Clients' experiences of dynamic interpersonal therapy (DIT): opportunities and challenges for brief, manualised psychodynamic therapy in the NHS

Venetia Leonidaki, Alessandra Lemma & Imogen Hobbis

Published online: 15 Oct 2015.

Submit your article to this journal ↗

Article views: 90

View related articles ↗

View Crossmark data ↗

Routledge
Taylor & Francis Group

Clients' experiences of dynamic interpersonal therapy (DIT): opportunities and challenges for brief, manualised psychodynamic therapy in the NHS

Venetia Leonidaki[a,b]*, Alessandra Lemma[c] and Imogen Hobbis[d]

[a]*School of Health and Human Sciences, University of Essex, Colchester, UK;* [b]*Camden and Islington Trust, iCope, Finsbury Health Centre, London, UK;* [c]*Psychological Therapies Development Unit, The Tavistock and Portman NHS Foundation Trust, Tavistock Centre, London, UK;* [d]*Department of Psychological Sciences, Norwich Medical School, University of East Anglia, Norwich, UK*

Dynamic interpersonal therapy (DIT) is a brief manualised psychodynamic intervention for depression. This is a first study exploring clients' experiences of DIT specifically and brief, manualised psychodynamic psychotherapy (PP) in general. Interpretative phenomenological analysis was the methodology employed. Five participants completed a semi-structured interview, three weeks to ten months after completing DIT. The scores of pre- and post-therapy outcome measures of depression and anxiety were also available. Two emerging superordinate themes are presented here: (1) 'The Distinct Features of DIT', referring to how its therapeutic style and time limitations were experienced and (2) the 'Impact of Therapy', referring to perceived outcomes. While previous findings showed that therapist's perceived limited activity in long-term PP was experienced as hindering/unhelpful, the perceived sense of direction in DIT appeared adequate to most participants. Secondly, the time limitations provoked complex responses. Reactions to the distinct elements of DIT are to be treated both as therapeutic opportunities and as challenges. Further, in line with psychoanalytic theory, most participants described relational changes that went beyond symptom relief and remained in progress after therapy ended. Intriguingly, there was no consistency between participants' qualitative accounts of change and the scores of the outcome measures.

Keywords: dynamic interpersonal therapy (DIT); brief psychodynamic psychotherapy; interpetative phenomenological analysis (IPA); qualitative research; clients' experiences

Depression is a complex and heterogeneous condition mainly characterised by low mood and/or inability to feel pleasure (National Institute for Health and Clinical Excellence [NICE, 2009]). Depression impairs social functioning, carries a risk for suicide and has a relapsing nature (Carr & McNulty, 2006). It also presents a high-comorbidity with other psychological disorders, with more than

half of individuals presenting with depression also meeting criteria for anxiety disorders (Kessler et al., 2003). As a response to the high rates of individuals suffering from psychological problems, mainly depression and anxiety, the Improving Access to Psychological Therapies (IAPT) programme was introduced to increase access to high-quality psychological interventions in England's National Health Service (NHS) (Department of Health [DoH], 2008a). As a result of the strong commitment of IAPT to evidence-based interventions (NICE, 2009), cognitive behavioural therapy (CBT), the therapy with the largest evidence base (Roth & Fonagy, 2005), has been by far the most widely available intervention in IAPT services. More recently, dynamic interpersonal therapy (DIT), a manualised, brief (16 sessions) psychodynamic intervention for depression (Lemma, Target, & Fonagy, 2010) was also introduced in IAPT for reasons explained below. This article presents a qualitative study of clients' experiences of DIT.

Introducing DIT to IAPT

DIT was introduced in IAPT for several reasons. Firstly, the need to offer a range of psychological interventions instead of a 'one size fits all' approach is increasingly recognised (DoH, 2010). Indeed, the UK Clinical Guidelines (NICE, 2009) for the management and treatment of adults with depression recommend brief psychodynamic therapy as an alternative to CBT, the first-line psychological intervention for depression. Secondly, in some controlled trials examining the efficacy of CBT, approximately only 50% of clients recover fully, while dropouts are frequent (Churchill et al., 2001; Hans & Hiller, 2013), which suggests that there are many clients who may not benefit from CBT. There is no robust evidence to guide systematic allocation of clients with depression to different treatment modalities (Roth & Fonagy, 2005). However by delivering and evaluating a range of talking therapies, the body of knowledge in this area can be enhanced.

DIT: core features

The development of DIT relied on a distillation of the active ingredients of other evidence-based, manualised, psychoanalytic/psychodynamic interventions (Lemma, Roth, & Pilling, 2008). In addition to the pragmatic reasons underlying its development, DIT has distinct theoretical and technical components, as described in detail in the following account.

Although DIT shares an emphasis on the interpersonal elements of depression with interpersonal therapy (IPT), which is another 16-session manualised intervention for depression offered in IAPT, the two therapies are significantly different. The IPT emphasises the links between depressive symptoms and social functioning, while DIT pays more attention to unconscious factors (Lemma, Target, & Fonagy, 2011a).

The theoretical underpinnings of DIT are embedded in the concepts of attachments (Bowlby, 1969/1982) and mentalisation (capacity for reflective functioning; Fonagy & Target, 1997), and in object relations (Glickauf-Hughes, &

Wells, 1997) and Sullivan's (1953) interpersonal theory. DIT focuses on: (1) the identification of an unconscious, repetitive pattern of relating connected to the presenting depressive symptoms and (2) the enhancement of the patient's capacity for mentalisation (Lemma et al., 2010).

In contrast to long-term psychodynamic/psychoanalytic psychotherapy (PP), in DIT the therapeutic stance is fairly active and the emphasis is on the here-and-now. Indeed the therapy is structured around the identification and exploration of an interpersonal-affect focus (IPAF), which conceptualises how a certain unconscious conflict is linked to depressive symptoms. (Lemma et al., 2011a).

DIT: current and future research activity

Relevant research on DIT to date has been limited to a pilot study, which mainly assessed its acceptability and effectiveness (Lemma, Target, & Fonagy, 2011b). In that study, fourteen of the sixteen participants completed the whole course of DIT. Almost 70% of the participants scored at or below the clinical cut-off for depression and anxiety at the end of therapy. Qualitative data also suggested that clients found the treatment acceptable and relevant to their problems (Lemma et al., 2011b).

Rationale for the current study

Although an RCT on DIT is currently being conducted, a qualitative study of DIT could provide complementary information to the RCT, including information about the processes and possible active ingredients of therapy and clients' experiences of DIT. Additionally, to our knowledge, there are no previous qualitative studies of clients' experiences of brief manualised PP (Leonidaki, in preparation). This is a gap in the literature as the qualitative findings regarding long-term PP (e.g. Lilliengren & Werbart, 2005; Palmstierna & Werbart, 2013) are not transferrable to brief PP, which is meant to have distinct goals and technical elements.

Current study

The current study uses qualitative methodology to explore the following questions:

- How did clients experience DIT, especially its brief nature?
- How did clients make sense of the possible impact of DIT on their difficulties and lives?

Method

Ethical approval

Full ethical approval was granted from the NHS Research Ethical Committee (reference number: 11/LO/1240).

Design

The qualitative helpful factors design (QHFD) guided the design of the current study. This is a methodological paradigm, used in psychotherapy process research, where clients are asked directly about the psychological intervention received via the use of open-ended questionnaires and/or interviews, and systematic methods of data analysis are employed (Elliott, 2010).

This study employed IPA, which is a particular stance towards conducting qualitative research and analysis (Larkin, Watts, & Clifton, 2006). IPA, concerned with what a particular experience is like for an individual in a specific context (Smith, Flowers, & Larkin, 2009), suited the aim of this study. Indeed, Smith et al. (2009) recommend IPA for exploring significant experiences that initiate reflection, such as those of therapy. Importantly, IPA allows an insider's perspective that goes beyond a descriptive level of analysis (Larkin et al., 2006).

Researchers

The first author and primary investigator, a trainee clinical psychologist at the time of this study, has had an interest in psychoanalysis, but also in other models of therapy. The second author is a psychoanalyst and one of the authors of the DIT manual. The third author, an experienced qualitative researcher and clinical psychologist, mainly delivers non-psychodynamic interventions.

Participants

Participants were recruited from an NHS psychological therapy service in a highly diverse area of London. The service operated using the IAPT model, as described by the DoH (2008b). Potential participants were given information about the study to help them decide about participating. At the time of the project, the service had five employed part-time DIT therapists, equal to two full-time staff. All the clinicians had similar experience and qualifications.

In line with IPA principles, the current study sought a purposive, homogeneous sample (Smith et al., 2009). Purposive sampling refers to a systematic selection of participants who will generate rich data about an investigated phenomenon. Homogeneity in IPA serves the purpose of gaining increased insight into the perspective of a phenomenon by focusing on only a part of the total population. Here, the criteria for homogeneity focused mainly on the nature and severity of the client' clinical difficulties, as these factors were clearly expected to influence the experience of therapy. Potential participants needed to have completed the whole course of DIT three weeks to 10 months before the recruitment and for their pre-therapy score on the patient health questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams 2001) to have been between the clinical cut-offs for mild and moderately severe depression (scores: 5–19). Individuals were excluded if they

Table 1. Information about participants: socio-demographic information, clinical presentation and treatment history.

Participant	Age	Ethnicity	Employment status	Marital status	Co-morbidity	Previous therapy	Length of previous therapy
Alan	60	White British	Retired	Married	Social anxiety disorder (SAD)	1. Counselling	1. 1 year
						2. Psychodynamic	2. 1 year
						3. CBT	3. 8 sessions
Eric	36	Other White	Unemployed	Single	SAD	CBT	8 sessions
Mathew	36	Black British	Full-time	Single	SAD	Computerised CBT	8 sessions
Lisa	27	Black British	Full-time	Single	SAD	No	N/A
Angela	56	Asian	Part-time	Married	No	Counselling	2 years

had psychosis or substance use or personality disorders, required an interpreter for the interview or their therapists were concerned about suicidal behaviour.

Twenty-three suitable potential participants were invited to participate in the study via letter. Only five accepted the invitation. Table 1 presents participants' characteristics. Pseudonyms were used to ensure anonymity.

IPA studies typically use a small sample size because they are primarily concerned with an in-depth, interpretative analysis of rich accounts. Smith et al. (2009) recommend three to six participants as a sufficient number.

Data collection

The schedule of a semi-structured interview was developed by drawing on literature about clients' experiences of therapy (e.g. Elliott & James, 1989; Lilliengren & Werbart, 2005). Subsequently, it was refined based on the feedback received from an independent audit by a peer-support group and the responses of the first two participants.

The interview schedule covered the following areas: participants' experiences of DIT, how their understanding of their difficulties was possibly shaped by DIT and the possible impact of DIT on participants' lives and relationships. The interviews were conducted in the service premises by the first author who had no previous relationship to the service. The interviews were audio-recorded and transcribed.

Questionnaires

Quantitative data can help situate the sample in qualitative research. Therefore the scores on the PHQ-9 (Kroenke et al., 2001) and the generalized anxiety disorder-7 (GAD-7) (Spitzer, Kroenke, Williams, & Lowe, 2006), completed as part of routine clinical practice, were used to calculate whether reliable and clinically significant change (RCSC) (Evans, Margison, & Barkham, 1998) was achieved. The PHQ-9 and the GAD-7 measure the presence and severity of depression or anxiety, respectively. The score range of the PHQ-9 is 0–27, while that of GAD-7 is 0–21, with higher scores indicating greater severity of symptoms. Both the PHQ-9 and the GAD-7 have excellent internal consistency ($\alpha = 0.89$ and $\alpha = 0.92$, respectively) and good test-retest reliability ($r = 0.84$ and $r = 0.83$, respectively), while both were standardised in primary care (Kroenke et al., 2001; Spitzer et al., 2006).

Analysis

Reliable and clinically significant change.   Based on the method described by Jacobson and Truax (1991), participants' scores on the PHQ-9 and GAD-7 were used to calculate RCSC. Normative data for the PHQ-9 were taken from Kroenke et al. (2001) and McMillan, Gilbody, and Richards (2010), while for the GAD-7, from Spitzer et al. (2006) and Richards and Borglin (2011).

Qualitative data.   The stages of the IPA analytic process (Smith et al., 2009) were followed. After reading each transcript several times and making reflective comments, emergent themes were identified for each interview. Subsequently, comparing the themes across the group led to higher-order clusters, constituting superordinate themes. The initial themes were repeatedly checked against the original text and further refined.

To enhance the trustworthiness of the analysis, an audit trail was kept, multiple extracts from participants were provided, the third author acted as 'additional analytical auditor' and peers provided feedback.

Results

RCSC results

According to Table 2, Alan's and Lisa's decrease in depressive symptoms achieved RCSC, while Matthew's relevant decrease achieved RC (Table 2). In relation to GAD-7, Eric and Lisa achieved RCSC. Eric's pre-therapy score on the PHQ-9 and Angela's pre-therapy score on the GAD-7 were so low that estimation of CSC was not applicable.

Table 2. Pre- and post-therapy scores on PHQ-9 and GAD-7 and CSC and RC.

	PHQ-9				GAD-7			
	Pre-therapy score	Post-therapy score	CSC	RC	Pre-therapy score	Post-therapy score	CSC	RC
Alan	10	3	Yes	Yes	14	11	No	No
Eric	6	2	N/A[a]	No	11	6	Yes	Yes
Matthew	17	10	No	Yes	14	12	No	No
Lisa	15	6	Yes	Yes	18	4	Yes	Yes
Angela	13	13	No	No	7	8	N/A[a]	No

[a]CSC was not applicable – pre-therapy score was already below the estimated clinical cut-off.

Qualitative findings

This article presents two emerging superordinate themes.

(1) Responses to Distinct Elements of DIT
     Subordinate themes:
     The level of direction in DIT as adequate or unsatisfactory
     The time limitations as a source of anxiety and incentive
(2) Impact of Therapy
     Subordinate themes:
     Feeling empowered to attend to own needs and to reach out for help
     Unblocking obstacles to enrich lifestyle and relationships
     'Rather the beginning of a journey than the end' (Eric)

The above themes are discussed below and illustrated by extracts from participants' accounts. English was not Eric's first language and this seems to have somewhat reduced the clarity of his ideas. However, every effort was made for his voice to be equally represented.

Responses to distinct elements of DIT

This superordinate theme captures the meaning attributed to two distinct elements of DIT: the DIT style and the limited number of sessions.

The level of direction in DIT as adequate or unsatisfactory.   With the exception of Eric, most of the participants painted a picture of an engaging therapist who would ask questions and prompt clients to reflect and draw conclusions. For example:

> I don't think he [the therapist] had to, he had to say much, just asking specific questions that he thought I needed to kind of ask myself sort of thing, and then I started talking and talking more about and so forth and so forth, and I know he 'd sometimes go over and over certain things, and he probably picked up on certain things I kept going over, and questioning me more about these certain things and so forth, and that's how I had conversations and discussions that helped me just to uumm pick through all the crap that was going on in my head sort of thing, uumm, so, so it was interesting, very interesting. (Matthew)

Alan and Angela noted how their therapist would move the sessions in a certain direction. Their calm tone of voice and the content of their speech convey a sense of containment which seems to result from their impression that their therapist was taking the lead at times:

> There were times I wanted to steer the therapy in a certain direction and [therapist's name anonymised] would steer it back into the direction that she thought we ought to go. (Alan)

> He [the therapist], yeah, he made me see things much more clearly. It was not just me talking all the time, he was able to [pause] uum pinpoint certain things, he was able to uuum, direct me to different path, different way of thinking. (Angela)

On the other hand, Eric perceived his therapist's style as 'uncertain', which seemed to have evoked feelings of discontent:

> Maybe because sometimes I would just [pause], I, he would be listening to me, he would be listening to me and I expected him to talk more to try to tell me this is, this is because of that, he always used 'maybe', 'perhaps', you know, which in my brain, I had the impression that he was not sure. (Eric)

Eric, and also Lisa, expressed a wish for more solution-focused interventions:

> But I don't think I got, you know, some solution, you know, about what to do, about how to, let's say, you have for example panic attacks, what you should do? ... To start thinking or to stop thinking, you know, I didn't get anything like, you know, distraction. (Eric)

> I wanted more in terms of, like cos with me and [her therapist's name], it was just us two, that I would have wanted like, for me to be able to bring someone else in and say how do I [pause] interact with that person. (Lisa)

Eric's and Lisa's views above could be appreciated more fully when they are placed in the context of their lived worlds, as that emerged in the interviews. In his interview, Eric talked about his need for 'a stronger authority' and a dream about how his 'dad [is] a stronger person than' him. In contrast, he expresses disappointment with his therapist's tentative style. In her interview, Lisa talked about having had 'high expectations' in her life in general and in her therapy in particular, as her expectation about DIT was that she 'would go in, and come out cured'. Instead Lisa left therapy feeling that she wanted more as described above.

The time limitations as a source of anxiety and incentive.   The time limitations evoked ambivalent feelings in some participants. While they appeared to have assisted the maintenance of focus in therapy and perhaps accelerated the processes, they may have also caused stress:

> You always had that in your mind, like week eleven, okay, oh no, we've only got like seven weeks, seven sessions left, and you always had that in mind but you had to try and cram, sometimes I felt like that I had to try and cram everything so that I made sure that I was making full use of [her therapist's name]. (Lisa)

> When you are fixed for a number of sessions, you think OK, I got five more ses-
> sions, I got four more sessions, I got three, and that feeling that you are not going to
> have this relationship, it's quite [sighs], I am not gonna say stressful, but it sort of
> concentrates your mind that there is going to be a final session ... because you know
> that there is going to be an end, everything comes to a point, you are a lot more
> motivated to get stuff out. (Alan)

The next extracts demonstrate how Alan's and Lisa's strong awareness of the time
left in therapy, combined with the clear structure of DIT, created a sense of orien-
tation and sequence:

> There are signposts so that you know where you are and where you are getting to-
> wards the end and although you don't really want to reach that destination um … at
> least you can see it ahead. (Alan)

> But I liked the process in terms of how it was broken down, like the initial phase and
> then the middle bit and then the end. (Lisa)

Lisa's tendency to fit things in 'a perfect little box', reported elsewhere in her
interview, could partly explain why she enjoyed the sense of structure and orien-
tation in DIT.

In contrast, Eric's scepticism towards the time constraints made him doubt
the overall value of a brief therapy and limited his ability to use the sessions
effectively:

> So, he was working really his hours, you understand, he was working reading his,
> you know, uum ... bu, but can you imagine somebody wants to help you and use the
> egg timer, you know, going down, I mean to 16 h, so I got the impression like this is
> instant help. You can't put things in a timeframe, you know.

> I: But I am interested in what you mean by instant help.

> I mean I was aware all the time I had 16 h and you know, so we have 16 h to talk
> about this and about that {..}so you don't feel like honest help, if somebody limits
> my time. (Eric)

Eric's long-standing difficulties in trusting others, described elsewhere in his
interview, may perhaps account for his apparent struggle with the brief nature of
therapy.

Trying to understand how Lisa's and Eric's lived experiences may have shaped
their views of DIT in the above two themes leads to tentative conclusions about
how one's internal and relational struggles may colour their experience of therapy.

The impact of therapy

This superordinate theme deals with the end products of DIT and its perceived impact, as reported by participants.

Feeling empowered to attend to own needs and to reach out for help.   DIT appeared to have increased most participants' awareness of their needs/vulnerabilities and empowered them to be more accepting of and/or attentive to them, often bringing about relational changes.

Angela and Lisa explained how DIT helped them recognise and prioritise their own needs and desires over 'pleasing other people' (Lisa):

> ... it [DIT] was all about me, it was me, me and me {...} after a very long time I was able to think about myself, how I feel, how things affect me{...}Yeah, I am a person, yes, I am important as well {...}I'm not here to serve the rest of the world, they owe me something as well you know and I'd like that. (Angela)

> ... But now it's, I'm kind of changing that and it's when someone calls me and asks me for something, 'well actually hold on a sec, um, let me check my diary' {...} And if it doesn't fit in my lifestyle I'm gonna have to say to you ''I'm sorry I can't do that' whereas before even if I couldn't do that, I always used to say 'yes' and then I would be stressing. (Lisa)

Eric was trying to act like 'a hundred percent a man' and hide his weaknesses and his concealed view of himself as 'a disabled person'. DIT seems to have helped him start changing this attitude, although this change also sounds painful:

> Maybe I didn't like the way, you know, that I started to think about myself like somebody who got problems, but actually I think that's not realistic; everyone, I think, at some stage, may need some help, some people more often than others and more help. (Eric)

In the next extract, Eric sounds to have started overcoming possible feelings of shame related to a bodily manifestation of his problems and becoming less withdrawn:

> That was one of the reasons that I accepted to talk to you because it [the attitude to the bodily manifestation] changed quite a lot since I spoke to doctor [referring to the DIT therapist], then I said to myself, look I don't care what somebody would think or if it happens, just don't fight it anymore, because I've been fighting it all my life. (Eric)

Three other participants also described how after DIT they adopted a more active role in expressing their needs than before:

What therapy helped me to realise was that I could actually tell people that I was having a problem. (Alan)

I'm trying to reach out to other people and talk to them {..} which is something I wasn't doing before. (Lisa)

I used to, I used not to, talk about things {...} but if there is something that really, really bothers me these days, I'll tell whatever it is that bothers me, and whether they'll get upset or not, that's down to them. (Matthew)

Overall, this theme should be seen as complementary to the following one.

Unblocking obstacles to enrich lifestyle and relationships. This theme captures a sense of discovery as if what was previously blocking participants' ability to relate fully to life and to others has been freed up so that participants can engage more meaningfully with activities and other people.

Angela described how, thanks to therapy, she became involved in things that she had always been interested in but had not previously dared to do. Such activities included going on holidays, learning to use computers and completing college. She also reported an increased ability to enjoy things:

I wouldn't enjoy it, I would sit there worrying about what my mum is doing so I think that DIT helped me to enjoy things more fully than I did before. (Angela)

The following accounts seem to convey a more flexible and enriched way of thinking and relating to others as the result of DIT:

Everything was always fit into a perfect little box and um it was good within the sessions to be able to say, well actually not everything in your life can be perfect{...} So it was good just to be able to have that, how to react with other people if something happens and it doesn't fit into that little box, how can you engage with other people to kind of see well actually this didn't happen, what's the next step, so it was really helpful. (Lisa)

What I found out from therapy was that there are different ways of relating to people, that you don't necessarily have to sort of [pause] come from the point of view of art, that you just, you know, engage them in conversations, that you just listen to them and there is nothing at all interesting but the give and take. (Alan)

I would be in a world of my own, and whatever, whatever, looking dozy, and looking sad and doing my own thing I don't know, now I am probably more engaging if somebody comes and speaks to me, I ll ... I don't know, I am more welcoming to speak to them and have a laugh and joke, I am not so ... I think the expressions on my face changed so in a way that I am not as miserable as I used to be [laughing]. (Mathew)

The above extracts convey a sense of the participants being more open to interactions with others and feeling more relaxed in these interactions.

'Rather the beginning of a journey than the end' (Eric).   Most participants reported that coming to terms with their psychic struggles was an ongoing process continuing after the end of DIT. The diversity of participants' emotional reactions to this realisation is of particular interest.

Matthew's and Angela's extracts convey a sense of stoicism and hope, seemingly deriving from their impression that DIT had equipped them with the psychic strength to approach their remaining struggles differently:

> I'll have good days and I'll have bad days, it's just deal, you deal better with the bad days. (Matthew)

> I have now come out of that depression and a long way down, I have come now quite a bit, but this does not stop me from feeling down at times**.** If I didn't have my DIT, I don't think, I would feel horrible, just loading my guilt and whatever, and I would feel worse and worse and worse. (Angela)

In contrast, Eric feels that DIT did not adequately prepare him to deal fully with his 'unsolved problems' after therapy had ended:

> What happened after my therapy, actually I found a job; I found even a girlfriend, then again; and it seemed you know like I got better, but what happened? I got so stressed in job, you know, it was a very demanding job, I couldn't handle it. I mean it's really like I hate to go to work in the morning sometimes, and I ended my relationship because of my problems being still unsolved. (Eric)

Although in the above extract, Eric describes not having maintained some of the changes that he achieved after the end of therapy, elsewhere in his interview he says that there are occasions on which he goes 'back to the DIT session in' his 'head and try to see what' he 'can use from there'. In fact, he reflects on how some of the conclusions drawn in therapy helped him to understand the reasons for his relationship breaking up:

> I tried to be strong and I broke up with somebody because I got like, I got sort of, you know, I didn't, didn't want, I didn't want so much softness {...} because I misunderstood that of being pity, instead of being loved. (Eric)

Finally, Lisa describes how the end-of-therapy letter helped the digestion of the therapeutic material after therapy had ended:

> So I didn't have that time to kinda process everything; Which is something that goodbye letter helps, you know that I can look back at it and process it a bit and think actually, this is what the session, I got out of the session, this is what we identified and worked on. (Lisa)

Integration of RCSC and qualitative results

With the exception of Lisa, who described DIT as 'life-changing' and achieved RCSC on the PHQ-9 and the GAD-7, participants' qualitative accounts of change and their RCSC findings did not often agree with each other. More specifically, while Eric described his experience of DIT and its impact in overtly negative terms, he achieved RCSC on GAD-7 while his pre- and post-therapy depressive symptoms were under the clinical cut-offs. Paradoxically, despite the fact that neither Matthew's nor Angela's symptoms achieved CSC, they both greatly praised DIT. Similarly, although Alan had 'nothing but praise for {...}the whole process', his anxiety symptoms did not achieve RC or CSC.

Discussion

Responses to distinct elements of DIT

These findings are initially discussed in relation to the first question that this article posed: how have clients experienced DIT, with a particular focus on findings pertinent to its active and brief aspects. Participants' overall reflections on the therapeutic style and length of therapy of DIT indicated that the model was acceptable, at least to a fair extent, to most clients. Some participants' complex reactions to these elements of DIT are also discussed.

The level of direction in DIT as adequate or unsatisfactory. Most participants described their therapists as providing guidance and focus without being overtly directive. These findings are congruent with the theoretical description of the DIT stance, which, although rooted in the analytic attitude, favouring reflection over action also aims to be more active and focused than the approach in long-term PP (Lemma et al., 2011a). Indeed, the perceived sense of adequacy of direction described here is different from the findings of studies of clients' experiences of long-term PP, where the therapist's reduced activity and limited guidance are commonly experienced as hindering/unhelpful (e.g. Lilliengren & Werbart, 2005; Yakeley & Wood, 2011). Hence, in contrast to qualitative findings regarding the style of long-term PP, the more active and collaborative style of DIT is perceived as engaging.

On the other hand, some participants felt that more guidance was needed. As in long-term PP, DIT appears to expect the client to be interested in reflecting on his/her difficulties, rather than the therapist directly suggesting strategies for relieving distress (Lemma et al., 2011a), an aspect which a couple of participants struggled with. In particular, Eric appeared to have perceived his DIT therapist's style as uncertain and Lisa wished for solution-focused interventions. These comments, when they are taken as face-value, may indicate limitations of the model as compared to action-oriented interventions. However, if one stays open to the idea that these comments may also represent clients' internal struggles then they can also be viewed as part of the therapeutic material that is generated in the sessions. Indeed, Eric's comment about his need for a strong authority figure and Lisa's

apparent tendency for perfectionism, described elsewhere in their interview, indicate that these comments may also reflect internal struggles.

The time limitations as a source of anxiety and incentive.   As stated in the introduction, to the best of our knowledge, this is the first study exploring clients' experiences of brief PP. Alan's and Lisa's extracts convey the sense that the time limitations were experienced as motivating and orientating influences in therapy, but they also created feelings of anxiety. These stressful feelings that the brief nature of DIT has created could hopefully be treated by the clinicians as opportunities for increasing insight, and perhaps should not discourage psychodynamic practitioners accustomed to long-term work from delivering a brief model.

In contrast, Eric's frustration seems to encapsulate more difficult dynamics, as Eric appeared to have rejected the potential value of DIT because of its brevity. Eric's negative reaction might be better understood in the light of Høglend's (1993) recommendations that individuals with difficulties in trusting others are less likely to benefit from brief therapy.

Both the adoption of an analytic attitude which favours reflection over action and the time limitations of DIT seem to correspond partly to the concept of the therapeutic frame, as defined by Gray (1994) both as a practical 'contract [...] setting out how the [therapeutic] work is to be conducted' (p. 7) and a framework that has connections with past experiences of care. In this theoretical context, these distinct elements of DIT discussed here – the active but analytic stance and the time limitations – can provide a context in which transference is manifested, shedding light on the client's internal representations. Indeed, in the current study for two participants (Eric, Lisa) whose lived worlds emerge in their interviews, connections can be drawn between their reactions to the therapeutic frame of DIT and their apparent internal and relational experiences. Thus, DIT therapists may want to pay close attention to their clients' reactions to these distinct elements of DIT, which may reveal information about the phenomenology of therapy but they could also represent transference reactions. The therapist then may need to decide whether to manage or interpret these feelings, as transference interpretations in DIT are encouraged only if they linked to the IPAF.

The impact of therapy

This superordinate theme refers to the nature of changes that participants experienced as the result of DIT. The discussion of this superordinate theme aims to answer the following question of our study: How did clients make sense of the possible impact of DIT on their difficulties and their lives?

Feeling empowered to attend to own needs/vulnerabilities and reach out.   Most participants appeared to have become more aware and accepting of their own

needs and desires and better able to attend to them after the end of the therapy. Paradoxically, the behavioural and emotional strategies previously employed by the participants, such as prioritising others' needs over their own or distancing themselves, may have prevented them from meeting their own needs. Indeed, relevant research suggests that behavioural strategies adopted by individuals with depression prevent them from accomplishing their needs satisfactorily (Hershenberg & Davilla, 2010; O'Connor, Berry, Lewis, Mulherin, & Yi, 2007). In fact, as with the current participants, research suggests that some depressed individuals may adopt an avoidant style towards others (Hershenberg & Davilla, 2010) or even adopt seemingly altruistic behaviours which are initiated by increased levels of empathic distress and interpersonal guilt (O'Connor et al., 2007). DIT conceptualises such reactions as part of the unconscious defences which may be there to protect the individuals from painful feelings but which end up maintaining their difficulties. It is one of the tasks of DIT to shift these defences and help clients to achieve tangible changes in their relationships with others. This seems to have been achieved for several participants who described having been more able to reach out to others (Alan, Lisa, Matthew) or having at least been less avoidant (Eric).

Unblocking obstacles to enrich lifestyle and relationships.   Unlike more traditional psychodynamic therapies which give the main weight to intrapersonal factors, DIT treats interpersonal factors as equally important for promoting change. Depression is conceptualised to be partly the result of temporary disorganisation of the attachment system caused by relationship difficulties. Therefore, a major aim of DIT is to encourage the clients to try new ways of relating with others, transferring what is learnt in the sessions to real life (Lemma et al., 2011a). Indeed, the participants in this study sounded to have become more open and engaging in relationships with others. Theses outcomes appear to be in line with the core aims of DIT.

There is also an implicit sense that clients' reflective capacity has been enhanced. For example, Angela's worrying, which she linked with a sense of guilt in other parts of her interview and which was previously blocking her capacity to enjoy things, became less prominent. Lisa's apparent overcoming of her tendency to fit everything into a little box led to more meaningful ways of relating. One cannot help wondering whether this apparently enhanced reflective capacity may partly account for the reported relational changes. Such a hypothesis would fit with the theoretical ideas of DIT about enhancing clients' ability to mentalise about their own and others' mind as a way of encouraging relational change (Lemma et al., 2010).

Rather the beginning of a journey than the end (Eric).   This final subtheme regarding the impact of DIT captures participants' perception that the process of change continued after the completion of therapy. This finding is compatible with the 'sleeper effect' (Levy, 2009, p. 203) phenomenon, which refers to the improvements brought about by PP carrying on after its termination (Taylor, 2008). Interestingly, one of the participants (Eric) described how although he has not been able to maintain all the progress made, he can use the insight gained in therapy to reflect on the reasons behind his setbacks. These reflections could also be viewed as part of the process of change, which continues after the end of therapy.

Further, participants' accounts in our study conveyed the sense that clients had an active role in the process of change after the end of therapy and a sense that part of the psychic change had not been entirely completed. This is in line with Holmes' (1994) comment that the sense that 'much psychic work has been left undone {...} balanced by an affirmation of the patient's autonomy and capacity to cope' (p. 13) colours the ending of brief PP. Indeed, this sense appears distinct to brief PP, given that in a recent review of clients' experiences of long-term PP (Leonidaki, in preparation) such findings did not come up. In the current study, our participants' different emotional reactions to the above realisation indicate the need for clinicians to prepare their clients for the emotional challenges attached to the end of time-limited PP. DIT itself places great emphasis on the emotional processing of the ending of therapy.

Integration of RCSC and qualitative results

Finally, given that systematic monitoring is at the heart of IAPT, the lack of concordance between the participants' reported changes and their RCSC scores on outcome measures may merit further investigation. This lack of concordance could, at least partly, be explained by DIT not being a symptom-focused therapy but instead aims for affective and relational changes and shifts in the capacity for thinking which are difficult to measure. If future research replicates the observed inconsistency between quantitative and qualitative evaluation of DIT, then a clear risk of a misleading evaluation of DIT by the use of IAPT outcomes measures and the need for employment and/or development of more sophisticated outcome measures may be identified.

Limitations

The limitations of this study occurred both as a result of the restricted sampling pool and also the nature of the methodology employed. The small sample size and the low response rate, albeit common elements of IPA research, introduce the risk of the sample not being representative of the wider sampling pool and hence limit the transferability of the findings. Recruitment difficulties, including

having to employ a retrospective method of recruitment due to time restrictions, accounted for this limitation. Additionally, as it is the case in every qualitative study, participants' expressed views have probably been influenced by various factors, such as how articulate and reflective participants were or the presence of social desirability bias. A limitation of the QHFD is that it relies on participants' retrospective recall of therapy, which may distort their memories. We tried to address this limitation by excluding individuals who had completed DIT more than 10 months prior to the interview. Although the original recruitment plan was to invite only clients who had completed therapy up to 6 months prior to the interview, because of recruitment difficulties the plan was revised to invite all the clients who completed therapy any time between 3 weeks and 10 months before the interview. No noticeable differences were observed in the interviews between clients who had completed therapy more recently than others.

Conclusion

The current study explored clients' experiences of DIT using IPA. It makes an original contribution to the literature by providing information about the acceptability and perceived impact of DIT, focusing for the first time on clients' experiences of the time-limited aspects of PP. The DIT style appeared mostly acceptable to clients, while the time constraints provoked emotionally charged responses, which can be treated as therapeutic opportunities. In line with psychoanalytic theory, DIT appeared to have brought about broad changes of an emotional and relational nature, while these changes remained ongoing after therapy had ended. Most of above reported changes were not captured by the IAPT outcome measures, however, which raises questions about the appropriate evaluation of PP via psychometric questionnaires measuring symptomatic changes.

Disclosure statement

References

Bowlby, J. (1969/1982). *Attachment and loss: Vol. 1. Attachment*. New York, NY: Basic Books.

Carr, A., & McNulty, M. (2006). Depression. In A. Carr & M. McNulty (Eds.), *The handbook of clinical psychology: An evidence-based practice approach* (pp. 291–343). Hove: Routledge.

Churchill, R., Hunot, V., Corney, R., Knapp, M., McGuire, H., Tylee, A., & Wessely, S. (2001). A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. *Health Technology Assessment, 5*, 1–173.

Department of Health (DoH). (2008a). *The IAPT pathfinders: Achievements and challenges*. London: Author. Retrieved from www.dh.gov.uk/publications

Department of Health (DoH). (2008b). *Improving access to psychological therapies: Commissioning for the whole community*. London: Author. Retrieved from http://www.dh.gov.uk/health/category/publications

Department of Health (DoH). (2010). *Equity and excellence: Liberating the NHS*. London: Author.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20*, 123–135. doi:10.1080/10503300903470743

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9*, 443–467.

Evans, C., Margison, F., & Barkham, M. (1998). The contribution of reliable and clinically significant change methods to evidence-based mental health. *Evidence Based Mental Health, 1*, 70–72.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*, 679–700.

Glickauf-Hughes, C., & Wells, M. (1997). *Object relations psychotherapy: An individualized and interactive approach to diagnosis and treatment*. London: Karnac Books.

Gray, A. (1994). *An introduction to the therapeutic frame*. London: Routledge.

Hans, E., & Hiller, W. (2013). Effectiveness of and dropout from outpatient cognitive behavioral therapy for adult unipolar depression: A meta-analysis of nonrandomized effectiveness studies. *Journal of Consulting and Clinical Psychology, 81*, 75–88. doi:10.1037/a0031080

Hershenberg, R., & Davila, J. (2010). Depressive symptoms and sexual experiences among early adolescent girls: Interpersonal avoidance as a moderator. *Journal of Youth and Adolescence, 39*, 967–976. doi:10.1007/s10964-009-9446-4

Høglend, P. (1993). Suitability for brief dynamic psychotherapy: Psychodynamic variables as predictors of outcome. *Acta Psychiatrica Scandinavica, 88*, 104–110. doi:10.1111/j.1600-0447.1993.tb03422.x

Holmes, J. (1994). Brief dynamic psychotherapy. *Advances in Psychiatric Treatment, 1*, 9–15. doi:10.1192/apt.1.1.9

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., … National Comorbidity Survey Replication. (2003). The epidemiology of major depressive disorder. *JAMA, 289*, 3095–3105.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9. *Journal of General Internal Medicine, 16*, 606–613. doi:10.1046/j.1525-1497.2001.016009606.x

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102–120. doi:10.1191/1478088706qp062oa

Lemma, A., Roth, A., Pilling, S. (2008). *The competences required to deliver effective psychoanalytic/psychodynamic therapy*. London: HMSO, Department of Health. Retrieved from www.ucl.ac.uk/CORE

Lemma, A., Target, M., & Fonagy, P. (2010). The development of a brief psychodynamic protocol for depression: Dynamic interpersonal therapy (DIT). *Psychoanalytic Psychotherapy, 24*, 329–346. doi:10.1521/psyc.2011.74.1.41

Lemma, A., Target, M., & Fonagy, P. (2011a). *Brief dynamic interpersonal therapy*. Oxford: Oxford University Press.

Lemma, A., Target, M., & Fonagy, P. (2011b). The development of a brief psychodynamic intervention (dynamic interpersonal therapy) and its application to depression: A pilot study. *Psychiatry: Interpersonal and Biological Processes, 74*, 41–48. doi: 10.1521/psyc.2011.74.1.41

Leonidaki. (in preparation). *Clients' experiences of psychodynamic psychotherapy. A systematic review of the literature*.

Levy, K. (2009). Psychodynamic and psychoanalytic psychotherapy. In D. C. S. Richard & S. Huprich (Eds.), *Clinical psychology: Assessment, treatment and research* (pp. 181–214). San Diego, CA: Elsevier.

Lilliengren, P., & Werbart, A. (2005). A model of therapeutic action grounded in the patients' view of curative and hindering factors in psychoanalytic psychotherapy. *Psychotherapy: Theory, Research, Practice Training, 42*, 324–339.

McMillan, D., Gilbody, S. M., & Richards, D. (2010). Defining successful treatment outcome in depression using the PHQ-9: A comparison of methods. *Journal of Affective Disorders, 127*, 122–129. doi:10.1016/j.jad.2010.04.030

National Institute for Health and Clinical Excellence (NICE). (2009). *Depression: The treatment and management of depression in adults (partial update of NICE clinical guideline 23)*. London: Author.

O'Connor, L., Berry, J. W., Lewis, T., Mulherin, K., & Yi, E. (2007). Empathy and depression: The moral system on overdrive. In T. F. D. Farrow & P. W. R. Woodruff (Eds.), *Empathy in mental illness* (pp. 49–75). Cambridge: Cambridge University Press.

Palmstierna, V., & Werbart, A. (2013). Successful psychotherapies with young adults: An explorative study of the participants' view. *Psychoanalytic Psychotherapy, 27*, 21–40. doi:10.1080/02668734.2012.760477

Richards, D. A., & Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study. *Journal of Affective Disorders, 133*, 51–60. doi:10.1016/j.jad.2011.03.024

Roth, A., & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research* (2nd ed.). New York, NY: The Guilford Press.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis*. London: Sage.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine, 166*, 1092–1097.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York, NY: Norton.

Taylor, D. (2008). Psychoanalytic and psychodynamic therapies for depression: The evidence base. *Advances in Psychiatric Treatment, 14*, 401–413. doi:10.1192/apt.bp.107.004382

Yakeley, J., & Wood, H. (2011). Patients' experiences of forensic psychotherapy. *Psychoanalytic Psychotherapy, 25*, 105–114. doi:10.1080/02668734.2010.519160