Practice-Based Psychotherapy Research in a Public Health Setting: Obstacles and Opportunities

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CITATION
Mental health care providers have been charged with the task of generating more evidence to support the quality and efficiency of their treatment practices. Health care policies are beginning to enforce the implementation of prescriptive treatment protocols with demonstrated efficacy for specific conditions. Psychotherapy treatment models designed for and evaluated in rigorously controlled experimental settings are frequently considered the hallmark of evidence-based practice. Experimental trials of psychotherapy brands have identified efficacious treatments for a number of specific conditions. However, the current experimental procedures for evaluating a specific treatment model may not be enough to account for the range of patients and challenges found in community practice settings. Clinicians express reservations that many research investigations do not address their most important concerns. Thus, clinical researchers are charged with the task of implementing research protocols of greater clinical utility. Public health practice settings offer numerous opportunities for joining clinical research and practice. However, implementing programmatic psychotherapy research in clinical practice settings presents a number of obstacles. In this article, a case example of implementing a research protocol in a public health safety-net hospital is the lens through which these obstacles are identified and possible solutions investigated. Experience gaps, financial constraints, design flaws, organizational culture, and clinician resistance are barriers to the implementation of practice-based psychotherapy research. With motivated efforts and creative problem solving, these barriers can be removed, opening an avenue for the advancement of practice-informed research and research-informed practice.

**Keywords:** practice-based research, safety-net hospital, effectiveness design, public health, psychodynamic psychotherapy research
Questions about the quality and effectiveness of clinical care have become paramount in many Western countries as the cost of health care continues to soar (Friedman, 2014; Ham, 1998; Kennedy, 2014; Levay & Lachman, 2005; Levy et al., 2014). Public health clinics are urged to evaluate and improve their treatment services as well as implement briefer and more targeted evidence-based practice interventions (Levy et al., 2014). While greater standardization, treatment effectiveness, clinical accountability, and cost-effectiveness is a valued priority for administrators, policymakers, clinicians, and patients alike, complexities arise when determining what evidence is considered acceptable. In the field of psychotherapy, some researchers suggest that clinicians are not well-enough trained in empirical research methods or evidence-based treatment models (e.g., Baker, McFall, & Shoham, 2009). On the other hand, many clinicians and researchers raise concerns that existing research methods do not adequately address treatment-related challenges and do not always reflect real-world clinical practice (e.g., Beutler, 2009; Busch et al., 2001; Morrison, Bradley, & Westen, 2003; Persons & Silberschatz, 1998; Westen, Novotny, & Thompson-Brenner, 2004). To better address clinical practice concerns, implementing research in clinical practice settings (Atkins, Frazier, & Cappella, 2006; Hohmann & Shear, 2002; National Institute of Mental Health, 1999; Wells et al., 2006) is essential. This article will discuss the design and implementation of a psychotherapy research project in a long-term psychodynamic therapy clinic treating traditionally underserved populations. This effectiveness-focused research design allows for the inclusion of extensive clinical data available in a real-world treatment setting. In this public-health hospital setting, patients are not excluded on the basis of comorbidity nor is length of treatment arbitrarily defined (rather, it is clinically determined). This review seeks to identify challenges to implementing psychotherapy research in this setting as well as to propose possible solutions for addressing obstacles.

**Randomized Control Trials: Gold Standard or Metallic Alloy**

Randomized control trials (RCTs), in which patients are randomly assigned to either a treatment or no-treatment condition, have generally been considered the gold standard for determining which psychotherapy models are awarded the “evidence-based treatment” title (Chambless & Hollon, 1998). The importance of RCTs in clinical research is hardly a matter of debate (Chambless & Ollendick, 2001; Norcross, Beutler, & Levant, 2006; Wampold, 2001; Westen, 2007) and some studies utilized RCTs effectively in clinical settings (e.g., Whipple et al., 2003, where half of a therapist’s caseload completed feedback forms and half did not; Tai et al., 2010, where motivational interviewing/enhancement therapy was implemented in some substance abuse treatments and not others; Costunguay et al., 2010a, where either both therapist and client reported helpful and hindering events from each therapy session or only the therapist did). However, RCT methodology is one constituent in a larger network of psychotherapy research methods for evaluating evidenced-based practice (Levant & Hasan, 2008; Levy et al., 2014). Just as creating a metallic alloy enhances the properties of its base element (e.g., iron into steel), the science of psychotherapy is enhanced by augmenting RCT findings with evidence from other established methods of outcome evaluation (e.g., effectiveness designs, qualitative methods, empirical single-case evaluations, and multitrait/multimethod assessment practices). As with any single research design, some trade-offs are inherent in psychotherapy RCTs (Hilsenroth, 2007; Hohmann & Shear, 2002; Sandell, Blomberg, & Lazar, 1997; Westen et al., 2004; Wisniewski et al., 2009). While RCTs provide greater confidence in causal linkages of specific interventions to therapeutic change, threats to internal validity of the experiment include the amount of time elapsed, patient heterogeneity, and therapist flexibility. RCT methodology is intrinsically slanted toward short-term models of treatment for patients with milder, less chronic forms of mental illness. Often stringent and narrowly defined exclusion criteria screen out cases seen more frequently in clinical practice, such as patients with multiple Axis I disorders, concomitant substance use, and/or comorbid personality disorders. Patient treatment preferences have a considerable impact on treatment outcome (Kocsis et al., 2009; Papakostas, 2009; Raue, Schulberg, Heo, Klimstra, & Bruce, 2009), a factor that RCTs, by
design, fail to take into consideration. The American Psychological Association (APA) now recognizes patients’ treatment preferences as an essential component of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006). Finally, RCTs’ treatment lengths typically range from 6 to 20 sessions which is drastically shorter than psychotherapies practiced in the community.

In contrast, mental health setting departments in public service settings are an opportune environment for generating clinically representative effectiveness research (Association of Schools of Public Health, 2008; Hohmann & Shear, 2002; Sandell et al., 1997). These clinics often offer long-term treatment services to diverse individuals with complex and persistent mental illness. Louis Castonguay (Castonguay, 2011, 2013; Castonguay et al., 2013) advocates for the integration of evidence-based research with practice-oriented research (POR) to conduct research that is relevant to clinicians. POR studies feature naturalistic settings and are based on standardized measures as part of routine clinical practice.

Our study too aimed for this type of integration with these two features; however, we discovered that implementing programmatic outcome research in our setting presented many challenges, none of which are unique to our institution. With reimbursement for treatment services dropping, practitioners must take on increased caseloads, work longer hours, and provide briefer sessions/treatment only to be faced with a cascade of consequent administrative paperwork. Infrastructure for psychotherapy research in these settings rarely exists and is difficult to construct with department resources strained in terms of time, budget, and personnel. Studying psychotherapy as practiced in the field generates unique challenges requiring flexible and innovative methodological solutions. The tension between the necessity of generating clinical research under representative conditions and the challenges faced in implementing such research is underlined in the APA Presidential Task Force on Evidence-Based Practice (2006) that recommends identifying and addressing barriers to conducting therapeutic processes in the field (a goal of this article).

There are those (e.g., Goldfried, 2013) who advocate for closing the gap between research and practice and have dealt with this tension successfully. Castonguay et al. (2010b) created practice-research networks (PRNs). Garland, Plemmons, and Koontz (2006) created the Practice and Research: Advancing Collaboration (PRAC) Project. These systems consisted of academic researchers and private clinicians collaborating to produce research that is both scientifically rigorous and clinically meaningful. Similarly, Curtis McMillen, Lenze, Hawley, and Osborne (2009) created practice-based research networks (PBRNs). While PBRNs can consist of private practitioners, they can also include (or be solely comprised of) a collection of community mental health centers. Often an academic center provides the initial funding and is the home of data and staff. (Tai et al., 2010, created the National Drug Abuse Treatment Clinical Trials Network (CTN) that utilizes an academic center and community-based treatment programs).

While a PBRN might be a goal for the future of our research, we face some obstacles at this point: (a) creating a PBRN will take more time than any of us have, especially as research is not a financially reimbursed activity for involved staff; (b) many PRNs utilize private clinicians, but the PFP is a public clinic with limited finances and personnel; (c) many PRNs utilize academic researchers, but we do not know of any psychodynamic psychotherapy research occurring at the CHA-affiliated academic institution (and wonder if a research team would invest in this with no prior interest on its part and no current funding on our part); and (d) PRN/PBRNs consist of researchers and practitioners who work collaboratively, but focus on their own activities; however, our researchers and clinicians are one and the same. Despite these obstacles, perhaps with time and planning we will be able to connect with researchers at our academic institution and directors of other clinics affiliated with this institution and create a PBRN.

Implementing Practice-Based Psychotherapy Research: A Case Example

Setting

The Program for Psychotherapy (PFP) is a long-term adult psychotherapy clinic at the Cambridge Health Alliance (CHA), a public
safety-net hospital in the Northeastern United States. Safety-net hospitals are characterized by “open door” policies in which patients are accepted for care regardless of their ability to pay. Many of their patients are low-income with federal- or state-funded insurance or no insurance (Bazzoli, Kang, Hasnain-Wynia, & Lindrooth, 2005; Forrest & Whelan, 2000; Huang, Silbert, & Regenstein, 2005; Mann, Melnick, Bamezai, & Zwanziger, 1995). The PFP serves its city of locale and surrounding towns including local universities, providing treatment for patients with diverse diagnoses, ethnicities, socioeconomic backgrounds, and sexual orientations. Exclusion criteria include current substance abuse, active suicidality or violence, or flagrant psychosis. Patients at high risk of harm to self or others are referred to other psychiatric teams in the hospital with greater access to medical, case management, and emergency services. Still, a number of PFP patients struggle with low-risk forms of substance abuse, chronic mental illness, and passive suicidal ideation as well as more severe risk issues that emerge during the course of treatment. The PFP is a training site incorporating 8 to 10 Fellows (postdoctoral psychology trainees, postgraduate social work trainees, occasional fourth-year psychiatry residents) who are immersed in the advanced study and practice of long-term psychodynamic psychotherapy. In this project’s infancy, patients of other PFP clinicians (licensed psychologists and social workers) participated in the research, but because of a reorganization of the hospital that eliminated these positions, research became limited to psychology and social work fellows’ patients and has continued that way presently (despite occasional psychiatry residents and the regeneration of licensed clinicians). At the time of this writing, data collection has yielded 273 intake packets, 87 three month follow-ups, 72 six month follow-ups, 38 twelve month follow-ups, 26 eighteen month follow-ups, 1 twenty-four month follow-up, and 53 posttermination follow-ups, for a total of 550 data points.

Goals

Research goals included: (a) systematic description of patients seen in the PFP, (b) assessment of both reliable and clinically significant changes in patients’ symptomatology and adaptive functioning over the course of treatment, (c) identification of patient factors related to treatment adherence and outcome, (d) examination of therapists’ treatment fidelity and process factors related to outcome, and (e) effect size comparisons with findings from other psychotherapy research benchmark studies.

Procedure

Clinicians call new patients to schedule 2 hr initial appointments: the first hour to complete questionnaires and the second to meet with the therapist. Patients then receive a call from a Research Assistant (RA) informing them about the study. When patients register for their first appointment, they are given a packet of self-report questionnaires that clinicians have earmarked for their new patients. Patients return completed packets to either registration staff or the therapist. If patients have not completed the packet before meeting with the therapist, the therapist offers them the choice to finish the packet after the session or at home and return it at the next session.

A letter about the study is included in the packet. If interested, patients sign two IRB-approved consent forms: one giving permission for their completed measures to be used for research purposes and the other giving permission to be contacted for follow-up. Only data from consenting patients is used for research. Patients are explicitly informed that participation is voluntary and that there will be no adverse effect for their treatment should they decline to participate. Patients are informed that their therapists will see their initial packets, but not their follow-up responses. Questionnaires from nonparticipating patients are used for clinical feedback only. Clinicians also complete IRB-approved consent forms before being asked to provide data on their patients. Both patients and therapists receive follow-up assessments via online surveys (patients can request paper packets), which they complete at 3 months and 6 months into treatment, and every 6 months thereafter. Follow-up data is collected within 4 to 6 weeks of therapy termination. Although this may seem a short time posttermination, our experience has shown with our population that a longer time interval significantly
decreases the number of participants who complete our measures. Initially, patients were not reimbursed for participation. With the acquisition of grants, patients were reimbursed for completing follow-up/termination measures (but not the initial packet because it is part of the intake protocol). Offering reimbursement significantly increased the rate of participation.

**Measures**

Patients and therapists are administered measures designed to assess multiple aspects of symptomatology, physical health, adaptive functioning, personality traits, and therapy process. The first prompt in the initial questionnaire packet is: “Please describe briefly what led you to seek treatment.” This open-ended prompt allows patients to describe primary concerns in their own words. Patients also provide basic demographic and treatment history information. Socioeconomic status is measured with both subjective (ranking of self-status within community) and objective (education/income/occupation) patient ratings on the MacArthur Network’s Sociodemographic Questionnaire (Adler, Epel, Castellazzo, & Ickovics, 2000; MacArthur Network on S. E. S. and Health, 1998). Psychiatric symptoms are assessed with the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). The Multi-Dimensional Health Profile (Ruehlman, Lanyon, & Karoly, 1999) measures physical health, medical service utilization, and health habits. The Schwartz Outcome Scale (Blais et al., 1999) is used to assess psychological health and well-being. Five-Factor Model personality traits are measured using the Ten-Item Personality Inventory (Gosling, Rentfrow, & Swann, 2003). Information covering a range of social/occupational/interpersonal functioning is collected with the Inventory of Interpersonal Problems-32 (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), Social Adjustment Scale (Weissman, 1999), Bell Object Relations Inventory O-form (Bell, Billington, & Becker, 1986), and Experiences in Close Relationships-short form (Wei, Russell, Mallinckrodt, & Vogel, 2007).

At follow-up, patients are asked to supply data related to clinical process, outcome progress, and quality of the therapeutic relationship. In addition to the measures above, patients complete the Comparative Psychotherapy Process Scale (DeFife, Hilsenroth, & Gold, 2008; Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005), the Combined Alliance-Short Form (Hatcher & Barends, 1996), and Patient Estimate of Improvement (Hatcher & Barends, 1996). Patients also provide qualitative descriptions of what they like most and least about their therapies. Therapists are asked to complete the Comparative Psychotherapy Process Scale, Combined Alliance-short form, Diagnostic and Statistical Manual for Mental Disorders-Fourth Edition (DSM–IV) diagnosis, and the Therapist Response Questionnaire (also known as the Countertransference Questionnaire; Betan & Westen, 2009). Partway through the research, Axis I and Axis II Prototypes (Westen & Shedler, 1999; Westen et al., 2010) were added to gather clinicians’ descriptions of patients’ personalities.

**Obstacles and Possible Solutions**

**Experience.** Training and experience in both empirical research methods and clinical practice are important to consider in building a practice-based research team. Most full-time therapists choose clinical practice because of their primary interests and abilities (Lampropoulos et al., 2002) as do academic research scientists. Individuals who invest time in both clinical research and practice do exist, albeit in small numbers (Westen, 2007). Many practicing therapists have not had graduate research training for a long time, if at all; practicing researchers may not have conducted psychotherapy since accruing clinical hours needed for internship and licensure.

Ideas for bridging the knowledge gap include: forming collaborative relationships between academic researchers and community clinicians; clinicians attending research method educational offerings; researchers opening small clinical practices or seeing a few patients through local counseling centers; hiring research employees in clinical settings; recruiting recent graduates of clinical research training programs; and journal reading seminars with discussion of relevant research articles. The PFP has addressed this knowledge gap in several ways. Before implementing this research, the directors consulted with psychiatry department leadership who expressed support
for this project; they then consulted with established clinician-researchers and attended intensive research training (as Fellows in the American Psychoanalytic Association’s Research Training Program). With the department’s support, five paid research hours were added to the PFP fellowships. A weekly research meeting was established in which to discuss pragmatic and didactic concerns and fellows became involved with both administrative tasks and generating research questions. Initially there was funding for a part-time research director with prior research experience. When she left, the position was eliminated in the budget. A graduate student at a local university then volunteered as an RA and with the first grant, a paid RA was hired. As soon as data was generated, the group began exhibiting posters at professional conferences that are the basis for some manuscripts-in-progress.

Design. Clinicians and researchers need to learn from each other. For example, therapists tend to value process-outcome studies, item-level data, information about the therapeutic relationship, periodic assessment of progress on specific treatment targets, and posttermination follow-up (Lueger, 2002) and research has found that providing therapists and patients feedback from quantitative case formulation and outcome data improves therapeutic alliance, treatment retention, and outcome (Hilsenroth, Peters, & Ackerman, 2004; Lambert, Whipple, et al., 2001; Lambert, Hansen, & Finch, 2001). Therapists explain that their patients seek psychotherapy for reasons other than just psychiatric symptom reduction, including insight for/resolution of recurrent relational, financial, and occupational difficulties, and coping with trauma and losses (DeFife, Goodman, Drill, & Beinashowitz, unpublished data). Clinicians also report treating patients for reasons not adequately addressed by DSM criteria, particularly enduring personality problems related to self-concept, interpersonal relatedness, relational intimacy, occupational functioning, and affect regulation (Westen, 1997).

As researchers integrate input from their clinical colleagues, they are charged with the difficult task of identifying or developing process measures that operationalize salient aspects of the therapeutic relationship and outcome measures that assess the functional domains that matter to clinicians and patients (Siefert & DeFife, 2012; Siefert, DeFife, & Baity, 2008; Westen, 1998). However, experimental methodology is difficult to implement in practice settings. Most clinics cannot implement randomization and would have difficulty conducting accurate intent-to-treat analyses or creating standardized treatment conditions. Effectiveness designs can be improved with the integration of some adaptation of experimental methods. Despite the many advantages of
psychotherapy effectiveness designs (Kazdin, 2008), the inclusion of some form of comparison group can complement the interpretation of outcome results. As an alternative to comparison groups, effectiveness studies can look to benchmark figures to address questions about their treatment’s comparative efficacy (Eisen & Dickey, 1996). Benchmarks can be generated at other clinical departments within the same setting or other clinics (though these may face the same implementation obstacles, not be available, or be too heterogeneous for an accurate comparison). Outcome benchmarks are perhaps most efficiently obtained from published psychotherapy research including effectiveness studies, RCTs, or meta-analyses (Hunsley & Lee, 2007; Levy et al., 2014). To improve the accuracy of comparison, a practice-based research protocol should include some commonly utilized and studied outcome measurements (Siefert & DeFife, 2012).

In addition, some clinics do not have the resources to create the infrastructure needed to collect patient data. However, measurements need not be based entirely on patient-report. Clinicians demonstrate high reliability and validity with patient-report data in areas such as adaptive functioning, symptomatic impairment, clinical history, and quality of social/occupational/developmental relationships (DeFife, Drill, Nakash, & Westen, 2010; Hilsenroth et al., 2012).

An ideal psychotherapy effectiveness study would obtain detailed, reliable, and clinically relevant data at regular intervals from multiple sources including the patients and people who know them well, therapists, and external observers of therapy sessions. Although information from all of these sources may not be possible to obtain, some may be. The PFP was able to build the infrastructure to collect both patient and clinician data. Measures were chosen for their psychometric reliability, range of therapeutic outcome domains, balance of comprehensiveness and manageable time constraints, and cross-method convergence between patient and therapist ratings as well as their ability to capture what clinicians want to learn about their patients.

Organizational culture. Implementing new procedures is a challenging task for organizations. Changes to the status quo can produce negative states: anxiety, conflict, resistance, confusion, frustration, and animosity. These reactions become heightened when change is implemented from outside the group. Establishing interpersonal attachments and group belonging is a primary motivation for human behavior (Baumeister & Leary, 1995; Bowlby, 1969), and workplaces with greater cohesion and relationships produce more, reduce turnover, and increase job satisfaction (Morrison, 2004). Cultural consonance (the degree to which individuals share the beliefs and behaviors of their surrounding culture) contributes to psychological health and well-being (Dressler, Balieiro, Ribeiro, & Dos Santos, 2007).

The PFP has always had a vibrant clinical atmosphere, but for years research was nonexistent. When the decision was made to initiate a research project, the originators did not want this to be an activity simply imposed by the “leaders” onto the clinicians. They hoped that the research would become a vital part of the clinic and helpful to clinicians. In a meeting for all clinicians, the originators described their vision and asked clinicians what they would like to know about their patients so that these ideas could be incorporated into the project. Discussions were held with administrative staff to understand how much support they could lend to the project (e.g., collecting questionnaires from patients). A weekly fellows’ research meeting was established as a forum for logistics, didactics, and brainstorming. As the research continued, fellows began to feel more ownership that has resulted in the research now being an integral part of the clinic and fellowship.

Clinician resistance. Divergence from common clinical practice and values can be difficult; resistance to new practice and research methods occurs in practitioners across modalities and across disciplines (Gold, 2005; Hemmelgarn, Glisson, & James, 2006; Hohmann & Shear, 2002; Lampropoulos et al., 2002). What concerns do clinicians have about implementing psychotherapy research with their patients? The concerns of PFP clinicians were not notably different from those previously identified by other therapists and researchers. Clinicians’ most frequently stated concern is that psychotherapy research as currently conducted bears little resemblance to their practices. Consequently, when therapists do enter the initial stages of implementing research, they often get
caught up in trying to operationalize too many broad concepts or consider every possible individual difference, as if the perfect research study needs to be designed to capture all the complexities of the clinical process. Therapists also worry that researchers will use research findings and treatment protocols to create strict mandates which will dictate clinical practice, a concern which bears some realistic merit (cf. Baker et al., 2009).

Other clinicians describe concerns that asking patients to participate in research and completing questionnaires is intrusive and detrimental to the therapeutic frame (Busch et al., 2001). However, clinical research is generally less intrusive than clinicians fear, and patients actually find therapeutic benefits in the process (e.g., Hilsenroth et al., 2004; Marshall et al., 2001).

A concern often unarticulated by therapists is the anxiety generated from having one’s therapeutic performance evaluated (Alpert, 1996; Josephs, Anderson, Bernard, Fatzer, & Streich, 2004; Lampropoulos et al., 2002; Luenger, 2002), specifically what would it mean if one’s patients were not improving. Evaluation fears, if unchecked, can create many obstacles in a therapist’s development. As with most biases and fears, exposure alleviates anxiety and conflict (Foa & Kozak, 1986). Involving clinicians in research tasks such as IRB coordination, patient tracking, data entry, and professional presentations creates a sense of involvement and ownership of the project (Goldfried et al., 1999). Sensitive and knowledgeable mentors can demonstrate how psychotherapy research (both the experience of conducting research and learning from the literature) can improve practice without creating rigid prescriptions or harsh condemnations. Patients do not often report feeling unduly burdened by completing questionnaires (even as some tasks/questionnaires can be considered tedious), and quite often express interest and curiosity (encouraging qualities to find in any patient seeking psychotherapy; Conte et al., 1990; McCallum & Piper, 1990; McCallum, Piper, Ogrodniczuk, & Joyce, 2003). Therapists see that their therapeutic relationships are rarely disrupted and are, in fact, more frequently improved. Over time, the practice-based research protocol becomes common practice and forms a new part of the organizational status-quo (Marshall et al., 2001).

The PFPs experience parallels the descriptions above. While clinicians were initially hesitant to embrace the implementation of research in the clinic, some of the following seemed to help: We implemented a weekly research meeting to trouble-shoot logistical issues, discuss occasional journal articles, generate research questions, and report results. This venue provided fellows the opportunity to become involved with essential administrative tasks and generate research questions (both of which helped fellows feel ownership of the project). It also exposed the fellows to clinician-researchers who valued both activities. In addition, clinicians saw that the research did not dictate the therapy, as the naturalistic therapy is what we are interested in studying. Clinicians are not responsible for asking their own patients to participate in the research because we did not want patients to feel even subtlety coerced into agreeing to participate. This seemed to ease therapists’ worries that asking patients to complete measures would be an intrusion in the therapy. With time, therapists saw that patients were not resistant to completing questionnaires and, in fact, were often interested in the measures and the study. Clinicians came to see that not only was their performance not evaluated, but, as promised, when looking at follow-up data, both patients and therapists were anonymous. As we began to exhibit posters, fellows witnessed their work coming to fruition which fueled enthusiasm for the research. Today fellows are actively involved in all aspects of the research.

**Preliminary Findings**

Preliminary findings are presented below. More detailed findings will be reported in future publications. It is reassuring to know that the hard work of implementing this research paid off, as the findings we are getting are both interesting and significant.

Patient-identified descriptors from the first 199 packets: Age: 19–64 years old ($M = 38$); ethnicity or race: 72.8% White, 6.8% Latino, 6.2% multiethnic/multiracial, 4.9% Black, 1.9% Black (not of Latino origin), 1.2% Asian American; sexual orientation: 73% heterosexual/straight, 9.5% bisexual, 6.7% homosexual/gay/lesbian, 6.08% gave very specific responses, and several others gave responses that would
each be its own category (the reporting of which would be too lengthy for the purposes of this article); education: 32.7% college; 24.4% some college, 18.5% some graduate school; 14.3% high school; 3.6% some high school; income: 74.85% <$35,000 (16.6% <$5,000; 12.3% $5,000–$11,000; 10.4% $12,000–15,000; 18.4% $16,000–$24,000; 17.2% $25,000–$34,000), 8% $35–$49,000, 6.8% $50,000–$74,000, 1.8% $75,000+.

Therapist-identified descriptors at 3-months: GAF: 40–69 (M = 58); comorbidity: 77.6%; Axis I diagnoses: 50% depressive disorders, 21% anxiety-related disorders, 9.2% adjustment disorders, 6.6% posttraumatic stress disorder, 4% bipolar disorders, 4% eating disorders, 2.6% substance abuse disorders, 1.3% attention deficit hyperactivity disorder/disruptive behavior disorders, 1.3% impulse control disorders; Axis II diagnoses: 50% deferred, 20% none, 5.7% histrionic features, 5.7% avoidant features, 4.3% narcissistic features, 2.9% dependent features, 2.9% depressive features, 2.9% borderline personality disorder, Cluster B features 1.4%. Cluster C features 1.4%. (When clinicians completed Axis II prototypes, Borderline Personality rose to 9.7%, suggesting that clinicians are more comfortable “describing” their patients than diagnosing their patients with formal personality disorders. This may still be underreporting, as the prototype measure was added to clinicians’ surveys partway through the research; thus, not all patients were included.)

A combination of HLM and traditional data analyses revealed that our patients do get better. With HLM, the best fitting growth curve model showed that symptom trajectories (as measured by the BSI) from intake to 12 months were characterized by logarithmic change, $\gamma = -0.02$, $p = .004$, showing decreasing symptoms over time and indicating that symptoms declined more quickly in treatment. Traditional data analysis revealed differences among subgroups: patients with initial high anxiety showed significant improvement at the 3 month follow-up, $t(16) = 3.24, p < .01$, which was a greater improvement than patients with initial moderate or low anxiety, $F(2, 57) = 11.05, p < .001$. Further, there is an overall increase in relational and occupational functioning (as measured by the SAS where lower score signifies better functioning) from intake to 3 months (intake $M = 2.13, SD = 0.51$; 3 month follow-up $M = 1.82, SD = 0.62; t(60) = 3.84, p = .000$) and from intake to termination (intake $M = 2.13, SD = 0.51$; termination $M = 1.90, SD = 0.45; t(43) = 3.20, p = .003$).

As expected, because of the PFP’s psychodynamic treatment/training, patients reported more psychodynamic-interpersonal process ($M = 3.76, SD = 1.01$) than cognitive–behavioral process ($M = 1.92, SD = 1.06$), $t(1,302) = 30.53, p = .000$. Therapists did too: psychodynamic-interpersonal ($M = 4.26, SD = .66$); cognitive–behavioral ($M = 1.22, SD = .68$), $t(1,366) = 55.49, p = .000$.

HLM was used to examine whether stable patient characteristics at intake (demographics and attachment style) predicted symptom presentation at intake or symptom change during treatment. Single predictor models tested whether individual characteristics predicted either baseline symptom level or symptom change. No significant difference was found in baseline symptom level or symptom change by gender, age, or income. Those with higher education levels, however, had significantly lower baseline symptom levels ($\gamma = -0.04, p = .04$), but were not significantly different in rate of symptom change. Those self-identifying as an ethnic/racial minority had higher baseline symptom levels than white patients ($\gamma = .39, p = .004$), but showed no differences in rates of symptom decline.

Attachment orientation did significantly relate (with one case being a trend) to both baseline symptoms and change: anxious ($\gamma = .17, p < .001$), avoidant ($\gamma = .09, p = .058$), and anxious/avoidant ($\gamma = .08, p < .024$) attachments all predicted more severe initial symptoms. Only those scoring higher on both anxious and avoidant attachment had flatter symptom decline ($\gamma = .15, p = .001$), indicating slower rate of improvement, than those who were low on both attachment characteristics.

**Future directions.** We continue to analyze our data at different time points utilizing more measures. For example, one current project studies the relationship of patients’ attachment styles (as measured by the ECERS) and object relations (as measured by the BORRTI) to therapists’ countertransference (as measured by the TRQ) and its effect on outcome.
Conclusions

Clinicians and researchers ultimately seek the same goals: to understand and describe human behavior, allocate health care resources equitably and economically, and deliver the highest quality patient care. Public health care systems in particular are in need of practice-based research projects to demonstrate the effectiveness of treatment and find solutions for increased cost-effectiveness in economically strained times. In these settings, researchers have the opportunity to produce meaningful solutions for diverse populations under clinically representative conditions. Quantitative, qualitative, and clinical observations are basic elements with unique properties, strengths, and weaknesses. Only through their combination can we achieve a stronger, more complete approach to both the practice and research of psychotherapy, but the integration does not happen without significant contributions of energy, intellect, and financial resources. Interest and curiosity are just catalysts in designing and executing a successful research project. If not properly attended to, experience and education gaps, financial constraints, design flaws, and clinic culture can prevent a project from getting off the ground. Clinicians and researchers can, and may ultimately need to, collaborate and overcome these obstacles in a true movement toward practice-informed research and research-informed practice.

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