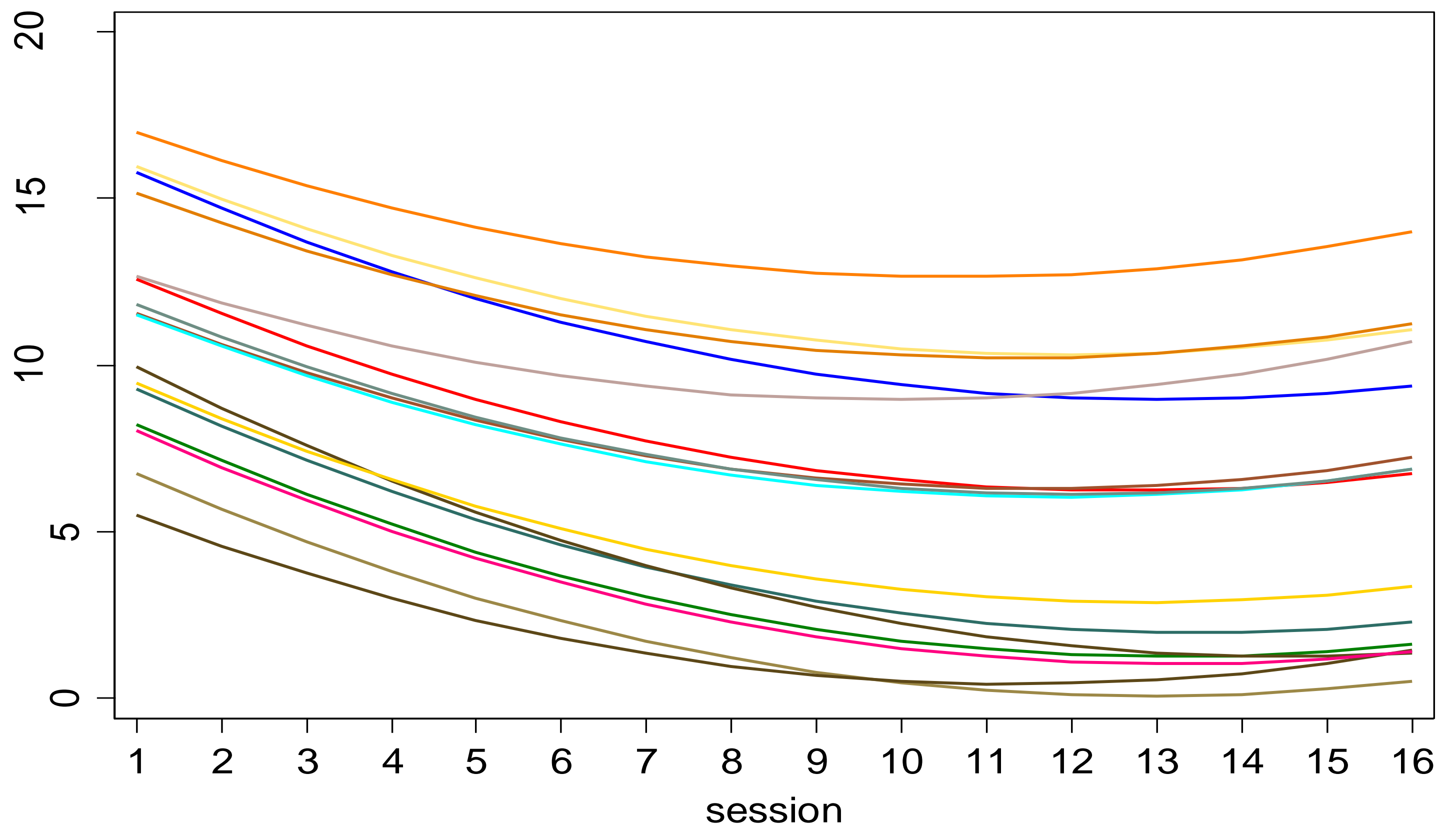

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β(quadratic)= .05, 95% CI: .03 .07 z=4.45 *p*<0.000

Internet-based DIT: pilot study

- Group online version of DIT – Online Group Dynamic Interpersonal Therapy
- N=24
  - Self-help DIT with group meetings facilitated by therapist 1 hour per week (n=8)
  - Self-help DIT with group meetings without facilitation by therapist (n=8)
  - Pure self-help group (n=8)
- 8-week programme with self-help materials and online group discussion

Lemma, A., & Fonagy, P. (2013). Feasibility study of a psychodynamic online group intervention for depression. *Psychoanalytic psychology, 30*(3), 367-380. doi: 10.1037/a0033239

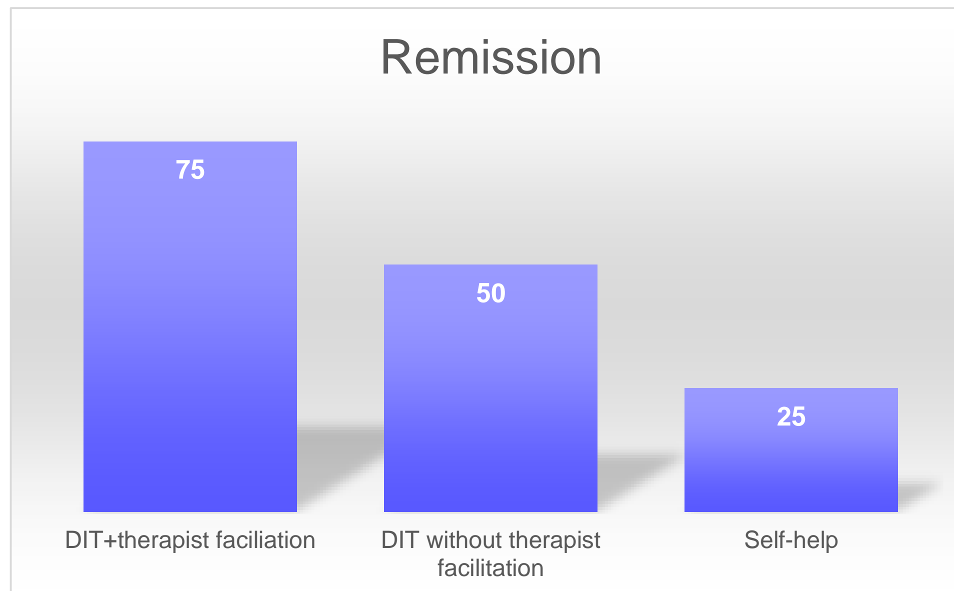
Internet-based DIT: pilot study

- inclusion criteria:
  - Over 18 years of age
  - Not in any other formal therapy at the time of applying
  - Scored no less than 5 (mild) on PHQ-9 and GAD-7
- exclusion criteria:
  - Scoring above 19 on PHQ-9
  - Scoring above 14 on GAD-7

Lemma, A., & Fonagy, P. (2013). Feasibility study of a psychodynamic online group intervention for depression. *Psychoanalytic psychology, 30*(3), 367-380. doi: 10.1037/a0033239

Internet-based DIT: pilot study

- Results:
  - DIT+therapist facilitation was superior to DIT without facilitation (75% versus 50% remission at treatment termination)
  - DIT superior to pure self-help: 62.5% versus 25% remission at treatment-termination



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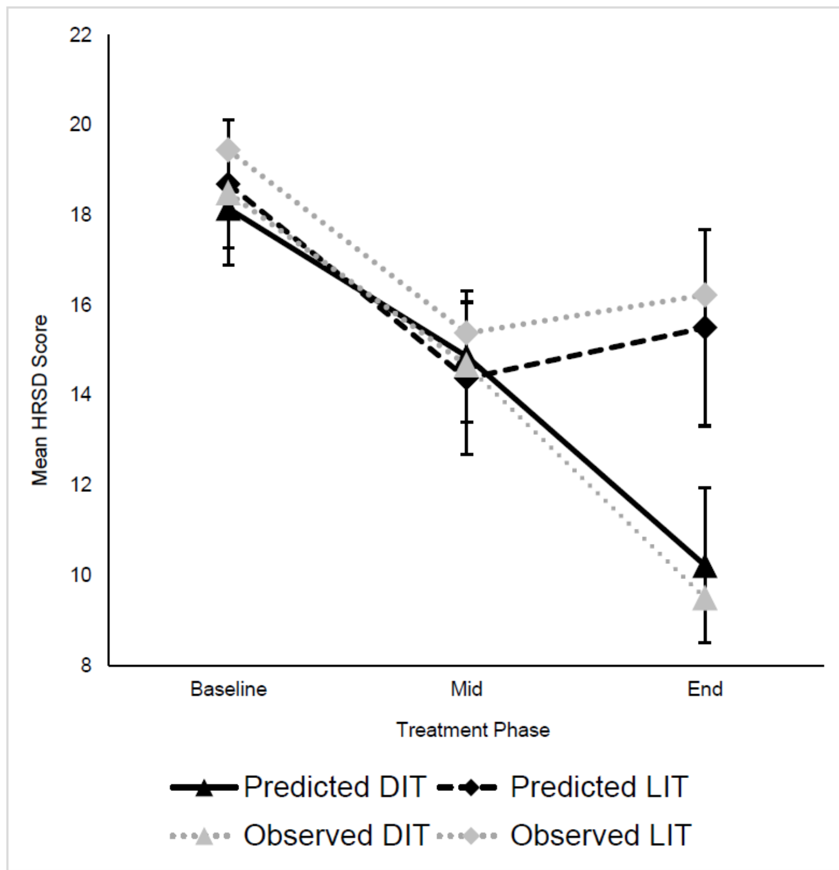
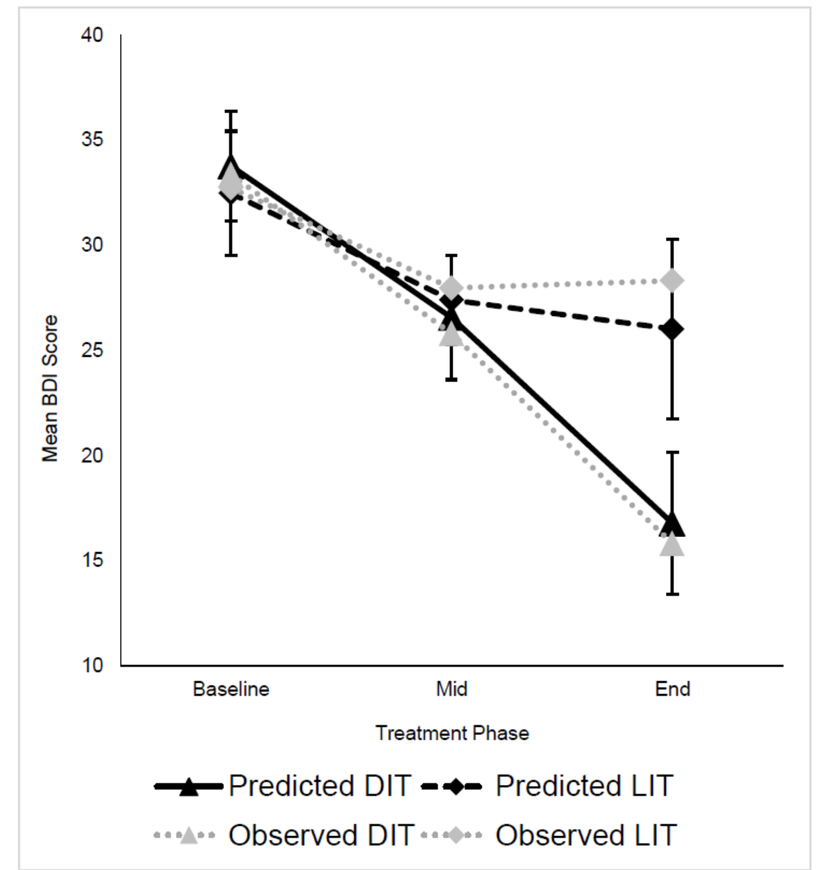
Superiority and Feasibility RCT

- 140 depressed patients randomized in a 3:2:1 ratio to
  - DIT (n = 68)
  - LIT (control intervention) (n = 53)
  - CBT (n = 19)
- Four IAPT treatment services in the UK

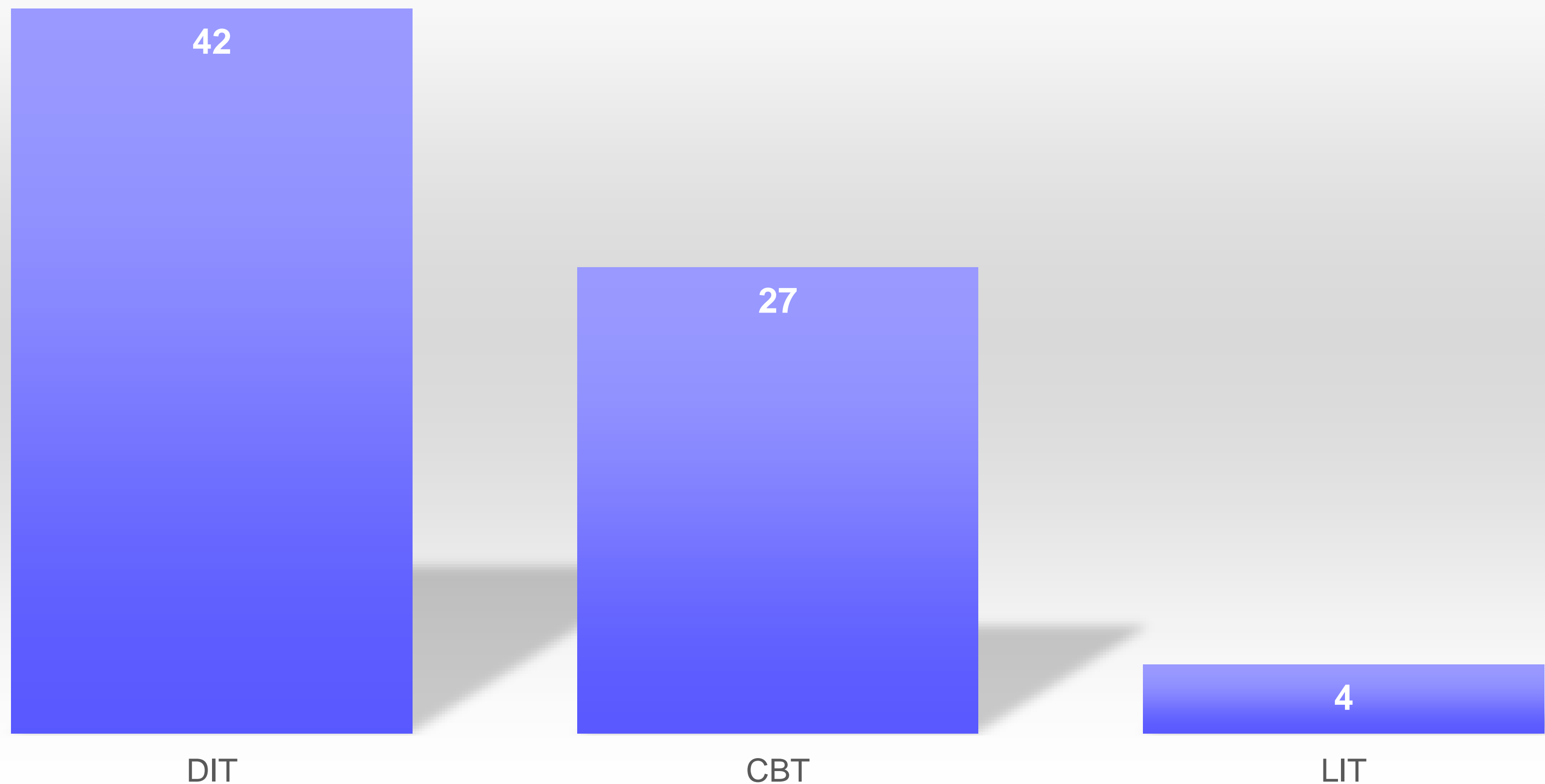
Primary outcome





Secondary outcomes

Cohen's d **= 1.69 for DIT versus LIT**



Secondary outcomes

- Medium to large effect size differences with LITP for general distress, interpersonal functioning, quality of life
- No significant differences with CBT
- Competency ratings were high for all DIT therapists (mean = 53.3, SD = 10.6, range: 19–65). All therapists were coded as adherent on 80% of recordings
- No relationship between competence and outcomes

Ongoing RCT: Pragmatic multicenter non-inferiority study

- N=504 randomized to one of four conditions:
  - f2f 16-sessions CBT
  - f2f 16-sessions DIT
  - Blended CGT (8 f2f sessions + 8 online modules)
  - Blended DIT (8 f2f sessions + 8 online modules)

Luyten, P., Claes, S., Van Busschbach, J. et al. (2021). Efficacy of blended care versus face-to-face psychotherapy for depression: A pragmatic, multi-centre non-inferiority trial. *Manuscript submitted for publication*.

DIT complex care

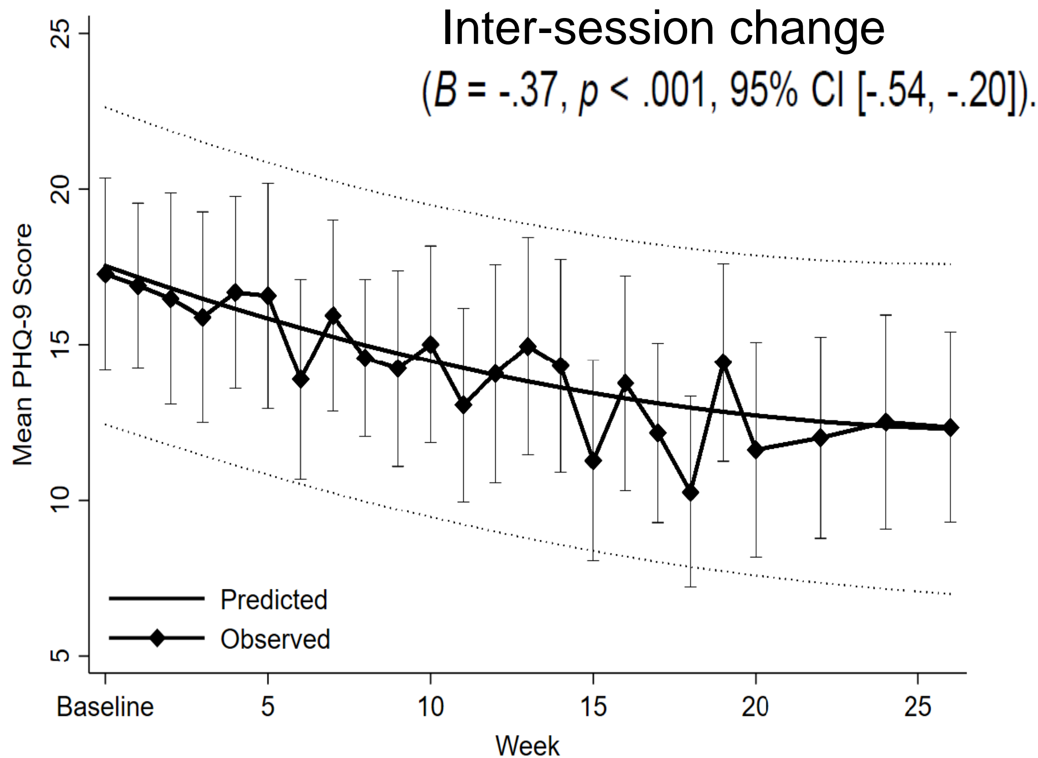


Figure 2. Predicted and observed mean PHQ-9 scores at each weekly session (time-points 1-20) and bi-weekly session (time-points 21-26) using all available data (*N* = 19). Errors bars reflect standard deviations and dotted lines reflect standard errors of the mean.

Rao, A. S., Lemma, A., Fonagy, P., Sosnowska, M., Constantinou, M. P., Fijak-Koch, M., & Gelberg, G. (2019). Development of dynamic interpersonal therapy in complex care (DITCC): a pilot study. *Psychoanalytic Psychotherapy, 33*, 77-98. doi: 10.1080/02668734.2019.1622147

DIT complex care

Table 4: The number and percentage of treatment completers showing reliable and clinically significant change.

Measure	CSC	Improvement	Deterioration	No Change
PHQ-9 (*N* = 15)	5 (33%)	10 (67%)	1 (7%)	4 (27%)
GAD-7 (*N* = 15)	9 (60%)	11 (73%)	2 (13%)	2 (13%)
CORE-34 (*N* = 14)	4 (29%)	10 (71%)	0 (0%)	4 (29%)
SOS-10 (*N* = 15)	4 (27%)	9 (60%)	0 (0%)	6 (40%)

Note. CSC = clinically significant change; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder-7; CORE-34 = CORE Outcome Measure-34; SOS-10 = Schwartz Outcome Scale-10.

Benchmarking: Improving Access to Psychological Therapies (IAPT)

April 2014 - March 2015:

1,267,193 referrals

815,665 referrals entered treatment;

for which 32.0 days was the average (mean) waiting time

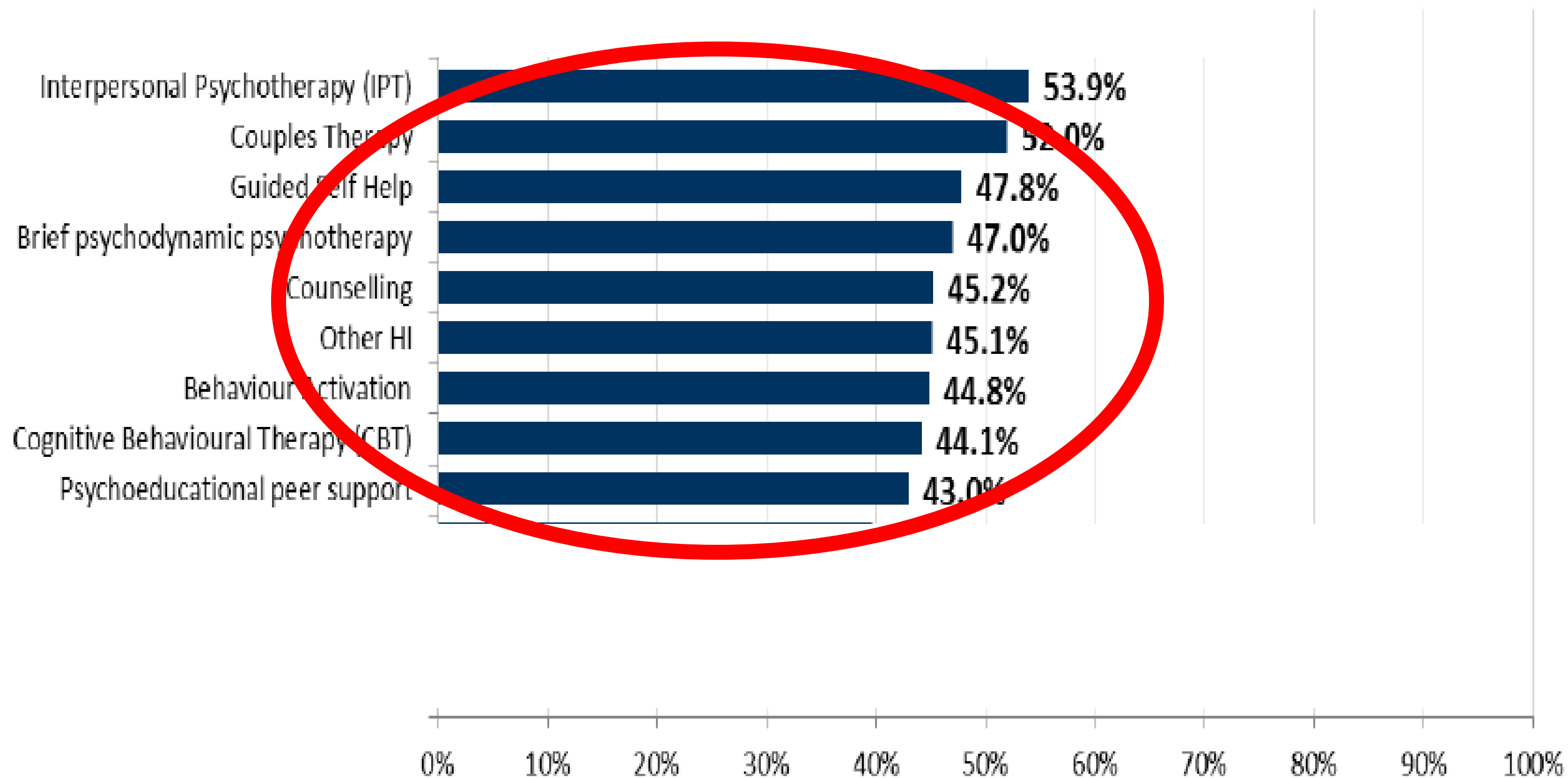
1,123,002 referrals ended;

of which 468,881 (41.8%) finished a course of treatment;

for which 6.3 was the average (mean) number of attended treatment appointments

Improving Access to Psychological Therapies (IAPT)

Figure 3: Recovery rates by therapy type for referrals with a problem descriptor of depression, 2014/15[23]



Qualitative research

- ‘Effective ingredients’ as reported by patients
  - therapy shedding light on previously sealed aspects of self;
  - the relational exchange with the therapist challenging intimate fears;
  - moving towards an interpersonal understanding of difficulties;
  - Putting the pieces together into a coherent narrative.
- **Activity and direction** is appreciated by patients, **the time-limited nature** provides a challenge but also opportunity
- Overall participants described an **interplay** between relational/mentalizing and insight-oriented mechanisms, consistent with the model’s proposed theory of change

Leonidaki, V., Lemma, A., & Hobbis, I. (2016). Clients’ experiences of dynamic interpersonal therapy (DIT): opportunities and challenges for brief, manualised psychodynamic therapy in the NHS. *Psychoanalytic Psychotherapy, 30*, 42-61. doi: 10.1080/02668734.2015.1081266
Leonidaki, V., Lemma, A., & Hobbis, I. (2018). The active ingredients of dynamic interpersonal therapy (DIT): an exploration of clients’ experiences. *Psychoanalytic Psychotherapy, 32,* 140-156. doi: 10.1080/02668734.2017.1418761

Tack and for more information:

patrick.luyten@kuleuven.be

p.luyten@ucl.ac.uk