A Typology for the Interpersonal Affective Focus in Dynamic Interpersonal Therapy Based on a Contemporary Interpersonal Approach

Tara McFarquhar[1, 2, 3], Patrick Luyten[1, 2, 4], and Peter Fonagy[1, 2]

[1] Research Department of Clinical, Educational and Health Psychology, University College London

[2] Anna Freud National Centre for Children and Families

[3] Department of Clinical Psychology, University of East Anglia

[4] Faculty of Psychology and Educational Sciences, University of Leuven

Author Note

Tara McFarquhar https://orcid.org/0000-0002-8931-1061

Patrick Luyten https://orcid.org/0000-0002-1161-2817

Peter Fonagy https://orcid.org/0000-0003-0229-0091

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Correspondence concerning the article should be addressed to Tara McFarquhar, Department of Clinical Psychology, University of East Anglia, Norwich Research Park, Norwich, NR4 7TJ, United Kingdom. Email: t.mcfarquhar@uea.ac.uk

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Abstract

Dynamic Interpersonal Therapy (DIT) is a brief, time-limited psychodynamic individual therapy in which depressive and anxious symptoms are understood as responses to interpersonal difficulties. Problematic interpersonal representations of the self and others are conceptualized in DIT as the interpersonal affective focus (IPAF), a predominant and recurring interpersonal pattern that is connected to the symptoms and becomes the foundation of treatment. This paper reports the development of a typology for classifying IPAFs, which characterizes the predominant style based on contemporary interpersonal approaches. If such a typology can be shown to have validity in a clinical setting, it could have multiple uses that would improve understanding of how DIT works and for whom it might be effective, for example, assisting the therapist in formulating the IPAF, allowing investigations of treatment outcome and process research, and informing training. A IPAF typology was developed by means of a hybrid method of qualitative analysis of transcriptions of audio recordings of DIT sessions using data from a randomized control and feasibility trial. Results revealed four themes, that is, patterns of relating, which could be described as hostile-dominant, hostile-submissive, friendly-dominant, or friendly-submissive. Limitations include the sample size and diversity, the impact of the inclusion and exclusion criteria of the pilot feasibility trial and the clinical need to titrate the IPAF. Future research should focus on the reliability and validity of the typology and whether it can be employed in outcome and process research.

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Dynamic Interpersonal Therapy (DIT) is a structured, brief psychodynamic psychotherapy initially developed as a treatment for depression and anxiety (Lemma et al. 2010). It is the only psychodynamic therapy to be included in IAPT (Increased Access to Psychological Therapy) services in the UK's NHS service (Clark, 2018). Delivered one-to-one, it typically lasts 16 weeks and aims to help the patient understand the link between their relationships and their presenting symptoms. During the initial phase, the patient and therapist work collaboratively to identify the interpersonal affective focus (IPAF), a key problematic and repeated pattern of interpersonal representations of the self and others that is related to the onset and course of depression or anxiety. By the fourth session, the IPAF becomes the cornerstone of treatment and the framework for understanding how the patient might begin to explore alternative ways of thinking and behaving.

This paper reports a method of consolidating and categorizing the problematic interpersonal style described by the IPAF in DIT into a typology. While there are a number of both categorical and dimensional approaches to interpreting interpersonal problems from self-report measures which will be discussed further, there is no method to date by which to classify IPAFs. IPAFs differ from self-report measures in that they are a collaborative model which incorporates the therapist's interpretation of the pattern of interpersonal representations. If IPAFs can be reliably categorized in this way, it may be a useful tool for clinicians to assist with case formulation in DIT and a number of interesting opportunities for further research also open up. First, a typology may provide a framework within DIT training to consider how treatment might be modified depending on IPAF type. For example, some IPAF types might benefit from an adjusted dose or model adaptation. Second, an IPAF typology could be used in outcome research, allowing an investigation of treatment outcome based on a classification of problematic interpersonal interactions informed by both the therapist and the patient, alongside self-report or therapist-rated baseline measures.

Empirical results reporting for whom DIT specifically is most effective are sparse, and the strong focus on interpersonal issues within psychodynamic theory contrasts with a surprising lack of research studies directly investigating their role in psychodynamic treatment (Luyten et al., 2012). Targeting treatment to those most likely to benefit is vital when demand exceeds scarce psychotherapy resources, and the role of interpersonal components in outcome is an underexplored area. In this regard, a valid and reliable IPAF typology might quickly identify patients who are more likely to have better outcomes in DIT or a lower risk of drop-out. Third, it could be used in process research to further understanding of how the IPAF component might facilitate or interfere with change over the course of treatment. It may be that different types of IPAF have different trajectories of change or different relationships with therapeutic alliance.

The following section will outline the DIT approach, the role of the IPAF in this treatment approach, and the theoretical basis for classifying IPAFs using contemporary interpersonal approaches. We close this section with an outline of the present study.

Dynamic Interpersonal Therapy

There is increasing evidence for the efficacy of brief psychodynamic therapies in the treatment of depression (e.g., Abbass et al., 2014; Driessen et al., 2015). Following on from the competency framework for psychoanalytic/dynamic therapies (Lemma et al., 2008), which comprises what is considered to be good clinical practice based on empirical evidence of efficacy, DIT was developed as a brief psychodynamic protocol. Evaluation in two small pilot studies indicated that it was associated with a significant improvement in symptoms (Lemma et al., 2011; Wright & Abrahams, 2015). A larger randomized controlled trial (N = 147) reported that 51% of patients showed clinically significant change post treatment, with a large effect size on pre to post Hamilton Rating Scale (HRSD-17) scores, and DIT was superior to low-intensity treatment (9%) and equal to cognitive-behavioral therapy (CBT) in reducing symptoms of depression (Fonagy et al., 2020). New formats are being developed for use with a wider range of patients, for example, DIT for Complex Care (Rao et al., 2019),

group DIT (Folkes-Skinner & Collins, 2021), arts-based DIT (Havsteen-Franklin et al., 2021), and DIT adapted for veterans with hegemonic masculine ideals (Chen & Dognin, 2017).

DIT is usually delivered over 16 weekly sessions. It requires the therapist to identify an attachment-related problem that has caused the patient to seek help for their depressive symptoms. This problem, the IPAF, encapsulating the repeated interpersonal pattern the patient describes, will be a key component of therapy. The therapist and patient then jointly focus on this problem to improve the patient's mentalizing of interpersonal issues, encourage new ways of thinking and feeling, actively use transference to highlight the patient's typical patterns of relating, and reflect on change (Lemma et al., 2010).

Over the course of the initial phase of treatment, the therapist sketches out a detailed picture of the patient's internal world of relationships. This will include early relationships, past significant relationships, current significant relationships and wider social networks. The IPAF formulation is then developed collaboratively with the patient, typically during the fourth session. The focus of the IPAF is the patient's mind in relation to self and others, rather than their behavior (Gelman et al., 2010). Defined as "the dominant internal relationship that is linked to the manifest problem", it is formulated by examining these narratives (the stories the patient reports about their relationships).

Four dimensions make up the IPAF: a self-representation (e.g., a demanding infant); an object representation (e.g., a rejecting mother); an affect linking the two (e.g., terror), and a defensive function (e.g., avoidance of own aggression) Further detail can be found in the clinician's guide (Lemma et al., 2011, p106). A defining feature of the IPAF is that it should be explicitly shared with the patient: the therapist aims to provide a focus for treatment that is meaningful to and agreed upon by the patient and it is never imposed upon the patient. The patient is encouraged to respond to the formulation and work with the therapist to refine it to ensure a good fit with the problems that brought them to treatment. This process is considered to have considerable therapeutic value if actively entered into by the patient. The therapist will share the ideas they have developed about the IPAF tentatively with the patient in session four. This might begin with the therapist saying something like "having listened to

what you have told me over the last few sessions about how you are feeling and what you are most concerned about in your life right now, I have some ideas about what's been going on for you and how this might help us to make sense of the symptoms that have brought you here. I would like to share these with you to see what you think so that we can see whether this might be of help in finding a focus for our work" (Lemma et al., 2011). The therapist will then present their ideas about how the problem developed, the relational pattern connected to its onset or maintenance and the impact on current relationships, all the while playing close attention to the patient's response and inviting them to comment, ask questions or disagree. This will lead to clarification of the IPAF and agreement on therapeutic goals in a way that is engaging for the patient.

The DIT model thus builds on attachment theory (Bowlby, 1958, 1969), Sullivan's interpersonal psychoanalysis (Sullivan, 1953), and object relations theory (Kernberg, 1976, 1985) by considering unconscious conflict to result from a clash between self and other representations, which produces a recurring interpersonal pattern and expectation of others (Lemma et al., 2011). Depressive symptoms are considered to be responses to perceived threats to attachment and the self; relationship problems cause the attachment system to become disorganized and lead to distorted thinking and feeling (Lemma et al., 2010). Behavioral and psychological defensive strategies then sustain the depression and anxiety.

The Theoretical Basis for Classification of IPAFs

The basis of DIT is rooted in the frequent observation of clinicians that patients with depression also typically report interpersonal problems (Lemma et al., 2010). We therefore considered contemporary interpersonal approaches an ideal basis for the development of a typology for classifying IPAFs. The interpersonal circumplex model was first developed in by the Kaiser Group (Freedman, Ossorio et al. 1951; Laforge, Leary et al. 1954; Leary 1957) in the 1950s. In an interpersonal circle, each behavior is considered to be a specific combination of two orthogonal dimensions: dominance-submission and love-hate. Behaviors situated close to each other on the circle are more alike, both conceptually and statistically,

and those further away are unrelated (90 degrees of separation) or in fact opposites (180º of separation) (Fournier et al. 2010). Many other theorists have proposed a “bipolar”’ representation of interpersonal dimensions, with the dominance–submission pole being variously described as agency, self-definition, achievement, autonomy, or introjective, and the love–hate pole as communion, relatedness, affiliation, intimacy, surrender, or anaclitic (Luyten & Blatt, 2013). This corresponds neatly with the self–other representation of the IPAF: both are contextualizing psychic pain as being rooted in some combination of problems with sense of self and relating to others. The interpersonal circumplex model is a well validated theoretical and empirical approach with decades of research and its applications have been well documented (for a review, see Gurtman, 2016 and Fournier et al., 2010).

One of the most widely used circumplex measures is the Inventory of Interpersonal Problems Circumplex (IIP-C) (Alden et al., 1990). The IIP-C is comprised of 64 items derived from the IIP-127 (Horowitz et al., 1988). Specifically, the IIP aims to identify interpersonal problems causing psychic pain to the individual in much the same way as the IPAF aims to describe the recurrent self–other representation that is limiting functioning. By determining each item’s orientation in the circumplex space based on their loadings on to the two underlying factors, love and dominance, Alden et al (1990) developed a set of eight circularly arranged scales using 64 IIP items: domineering (PA), vindictive (BC), cold (DE), socially avoidant (FG), non-assertive (HI), exploitable (JK), overly nurturant (LM), and intrusive (NO). Correlations between adjacent sub-scales were higher than between opposing sub-scales, that is, the sub-scale correlations decrease as one moves around the circumplex.

Another method by which to divide the IIP-C is to bisect it along the underlying dimensions of love and dominance (see Gurtman, 1996, figure 1). Interpersonal styles can then be described as particular combinations of these two dimensions in a broader sense: the love dimension ranging from hostile/cold behavior to warm/friendly behavior, and the dominance dimension ranging from yielding/submissive behavior to controlling/dominating behavior (Carson, 1969; Horowitz et al., 2000; Kiesler, 1983). Gurtman (1996) developed a

four-fold typology of interpersonal problems based on the circumplex for 104 outpatients. The system of quadrants formed by the intersection of love and dominance were named (after Carson, 1969) friendly-dominant (0–90°), hostile-dominant (90–180°), hostile-submissive (180–270°), and friendly-submissive (270–360°), and individuals could be placed in one partition of the circle based on their IIP results for distress, angular displacement, and vector length. A descriptor summarizing the key problems for each quadrant was arrived at: friendly-dominant was characterized by being overly controlling, intrusive, and revealing; hostile-dominant by having problems getting along with others, being aggressive, and lacking in social feeling; hostile-submissive by having problems feeling close to people and being open, and friendly-submissive by having problems of dependency, exploitability, and lacking assertiveness.

These findings that IIP items can be divided into clusters according to their angular position and vector length when co-ordinates are translated into a circular frame, informed the basis of this study. There are several ways to subclassify interpersonal problems within the IIP, on which we might base an IPAF typology, including four categories (Gurtman, 1996), five categories (Horowitz, 1979), six categories (Horowitz et al., 1988) eight categories (Alden et al., 1990) and 10 categories (Clementel-Jones et al., 1996).

The Current Study

If IIP items can be identified in IPAFs, then it may be possible to use one of the frameworks described above to cluster IPAFs semantically into types. This would provide a tool for clinicians based on collaborative work with the patient which may helpfully inform the formulation of the IPAF. It is a broader tool than the dimensions of the IPAF alone and may be easier to hold in mind over the course of treatment. With further validation, the IPAF typology could be investigated in relation to outcome, either alone or alongside self-report measures of interpersonal function such as the IIP. The process of therapy may also vary by IPAF type and mapping this may also have clinical utility. This will be important to promote wider-scale adoption of the model.

Transcripts of DIT sessions in which the IPAFs were shared with the patient were obtained from a randomized controlled and feasibility trial of DIT. A qualitative analysis of the transcripts was conducted, employing the IIP items as codes, but also allowing codes to emerge organically. If the IIP derived codes were found to be well represented in the transcriptions, they could then be assigned to categories. By using a pre-determined analytic framework in this way, it was expected that IPAFs could be categorized in a typology based on the IIP. As noted in the previous section, there are numerous well validated methods by which IIP items can be categorized. We considered Gurtman's (1996) four-fold IIP typology the most appropriate framework on which to base an IPAF typology, due to its high face validity and broad method of discriminating themes. Gurtman (1996) in particular highlighted the importance of qualitative differences in interpersonal tendencies which can be obscured by a dimensional approach. His four problem types were each coherently represented and notably dissimilar from each other on a range of independent validated measures. Our aim was to produce a tool which allows for a nuanced interpretation of IPAFs while also being simple to use and easy to hold in mind.

This study therefore provides a novel contribution to the field as it applies a widely researched framework (contemporary interpersonal theory) and measure (the IIP) to clinical material to produce inductive results relevant to the application of DIT. The IPAF typology aims to classify the collaborative formulation which results from several sessions of therapy and captures the perspective of both the patient and the therapist. We are not aware of other studies using the IIP to code clinical materials with a qualitative methodology.

Method

Participants

The study participants were part of a randomized controlled and feasibility trial of DIT (for a detailed description of the study design and results, see Fonagy et al, 2020). Participants were randomized to either 16 weeks of DIT (n = 73), low-intensity treatment (control intervention; n = 54), or CBT (n = 20). DIT was delivered within IAPT services by

trained DIT practitioners with an approved DIT supervisor. Competency ratings were high for all DIT therapists (M = 53.3, s.d. = 10.6, range: 19–65). All therapists were rated as adherent on 80% of recordings. The trial was granted ethical approval by an NHS Research Ethics Committee and informed consent for the recording of therapy sessions was obtained from all participants. Table 1 describes their demographics.

[Place Table 1 here]

IPAF Identification

The process of identifying the IPAFs was undertaken by the first author (not a DIT therapist) and discussed with the second author (a DIT therapist and developer, along with the third author, though neither were clinicians on the trial from which the data is drawn). In DIT, the therapist should typically introduce the idea of finding a focus for the work that makes sense of the presenting symptoms and current concerns in session 4. The first author listened to the audio recording of DIT sessions to identify the IPAF session, beginning at session 4 and working forwards (sessions 5-7) or backwards (session 3) if required. Notes were recorded for each component of the IPAF (self, other, affect, defense) and discussed with the second author. If the first and second authors agreed that no attempt to present the IPAF was apparent between sessions 3 and 7, the participant was excluded from the analysis on the grounds of deviation from the DIT model. It was expected that there would be some patients for whom the IPAF was difficult to identify. The clinician is permitted within the model to titrate the comprehensiveness of the IPAF according to what they consider the patient is capable of taking in, and it is not uncommon for the defensive function to be addressed in later sessions. For these reasons, a case was included where there was at least some attempt to bring the patient to a focus of treatment. The relevant IPAF session was then transcribed verbatim by researchers working on the trial (none of whom were coders) and the names of people and places were removed to preserve anonymity.

Qualitative Analysis: A Hybrid Method

A hybrid method of qualitative analysis was selected for this study based on the approach described by Miles and Huberman (1994) and a template approach (Crabtree & Miller, 1992). Both involve the use of a codebook based on a pre-existing framework from existing theory or prior research, which is then refined as the analysis proceeds. Miles et al. (2013) refer to this process as *deductive coding*. A provisional list of codes is developed prior to the analysis from a conceptual framework. Once coding has begun, the codes are revised based on their utility and goodness of fit to produce a framework that fits and accounts well for what is said in the transcripts. Data-driven, inductive coding was also applied in which new codes are allowed to emerge progressively (Boyatzis, 1998). Inductive coding ensures that the a priori coding frame is not force-fitted on to the data and empirical validity is maximized.

The stages of coding were adapted from a study adopting a similar hybrid approach (Fereday & Muir-Cochrane, 2006). An a priori codebook consisting of the items from the IIP-127 (Horowitz et al., 1988) was developed, each item providing its own label and description. The IIP-127 and the IIP-C contain the same 64 items. The first author listened to the audio recording, checking that the transcription was accurate, and then carefully read and re-read the IPAF transcript, making notes to summarize the IPAF presented to the patient and their response. The purpose of this stage was to allow initial processing of the data by the researcher by becoming immersed in the transcripts. The codebook was then applied to meaningful units of text as codes using the qualitative data management program Atlas.ti v7.5.15 for each of the transcripts. Text was coded by matching the codes with passages of the transcripts selected as representative of the code. Inductive coding was employed where a pre-existing code did not capture the participant's description of an element of their interpersonal style.

The next stage involved the process of discovering themes and patterns in the data (Crabtree & Miller, 1992). Each identified code was clustered across the sample into a theme. The decision as to which theme a code was allocated to was guided by the vector

angle of the IIP item cluster identified by Gurtman's (1995) hierarchical cluster analysis of the IIP-127. This paper reports a vector angle for 20 IIP item clusters, for example, Gurtman's cluster 6 (social avoidance) was located at an angle of 201°, within the hostile-submissive quadrant of the circumplex. Gurtman (1996) further grouped the item clusters to produce a table of interpersonal problems characteristic of each quadrant. The process of allocating codes to themes (equivalent to Gurtman's quadrants) involved the careful comparison of each to Gurtman's clusters. The deductive and inductive codes were each considered in terms of their similarities and differences to the descriptors of each quadrant and the vector angle of the relevant cluster.

The final stage involved checking and refining codes within their clusters and determining whether they were a true representation of the data and really described a distinct, stand-alone code. Any codes that did not seem to fit within a theme were discussed with the second author and care was taken not to "force" codes into themes where there did not appear to be a good fit. This was a particularly important part of the process of this qualitative analysis because it was informed by a pre-existing measure. The possibility that codes would be identified that were not semantically aligned with any particular quadrant was always held in mind and considered to be vital part of the analysis.

Results

Of the 73 DIT participants, 12 discontinued the treatment before they had completed four sessions. Of the remaining 61, indicators of an IPAF were identified for 48 participants.

Allocating Codes

Of the total number of codes identified, 51 (76.1%) were deductive, that is, drawn from the IIP, and 16 (23.9%) were inductive, that is, derived directly from the transcripts (see supplemental materials, Appendix A). Of the deductive codes, 33 (64.7%) came from the IIP-C and 18 (35.3%) from the IIP-127 items not included in the IIP-C. Codes were reviewed and

allocated to a theme represented by each of the IIP quadrants. Where codes were deductive and drawn from IIP-C subscales located in the middle of the quadrants, such as vindictive/self-centered, socially inhibited, overly accommodating, and needy/intrusive, the process of allocating to a theme was relatively simple: these codes were typically clear expressions of problems located in the relevant quadrant and had cluster vector angles to indicate this (Gurtman, 1995). Where the code was on the border of a quadrant (as in the case of those drawn from the domineering/controlling, cold/distant, non-assertive, or self-sacrificing IIP-C subscales), the relevant cluster vector angle and Gurtman's quadrant descriptors were considered.

Codes drawn from items included in the IIP-127 but not the IIP-C were each compared to Gurtman's descriptors and the most semantically appropriate quadrant was selected. For example, the items "find it hard to feel comfortable around others" and "find it hard to make friends" were considered similar to Gurtman's (1996) hostile-submissive quadrant descriptor, which includes "hard to feel comfortable around others, tell others personal things" and "hard to make friends, socialize".

Inductive codes were allocated to themes after the deductive codes, through a process of systematic examination of their similarities to and differences from the codes grouped under each theme. For example, the code "find it hard to say sorry" was considered most comparable to the intolerance of vulnerability or lack of remorse described by the hostile-dominant codes, and in opposition to the friendly-submissive codes describing a pattern of trying to please too much and being easily taken advantage of.

Two "universal". codes were identified that did not fit into any one discrete theme, but rather described a problematic way of relating that could apply to several themes. Consultation between the primary coder (the first author) and a co-researcher who is a clinician and DIT practitioner (the second author) was an important part of handling the inductive and universal codes. The decision as to whether these codes should be assigned to a theme or considered applicable to more than one theme was taken following a careful examination of the quotes.

Theme: Hostile-Dominant

Fifteen codes were categorized as hostile-dominant. Of these, 11 (73.3%) were drawn from the IIP-127 and 4 (26.7%) were inductive. The codes described a pattern of aggression toward or excessive irritation with others, a need for control and independence, difficulty putting the needs of others before their own or making commitments to others and feeling suspicious or jealous of others. The quotes describe examples such as feelings of unreasonable rage toward others, which could result in verbal assaults, a desire to hit people, and angry text messages.

> *"It just felt like pure rage I was so horrible to him, I started sending him so many messages like I don't wanna see you again, I hate you and . . . I just I don't know what's wrong with me."*

A lack of tolerance of others in shared physical spaces was described, such as flat mates playing music. Being unavailable in romantic relationships and a lack of remorse over infidelity were reported. A fear of losing control over others and feeling like a "control freak" were described, and friendships were ended because they felt unable to apologize.

> *"I was really proud, and I wouldn't, I didn't see a reason to try and say sorry to her . . . I don't think I know how to like, be vulnerable and like, just say I'm sorry and like, I really miss our friendship. I didn't know how to do it. I just went, straightaway knew our friendship was over after we had that argument."*

Some acknowledged being overly judgmental or critical. Jealousy of others' appearance was reported:

"I felt really like jealous of her she's like really beautiful blonde and I just felt like the ugly sidekick . . . I get very like jealous and upset. I know it's not helpful."

Some reported frequently feeling that others were not considerate enough of them and their feelings, for example, experiencing uncontrollable pain and anger at their partner looking at social media during a meal or going outside to smoke. A strong feeling that they must cope alone because others could not be depended upon was reported by some patients. While some expressed a desire for more supportive relationships, others found the "everydayness" of relationships boring.

Theme: Friendly-Dominant

Eleven codes were categorized as friendly-dominant. Of these, eight (72.8%) were derived from the IIP-127 and three (27.2%) were inductive. The codes described a desire to be noticed, opening up too much to others or trying to please others too much, being overly responsible or excessively guilty for failures, overly investing in relationships compared with the other party, feeling "too much", "too clingy", or "too full-on" for others, difficulty being alone, and being overly sensitive to criticism, rejection, or others' reactions to them. Examples included trying too hard to win affection and attention and getting carried away in relationships:

"When I fell in love with someone, I use to get into a terrible state and I'd find the emotions overwhelming. I'm sure, I know I was, ahh . . . I was just emotionally too intense for most other men."

Patients described worrying about being "too much" or "too intense" for others or overwhelming them with their emotions and needs. Some found it very difficult to tolerate requests from the other for space, describing themselves as desperate and anxious about losing relationships. Some reported anxiety about spending time alone: weekends felt

intolerable without plans or they were constantly watching the clock until their partner came home.

> *"I hate so much to be alone, I'm just always really stressed when the weekend is coming. For example, yesterday my housemate asked me 'What are your plans for the weekend?' and I have no plans and I started to feel really anxious."*

One described crying uncontrollably when arriving home to find that her flat mates were out; not knowing where they were was unbearably painful. She described feeling she always "had to fight to have company".

Feeling a strong sense of responsibility and need to fix everyone else's problems was described.

> *"I know how it feels to feel low, and to have no one, I just have to make sure everyone doesn't feel like that. I have to make sure everyone feels good about themselves, I have to make sure everyone feels happy and I have to try and resolve everyone's problems, I don't know why."*

Some patients described the need to always give an outward appearance of being in a good mood, happy and supportive. Some recognized that they were overly sensitive to the judgement of others and too afraid of other's seeing their mistakes. Some felt the need to hide their true self or take on roles such as the "fun" or "attentive" friend, which they did not feel were authentic.

Theme: Friendly-Submissive

Seventeen codes were categorized as friendly-submissive. Fourteen (82.4%) derived from the IIP-127 and three (17.6%) were inductive. The themes described difficulty feeling or expressing anger, difficulty prioritizing own needs or setting limits on others, excessive

dependence on others, a weak sense of self and own desires, feeling inferior or child-like, and feeling unlovable. Patients described being fearful of their own anger, which led to them suppressing it, working hard to calm themselves down, or forcing themselves to be apologetic rather than angry. Expressing anger did not feel like an option for some; one patient described allowing themself to "be cross in private".

Some reported engaging in activities they did not want to do because of an inability to say no, such as agreeing to work assignments or doing favors for others. One patient described how they often agreed to social engagements despite being very aware that they did not want to go to them. One therapist suggested to their patient that they often found themselves in the position of feeling as if the other person was "the manager". Patients frequently described allowing others to take advantage of them.

Therapists often drew attention to how the patient was failing to look after themselves by putting the needs of others before their own, for example, by not responding to their own exhaustion or allowing themselves any leisure time. Making reasonable demands of others was often described as difficult- patients described "constantly reining in" their own feelings, being "ridiculously polite", and finding it very hard to ask others to do something.

Following peers in life decisions rather than making one's own choices was a theme, for example, selecting a university based only on where their friends were going. This was sometimes accompanied by a loss of sense of self: it was difficult to know what they found interesting or preferred.

> *"I'm so easily influenced I guess, by whomever I'm talking to, that I don't actually have opinions of my own, not really. I just kind of . . . listen or read other people's and kind of latch on to those but I really struggle . . . like I don't ever remember being very sure of myself really."*

Some felt unable to define themselves completely, feeling empty or as if they did not exist, or out of touch with who they are. Some patients described feeling like a child, often

deferring decisions to their parents or partner. One patient in his 70s described himself as “infantile” and recounted how he had often turned employers into father figures. Many patients described holding back and allowing others to take control, or not being able to confront others because of their desire “to keep the peace”.

There were many examples of patients recognizing that they were dependent or reliant on others to do things that they knew others did for themselves, such as domestic chores, shopping, and paying bills. Some described themselves as unable to look after themselves, reliant on their parents for help, not responsible enough, lacking their own motivation or “get up and go”, unable “to stand on their own two feet”, “inert”, and “pathetic”.

> *“He does everything for me and he said on the weekend ‘I don’t want to be with you anymore, but I don’t feel I can leave you because I don’t feel that you’ll be OK’. And I was just like ‘Well . . . you can leave me, but I won’t be OK’. I didn’t say that to him but like . . . I don’t feel like I can live without him”*

It was very common for patients to report that they found it difficult to believe that others would find them lovable, and they often cited these feelings as what they would most like relief from in treatment. These feelings included finding it hard to trust that others would like them or find them acceptable, being “un-preferred”, or feeling “invisible”, “dull”, “undesirable”, “ugly”, “dirty”, “damaged”, “bad”, “unlikable”, “boring”, “disgusting”, and “not quite right”. Finding it hard to feel good enough was very commonly reported and reached across all areas of life: friendships, partners, work, study and homemaking. Some described themselves as feeling “weak”, “useless”, “good to nobody”, “incompetent”, a “failure”, “riddled with self-doubt and insecurities”, “not up to it”, “flawed”, “not special”, “undeserving”, and “not up to scratch”.

> *“I just don’t feel like I can do that course, I don’t feel like I’m going to get any grades, I don't feel like I’m ever going to get into university, I feel like I’m too old, I’ve wasted*

so much of my life and that it's pointless, I'm never going to get anywhere . . . I'm too scared to face someone I don't know, because of the fear of not being good enough"

Similarly, feeling others were better than the self was also reported, for example, feeling inferior, less clever, less cultured, or "at the bottom of the food chain". Although the way these feelings were defended against was connected to other themes, having these strong doubts about their own value was frequently connected with vulnerability to being dominated by others or continually adopting a submissive stance.

Theme: Hostile-Submissive

Twenty-two codes were categorized as hostile-submissive. Of these, 18 (82.0%) derived from the IIP-127 and four (18.0%) were inductive. The codes were characterized by difficulties socializing, difficulties opening up to or feeling close to others, trouble with being assertive or self-confident, a lack of a sense of belonging, feeling unwanted or excluded, difficulty trusting others, and feeling judgement too strongly. Patients reported that they could not be bothered to socialize or that they found it very tiring and "a constant effort". One patient described his teenage years as "totally wasted" because his shyness and insecurity made it so difficult to be around others and he had often wondered how other people were able to "be good company". Another reported ruminating constantly for 2 weeks before a party about why he had been invited. Several were also afraid to invite others to parties or holidays because they were afraid that no one would come.

Finding it hard to open up to others was very commonly reported. Avoiding getting into conversations was often mentioned.

"I do kind of definitely . . . avoid sharing. I often find I'm, like, caught up in any kind of emotion and I'll think you know, whatever, I'll start, like you know, writing a text somebody to saying, 'oh I'm so sad' and then I think, just that I shouldn't. Like, that I'm infringing on other people or, invading them."

Moving from an acquaintance stage to becoming friends with a person was described as hard, and there was a recognition by some patients that they were “standoffish”, with one describing himself as being like a “zombie”. Being unable to tell the other person what they were feeling, patients reported employing sarcasm, making jokes, feigning lack of interest, or trying to make the other person feel guilty rather than tackle an issue.

Many described often feeling embarrassed by their appearance, their interests, or their perceived ignorance. This was particularly marked in a group social setting and in the workplace. Sometimes patients described being scared of being around others or talking to others, which made them avoid situations such as socializing with strangers, job interviews, and medical appointments. Some participants found joining a group particularly difficult, often experiencing the feeling of being excluded or that they “don’t belong”.

Finding it difficult to feel close to others was very commonly reported. Patients described feeling alone or disconnected, even when with others or in a relationship, keeping people at a distance, feeling the need to protect themselves from others, or being “an outsider”. Some described themselves as “emotionally unavailable” and a dichotomous feeling of at once wanting relationships and also not wanting them because they were too overwhelming, too much effort, or made them feel too vulnerable. Feeling dismissed or ignored by others was often cited; for example, not feeling understood by others or that their opinions were valid, or that they were overlooked or unacknowledged. The other was often described as “disinterested”. One patient felt that others were “not really seeing me as a human being”.

Difficulty trusting others was also frequently described. Suspicion or even paranoia about other people’s motives and agendas was common, and patients described questioning themselves on whether another person could genuinely be relied upon or whether the other being there for them was conditional. For a number of patients, there was a concern about the therapist’s agenda. Perhaps they were interested in them only for research purposes,

considered their problems “petty and juvenile”, or they might throw the patient aside at the end of treatment.

Some patients reported difficulty getting along with others, describing themselves as “awkward”, “weird”, not “a very good guest”, “moody”, “impossible to live with”, “difficult”, “a monster”, “a geek”, “an outsider”, or “a misfit”. One patient recounted how difficult she found it to go on holiday with others or live in share accommodation, describing herself as “moody”, “difficult”, and “awful”.

Problems with being assertive were common, for example, not feeling able to take control at work or allowing others to take charge. One patient described how he avoided checking up on projects he managed because he was afraid of finding problems:

> *“I feel that I don’t take control over my life because I’m always walking away from things and it’s even like I’m running away from my own life instead of actually saying ‘I am going to take the reins, I’m gonna do this. I’m in control. I can . . . I can affect the outcome.’ Erm it’s almost like I’m, I’m letting everybody else affect the outcome of my life.”*

One patient described feeling as if others “ride rough-shod” over him. Feeling “helpless”, “powerless”, and “in the wrong” were described. Being self-confident was often cited as being very difficult. One patient described how he gave up his career, for which he had considerable talent, after a particularly difficult audition because he felt unable to recover from the criticism. An underlying feeling of being inferior or always in the wrong was reported, making it difficult to express opinions or take on responsibility. Many expressed a desire to better articulate what they want without fear of others’ reaction, which might be dismissive or humiliating. As one therapist put it, “the language of desire feels so difficult”.

A general feeling of discomfort around others was common; patients often found it easier to be alone. Some recognized that they were distancing themselves from safe situations, such as close groups of friends. Others found going shopping, into town, or

standing in queues very difficult. Some found it almost impossible to relax and enjoy themselves with others; the feeling of not wanting to be there or the desire to go home was always with them. A sense of belonging was lacking for many.

Patients described feeling “on the outside”, not fitting into a category, “not needed”, “just there out of habit”, “disconnected”, not having a place, “isolated”, “being an odd one”, “without a cohort”, “out of the picture”, “stranded”, and “on the edge”. Many patients recognized that they felt others’ judgment very strongly. One described how she always felt others thought she was “failing at life”.

Universal Codes

Two codes occurred frequently across the transcripts but did not fit semantically within any one quadrant: feeling neglected by others and that others were unavailable to them. These codes could be considered to be interpersonal problems that could be part of more than one, if not all, themes, and which generally describe feelings of not being kept in mind by others. The word “neglected” was commonly coded and was considered to be a separate code to “feeling unwanted or excluded by others” because it implied a less active interest of the other in the self.

> *“I suppose I put my barriers up again like when I was a child and mum didn’t really give me attention, so my barrier went up and it was like well if she doesn’t love me or care for me then I’m not gonna you know dwell on it”. Therapist: “It sounds really hard . . . one thing that you can say here is that people have been quite neglectful, quite absent as the caring figures.”*

Where the patient might attribute a reason to being excluded, for example, being boring, feeling neglected was used to code descriptions of feeling insignificant to or abandoned by the other. Patients reported feeling “un-noticed”, “invisible”, as if a relationship

was all one-way, or that caregivers were absent or unable to provide comfort or affection. The other is “busy doing their own thing” or “doesn’t seem to care”.

Feeling that others are unavailable was also frequently reported alongside codes from multiple themes. In this case, the other may be physically present at times but is insensitive, undependable, or too preoccupied with themselves. One patient described his mother as “filling all the space with ‘I’”. They may also disappear unpredictably and be hard to stay connected to. The patient feels as if he “can’t get through to them” or that they are “unreachable”. Other descriptors included the other having “their own agenda” and being “behind a grid”.

Development of the IPAF Typology

Having successfully allocated codes to each of the themes, the next step was to use the qualitative framework to produce a IPAF typology (see supplemental materials, Appendix B). Each theme (hostile-dominant, friendly-dominant, friendly-submissive, and hostile-submissive) was placed in a 2 × 2 matrix. Each cell contained one theme and the codes associated with it, providing a concise interpersonal descriptor of each theme. This stage involved a number of amendments to the cells, to link conceptually similar codes and reduce unnecessary wording. Likert scales were added to each of the four cells to allow the user to quantify how like their patient’s IPAF each type is. After reviewing each type, the clinician can select the cell that is most representative of the types of problems described by the IPAF.

A brief introduction for users of the typology was written detailing the purpose of the typology and its method of application (see supplemental materials, Appendix C). Clinicians are guided to consider steps 4 and 5 of the DIT formulation aide-memoire (Lemma et al, 2011, p113) when making a selection. These steps describe the recurrent self-other representation meaningfully connected to the presenting symptoms and the defensive function of that self-other representation, i.e., what is the patient afraid of or trying to avoid in himself? The user should consider what is defended against, rather than the defensive

behavior alone, when selecting a category. For example, the patient may describe a friendly-submissive interpersonal style themselves, yet the clinician notes hostility. In this case, the clinician should decide whether hostile-submissive is a better descriptor. While the exact combination of IPAF dimension descriptors can legitimately be expected to vary somewhat within IPAF categories, an overview of typical expressions of each are summarized.

The notes also highlight the problems that were found to be less helpful in discriminating the IPAF types (universal codes) and cautions the user that these problems may be indicated for more than one IPAF.

Discussion

A qualitative analysis revealed that four discrete categories of IPAFs were identifiable in the transcriptions, describing patterns of relating that could be labelled as hostile-dominant, friendly-dominant, friendly-submissive, and hostile-submissive, suggesting that the IIP can be usefully employed as a basis for informing an IPAF typology. The codes in each category are very similar to those identified statistically in the quadrants of the IIP-C (Gurtman, 1995, 1996) and the inductive themes all matched closely with the clusters (for a detailed comparison of our analysis and Gurtman's, 1995, see Appendix D).

A small number of IIP codes were not identified in the qualitative analysis. For the friendly-dominant type, "trying to change others too much" was not observed. For the friendly-submissive type, finding it hard to compete or being too gullible were not noted, and for hostile-dominant, manipulating or exploiting others, difficulty with authority, arguing or fighting too much were not described in the IPAFs. It is not unexpected that a sample of IPAFs do not fully describe the population. However, it is possible that patients with these types of problems would have been less likely to seek treatment or be referred to the trial, or they may have found the triage process for a clinical trial difficult. The best fit with the quadrant descriptors seemed to be with hostile-submissive types. If the opposing quadrants are reciprocal and complementary (Carson, 1969; Leary, 1957) and a therapist would typically be expected to adopt a friendly-dominant style, it is unsurprising that hostile-

submissive problems would be clearly represented. The finding that hostile-submissive problems were more clearly represented than hostile-dominant ones is consistent with early work on the IIP: problems of assertiveness were very salient in brief dynamic psychotherapy (and successfully treated) compared with problems of intimacy, and problems of intimacy were rated as less distressing (Horowitz et al., 1988).

The hostile-dominant type seemed to lack some of the most aggressive IIP items. Perhaps individuals with these types of problems are also less likely to seek treatment or less likely to have been selected as suitable for DIT. These items are typically associated with personality disorder—a diagnosis of which was an exclusion criterion for the trial. It is conceivable that highly aggressive or manipulative patients would have been more likely to drop out of treatment; it may have been more difficult for them to comply with a fairly rigid treatment schedule or to develop rapport with the therapist. The therapist may also decide to delay sharing the IPAF with these patients or find it more challenging to stay within the DIT model when working with them, and consequently they may be over-represented among those excluded from this study.

An unexpected yet important finding was the presence of two “universal” codes not found in the IIP quadrants. The feelings of being neglected by others and that others are unavailable to them were frequently discussed by therapists and their patients, but these items were not useful in discriminating the four types of IPAF; rather, they seemed applicable in one sense or another to all the types. There were no clusters in Gurtman’s (1995) IIP typology that paralleled these items. It may be that these items are tapping into something the IIP does not capture. Alternatively, they may relate somehow to the underlying factor of distress; it is known that this factor is distinct from love and dominance (Gurtman, 1992). Early adversity and particularly interpersonal neglect and abuse are transdiagnostic factors implicated in most if not all mental disorders, including depression (McLaughlin et al., 2010; Myers et al., 2014). These factors are also known to be related to the so-called “p factor”, a dimension of general psychopathology ranging from high to low

severity (Caspi & Moffitt, 2018). Thus, it is possible that general interpersonal distress is also related to the p factor.

Many of the quotes associated with these “universal” codes describe past relationships, which is consistent with the DIT model and a good sign of adherence: therapists should discuss the links between past relationships and the current pattern. They are also consistent with interpersonal models, which emphasize problems resulting from unavailable caregivers (e.g., Arieti & Bemporad, 1978, 1980; Sullivan, 1940, 1953). Discussion of these codes may be a mentalizing tool used by the DIT therapist to describe the process of pattern development and to get to the crux of the developmental origin.

Clinical Implications

As with the wider research area investigating which treatments work best for which patients, establishing which patients are most likely to benefit from DIT is important for patients, clinicians, and healthcare stakeholders alike. This study indicates that contemporary interpersonal approaches provide a good basis for classifying four distinct types of IPAF. Future research may reveal an association with outcomes and processes in DIT.

The purpose of the typology is to provide the clinician with an additional tool to help them consider early in treatment whether the patient is likely to benefit from DIT and also to provide a framework for thinking about how they might tailor treatment to a particular patient. An early indicator of the likely success of DIT for a particular patient could improve outcomes for the patient and the wider service. The items derived from the IIP provide a useful framework for considering how the IPAF dimensions might be more specifically characterized, an area requiring further research. The typology allows the therapist to consider how alike or unlike the IPAF is to each of the categories. Therapist competencies such as anticipating how a patient is likely to behave in sessions and encouraging a move away from behaviors that impede the therapy could be informed by the typology. The IPAF type will be relevant throughout all phases of treatment. In the initial phase, the emerging

IPAF type may have a bearing on the way in which the clinician engages with the patient; for example, patients with more hostile IPAFs may be wary of and inexperienced with engaging in a trusting relationship with another person. More submissive patients may passively accept what is offered in therapy and the clinician may need to enlist them in more active participation. During the middle phase, in which the IPAF is explored and reflected upon in terms of relationship difficulties, the type is also relevant. Patients with friendly-submissive IPAFs may need to focus on working through their dependency issues as part of tackling the IPAF; conversely, patients with hostile-dominant IPAFs may be more focused on problems with accepting support and tolerating intimacy both in the therapeutic relationship and outside treatment. The way in which the therapist approaches ending the therapy with the patient may also be different depending on the IPAF type, as it may be experienced as abandonment by those with more affiliative profiles and potentially as humiliating by those who find it difficult to tolerate vulnerability. The IPAF type will also be pertinent to the way in which the clinician makes use of the transference and countertransference; its interpretation may be aided by the interpersonal principles of reciprocity. An individual's interpersonal behavior elicits responses from a partner that are reciprocal or complementary, whereby dominance elicits submissiveness in the other and vice versa, and hostility and affiliative behaviors provoke similar responses (Carson, 1969; Kiesler, 1983; Leary, 1957). The IPAF type therefore will be relevant to the understanding of the operation of transference in the patient's interpersonal relating. Interpretation of the IPAF is a continual session-by-session process, which may be aided by a framework on which to "hang" the IPAF. An investigation of the association between IPAF type and outcome may usefully inform the DIT competencies. For example, what guidelines might be useful for clinicians when the IPAF proves difficult to formulate, and is this difficulty associated with poorer outcome and risk of drop-out?

Good patient outcomes produced by effectively targeted treatments likely rest on an aggregated approach. An IPAF type might contribute to a multivariable treatment selection

approach combining self-report predictors such as interpersonal problems, demographic variables, and clinical measures with biomarkers.

Limitations and Recommendations for Future Research

The obvious limitation of this study is the small sample: the deductive and inductive codes described by this typology have been limited by those described in the IPAFs available for analysis and it is possible that more codes would be identified in a larger sample. In particular, this sample seems lacking in items describing hostile-dominant problems. The sample is not particularly diverse in terms of demographics: twice as many women than men took part and the sample was overwhelmingly White (77.9%).

The reliability of the coding process awaits further research. The aim of this study was achieved- to establish the possibility of applying the IIP as a framework for a typology- but we are yet to demonstrate its use by researchers or clinicians outside of our team. One issue with using an IPAF typology with a view to examining outcomes is that it is difficult to be sure that the IPAF agreed upon in session 4 is what is actually worked on in therapy. It is possible that it might be modified or even abandoned and replaced as DIT progresses and the relationship between the patient and therapist develops. A cross-check with the end of treatment letter given to patients in session 16, detailing the work they have done, might provide one avenue to establish the consistency of the IPAF.

Future research into the development of an IPAF typology should be directed first toward its application in this sample (the subject of a planned paper) and later a larger and ideally more diverse sample of patients by multiple raters to assess reliability and validity and determine whether it could be usefully incorporated into DIT training. Studies exploring associations with other measures of functioning and personality, such as the IIP, the Hierarchical Taxonomy of Psychopathology (Kotov et al., 2017)-based assessments and the Shedler–Westen Assessment Procedure (Shedler & Westen, 2007), are needed to assess validity. Testing should be undertaken by DIT clinicians and their feedback sought to determine its usability. The way in which the typology is applied to the IPAF dimensions is

conceptual at this stage and further process research would be required to develop strategies to enable clinicians to apply it in the course of their routine DIT practice. Examples of the IPAF dimensions described in clinical cases for the four types of IPAF would be useful for clinicians, but the complexity and limitations of that application would need to be more fully assessed in order to go beyond the brief examples given in the Notes for Use. An exploration of how the typology might be applied when more than one IPAFs is indicated would also be useful. For instance, the presence of two IPAFs is typically related to disorganized attachment characterized by two (often opposing) patterns of relating to self and others (e.g., victim-perpetrator), as described in the DIT clinician's guidelines (Lemma et al, 2011).

Consultation with DIT clinicians could be built into a pilot study to provide insight into how "clinician-friendly" the typology is in practice. For example, does it feel too complicated or difficult to hold the IPAF types in mind for a practitioner who is unfamiliar with the IIP? Could the types be reformulated in a simpler way, or is more detail required to allow distinction between IPAFs? Is the current list of the types of problems that are likely within an IPAF type helpful, or would a vignette style for each type be preferable? Translated versions would also be useful to assess cross-cultural reliability and validity now that DIT is being delivered in languages other than English, such as Italian, French, and Dutch.

References

Abbass, A. A., Kisely, S.R., Town, J.M., Leichsenring, F., Driessen, E., De Maat, S., Gerber, A., Dekker, J., Rabung, S., Rusalovska, S., & Crowe, E. (2014). Short-term psychodynamic psychotherapies for common mental disorders (Review). *The Cochrane Database of Systematic Reviews,* 7, CD004687. https://doi.org/10.1002/14651858.CD004687.pub4

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment, 55*(3-4),

521-536. https://doi.org/10.1080/00223891.1990.9674088

Arieti, S., & Bemporad, J. R. (1978). *Severe and mild depression*: The psychotherapeutic approach. Basic Books.

Arieti, S., & Bemporad, J. R. (1980). The psychological organization of depression. *American Journal of Psychiatry, 137*, 1360–1365. https://doi.org/10.1176/ajp.137.11.1360

Blatt, S. J. (2002). Patient variables: Anaclitic and introjective dimensions. In W. Sledge & M. Hershen (Eds.), *Encyclopedia of psychotherapy* (pp. 349-357). Academic Press.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical and research perspectives*. American Psychological Association. https://doi.org/10.1037/10749-000

Blatt, S. J. (2008). *Polarities of experiences: Relatedness and self-definition in personality development, psychopathology and the therapeutic process*. American Psychological Association. https://doi.org/10.1037/11749-000

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis, 39*(5), 350-373. http://www.psychology.sunysb.edu/attachment/online/nature%20of%20the%20childs%20tie%20bowlby.pdf

Bowlby, J. (1969). *Attachment and loss, Volume I: Attachment*. Hogarth Press.

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage Publications.

Carson, R. C. (1969). *Interaction concepts of personality.* Aldine Publishing Co.

Caspi, A., & Moffitt, T. E. (2018). All for one and one for all: Mental disorders in one dimension. *The American Journal of Psychiatry, 175*(9), 831–844. https://doi.org/10.1176/appi.ajp.2018.17121383

Chen, C. K., & Dognin, J. S. (2017). Addressing the influence of hegemonic masculinity on veterans through brief dynamic interpersonal therapy. *Psychology of Men & Masculinity, 18*(3), 238–242. https://doi.org/10.1037/men0000118

Clark, D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. *Annual Review of Clinical Psychology, 14*, 159-183.

https://doi.org/10.1146/annurev-clinpsy-050817-084833

Clementel-Jones, C., Azzone, P., Battacchi, M. W., Freni, S., Giampieri, E., & Marano, G. (1996). Italian translation of the Inventory of Interpersonal Problems, validity and stability of factor structure. *New Trends in Experimental & Clinical Psychiatry, 12(4),* 253-259.

Crabtree, B. F., & Miller, W. L. (1992). A template approach to text analysis: Developing and using codebooks. In B. F. Crabtree & W. L. Miller (Eds.) *Doing Qualitative Research.* (pp. 93-109). Sage Publications.

Crabtree, B. F., & Miller, W. L. (1999). Using codes and code manuals: a template organizing style of interpretation. In B. F. Crabtree & W. L. Miller (Eds.) *Doing qualitative research,* (2nd ed., pp. 163-178). Sage Publications.

Driessen, E., Hegelmaier, L. M., Abbass, A. A., Barber, J. P., Dekker, J. J. M., Van, H. L., Jansma, E.P. & Cuijpers, P. (2015). The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis update. *Clinical Psychological Review, 42*, 1-15. https://doi.org/10.1016/j.cpr.2015.07.004

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5*(1), 80-92. https://doi.org/10.1177/2F160940690600500107

Folkes-Skinner, J., & Collins, L. (2021). Group dynamic interpersonal therapy (GDIT): adapting an individual interpersonal therapy to a group setting in an NHS IAPT service: a pilot study. *Psychoanalytic Psychotherapy*. Advance online publication. https://doi.org/10.1080/02668734.2021.2001685

Fonagy, P., Lemma, A., Target, M., O'Keeffe, S., Constantinou, M. P., Ventura Wurman, T., Luyten, P., Allison, E., Roth, A., Cape, J., & Pilling, S. (2020). Dynamic interpersonal therapy for moderate to severe depression: A pilot randomized controlled and feasibility trial. *Psychological Medicine, 50*(6), 1010-1019. https://doi.org/10.1017/S0033291719000928

Fournier, M. A., Moskowitz, D. S., & Zuroff, D. C. (2010). Origins and applications of the interpersonal circumplex. In L.M. Horowitz & S. Strack (Eds.), Handbook of interpersonal psychology: Theory, research, assessment, and therapeutic interventions. (pp. 57-73). John Wiley & Sons https://doi.org/10.1002/9781118001868

Gelman, T., McKay, A., & Marks, L. (2010). Dynamic interpersonal therapy (DIT): Providing a focus for time-limited psychodynamic work in the National Health Service. *Psychoanalytic Psychotherapy, 24*(4), 347-361. https://doi.org/10.1080/02668734.2010.513556

Gurtman, M. B. (1992). Construct validity of interpersonal personality measures: The interpersonal circumplex as a nomological net. *Journal of Personality and Social Psychology, 63*(1), 105-118. https://doi.org/10.1037/0022-3514.63.1.105

Gurtman, M. B. (1995). Personality structure and interpersonal problems: A theoretically-guided item analysis of the Inventory of Interpersonal Problems. *Assessment, 2*(4), 343-361. https://doi.org/10.1177/1073191195002004005

Gurtman, M. B. (1996). Interpersonal problems and the psychotherapy context: The construct validity of the Inventory of Interpersonal Problems. *Psychological Assessment, 8*(24), 1-255. https://doi.org/10.1037/1040-3590.8.3.241

Gurtman, M.B. (2016). Interpersonal Circumplex. In V. Zeigler-Hill & T. Shackelford. (Eds.), Encyclopedia of Personality and Individual Differences. https://doi.org/10.1007/978-3-319-28099-8_1233-1

Havsteen-Franklin, D., Oley, M., Sellors, S. J., & Eagles, D. (2021). Drawing on dialogues in arts-based dynamic interpersonal therapy (ADIT) for complex depression: A complex intervention development study using the Medical Research Council (UK) phased guidance. *Frontiers in Psychology, 12*, Article 588661. https://doi.org/10.3389/fpsyg.2021.588661

Horowitz, L. M. (1979). On the cognitive structure of interpersonal problems treated in psychotherapy. *Journal of Consulting and Clinical Psychology, 47*, 5-15. https://doi/10.1037/0022-006X.47.1.5

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, V. S. (1988). Inventory of Interpersonal Problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*(6), *885-892.* https://doi.org/10.1037//0022-006x.56.6.885

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000). *IIP-64/IIP-32 professional manual.* The Psychological Corporation.

Kernberg, O. (1976). *Object relations theory and clinical psychoanalysis.* Aronson.

Kernberg, O. (1985). *Internal world and external reality: Object relations theory applied*. Aronson.

Kiesler, D. (1983). The 1982 interpersonal circle: A taxonomy for complementarity in human transactions. *Psychological Review, 90*(3), 185-214. https://doi.org/10.1037/0033-295X.90.3.185

Kotov, R., Krueger, R. F., Watson, D., Achenbach, T. M., Althoff, R. R., Bagby, R. M., Brown, T.A., Carpenter, W.T., Caspi, A., Clark, L.A., Eaton, N.R., Forbes, M.K., Forbush, K.T., Goldberg, D., Hasin, D., Hyman, S.E., Ivanova, M.Y., Lynam, D.R., Markon, K., . . . Zimmerman, M. (2017). The Hierarchical Taxonomy of Psychopathology (HiTOP): A dimensional alternative to traditional nosologies. *Journal of Abnormal Psychology, 126*(4), 454-477. https://10.1037/abn0000258

Leary, T. F. (1957). *Interpersonal diagnosis of personality: A functional theory and methodology for personality evaluation*. Ronald Press.

Lemma, A., Roth, A., & Pilling, S. (2008). The competences required to deliver effective psychoanalytic/psychodynamic therapy. https://www.researchgate.net/publication/237553451_The_Competences_Required_to_Deliver_Effective_PsychoanalyticPsychodynamic_Therapy

Lemma, A., Target, M., & Fonagy, P. (2010). The development of a brief psychodynamic protocol for depression: Dynamic Interpersonal Therapy (DIT). *Psychoanalytic Psychotherapy, 24*(4), 329-346. https://doi.org/10.1080/02668734.2010.513547

Lemma, A., Target, M., & Fonagy, P. (2011). *Brief Dynamic Interpersonal Therapy. A*

Clinician's Guide. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199602452.001.0001

Luyten, P., & Blatt, S. J. (2013). Interpersonal relatedness and self-definition in normal and disrupted personality development. *American Psychologist, 68*(3), 172-183. https://doi.org/10.1037/a0032243

Luyten, P., Blatt, S. J., & Mayes, L. C. (2012). Process and outcome in psychoanalytic psychotherapy research: The need for a (relatively) new paradigm. In R. A. Levy, J. S. Ablon, & H. Kächele (Eds.), Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence (pp. 345–359). Humana Press - Springer. https://doi.org/10.1007/978-1-60761-792-1_21

McFarquhar, T. (2021). *Outcomes in Psychotherapy for Depression: The Role of Interpersonal Problems* [Doctoral thesis (PhD), UCL (University College London)] UCL Discovery. https://discovery.ucl.ac.uk/id/eprint/10132904/

McLaughlin, K.A., Conron, K.J., Koenen, K.C., & Gilman, S.E. (2010). Childhood adversity, adult stressful life events, and risk of past-year psychiatric disorder: A test of the stress sensitization hypothesis in a population-based sample of adults. *Psychological Medicine;40*(10),1647-1658. https://doi.org/10.1017/S0033291709992121

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source-book* (2nd ed.). Sage Publications Inc.

Miles, M. B., Huberman, A. M., & Saldana, J. (2013). Fundamentals of qualitative data Analysis. *Qualitative Data Analysis. A Methods Sourcebook* (3rd ed.). Sage Publications.

Myers, B., McLaughlin, K.A., Wang, S., Blanco, C., & Stein, D.J. (2014). Associations between childhood adversity, adult stressful life events, and past-year drug use disorders in the National Epidemiological Study of Alcohol and Related Conditions (NESARC). *Psychology of Addictive Behaviors, 28*(4):1117-1126. https://doi.org/10.1037/a0037459

Rao, A., Lemma, A., Fonagy, P., Sosnowska, M., Constantino, M., Fijak-Koch, M., &

Gelberg, G. (2019). Development of dynamic interpersonal therapy in complex care (DITCC): a pilot study. *Psychoanalytic Psychotherapy, 33*(2), 77-98. https://doi.org/10.1080/02668734.2019.1622147

Shedler, J., & Westen, D. (2007). The Shedler–Westen Assessment Procedure (SWAP): making personality diagnosis clinically meaningful. *Journal of Personality Assessment, 89*(1), 41-55. https://doi.org/10.1080/00223890701357092

Sullivan, H. S. (1940). Conceptions of modern psychiatry: the first William Alanson White Memorial Lectures. *Psychiatry, 3*, 1-117.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. W W Norton & Co.

Wright, D., & Abrahams, D. (2015). An investigation into the effectiveness of Dynamic Interpersonal Therapy (DIT) as a treatment for depression and anxiety in IAPT. *Psychoanalytic Psychotherapy, 29*(2), 160-170. https://doi.org/10.1080/02668734.2015.1035740

Table 1: Demographics of Participants with an Identifiable Interpersonal Affective Focus

Demographic		**IPAF identified (*n* = 48)**
Gender *n* (%)	Male	15 (31.3)
	Female	33 (68.7)
Age (years)	Mean (*SD*)	39.2 (13.1)
	Range	19–70
Current medication *n* (%)	Yes	24 (50.0)
	No	20 (41.7)
	Unknown	4 (8.3)
Ethnicity *n* (%)	White	39 (81.3)
	Black	3 (6.3)
	Asian	2 (4.2)
	Mixed	2 (4.2)
	Other	1 (2.1)
Marital status *n* (%)	Single	24 (50.0)
	Married/living together	13 (27.1)
	Divorced/separated	7 (14.6)
	Other	3 (6.3)
	Unknown	1 (2.1)
Employment *n* (%)	Full time	25 (52.1)
	Part time	6 (12.5)
	Unemployed	10 (20.8)
	Student	1 (2.1)
	Retired	1 (2.1)
	Other	3 (6.3)

	Unknown	2 (4.2)
Income *n* (%)	<£10,000	8 (16.7)
	£10,000–30,000	18 (37.5)
	£30,000–50,000	7 (14.6)
	>£50,000	10 (20.8)
	Unknown	6 (12.5)
HRSD time 1 Mean (*SD*)		18.4 (3.9)

Note: HRSD, Hamilton Rating

Supplemental Material

Appendix A: List of Deductive and Inductive codes identified

CODES	
Deductive (*n* = 51)	**Inductive (*n* = 16)**
Feel embarrassed in front of others too much	Feel others are better than they are
Find it hard to feel or act competent as a parent	Feel unwanted or excluded by others
Find it hard to ask others to get together socially	Find others intrusive
Find it hard to be assertive	Find it hard to define self
Find it hard to be self-confident when with others	Find it hard to feel like they belong
Find it hard to confront others with problems	Find it hard to say sorry
Find it hard to express feelings to others directly	Too often upset or angered by others' lack of consideration for them
Find it hard to feel angry at others	
Find it hard to feel close to others	Too easily become over-invested in romantic relationships
Find it hard to feel comfortable around others	
Find it hard to get along with others	Feel they are "too much" for others
Find it hard to have others depend on them	Feel others are less committed to relationships than they are
Find it hard to introduce self to new people	
Find it hard to join in groups	Feel the judgement of others strongly
Find it hard to let others know what they want	Feel neglected by others
Find it hard to let others know when they're angry	Find it hard to feel good enough
Find it hard to make a long-term commitment to others	Feel others are unavailable
	Feel dismissed or ignored by others
Find it hard to make friends	Find it hard to rely on others
Find it hard to make reasonable demands of others	
Find it hard to open up and tell feelings to others	
Find it hard to put needs of others before own	
Find it hard to relax and enjoy going out with others	

Find it hard to say no to others Find it hard to socialize Find it hard to spend time alone Find it hard to take charge of own affairs without help from others Find it hard to trust others Act like a child too much Too aggressive toward others Too easily bothered by the demands of others Too envious or jealous of others Too critical of others Feel too guilty for what they have failed to do Get irritated or annoyed too easily Find it hard to show affection to others Too easily lose a sense of self when around strong-minded people Worry too much about others' reactions to them Let others take advantage of them too much Open up to others too much Feel too responsible for solving other people's problems Put the needs of others before own too much Too afraid of others Too dependent on others Too easily persuaded by others Too independent Too sensitive to criticism or rejection Too suspicious of others Try to control others too much Try to please others too much	

Want to be noticed too much Find it hard to believe that others will find them lovable	

Appendix B: IPAF Typology

Indicate using the Likert scale the extent to which each IPAF type as a whole is like the patient's IPAF. Then circle the category that best characterizes the IPAF. If it is impossible to select one category due to lack of detail or excessive overlap between categories, select "unclassifiable" and note the reason(s).

Hostile-Dominant	**Friendly-Dominant**
• Get irritated or annoyed too easily • Try to control others too much • Find others intrusive • Too independent- hard to rely on others or have others depend on them • Often upset or angered by others' lack of consideration for them • Too easily bothered by the demands of others • Too envious or jealous of others • Find it hard to put needs of others before own • Find it hard to make a long-term commitment to others • Too aggressive toward others • Too critical or suspicious of others • Find it hard to say sorry	• Feel they are "too much" for others • Find it hard to spend time alone • Try to please others too much • Feel others are less committed to relationships that they are • Easily become over-invested in romantic relationships • Want to be noticed too much • Open up to others too much • Feel too responsible for solving other people's problems • Feel too guilty for what they have failed to do • Feel too sensitive to criticism or rejection • Worry too much about others' reactions to them

Not at all like IPAF		Somewhat like IPAF			Very much like IPAF		Not at all like IPAF		Somewhat like IPAF			Very much like IPAF	
1	2	3	4	5	6	7	1	2	3	4	5	6	7

Hostile-Submissive	**Friendly-Submissive**
• Find it hard to trust others • Find it hard to open up or to express feelings to others directly • Find it hard to feel close to others • Find it hard to show affection to others • Find it hard to be self-confident or assertive with others • Find it hard to let others know what they want • Feel dismissed, ignored or excluded by others • Hard to feel a sense of belonging or being wanted • Feel the judgement of others strongly • Find it hard to feel comfortable around others • Feel embarrassed in front of others too much • Too afraid of others • Find it hard to get along with others • Find it hard to socialize or make friends • Find it hard to relax and enjoy going out with others • Find it hard to join new groups or introduce self	• Find it hard to say “no" to or make reasonable demands of others • Put the needs of others before own too much • Too easily persuaded by others or easily lose a sense of self • Feel taken advantage of too much • Find it hard to feel or express anger • Find it hard to confront others with problems • Too dependent on others for help • Find it hard to feel good enough compared to others • Hard to believe others will find them lovable • Act like a child too much • Find it hard to feel or act competent as a parent

Not at all like IPAF		Somewhat like IPAF			Very much like IPAF		Not at all like IPAF		Somewhat like IPAF			Very much like IPAF	
1	2	3	4	5	6	7	1	2	3	4	5	6	7

Unclassifiable ☐ *reason……*

Appendix C: IPAF Typology: Notes for use

The typology is designed to be used by DIT clinicians to help formulate the interpersonal affective focus (IPAF) formulation (session 4). Its purpose is to provide a classification tool that helps the therapist in capturing the particular problematic interpersonal style for which the patient is seeking treatment.

During the formulation of the typology, it was noted that two items occurred across all categories. These items may be present in any of the four categories: feel others are neglectful, feel others are unavailable.

Steps 4 and 5 of the DIT formulation aide-memoire (Lemma et al, 2011, p113) will be relevant in considering how the dimensions of the IPAF might be categorized. How does the patient experience himself in relation to others and how is that meaningfully connected to the affect which is linked to activation of the recurring pattern? Next, what is the defensive function of the recurring pattern? Ideally, the clinician should explore the defensive function with the patient to ensure that it is fully integrated within the IPAF. The user should consider what is defended against, rather than the defensive behavior alone, when selecting a category. For example, the patient may describe a friendly-submissive interpersonal style themselves, yet the clinician notes hostility. In this case, the clinician should decide whether hostile-submissive is a better descriptor. The exact IPAF formulation can and will vary somewhat within categories, but a self, other, affect and defense examples typical of each are summarize below.

In a HD IPAF, the self is described as independent, controlling and easily bothered by the demands of others and/or critical or suspicious of the other. The other may be described as annoying, intrusive, inconsiderate or needy. The affect may be irritability or superiority defending against a fear of intimacy.

In an FD IPAF, the patient may describe themselves as too much a pleaser, overly invested in relationships or an over-sharer. The other may be described as rejecting, less committed or critical. Affect may be related to shame or panic related to loss of the others

attention, defending against feelings of frustration and aggression towards the other because others do not care or support for the patient as he/she cares for or supports them.

In a FS IPAF, the self may struggle to make reasonable demands or prioritize themselves. They may feel overly dependent, incompetent, or unlovable. The other may be experienced as taking advantage, difficult to confront or in greater need. Affect may be feelings of impotence or anxiety about not being good enough. The defensive function of this constellation is to defend against feelings of frustration and aggression towards the other because they are felt not to provide the love and support the patient feels entitled to receive.

In a HS IPAF, the self may find it difficult to be open, trusting, self-confident or to show affection. They may find themselves uncomfortable, embarrassed or afraid around others. The other will typically be felt as judgmental, dismissing or excluding. Affect may be around feelings of shame or withdrawal and defenses may be against their negative feelings about others.

In some cases, it may not be possible to classify the IPAF. First, the IPAF may lack the detail or explicit discussion between the patient and the clinician that would allow a category to be selected with confidence. Secondly, the IPAF may contain items from multiple categories to such an extent that one category cannot be selected. The rater should then select “unclassifiable” and note the reason. This also includes instances where the patient appears to have two opposite IPAFs.

Rater should

(I) indicate using the Likert scale the extent to which each category as a whole describes the IPAF

(II) identify which category best describes the IPAF

(III) if unable to select one category, note the reason(s) why.

Appendix D: Comparison of qualitative analysis and Gurtman's (1995) analysis

For the friendly-dominant type, both our analysis and Gurtman's (1995) identified being overly responsible or overly involved, difficulty being alone, being overly revealing or self-disclosing, trying to please others too much, being overly reactive and wanting to be noticed too much. The inductive themes identified (feeling too much for others, overly investing and feeling less committed in relationships) were very much in keeping with Gurtman's cluster titled "overly-intimate".

For friendly-submissive, both our analysis and Gurtman's identified difficulty expressing anger or aggression, excessive dependence, difficulty prioritizing one's own needs or setting limits, being easily taken advantage of or overwhelmed by others, and difficulty feeling good enough or superior to others.

The hostile-submissive type was almost identical to the hostile-submissive quadrant description, although some additional specific themes around feeling ignored, excluded, unwanted, or judged were identified. These are in keeping with Gurtman's "distrust/lack of intimacy" cluster. Both describe a pattern of social anxiety and avoidance, coldness, and lack of intimacy.

The hostile-dominant type was also closely matched, describing aggression or irritation with others, a need for control and independence, difficulty putting the needs of others before one's own or making commitments to others, and feeling suspicious or jealous of others. The inductive themes identified (finding others intrusive or lacking in consideration and having difficulties saying sorry) are comparable to Gurtman's hostile-control cluster.