Revised Curriculum for Dynamic Interpersonal Therapy for Depression

Alessandra Lemma, Mary Target and Peter Fonagy

With contributions from Deborah Abrahams and Jeremy Clarke

Based on: Lemma, A, Target, M, & Fonagy, P. (2011). *Brief dynamic interpersonal therapy: A clinician's guide*. Oxford, UK: Oxford University Press.

This is a revision of: Lemma, A., Target, M., & Fonagy, P. (2009). *Manual for Dynamic Interpersonal Therapy (DIT)*. London: University College London.

Cite as: Lemma, A., Target, M., Fonagy, P., Abrahams, D., & Clarke, J. (2017). Revised curriculum for dynamic interpersonal therapy for depression. London, UK: University College London.

Contents

Curriculum for Dynamic Interpersonal Therapy

Introduction

This curriculum constitutes a refresh of the curriculum for Dynamic Interpersonal Therapy (DIT) published in 2011, which formed the basis of IAPT training delivered by the Tavistock & Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families (AFNC).

This refresh continues to be based on the manual for DIT (A Lemma, Roth, & Pilling, 2009; A. Lemma, Target, & Fonagy, 2009; A Lemma, Target, & Fonagy, 2011) but expands the length of training from 5 to 20 days in order to ensure that:

1. A broader range of mental health workers with less experience of working in a psychodynamic approach can be trained to deliver DIT
2. The training may be provided by a wider range of training organisations than those representing the developers. To these ends the curriculum has been modified extensively taking a rigorous competency based approach providing a clear and transparent structure and practice points which trainers can use to ensure the delivery of these competencies.

Five Year Forward View

The refresh is in line with the *Five Year Forward View* (Mental Health Taskforce, 2016) and *Achieving Better Access to Mental Health Services by 2020* (Department of Health & NHS England, 2016). The documents underscore the importance of patient choice in accessing psychological therapies.

Currently, the availability of DIT is restricted by the absence of psychological therapists with DIT training. The small number of therapists trained in this evidence-based method is a key reason for the shortfall. Further, because the trainings to date had been offered to individuals with existing competencies in psychodynamic work, trained therapists frequently left the service for employment in secondary care or private practice. The aim of the curriculum refresh and the revised entry criteria is to extend the range of people who will be able to practise DIT to include a number of counsellors already working in IAPT services without psychodynamic training but interest in the delivery of this modality as well as some people that are not currently working in IAPT who could be recruited in as new staff.

HEE Quality Framework

The proposed curriculum was drawn up in order to increase compliance with the HEE Quality Framework in relation to a number of quality standards (QS) in all the quality domains (Health Education England, 2016).

1. *Learning environment and culture*. The new curriculum focuses on supporting an ethos of patient empowerment (QS 1.6) and delivering clinically and therapeutically effective care where trainees are provided with the tools to monitor patients' and service users'

experience (QS 1.4) and where learning outcomes are extremely clear and explicit so that learners can demonstrate the achievement of professional standards (QS 1.2).

2. *Educational governance and leadership*. By lowering the barrier to acceptance for the training programme, the refreshed curriculum will ensure that the training is increasingly offered based on the principles of equality and diversity (QS 2.3); through the improved specification of curriculum elements, arrangements can be put in place to accurately measure educational performance against the standards demonstrating accountability (QS 2.1).
3. *Supporting and empowering learners*. By broadening the providers (training centres) involved in the delivery of DIT beyond the site managed by the developers, we can increase the likelihood that learners can be more closely linked with local services and that placements respond to local as well as national developments (QS 3.1).
4. *Supporting and empowering educators*. The refreshed curriculum provides more detailed description of competencies to be taught, and the developers undertake to provide support and resources to ensure that educators can deal effectively with concerns and difficulties that they face in delivering DIT (QS 4.2).
5. *Developing and implementing the curriculum and assessments*. The refresh of the DIT curriculum was designed to achieve a 'step change' in providing practical experience to support learners in achieving required outcomes (QS 5.1 and QS 5.2). The curriculum now specifies the use of video recordings of the therapist as the basis for supervision, as well as extensive videotaped role-plays to enhance experiential learning during training and in clinical practice settings (QS 5.3). Assessments will largely be based on the submission of video materials (QS 5.3) with an increased emphasis on patient participation in the training programme (QS 5.4).
6. *Developing a sustainable workforce*. The expansion of training from 5 to 20 days enables the progression of learners to be more effectively monitored (QS 6.3) and thus the level of public protection through teaching and assessment facilitates transition from education to employment (QS 6.5). As stated above, the inclusion of IAPT workers without specialist training will broaden access to this modality and ensure a more stable workforce.

Expertise and evidence base of the curriculum

The evidence base for short-term psychodynamic psychotherapy for depression is supported by a large number (k=46) of randomised controlled trials. Appendix A lists some of these references.

The refreshed curriculum was developed by the same group that originated DIT (A Lemma et al., 2009; A. Lemma et al., 2009; A Lemma et al., 2011). The group has 6 years of experience in delivering training in the modality to several hundred participants.

The refresh is further informed by recent evidence to emerge from a randomised controlled trial of DIT, which demonstrated its effectiveness when delivered by therapists who had undergone the training with the developers and showed superiority relative to an enhanced minimal treatment control.

Training structure and method

Each of the 20 training days will be divided into four sessions; generally, each morning and afternoon will include 50% active learning time (mainly by videotaped role-plays). Thus, each didactic presentation will be practised through role-play in groups of three, with one trainee watching and video-recording a role-play therapy interaction in which the other two trainees play the patient and therapist. Experiential exercises in the form of role-play and responsive interaction with video content will form a core component of training in order to link teaching material to clinical context and interpersonal experience.

Some points will be best illustrated through watching a video clip, from which depression or therapeutic techniques can be individually rated by each participant, with the ratings and observations then discussed in a larger group.

It is expected that much of the 20 days' face-to-face teaching will be concerned with clinical skills. The theoretical basis will be assumed on the basis of previously presented materials or prior attendance at other courses in which basic psychodynamic theory has been covered. An assessment of this component will be a part of the programme and will be a pre-condition of attendance at the practical clinical element of the course.

Entry criteria

The proposed course is a postgraduate certificate.

A Diploma level qualification in counselling (not necessarily psychodynamic) will be the minimum entry requirement.

There is no specified requirement for experience of personal psychodynamic psychotherapy during the course of prior training or during the proposed DIT training although this will be encouraged during the training

Plan for assessment

There will be four components to the assessment:

1. *Theoretical basis of DIT*. This will be delivered in advance of the course. The content of this component will be based on the initial chapters of the DIT manual, which will not be covered as part of the training. Satisfactory completion of this component is essential for progression.
2. *Knowledge of DIT*. This will be assessed after the first half of the programme, which covers sessions I.1–I.3 and II.1–II.3, by a mixture of role-play and clinical videos. There will be a further requirement of submission of a clinical log. Satisfactory completion of this component is essential for progression.
3. *Intervention with DIT*. This will be assessed at the end of the training by the same method as for component 2 and will cover the remaining sessions of teaching. Satisfactory completion of this component is essential for progression.

4. *Clinical experience*. Trainees will present logs and video records of their supervised clinical experience of three cases treated with DIT.

Evaluation and Pass criteria

1. Theoretical basis of DIT:

Once trainees enrol on the course, they will be given access to the podcasts and be required to view them before commencing the formal training.

Completion of this component will be assessed by a multiple-choice test that would be marked by the organisation.

A minimum pass rate of 60% will be required to begin the DIT training.

Organisations are required to provide a sample of the multiple-choice tests to the DIT-AWG.

2. Knowledge of DIT and Intervention with DIT:

Satisfactory completion of these two components, assessed by multiple choice tests, with the assessment passed at 60% or better, is essential for progression.

3. Clinical component:

Trainees will be required to see 4 cases.

Three tapes, one from each of the phases of the therapy, will be rated for each case. Additional recordings may be required if concerns are identified.

Three cases will be used for summative assessment and one case (the first one) will serve as a formative assessment.

Tapes will be rated using the adherence and competence scales used in the REDIT trial (Fonagy et al, in preparation).

Each tape will need to pass at 75% (minimum 4/5 point rating for all items).

Trainees will provide a training log of their clinical work. Random samples of the clinical logs and individual sessions from different stages of the model will be evaluated by the DIT-AWG.

Evidence of demand

The starting point for evidence of demand for IAPT was a business case to address unmet need for access to evidence-based therapies for depression and anxiety, as the preferred

treatment option for most patients (Layard & Clark, 2014; McHugh, Brennan, Galligan, McGonagle, & Byrne, 2013). An ambitious access target was set at 15% of prevalence by 2015. However, while the target was met (nationally) it was already clear that demand exceeded this: the *Five Year Forward View for Mental Health* (2016) set a new target for 2021 at 25%. In addition, services should offer treatment within a waiting time of 6 weeks for 75% of patients seeking access; 50% should recover; and availability of choice should improve (NHS England, 2016).

A recent report (Allen & Clarke, 2016) based on interviews with 30 IAPT clinical leads, commissioned by the Tavistock & Portman NHS Foundation Trust at the request of HENCEL, identified strong demand for DIT at service and CCG level to improve uptake, completion and recovery rates through increased patient choice, improved staff retention through opportunities for professional development, and improved sustainability in an identified area of skills and capacity gaps.

Similar needs were identified by Strategic Commissioners across 10 CCGs in the NHS in Greater Manchester. IAPT's annual workforce surveys indicate acute gaps in the DIT workforce nationally. Across the existing and new entrant psychological workforce there is considerable interest in training in DIT, but to date the entry criteria that were set for DIT have acted as a barrier to many including clinical and counselling psychology trainees and graduates, existing HI and LI IAPT therapists, counsellors and psychotherapists, third year psychiatry trainees looking for suitable training placements for their psychotherapy cases, third sector providers of psychological therapy, etc.

Course accreditation

The course will be accredited by an appropriate professional body, as yet to be determined.

Training the trainers

Who will train the new workforce? Our intention is to significantly broaden the base of those eligible to offer training but of course, trainers will need to familiarize themselves with the principles and practice of DIT. Organisations with adequate staff who are either qualified DIT supervisors or who meet the criteria of psychoanalytic/dynamic competencies on the UCL website will be eligible to apply for training status. DIT-AWG will be offering a fast-track process for staff who are unfamiliar with the DIT model to undergo an intensive training and see two to four training cases so that they are in a position to deliver the extended DIT training. This would involve a 3-day, on-site training for a small group of up to eight trainers, followed by group supervision, provided online or in person, depending on geographical location. Larger groups would require a 4-day basic training. The number of training cases will depend on the ease with which individuals pick up the model: it will be no fewer than two and up to four cases, with each case taking at least 16 weeks to complete treatment.

Following this, we would offer a 3-day training in implementing and delivering the new extended DIT training.

DIT-AWG anticipates that it would take an organisation 6–9 months to be in a position to start offering the DIT training to a cohort of IAPT trainees, assuming they have no qualified DIT supervisors to offer the training. With qualified supervisors, there would be a much shorter lead time in which they would need to undertake the 3-day training familiarising themselves with the new syllabus. There is an existing network of DIT supervisors across England who would be eligible to be contracted as DIT trainers and supervisors.

Alongside this, DIT-AWG would be offering regular consultations to discuss difficulties that may arise in the training process. This could be delivered in two ways: 1) via an online forum. DIT-AWG would provide secure access to a trainers' section on the DIT website, www.d-i-t.org, where questions could be posted and responses could become a shared resource, or 2) via organisational consultation as required.

Collaboration with training providers

There are numerous trainings in dynamic psychotherapy across the country. We envision a simple call for interest of those willing to provide the training, ideally linked to existing IAPT training sites. In the first instance, sites willing to provide the training will have to undergo the 'train the trainer' programme. This is well established for DIT, as a number of training sites have already opened (WPF, Northern School). The training is provided initially jointly with the developers and then independently, with clinical submissions by trainees randomly sampled to assure quality.

Representative experts in the model would be brought together in a single oversight group which would be responsible for quality control of the training provision, coordinated by the British Psychoanalytic Council (BPC). Videotapes of trainees would be regularly reviewed by the Quality Board of the current joint providers. The BPC will have responsibility for accrediting those who have satisfied the board of examiners, and a register will be kept by the BPC. We anticipate that a DIT UK Network will be set up in conjunction with the BPC and the current joint providers of DIT. This network will provide a geographical map of accredited DIT practitioners as well as supervisors.

Theoretical pre-training course

1. Introduction to relevant psychodynamic ideas

Learning objective: To know about the key psychoanalytic ideas underpinning the model.

- Will provide a succinct theoretical overview of
  - Attachment theory
    - Reciprocity: attachment behaviours of infants are reciprocated by adult caregiving behaviour, leading to attachment to that particular adult
    - Attachment is a 'dyadic regulatory system':
      - infant's signals are responded to (or not)
      - signals acquire meaning for the baby
      - meaning will be accurate, minimised, displaced, escalated or distorted in relation to the baby's original state, according to the adult's characteristic responses
      - based on derived meaning the baby learns to seek or avoid closeness
      - experiences are aggregated into the baby's representational system ('internal working models')

    - Hallmarks of adult attachment style
      - Autonomous (secure): coherent; undefended access to consistent memories and judgments, presenting a credible autobiographical account, value attachment and acknowledge impact
      - Dismissing (avoidant): unable to remember, idealise, devalue
      - Preoccupied (resistant): entangled in angry, passive, fearful associations
      - Unresolved with respect to trauma (disorganised): slips, contradictions, gaps, confusion, reliving of trauma

  - Object relations theory (particularly O. Kernberg and D. W. Winnicott)
    - Self, other relationship representations
    - Role of affect in object relationships
    - Holding and containment, and splitting and fragmentation

  - Interpersonal theory (Harry Stack Sullivan)

    - The interpersonal model of development
    - The theory of reflected appraisals
    - Social interactions and the role of parataxic distortions
    - The role of interpersonal needs and the disruptive effects of anxiety.

- Will highlight common features of recent psychoanalytic ideas
  - The impact of early childhood experiences on adult functioning

- The internal and external forces that shape the mind and therefore inform our perception of ourselves in relationships with others
- The existence of a non-conscious realm of experience that is a motivating force
- Non-conscious, 'affect-laden' representations of objects and relationships act as mediators of self-image and self-organisation, and determinants of 'environmental' impact
- The defensive processes (projective and introjective) that underpin the subjective experience of relationships and serve to maintain negative views of the self and others
- The ubiquity of the transference, by which patients respond to others – and to the therapist – according to developmental models that have not been updated or challenged.

2. Introduction to relevant aspects of a diagnosis of depression

Learning objective: To appreciate the lived experience of depression, its phenomenology, and the normalizing of the symptomatology of depression as a reaction to the experience of life experiences, and to understand that depression is not a unitary disorder through a review of key facts about the complexity of depression

- Depression is 'a heterogeneous group of related disorders' in which 'incomplete recovery and relapse are common'
  - Less than half of treated patients achieve full remission and sustain it over a period of 2 years following treatment
  - It is common for depressed people to have a comorbid psychiatric diagnosis (e.g., anxiety, various personality disorders)
  - Patients meeting criteria for a major depressive disorder are nine times more likely than chance to meet criteria for other conditions
  - 50–90% of patients with DSM Axis I conditions also meet criteria for other Axis I or Axis II conditions.

- Psychosocial factors are implicated in recurring or persistent depression
  - Poverty, homelessness, unemployment and chronic physical illness play a role
  - Lack of a confiding relationship is a strong risk factor for depression
  - 'Early life experiences such as poor parent-child relationship, marital discord and divorce, neglect, physical abuse and sexual abuse almost certainly increase a person's vulnerability to depression in later life' (National Institute for Health and Clinical Excellence, 2010, p.25).

- Depression significantly interferes with social and occupational functioning and physical health (including mortality)
  - Nearly two-thirds of suicides occur in depressed people
  - Marital and family relationships are negatively affected
  - May lead to neglect and difficulties in children of depressed parents.

3. Introduction to key features of DIT

Learning objective: To understand the links between some of DIT's key features and their relationship to depression and the theoretical ideas presented

- DIT is rooted in a belief in
  - The social origins and nature of individual subjectivity
  - The importance of attachments, and that threats to attachments can lead to depressive reactions
  - The importance of the capacity to mentalize experience, without which the patient is more vulnerable to developmentally primitive modes of experiencing internal reality
  - Past relationships are understood to contribute to current difficulties through the activation of internalised representations of self and others that may trigger and/or maintain depressive symptoms.

- The core aims of DIT therefore are
  - To help the patient to think about their depressive symptoms in relation to what is happening in their relationships now (including the relationship with the therapist)
  - To systematically focus on
    - The patient's state of mind, not on their behaviour
    - Their affects in the here-and-now of the session or the recent past, not on the interpretation of unconscious or distal events.

Learning objective: Knowledge of the interpersonal tradition of the understanding of depression

- Interpersonal problems are marked in severe depression and evident even in mild or moderate depression
- Potential for depressed mood to elicit negative responses from others
- Patients with depression tend to select and generate interpersonal scenarios with the propensity to evoke distress (e.g., conflicted interactions leading to rejection)
- Interpersonal interactions are complex, very rapid and largely non-conscious – beyond the capacity of the conscious mind to monitor
- Interpersonal experiences trigger interpersonal relationship representations, which can trigger negative subjective experiences
- Distorted internal representations of relationships can generate interpersonal problems that disrupt relationships and trigger depression
- Understanding the way in which distorted representations of relationships can create and maintain depression is key to the DIT approach to therapy
- Clinical experience of relationship with a patient allows more complex, deeper understanding of thoughts, feelings and behaviour, beyond the normal range of conscious experience and common-sense psychology
- Clinical sensitivity to the evolving relationship with a patient is a key instrument for treatment.

4. Introduction to mentalizing theory and its application to depression

Learning outcome: To have a good grasp of a mentalizing-informed representational view of the mental world

- Mental representations of relationships, where non-conscious and unconscious representations and affective associations underlie conscious thoughts and feelings about external relationships and actual other people, e.g., self–object–affect triad
- These representations mediate self-organisation and a sense of coherence and meaning, and determine the nature and degree of impact of the social environment
- Accumulating evidence that children transform early interactions with caregivers into cognitive–affective schemas of self and other, which regulate and direct subsequent behaviour
- How representations become distorted by impulses, conflicts and defences (may reflect genetic predisposition and/or prior experience) and explain the stability of maladaptive representational structures.

Learning outcome: To understand the manifestation of depression in terms of a limited failure of mentalizing

- DIT focuses on apparent dysfunctions in interpersonal cognition concerned with an individual's distorted and inadequate understanding of others' thoughts and feelings (mentalizing)
- DIT assumes failures of self and other understanding in depression to be strongly tied to particular self–other interaction patterns evolved from childhood experiences, real or fantasised
- Focus on mentalizing follows evidence
    - Demonstrating theory of mind deficits in patients with unipolar and bipolar depressive disorders
    - That disorganised attachment is associated with both mentalizing problems and depression.

- Re-emergence of a pre-reflective, physical self-experience in place of a psychological self-experience
    - Psychological experience is felt to be far too real: equation between psychological and physical pain, and between emotional and physical exhaustion
        - Certainty about mental states
        - Limited appreciation of the nature of the experience of having someone else define what is on one's own mind
    - A state of 'hyper-embodiment' may ensue: subjective experiences are primarily physical in nature
    - Lack of drive understood as a regressive embodiment of disempowering thought
    - Intensity of worries about the future, and the overpowering nature of self
    - Blame associated with past experience, implies similar loss of perspective

- Limiting of mentalizing of others to ideas and themes consistent with the individual's self-interest or preoccupations
- Limited or no recognition of ambivalence.

- The therapeutic task is the elaboration of the psychological nature of the state that is felt to compress the body rather than being available for reappraisal as a belief or a thought
  - In the absence of mentalizing, self-questioning may function as a persecutory attack upon the self-representation
  - Distortions of cognitions are considered indications of pseudomentalizing ('hypermentalizing').

Learning outcome: To engage participants in thinking about the contribution of DIT within an IAPT service (e.g., DIT as a high-intensity intervention; which kinds of depressed patients might be suitable for DIT as opposed to CBT or IPT)

- Depression is a heterogeneous condition, often experienced differently by different people, and often experienced recurrently and chronically by the same person at different times (National Institute for Health and Care Excellence, 2017; National Institute for Health and Clinical Excellence, 2010)
  - Understanding the phenomenology of depression can help inform more nuanced diagnosis and matching of treatment to the person's explanatory model for their current episode of depression
  - Where a person's belief is that the origins of their depression relate to their childhood and family background, albeit the focus of their current episode and treatment will be on an interpersonal conflict in the 'here and now', the concept that something significant in their experience of depression is being repeated, without awareness of how or why, is a positive indicator for DIT as a first-line 'best fit' offer.

- Remission rates in depression treatment leave many patients without full recovery, and relapse rates mean that for those who do recover there may be ongoing need for support or further treatment (National Institute for Health and Care Excellence, 2017; National Institute for Health and Clinical Excellence, 2010):
  - Equivalence of outcome has been established between psychodynamic and cognitive–behavioural therapies for depression (Driessen et al., 2013), similarly with IPT and CBT, and several other therapies (Barth et al., 2013; Cuijpers et al., 2013)
  - Personalised algorithms (e.g., the Personalised Advantage Index) or 'precision medicine' tools, such as those that exist in cancer treatment to guide treatment selection for specific kinds of patients with specific types of cancer, either do not exist or are yet to be sufficiently well established on putative moderators that have been shown to have predictive value for use in depression (Chekroud et al., 2016; DeRubeis et al., 2014)
  - Identifying patient preference – mediated by therapist guidance to inform choice in relation to the presenting condition, treatment history and knowledge of the

different treatment options – has been proposed as the next best alternative strategy to achieve best 'fit' and/or to switch to a better 'fit' if the initial selection has not worked (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Markowitz & Milrod, 2015; Swift & Callahan, 2009; Williams et al., 2016)
    - Where a person has previously tried CBT or counselling (the most common offers) but a need for further help is indicated to avoid an entrenched pattern of chronic depression, relapse and/or increased risk, then referral within the IAPT team to a DIT colleague is positively indicated as a second line step-up and/or step-across offer, or as a follow-on offer at follow-up.

- IAPT services include routine measurement of outcome as part of the delivery of DIT and therapists are required to understand and be able to integrate with their clinical work the use of outcome measures employed by the service.
    - To become familiar with PHQ9, GAD7 and any other measures routinely used by the service, and to be able to score and interpret these measures.
    - To learn to communicate about the measures with patients, both to support the administration of the measure and to be able to review the results within sessions and the pattern of results across sessions.

- IAPT services must strive to achieve equity of access, and parity of esteem (Royal College of Psychiatrists, 2013), for patients with depression. They also have a duty to reduce health inequalities (Health and Social Care Act 2012; Equalities Act 2010). This requires careful monitoring, outcomes tracking, and continuous efforts to improve service quality and recovery outcomes, e.g., by using MHIN benchmarking data and giving attention to known barriers to access (National Institute for Health and Care Excellence, 2011):
    - Understanding equity and access from a public mental health and complex/recursive healthcare systems perspective (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005) – i.e., how to improve unequal access for those with unequal needs? How to reduce health inequalities?
    - DIT may have a valuable role to play in improving uptake, completion and recovery rates as part of a pluralistic treatment offer that aims to maximise access across the whole population
    - Reaching under-served (e.g.. older people, men), poorly served (e.g.. socioeconomically deprived, Muslim patients) and/or 'harder-to-reach' populations (e.g., BME, LGBT) is more achievable when there is a full suite of personalised options within an integrated service model (delivered, ideally, by a team that reflects the local population diversity)
    - Where the service has identified gaps in its reach and/or specific populations of depressed patients who are not achieving equal access and equal outcomes from existing pathways into and through the service, then making DIT more prominently part of a targeted pathway offer to those 'harder-to-reach' groups is a positive strategy for improvement of the IAPT pathway as an additional self-referral option and/or quality improvement initiative led by the DIT staff.

Face-to-face training components

I. Knowledge

1. General

Learning outcome: Knowledge of the psychological and interpersonal difficulties experienced by patients with a diagnosis of depression

- Phenomenology of depression: common interpersonal problems of depression, somatic complaints and presentations, painful affect states, distorted self-image, hopelessness, etc.

Co-occurring difficulties: anxiety, trauma, personality disorders, substance dependence and misuse. The aim is for the trainee to recognise the complexity of difficulties that commonly present alongside depression, and to be able to communicate to patients that the focus of the current work will be on the referral syndrome of depression.

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

Learning outcome: Knowledge that DIT is grounded in object relations theory, attachment theory and mentalizing, and interpersonal psychoanalysis

- Knowledge of attachment-based, interpersonal and object relational models of depression
- Knowledge of developmental factors, e.g., a history of loss, implicated in the dynamic interpersonal model of depression.

3. Knowledge of the aims and focus of treatment

Learning outcome: Awareness that DIT aims to help the patient:

- *Understand the connection between their presenting symptoms and significant difficulties in their relationships*, by working with them to identify a core, non-conscious, repetitive pattern of relating (and making this the focus of the therapy)
- *Develop a better capacity to mentalize*, through identifying non-mentalizing discourse and learning to incorporate mental states into the narrative. Learn to recognise different types of non-mentalizing and how mentalizing capacities can fluctuate, in particular how mentalizing can diminish in the context of raised affect and interpersonal challenges.

Learning outcome: Understanding that the primary aim of DIT is to enhance the patient's interpersonal functioning

- Appreciating how interpersonal events impact on mood, and how to make such links

- Develop a capacity to think about and relate changes in the patient's mood to particular thoughts and feelings (conscious and non-conscious). Learn to help a patient to identify connected feelings, thoughts and fantasies.

Learning outcome: An ability to draw on knowledge that DIT systematically focuses on mental states in the context of recent interpersonal experience

- Learn how to hold a focus on the patient's state of mind, rather than their behaviour. This involves developing an understanding that the therapist's task is to help the patient move from thinking about behaviour and actions, and starting to recognise the mental states that underpin behaviour
- Retain a focus on the patient's experience in the here-and-now of the session or recent past, rather than the interpretation of distal events.

Learning outcome: Understanding the circumscribed interpersonal and affective focus (IPAF) that is linked with the onset and/or maintenance of symptoms, and being able to distinguish and elaborate the structure and function of the IPAF

- A pattern of experience of external relationships (in terms of self and other representations and affect) is identified. Develop the ability to hone down this pattern, using the IPAF structure, from the patient's descriptions of experiences, interactions and interpersonal events
- The pattern is seen to apply to different relationship contexts. The therapist learns how the IPAF, derived from one particular list of interactions, can be applied to further, different interpersonal situations that arise.
- Identify dynamic underpinnings of the IPAF, showing the role of conflict and defence (the gain to the individual of maintaining the painful IPAF). Help the patient to reach an understanding of the costs and benefits of the IPAF (for example, by adopting a victim role, the individual may feel humiliated and saddened, but may gain some sympathy and social concessions or sense of moral authority), and develop an understanding of how these might become barriers to the therapeutic alliance and progress.

4. Knowledge of the treatment strategy

Learning outcome: Ability to draw on knowledge that the three main phases of the treatment have distinct aims.

An **initial phase** aims to elicit and assess the quality and patterning of relationships (eliciting interpersonal narratives), past and present, as the basis for:

- Identifying a dominant, recurring, non-conscious interpersonal and affective pattern that will become the focus of the therapy (the IPAF)
- Using the pattern to help the patient to understand their current symptoms and to set interpersonal goals related to the IPAF.

A **middle phase** focuses on helping the patient to elaborate and work on the IPAF:

- Linking recent events (including events within the therapy) and current mood to the IPAF
- Highlighting the costs and benefits to the patient of maintaining their core interpersonal and affective pattern
- Helping to translate the IPAF into interpersonal change connected to the goals set in the initial phase.

An **ending phase** focuses on helping the patient to reflect on the affective experience of ending and so prepare for ending and plan for the future:

- The ending is important because of the risk that the patient will revert to the IPAF to interpret the present situation (e.g., that everyone abandons them), making relapse more likely
- It gives the opportunity to review progress and, very importantly, to anticipate challenges in the future for the particular patient

Learning outcome: Ability to apply the identified IPAF to the patient-therapist relationship to explore the IPAF further

- Monitoring the therapeutic relationship. The therapist learns to share observations with the patient about the patient-therapist relationship – for example in a situation where the patient appears to be attempting to appease the therapist by withholding how difficult things still are
- Noticing patterns. The therapist recognises and conveys to the patient their recognition that, for example, the patient appears particularly eager to please the therapist after coming back from a break
- Linking these observations and patterns within the patient-therapist relationship to the IPAF, as a live illustration of it. The trainee develops the ability to use an in-therapy event, for example an exchange in which the therapist is experienced as being distracted, and connect it to the object representation in the patient's IPAF being of someone who is uninterested and neglectful.

Learning outcome: Recognise that DIT makes use of expressive, supportive and directive techniques to support the aims of the treatment

- Distinguishing these techniques within the process of therapy. For example, in a video recording of a DIT session, participants are asked to identify the different techniques specifying examples of each
- Understanding the different functions of these techniques, and their use at different stages of the therapy. The therapist identifies the indications and contraindications for the use of the three types of intervention above – for example, directive work is done in obtaining the material required for the IPAF, not to instruct patients on to how to change the IPAF.

II. Interventions

1. Therapeutic stance

Learning outcome: Competence to establish the basic therapeutic stance that provides the foundation for exploration essential to DIT

- Establish and maintain an involved, empathic relationship with the patient
- Establish and sustain an active, collaborative stance where decision-making is shared between the patient and the therapist and the route followed is chosen by mutual agreement
- Adopt a 'not-knowing', curious, non-judgmental stance when exploring the patient's mental states, to communicate a genuine attempt to find out about their mental experience.

2. Assessment of the severity of the patient's depression

Learning outcome: Ability to assess risks associated with depression and, as far as possible, manage these risks

- Assess the patient's overall functioning, including within this an awareness of the severity of depression
- Assess the level of risk, including threats to collaboration
- Develop strategies with the patient for how to manage these risks
- Involve relevant professional networks to support the therapy where appropriate.

3. Assessment of the quality and patterning of the patient's current and past interpersonal functioning and formulation of a focus

Learning outcome: Ability to clearly restate interpersonal narratives accompanying interactions in a clear and understandable way; identify and foreground recurring patterns of interaction which appear linked to depression; draw on the nature of the therapeutic relationship to enrich the interpersonal formulation

- Elicit, clarify and elaborate narratives about relationships. In the context of an early session, for example, develop the capacity to keep the patient focussed on telling the therapist about their relationships, concentrating on major relationships and gathering interpersonal narratives for them
- Draw the patient's attention to repetitive patterns in their relationships
- Identify one dominant repetitive interpersonal pattern that is connected to the onset/maintenance of the depression and that will become the focus of the therapy – the Interpersonal Affective Focus (IPAF). Learning to focus on the pattern that seems to be most connected to the presenting depressed mood in a collaborative way that actively engages the patient in arriving at the formulation, e.g., explicitly asking the patient for

their view on what keeps happening with people that best accounts for their feeling of hopelessness

- Actively reflect on, and make use of, how the patient reacts to the therapist and what they seem to expect from therapy, as well as how the therapist feels in dealing with them, to arrive at the formulation of the IPAF. For example, in a case where the patient seems to demonstrate a pattern of describing relationships in terms of the other as disappointing and uninterested and where in the therapeutic interaction they seem hostile and to have negative expectations, leaving the therapist feeling inadequate. While not immediately discussing this with the patient, the therapist notes this as a barrier to progress and something that is perhaps felt to help the patient reduce the risk of relationships.

4. Engaging the patient in DIT

Learning outcome: Ability to act in a manner that is consistent with the aims of the therapy including ability to communicate simply, to show self-reflective openness, to adjust to the style of communication of the patient and to be able to link the patient's current experience to the DIT formulation with sufficient appeal to engage the patient in therapy

- Communicating with the patient in a direct, transparent manner that invites them to provide feedback on the formulation and process of therapy. The therapist needs to demonstrate a capacity to actively engage the patient in providing feedback on the hypotheses shared by the therapist about relational patterns and/or their experience of the therapy
- Responding to requests by the patient for clarification in a direct and clear manner that models a self-reflective stance that is open to correction. The therapist needs to demonstrate a capacity to engage directly and non-defensively with the patient's experience of the requirement for questionnaires and of the process
- Identifying the patient's level of reflectiveness or psychological-mindedness and to communicate in an attuned manner so that the patient can enter into thinking about themselves with someone else. For example, relate to and gradually engage a patient who is very withdrawn and perhaps silent, by beginning with relatively neutral and accessible topics to establish common ground
- Introduce the patient to the rationale and aims of DIT through the use of 'live' material in the session (e.g., by drawing the patient's attention to recurring interpersonal dynamics as they describe themselves and their relationships). The therapist draws on these examples to illustrate the way of working, using elements of the interpersonal narrative, and the in-session experience.

5. Help the patient identify the areas of interpersonal functioning they would most like to change during therapy

Learning outcome: Ability to engage the patient in identifying life objectives that hold great value for them and frame the IPAF around these as obstacles to these valued objectives, and conflicts and defences maintaining the IPAF because of their relationship with such values

- Identify and agree with the patient interpersonal problems of highest priority, which are most clearly linked to the depression
- Collaboratively frame an IPAF that is in the area of most interpersonal concern (valued activity)
- Identify the patient's defences and conflicts linked to the patient's value system that account for the maintenance of the IPAF despite its close link to depression. Once the relationship pattern linked to depression is established, identify what aspects of the patient's value system conflict with the abandonment of interpersonal expectations that generate depression
- Engage the patient in choosing realistic goals which are connected to the IPAF. These should be concrete steps towards addressing the interpersonal challenges involved, with an emphasis on identifying goals that are within the patient's capacity to attain
- Respond to any feelings the patient has about areas it may not be possible to work on. Agree the leading problematic relationship issues and find an agreed focus, with goals related to this. Learn to acknowledge with the patient that there may be other pressing concerns not within the scope of the therapy.

6. Maintain a focus on the agreed IPAF throughout the middle phase of the treatment

Learning outcome: Ability to maintain a focus on an agreed IPAF and return to it notwithstanding the complex narratives which the patient brings to their session based on their current life experience

- Elicit interpersonal narrative(s) and track the agreed IPAF as it emerges in the narrative(s) as the basis for any intervention.
- Maintain a focus on current significant relationships that demonstrate the activation of the IPAF and its relationship to depression
- Take a stance of curiosity about interpersonal scenarios (e.g., asking questions and requesting clarifications as necessary, bringing into focus an interpersonal exchange so as to highlight a salient repetitive pattern). The therapist's task is to learn how to elaborate in detail the specific interpersonal interaction that occurred even when the patient is focused on implication or other contextual aspects of the interaction
- Identify areas of difficulty in the patient's relationships that relate to the IPAF, in a consistently non-judgmental way
- Understand the patient's characteristic ways of managing areas of difficulty in their relationships and point out the cost, as well as the hoped-for benefit, of these strategies and the difficulty the presence of these benefits poses for abandoning the strategy
- Help the patient practise the skill of recognising internal states (feelings and thoughts) as they relate to the IPAF
- Invite reflection on the non-conscious assumptions behind feelings and thoughts when in a relationship, in order to highlight the way these assumptions perpetuate or exacerbate interpersonal difficulties
- Draw the patient's attention to their affective state in the session in relation to the discussion about the IPAF. Having identified the IPAF from a narrative and elaborated its

role in maintaining defensive and conflictual aspects, explore the emotional impact of the experience on the therapy
- Attend to the therapeutic relationship in order to draw the patient's attention to moments when the relationship between therapist and patient reflects the activation of the agreed IPAF, and discuss the complications such moments could create for the patient in other important current relationships

7. Identify selective foci for the content of interventions

Learning outcome: Ability to learn to be highly selective in relation the content of the emerging narrative that should serve as the focus of intervention, and follow the key principles associated with this selection process

- Focus on the patient's mind, not on their behaviour
- Follow shifts and changes in the patient's understanding of their own and others' thoughts and feelings
- Focus on the patient's affects (primarily in relation to the here-and-now of the session and their current circumstances)
- Focus on their current relationships, including the relationship with the therapist.

8. Work collaboratively with the patient towards an understanding of the transference experience

Learning outcome: Ability to work collaboratively with the patient to explore the interpersonal problems that arise in the context of the therapeutic relationship, including working on misunderstandings that arise, and use these to illuminate the relevance of the IPAF to avoiding interpersonal difficulties that generate depression

- Help the patient to be curious about what is happening in the therapeutic relationship. For example, learning how to respond to a patient who appears to dismiss what the therapist says with 'Yes, but…'. The therapist uses clarification and elaboration to elicit a detailed picture of what is transpiring between patient and therapist
- Identify and respond to enactments/ruptures in the therapeutic relationship. For example, if a patient reacts to the therapist yawning as evidence of their lack of interest, the therapist needs to demonstrate an open, non-defensive stance to the patient's experience of the therapist
- Acknowledge and explore openly with the patient any enactments on the part of the therapist. The therapist needs to demonstrate a capacity to model a self-reflective stance in relation to this event, *before* making any transference interpretations, that communicates the therapist's perspective about the impasse or rupture and that engages with the patient's response to the intervention
- Use the IPAF to help understand misunderstandings that may arise in the patient–therapist relationship.

9. Support a balanced mentalizing stance in relation to the IPAF, carefully following a prescribed sequence of interventions

Learning outcome: Ability to assist the patient to recover mentalizing when it is temporarily lost, most likely as a consequence of intense emotional arousal

- Recognising and valuing the patient's current state – it is essential that the therapist is trained to be able to confidently identify and validate the current state of the patient.
- Helping the patient develop curiosity about their motivations, be able to present various reactions a person could have in relation to an experience, and prompt the patient to think of these in relation to their own reports of their thoughts and feelings
- Clarification and elaboration to gather a detailed picture of the feelings associated with a specific interpersonal scenario related to the IPAF. In the case of a highly emotionally charged narrative, the trainee needs to be able to maintain the capacity to elaborate the patient's thoughts and feelings around this experience, staying as close as possible to the IPAF
- Helping the patient make connections between actions and feelings. The therapist needs to be able to help the patient identify what mental states have led to actions in relation to the emotions generated by the IPAF
- Sharing the therapist's perspective so as to help the patient to consider an alternative experience of the same event
- Helping the patient shift their focus from a non-mentalizing interaction with the therapist towards an exploration of current feelings and thoughts (as manifested in the patient–therapist interaction, or in recent experiences outside the therapy room). For example, this may involve role playing an entire sequence involving an upsetting misunderstanding between patient and therapist with intense upset on both sides, through elaboration and clarification of the event, to using the IPAF to bring an alternative perspective to the event and restoring a mentalizing therapeutic relationship with experiential deepening of the IPAF.

10. Encourage interpersonal change

Learning outcome: Ability to use the understanding of the IPAF to help the patient through encouragement to bring about change in their interpersonal relationships

- Balance helping the patient to explore the IPAF while supporting them to make use of their understanding to change current relationship patterns that may be linked with the onset and /or maintenance of depression. For example, in a middle phase session where the IPAF is by now well established, the therapist should (a) demonstrate a capacity to engage the patient in revisiting their goals in relation to the IPAF, and (b) help the patient explore how they would like to engage differently in a key attachment relationship, and how they might approach this before the next session
- Monitor and respond to the patient's experience of the therapist's more active stance. For example, if the patient appears to become passive and non-communicative in response to the therapist's invitation to try a different way of approaching a key attachment figure,

the therapist needs to demonstrate their capacity to engage the patient in exploring their experience of the therapist's active stance.

11. Integrate routine outcome monitoring into the therapeutic process

Learning outcome: Ability to use routine outcome monitoring as part of the therapeutic process to support collaborative working, demonstrate responsiveness to the patient's experience and link the process of mutual feedback to the IPAF and the therapeutic relationship

- Engage the patient in reflecting on their individual symptom scores seen in response to the questionnaires, linking this to external interpersonal events, events in the therapy and the IPAF
- Use and interpret weekly questionnaire data in order to track progress, and use it to guide negotiation of any changes to the intervention indicated by the data (e.g., in response to evidence of a deterioration in levels of depression)
- Respond to the patient's use of the questionnaires in the context of the evolving transference relationship. For example in the case of a patient whose IPAF includes a need to submit and please despite non-conscious resentment about doing this, the therapist needs to be able to go through the items that suggest change and consider these in the light of the IPAF, then move to thinking with the patient about what their responses may also be showing about the therapy relationship and their experience of the therapist.

12. Explore the unconscious and affective experience of ending

Learning objective: Ability to negotiate the end of the treatment, including exploring the meaning of the end of therapy in terms of the IPAF, the negative feelings in relation to separation, managing potential negative therapeutic responses to ending, and summarizing the therapist's experience of achievements and limitations of the therapy work

- Assess the patient's sensitivity to separation so as to ensure that the meaning of the ending is worked on from the outset
- Systematically draw attention to and explore the patient's feelings, non-conscious fantasies and anxieties about the ending of therapy
- Recognise and respond to indications of regression or other shifts near the end of treatment (e.g., a symptomatic deterioration, replacement of therapy with other intervention) 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 aims), including helping the patient express disappointment, where appropriate, while being able to respond non-defensively to the patient's negative feedback about aspects of the therapy. This will involve first clarifying what goals had been set, what has or has not been achieved, identifying missed opportunities and trying to incorporate the experience of the review into aspects of the IPAF where possible

- Compose a ‘goodbye’ letter that reviews the original agreed formulation and the progress made in working on the issues identified at the start of therapy; map how these issues might have been modified in the course of treatment, ensuring reflect the patient’s achievements are recognised.
- Engage the patient in responding to and refining the letter. Learn to work with the patient on arriving at an agreed understanding, and a letter that reflects this understanding.

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Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *Can J Psychiatry, 58*(7), 376-385. doi:10.1177/070674371305800702

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Williams, R., Farquharson, L., Palmer, L., Bassett, P., Clarke, J., Clark, D. M., & Crawford, M. J. (2016). Patient preference in psychological treatment and associations with self-reported outcome: National cross-sectional survey in England and Wales. *BMC Psychiatry, 16*, 4. doi:10.1186/s12888-015-0702-8

Appendix A

Comprehensive compilation of randomised controlled trials (RCTs) involving psychodynamic treatments (PDTs)

Source: Peter Lilliengren, PhD, assistant professor
Department of Psychology, Stockholm University, Sweden
http://w3.psychology.su.se/staff/peli/indexeng.html

Last updated: 2016-11-30

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
Ahola, P., Joensuu, M., Knekt, P., Lindfors, O., Saarinen, P., Tolmunen, T., … Lehtonen, J. (2016). Effects of scheduled waiting for psychotherapy in patients with major depression. *Journal of Nervous and Mental Disease*. doi: NMD.0000000000000616	**Depression**	**Long-Term Psychodynamic Psychotherapy** (At least 12 months, biweekly sessions, no reference to manual)	**Waitlist** (6 moths)
Ajilchi, B., Nejati, V., Town, J. M., Wilson, R., & Abbass, A. (2016). Effects of intensive short-term dynamic psychotherapy on depressive symptoms and executive functioning in major depression. *Journal of Nervous and Mental Disease*, *204*, 500-505. doi: 10.1097/NMD.0000000000000518	**Depression**	**Intensive Short-Term Dynamic Psychotherapy** (ISTDP; Davanloo, 1990)	**Waitlist**
Barber, J. P., Barrett, M. S., Gallop, R., Rynn, M. A., & Rickels, K. (2011). Short-term dynamic psychotherapy versus pharmacotherapy for major depressive disorder: A randomized, placebo-controlled trial. *Journal of Clinical Psychiatry, 73*, 66-73. doi: 10.4088/JCP.11m06831 Zilcha-Mano, S., Dinger, U., McCarthy, K. S., Barrett, M. S., & Barber, J. P. (2014). Changes in well-being and quality of life in a randomized trial comparing dynamic psychotherapy and pharmacotherapy for major depressive disorder. *Journal of Affective Disorders*, *152-154*, 538-542. doi: 10.1016/j.jad.2013.10.015	**Depression**	**Supportive Expressive Therapy** (Luborsky, 1984)	**1. Placebo** **2. SSRI/SNRI**
Barkham, M., Rees, A., Shapiro, D. A., Stiles, W. B., Agnew, R. M., & Halstead, J., ... Harrington, V. M. (1996). Outcomes of time-limited psychotherapy in applied settings: replicating the Second Sheffield Psychotherapy Project. *Journal of Consulting and Clinical Psychology, 64*, 1079-1085. doi: 10.1037/0022-006X.64.5.1079	**Depression**	**Psychodynamic-interpersonal Therapy** (Hobson, 1985)	**CBT** (no reference)
Barkham, M., Shapiro, D. A., Hardy, G. E., & Rees, A. (1999). Psychotherapy in two-plus-one sessions: Outcomes of a randomized controlled trial of cognitive-behavioral and psychodynamic-interpersonal therapy for subsyndromal depression. *Journal of Consulting and Clinical Psychology, 67*, 201-211. doi: 10.1037/0022-006X.67.2.201	**Depression** (subsyndromal)	**Psychodynamic-interpersonal Therapy** (3 sessions; Barkham & Shapiro, based on Hobson, 1985)	**CBT** (Beck et al 1979; Beck, 1995)

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
Bastos, A. G., Guimaraes, L. S. P., & Trentini, C. M. (2014). The efficacy of long-term psychodynamic psychotherapy, fluoxetine and their combination in the outpatient treatment of depression. *Psychotherapy Research, 25*, 612-624. doi: 10.1080/10503307.2014.935519 Bastos, A. G., Pinto Guimarães, L. S., & Trentini, C. M. (2013). Neurocognitive changes in depressed patients in psychodynamic psychotherapy, therapy with fluoxetine and combination therapy. *Journal of Affective Disorders, 151*, 1066-1075. doi: 10.1016/j.jad.2013.08.036	**Depression**	**Long-term psychodynamic psychotherapy** (LTPP; Gabbard, 2004; 2010)	**1. Fluoxetine alone** **2. LTPP + fluoxetine**
Beutel, M. E., Weissflog, G., Leuteritz, K., Wiltink, J., Haselbacher, a., Ruckes, C., … Brahler, E. (2013). Efficacy of short-term psychodynamic psychotherapy (STPP) with depressed breast cancer patients: results of a randomized controlled multicenter trial. *Annals of Oncology*, *25*, 378-384. doi: 10.1093/annonc/mdt526 Weißflog, G., Brähler, E., Leuteritz, K., Barthel, Y., Kuhnt, S., Wiltink, J., … Beutel, M. E. (2015). Does psychodynamic short-term psychotherapy for depressed breast cancer patients also improve fatigue? Results from a randomized controlled trial. *Breast Cancer Research and Treatment, 152*, 581-588. doi: 10.1007/s10549-015-3494-0	**Depression** (in breast cancer patients)	**Supportive-expressive therapy** (Haselbacher, Barthel, Brähler et al., 2010; based on Luborsky, 1984)	**Treatment as usual (TAU)**
Bloch, M., Meiboom, H., Lorberblatt, M., Bluvstein, I., Aharonov, I., & Schreiber, S. (2012). The effect of sertraline add-on to brief dynamic psychotherapy for the treatment of postpartum depression: A randomized, double-blind, placebo-controlled study. *Journal of Clinical Psychiatry*, *73*, 235-241. doi: 10.4088/JCP.11m07117	**Depression** (post-partum)	**Brief Dynamic Psychotherapy** (BDT; Malan, 1979) **+ placebo meds**	**Brief Dynamic Psychotherapy** (BDT; Malan, 1979) **+ Sertraline**
Bressi, C., Porcellana, M., Marinaccio, P. M., Nocito, E. P., & Magri, L. (2010). Short-term psychodynamic psychotherapy versus treatment as usual for depressive and anxiety disorders: A randomized clinical trial of efficacy. *Journal of Nervous and Mental Disease*, *198*, 647-652. doi: doi: 10.1097/NMD.0b013e3181ef3ebb	**Mixed sample** (depression and anxiety)	**Brief Dynamic Psychotherapy** (BDT; Malan, 1976; Osimo & Malan, 1992)	**TAU**
Burnand, Y., Andreoli, A., Kolatte, E., Venturini, A., & Rosset, N. (2002). Psychodynamic psychotherapy and clomipramine in the treatment of major depression. *Psychiatric Services, 53*, 585-590. doi: 10.1176/appi.ps.53.5.585	**Depression**	**PDT + clomipramine**, (unclear which model, Safran & Muran is mentioned among references)	**Supportive care + clomipramine**
Clarici, A., Pellizzoni, S., Guaschino, S., Alberico, S., Bembich, S., Giuliani, R., … Panksepp, J. (2015). Intranasal administration of oxytocin in postnatal depression: Implications for psychodynamic psychotherapy from a randomized double- blind pilot study. *Frontiers in Psychology*, *6*, 426. doi: 10.3389/fpsyg.2015.00426	**Depression** (post-partum)	**Psychodynamic approach** (non-manualized?) **+ oxytocin**	**Psychodynamic approach** (non-manualized?) **+ placebo**
Connolly Gibbons, M. B., Thompson, S. M., Scott, K., Schauble, L. A., Mooney, T., Thompson, D., … Crits-Christoph, P. (2012). Supportive-expressive dynamic psychotherapy in the community mental health system: A pilot effectiveness trial for the treatment of depression. *Psychotherapy*, *49*, 303-316. doi: 10.1037/a0027694	**Depression**	**Supportive-expressive therapy** (manual adapted from Luborsky, 1984)	**TAU**
Connolly Gibbons, M. B., Gallop, R., Thompson, D., Luther, D., Crits-Christoph, K., Jacobs, J., … Crits-Christoph, P. (2016). Comparative effectiveness of cognitive therapy and dynamic psychotherapy for major depressive disorder in a community mental health setting. *JAMA Psychiatry*, *73*, 904-9912. doi: 10.1001/jamapsychiatry.2016.1720	**Depression**	**Supportive-expressive therapy** (Book, 1998; Luborsky, 1984)	**CBT** (Beck, 1995)
Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. I. Impact on	**Depression** (post-	**Psychodynamic therapy** (Cramer	**1. TAU**

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
maternal mood. *British Journal of Psychiatry, 182*, 412-419. doi: 10.1192/bjp.182.5.412 Murray, L., Cooper**,** P. J, Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression: 2. Impact on the mother-child relationship and child outcome. *British Journal of Psychiatry, 182*, 420-427. doi: 10.1192/bjp.182.5.420	partum)	et al, 1990; Stern, 1995)	**2. Non-directive counseling** (Holden et al, 1989) **3. Cognitive-Behavioural Therapy** (Hawton et al, 1989)
Covi, L., & Lipman, R. S. (1987). Cognitive behavioral group psychotherapy combined with imipramine in major depression. *Psychopharmacology Bulletin, 23*, 173-176. http://www.ncbi.nlm.nih.gov/pubmed/3602315	**Depression**	**Traditional Group Therapy** (based on "psychodynamic- Interpersonal" theories but with no reference)	**1. CBT group therapy** (Beck, 1979; Covi, 1982) **2. CBT group therapy + Imipramine**
Covi, L., Lipman, R. S., Derogatis, L. R., Smith, J. E., & Pattison, J. H. (1974). Drugs and group psychotherapy in neurotic depression. *American Journal of Psychiatry, 131*, 191-198. doi: 10.1176/ajp.131.2.191	**Depression** (chronic)	**Psychodynamically oriented group therapy** (no reference) **+ medication or placebo**	**Brief supportive contact + medication or placebo**
de Jonghe, F., Hendriksen, M., van Aalst, G., Kool, S., Peen, J., & Van, R., et al. (2004). Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *British Journal of Psychiatry, 185*, 37-45. doi: 10.1192/bjp.185.1.37	**Depression**	**Short Psychodynamic Supportive Psychotherapy** (de Jonghe, 2005)	**Short Psychodynamic Supportive Psychotherapy + antidepressants**
de Jonghe, F., Kool, S., van Aalst, G., Dekker, J., & Peen, J. (2001). Combining psychotherapy and antidepressants in the treatment of depression. *Journal of Affective Disorders*, *64*, 217-229. doi: 10.1016/S0165-0327(00)00259-7	**Depression**	**Short Psychodynamic Supportive Psychotherapy** (de Jonghe, 2005) **+ medication**	**Medication alone**
de Roten, Y., Ambresin, G., Herrera, F., Fassassi, S., Fournier, N., Preisig, M., & Despland, J.-N. (2017). Efficacy of an adjunctive brief psychodynamic psychotherapy to usual inpatient treatment of depression: Results of a randomized controlled trial. *Journal of Affective Disorders*, *209*, 105-113. doi: 10.1016/j.jad.2016.11.013	**Depression**	**Intensive Brief Psychodynamic Psychotherapy** (IBPP; Despland et al., 2010) **+ TAU**	**TAU only**
Dekker, J. J. M., Koelen, J. A., Van, H. L., Schoevers, R. A., Peen, J., Hendriksen, M., … de Jonghe, F. (2008). Speed of action: The relative efficacy of short psychodynamic supportive psychotherapy and pharmacotherapy in the first 8 weeks of a treatment algorithm for depression. *Journal of Affective Disorders*, *109*, 183-188. doi: 10.1016/j.jad.2007.10.015 Dekker, J., Van, H. L., Hendriksen, M., Koelen, J., Schoevers, R. A., Kool, S., … Peen, J. (2013). What is the best sequential treatment strategy in the treatment of depression? Adding pharmacotherapy to psychotherapy or vice versa? *Psychotherapy and Psychosomatics*, *82*, 89-98. doi: 10.1159/000341177	**Depression**	**Short Psychodynamic Supportive Psychotherapy** (de Jonghe, 2005)	**Pharmacotherapy**
Dekker, J., Molenaar, P. J., Kool, S., Van Aalst, G., Peen, J., & de Jonghe, F. (2005). Dose–effect relations in time-limited combined psycho-pharmacological treatment for depression. *Psychological Medicine*, *35*, 47–58. doi: 10.1017/S0033291704002685	**Depression**	**Short Psychodynamic Supportive Psychotherapy** (de Jonghe, 2005) **8 sessions + medication**	**Short Psychodynamic Supportive Psychotherapy** (de Jonghe, 2005) **16 sessions + medication**
Driessen, E., Van, L. H., Don, F. J., Peen, J., Kool, S., Westra, D., … Dekker, J. J. M. (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*, 1041-1050. doi: 10.1176/appi.ajp.2013.12070899 Driessen, E., Van, H. L., Peen, J., Don, F. J., Kool, S., Westra, D., … Dekker, J. J. (2014).	**Depression**	**Short-term psychodynamic supportive psychotherapy** (de Jonghe, 2005)	**Cognitive-Behavior Therapy** (CBT; Molenaar et al., 2009)

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
Therapist-rated outcomes in a randomized clinical trial comparing cognitive behavioral therapy and psychodynamic therapy for major depression. *Journal of Affective Disorders*, *170C*, 112-118. doi: 10.1016/j.jad.2014.08.023			
Fonagy, P., Rost, F., Carlyle, J.-A., McPherson, S., Thomas, R., Fearon, R. M. P., … Taylor, D. (2015). Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS). *World Psychiatry*, *14*, 312-321. doi: 10.1002/wps.20267	**Depression** (treatment resistant)	**Long-Term Psychoanalytic Psychotherapy** (LTPP; Taylor, 2015)	**TAU**
Gallagher-Thompson, D., & Steffen, A. M. (1994). Comparative effects of cognitive-behavioral and brief psychodynamic psychotherapies for depressed family caregivers. *Journal of Consulting and Clinical Psychology, 62*, 543-549. doi: 10.1037/0022-006X.62.3.543	**Depression** (among family caregivers)	**Brief Psychodynamic Therapy** (Mann, 1973)	**CBT** (Beck et al., 1979; Lewinsohn et al, 1985; Gallagher et al, 1981)
Gallagher, D. E., & Thompson, L. W. (1982). Treatment of major depressive disorder in older adult outpatients with brief psychotherapies. *Psychotherapy: Theory, Research, and Practice, 19,* 482-490. doi: 10.1037/h0088461	**Depression**	**Brief relational/insight psychotherapy** (Bellak & Small, 1965)	**Behavioral therapy/Cognitive therapy** (Lewinsohn et al, 1976; Gallagher et al., 1981)
Hardy, G. E., Barkham, M., Shapiro, D. A, Stiles, W. B., Rees, A, & Reynolds, S. (1995). Impact of Cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. *Journal of Consulting and Clinical Psychology*, *63*, 997-1004. doi: 10.1037/0022-006X.63.6.997	**Depression + personality disorder cluster C**	**Psychodynamic-Interpersonal Therapy** (PIT; Hobson, 1985)	**CBT** (Firth & Shapiro, 1985)
Hersen, M., Himmelhoch, J. M., Thase, M. E., & Bellack, A. S. (1984). Effects of social skill training, amitriptyline, and psychotherapy in unipolar depressed women. *Behavior Therapy, 15*, 21-40. doi: 10.1016/S0005-7894(84)80039-8	**Depression**	**Time-limited dynamic therapy** (no reference) **+ placebo**	**1. Social skill training + placebo** **2. Amitriptyline**
Huber, D., Henrich, G., Gastner, J., & Klug, G. (2012). Must all have prizes? The Munich Psychotherapy Study. In R. A. Levy, J. S. Ablon, & H. Kächele (eds.), *Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence* (pp. 51-69). New York, NY: Springer. http://link.springer.com/chapter/10.1007%2F978-1-60761-792-1_4#page-1 Huber, D., Huber, D., Zimmermann, J., Henrich, G., & Klug, G. (2012). Comparison of cognitive-behaviour therapy with psychoanalytic and psychodynamic therapy for depressed patients – A three-year follow-up study. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 58, 299-316. doi: 10.13109/zptm.2012.58.3.299 Huber, D., Henrich, G., Clarkin, J., & Klug, G. (2013). Psychoanalytic versus psychodynamic therapy for depression: A three-year follow-up study. *Psychiatry*, *76*, 132-149. doi: 10.1521/psyc.2013.76.2.132	**Depression**	**Psychoanalysis** (non-manualized)	**1. LTPP** (non-manualized) **2. CBT** (non-manualized; patients not randomly assigned to this group)
Johansson, R., Björklund, M., Hornborg, C., Karlsson, S., Hesser, H., Ljótsson, B., … Andersson, G. (2013). Affect-focused psychodynamic psychotherapy for depression and anxiety through the Internet: a randomized controlled trial. *PeerJ*, *1*, e102. doi: 10.7717/peerj.102	**Depression and/or anxiety**	**IPDT** (Affect-focused; based on Frederick, 2009)	**Online therapist support and clinical monitoring**
Johansson, R., Ekbladh, S., Hebert, A., Lindström, M., Möller, S., Petitt, E., … Andersson, G. (2012). psychodynamic guided self-help for adult depression through the internet: A	**Depression**	**IPDT** (SUBGAP; based on Silverberg, 2005)	**Psychoeducation + support**

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
randomised controlled trial. *PLOS ONE*, *7*, e38021. doi: 10.1371/journal.pone.0038021			
Knekt, P., & Lindfors, O. (2004). A randomized trial of the effect of four forms of psychotherapy on depressive and anxiety disorders. Helsinki: Kela. https://helda.helsinki.fi/handle/10250/3315 Knekt, P., Lindfors, O., Ske, L. S. Ä., & Virtala, E. S. A. (2013). Randomized trial on the effectiveness of long- and short-term psychotherapy on psychiatric symptoms and working ability during a 5-year follow-up. *Nordic Journal of Psychiatry, 67*, 59-68. doi: 10.3109/08039488.2012.680910 Knekt, P., Virtala, E., Härkänen, T., Vaarama, M., Lehtonen, J., & Lindfors, O. (2016). The outcome of short- and long-term psychotherapy 10 years after start of treatment. *Psychological Medicine*, 46, 1175-1188. doi: 10.1017/S0033291715002718 Lindfors**,** O., Knekt, P., Virtala, E., & Laaksonen, M. A. (2012). The effectiveness of solution-focused therapy and short- and long-term psychodynamic psychotherapy on self-concept during a 3-year follow-up. *Journal of Nervous and Mental Disease*, *200*, 946-953. doi: 10.1097/NMD.0b013e3182718c6b Lindfors, O., Knekt, P., Heinonen, E., Härkänen, T., Virtala, E., & The Helsinki Psychotherapy Study Group. (2015). The effectiveness of short- and long-term psychotherapy on personality functioning during a 5-year follow- up. *Journal of Affective Disorders*, *173*, 31-38. doi: 10.1016/j.jad.2014.10.039 Maljanen, T., Knekt, P., Lindfors, O., Virtala, E., Tillman, P., & Härkänen, T. (2016). The cost-effectiveness of short-term and long-term psychotherapy in the treatment of depressive and anxiety disorders during a 5-year follow-up. *Journal of Affective Disorders*, *190*, 254-263. doi: 10.1016/j.jad.2015.09.065	**Depression and/or anxiety**	**STPP** (Malan, 1976; Sifneos, 1978)	**1. Solution-focused therapy** (de Shazer et al, 1986) **2. LTPP** (Gabbard, 2004)
Kool, S., Dekker, J., & Duijsens, I. (2003). Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. *Harvard Review of Psychiatry, 11*, 133-142. doi: 10.1080/10673220303950	**Depression**	**STDP** (de Jonghe, 2005) **+ pharmacotherapy**	**Pharmacotherapy**
Kornblith, S., Rehm, L., W, O. M., & Lamparski, D. M. (1983). The contribution of self-reinforcement training and behavioral assignments to the efficacy of self-control therapy for depression. *Cognitive Therapy and Research, 7*, 499-528. doi: 10.1007/BF01172888	**Depression**	**Psychodynamic group therapy** (Wolf, 1965; Bernard & Klein, 1977)	**Self-reinforcement training and behavioral assignments** (Rehm, 1977)
Kramer, U., de Roten, Y., Perry, J. C., & Despland, J.-N. (2013). Change in defense mechanisms and coping patterns during the course of 2-year-long psychotherapy and psychoanalysis for recurrent depression: A pilot study of a randomized controlled trial. *Journal of Nervous and Mental Disease*, *201*, 614-620. doi: 10.1097/NMD.0b013e3182982982	**Depression** (recurrent)	**Supportive-Expressive Therapy** (Luborsky, 1984) All patients were also given pharmacological treatment	**1. Cognitive therapy** (Beck, 1995) **2. Psychoanalysis** (Robertson, 2002). **3. Clinical management** (Csank, 2002; Novalis et al., 1993).
LaPonite, K., & Rimm, D. C. (1980). Cognitive, assertive, and insight-oriented group therapies in the treatment of reactive depression in women. *Psychotherapy: Theory, Research & Practice*, *17*, 312-321. doi: 10.1037/h0085928	**Depression**	**Insight-oriented group** therapy (No reference)	**1. Cognitive group therapy** (Beck, 1967) **2. Assertiveness training** (no

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
			reference)
Lemma, A., & Fonagy, P. (2013). Feasibility study of a psychodynamic online group intervention for depression. *Psychoanalytic Psychology*, *30*, 367-380. doi: 10.1037/a0033239	**Depression**	**Online Group Dynamic Interpersonal Therapy** (OLDIT; Fonagy & Target, 2008)	**Internet discussion group**
Ludwig, G., Krenz, S., Zdrojewski, C., Bot, M., Rousselle, I., Stagno, D., … Stiefel, F. (2013). Psychodynamic interventions in cancer care I: Psychometric results of a randomized controlled trial. *Psycho-oncology, 23*, 65-74. doi: 10.1002/pon.3374	**Mixed depression and anxiety** (in cancer patients)	**Brief Dynamic Psychotherapy** (Mann, 1973; Davanloo, 1994)	**Waitlist**
Maina, G., Forner, F., & Bogetto, F. (2005). Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. *Psychotherapy and Psychosomatics, 74*, 43-50. doi:10.1159/000082026	**Depression** (mild to moderate)	**Brief Dynamic Psychotherapy** (BDP; Malan, 1979)	**1. Brief Supportive Psychotherapy** (BSP; Novalis et al., 1993) **2. Waitlist**
Maina, G., Rosso, G., Crespi, C., & Bogetto, F. (2007). Combined brief dynamic therapy and pharmacotherapy in the treatment of major depressive disorder: A pilot study. *Psychotherapy and Psychosomatics*, *76*, 298-305. doi: 10.1159/000104706 Maina, G., Rosso, G., & Bogetto, F. (2009). Brief dynamic therapy combined with pharmacotherapy in the treatment of major depressive disorder: Long-term results. *Journal of Affective Disorders*, *114*, 200-207. doi: 10.1016/j.jad.2008.07.010	**Depression**	**Brief Dynamic Psychotherapy** (BDP; Malan, 1963; 1976) **+ medication**	**Brief Supportive Psychotherapy** (BSP; Novalis et al., 1993) **+ medication**
Maina, G., Rosso, G., Rigardetto, S., Chiadò Piat, S., & Bogetto, F. (2010). No effect of adding brief dynamic therapy to pharmacotherapy in the treatment of obsessive-compulsive disorder with concurrent major depression. *Psychotherapy and Psychosomatics*, *79*, 295-302. doi: 10.1159/000318296	**OCD + depression**	**Brief Dynamic Psychotherapy** (BDP; Malan, 1979) **+ medication**	**Medication only**
Martini, B., Rosso, G., Chiodelli, D. F., De Cori, D., & Maina, G. (2011). Brief dynamic therapy combined with pharmacotherapy in the treatment of panic disorder with concurrent depressive symptoms. *Clinical Neuropsychiatry*, *8*, 204-221. http://www.clinicalneuropsychiatry.org/pdf/04_martini.pdf	**Panic disorder + depression**	**Brief Dynamic Psychotherapy** (BDP; Malan, 1963) **+ medication**	**Brief Supportive Psychotherapy** (BSP) **+ medication**
McLean, P., & Hakstian, A. (1979). Clinical depression: Comparative efficacy of outpatient treatments. *Journal of Consulting and Clinical Psychology, 47*, 818-836. http://www.ncbi.nlm.nih.gov/pubmed/389965	**Depression**	**Short-Term Psychotherapy** (Marmor, 1975; Wolberg, 1967)	**1. Relaxation therapy** (no reference) **2. Behavior therapy** (McLean, 1976 **3. Drug therapy**
Rosso, G., Martini, B., & Maina, G. (2013). Brief dynamic therapy and depression severity: A single-blind, randomized study. *Journal of Affective Disorders, 147*, 101-106. doi: 10.1016/j.jad.2012.10.017	**Depression**	**Brief Dynamic Psychotherapy** (BDP; Malan, 1976)	**Brief Supportive Psychotherapy** (BSP; Novalis et al., 1993)
Salminen, J. K., Karlsson, H., Hietala, J., Kajander, J., Aalto, S., & Markkula, J., et al. (2008). Short-term psychodynamic psychotherapy and fluoxetine in major depressive disorder: A randomized comparative study. *Psychotherapy and Psychosomatics, 77*, 351-357. doi: 10.1159/000151388	**Depression**	**Short-term psychodynamic psychotherapy** (STDP; Malan, 1976; Mann, 1973)	**Fluoxetine**

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
Sanchez, V. C., Lewinsohn, P. M., & Larson, D. W. (1980). Assertion training: effectiveness in the treatment of depression. *Journal of Clinical Psychology, 36*, 526-529. http://www.ncbi.nlm.nih.gov/pubmed/7372826	**Depression**	**"Traditional" Group Therapy** (No specific reference)	**Assertion training**
Sandahl, C., Lundberg, U., Lindgren, A., Rylander, G., Herlofson, J., Nygren, A., & Asberg, M. (2011). Two forms of group therapy and individual treatment of work-related depression: A one-year follow-up study. *International Journal of Group Psychotherapy*, *61*, 539-555. doi: 10.1521/ijgp.2011.61.4.538	**Depression** (work-related)	**Focused psychodynamic group therapy** (FGT; Sandahl & Lindgren, 2003)	**1. Cognitive Group Therapy** (no specific reference) **2. Comparison condition**
Scheidt, C. E., Waller, E., Endorf, K., Schmidt, S., König, R., Zeeck, A., … Lacour, M. (2013). Is brief psychodynamic psychotherapy in primary fibromyalgia syndrome with concurrent depression an effective treatment? A randomized controlled trial. *General Hospital Psychiatry, 35*, 160-167. doi: 10.1016/j.genhosppsych.2012.10.013	**Fibromyalgia + depression**	**Psychodynamic-interpersonal psychotherapy** (Hobson, 1985; Goldberg et al., 1984; Guthrie, 2013)	**TAU**
Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 62*, 522-534. doi: 10.1037/0022-006X.62.3.522	**Depression**	**Psychodynamic-interpersonal psychotherapy** (Hobson, 1985; Goldberg et al., 1984)	**Cognitive Therapy** (CT; Beck, Rush, Shaw, and Emery, 1979)
Shapiro, D., & Firth, J. (1987). Prescriptive v. exploratory psychotherapy outcomes of the Sheffield Psychotherapy Project. *British Journal of Psychiatry, 151*, 790-799. doi: 10.1192/bjp.151.6.790 Shapiro, D. A, & Firth-Cozens, J. (1990). Two-year follow-up of the Sheffield Psychotherapy Project. *British Journal of Psychiatry*, *157*, 389-391. doi: 10.1192/bjp.157.3.389	**Depression and anxiety**	**Exploratory therapy** (no specific reference)	**Prescriptive therapy** (no specific reference)
Simpson, S., Corney, R., Fitzgerald, P., & Beecham, J. (2003). A randomized controlled trial to evaluate the effectiveness and cost-effectiveness of psychodynamic counselling for general practice patients with chronic depression. *Psychological Medicine, 33*, 229-239. doi: 10.1017/S0033291702006517	**Depression** (chronic)	**Psychodynamic counselling** (Burton, 1998)	**General practice**
Thompson, L. W., Gallagher, D., & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. *Journal of Consulting and Clinical Psychology, 55*, 385-390. doi: 10.1037/0022-006X.55.3.385	**Depression** (among elderly)	**Brief psychodynamic therapy** (Horowitz & Kaltreider, 1979)	**1. Cognitive Therapy** (CT; Beck, Rush, Shaw, & Emery, 1979) **2. Behavioral Therapy** (BT; Gallagher & Thompson, 1981; Lewinsohn, 1974) **3. Delayed-treatment control**
Thyme, K. E., Sundin, E. C., Stahlberg, G., Lindstrom, B., Eklof, H., & Wiberg, B. (2007). The outcome of short-term psychodynamic art therapy compared to short-term psychodynamic verbal therapy for depressed women. *Psychoanalytic Psychotherapy, 21*, 250-264. doi: 10.1080/02668730701535610	**Depression** (among women)	**Short-Term Psychodynamic Verbal Therapy** (Mann, 1973)	**Art psychotherapy** (no reference)
Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., & Soininen, M. (2007). Childhood depression: A place for psychotherapy. An outcome study comparing individual psychodynamic psychotherapy and family therapy. *European Child and Adolescent Psychiatry, 16*, 157-167. doi: 10.1007/s00787-006-0584-x	**Depression** (among children)	**Focused Individual Psychotherapy** (Malan & Osmimo, 1992; Davanloo, 1978)	**Systems Integrative Family Therapy** (Byung-Hall, 1995; Will, 1985)

Reference (**primary** and secondary articles)	**Patient sample**	**PDT model**	**Comparison group(s)**
Garoff, F. F., Heinonen, K., Pesonen, A.-K., & Almqvist, F. (2012). Depressed youth: Treatment outcome and changes in family functioning in individual and family therapy. *Journal of Family Therapy*, *34*, 4-23. doi: 10.1111/j.1467-6427.2011.00541.x			
Vitriol, V. G., Ballesteros, S. T., Florenzano, R. U., Weil, K. P., & Benadof, D. F. (2009). Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. *Psychiatric Services, 60*, 936-942. doi: 10.1176/appi.ps.60.7.936	**Depression** (+ childhood trauma)	**Brief psychodynamic psychotherapy** (Kudler et al, 2003; Davies et al, 1994)	**TAU**

Appendix B

Breakdown of training hours

The extended DIT course will run for one year over three academic terms. It is a blended training, comprised of 20 face-to-face days of teaching and distance learning as well as seeing three DIT cases on placement. There are formal assessed components of the training.

Category	Activity	Hours	Description
Guided independent study	Assessment in Module 1: Theoretical Basis of DIT	25	Approved and accredited theoretical content ahead of face-to-face training.
Scheduled learning and teaching activities	Small group teaching (10 days) in Module 2, Knowledge Base of DIT	80	Tutorials, group supervision and small group work
Scheduled learning and teaching activities	Workshops (10 days) in Module 3: Interventions in DIT	80	Skills-oriented workshops with video practice materials
Scheduled learning and teaching activities	One-to-one supervision and assessment in Module 4: Clinical Experience in DIT	30	One-to-one meetings with personal tutor; assessment of submitted recorded DIT sessions
Scheduled learning and teaching activities	Assessment, preparation and completion	10	Video recordings of DIT sessions at different stages of the model
Guided independent study	Reflective learning activity	10	Reflection after workshops and supervision
Placement	Employer-based learning	80	Providing 16 sessions of DIT to three training patients and writing up process notes after each session
Guided independent study	Reflective learning activity	10	Reflection after viewing video recordings
Guided independent study	Assessment preparation and completion	15	Preparing and writing case log and essay describing therapy processes towards accreditation
TOTAL HOURS		**340**	

Appendix C

Regional Areas of IAPT England