What Works, When, and Why: An Outcome Study of Psychodynamic Psychotherapy
Rebecca Drill, Jack Beinashowitz, Ora Nakash and Dennis Plant

J Am Psychoanal Assoc 2006 54: 1353
DOI: 10.1177/00030651060540040112

The online version of this article can be found at:
http://apa.sagepub.com/content/54/4/1353
WHAT WORKS, WHEN, AND WHY: AN OUTCOME STUDY OF PSYCHODYNAMIC PSYCHOTHERAPY

Rebecca Drill, Jack Beinashowitz, Ora Nakash, and Dennis Plant
(Department of Psychiatry, The Cambridge Hospital, Harvard Medical School)

There is currently a lack of adequate investigation into changes individuals make in psychotherapy within more naturalistic settings, particularly for long-term psychodynamic treatment. In addition, psychotherapy outcome researchers have typically pre-screened participants using arguably selective exclusion criteria that limit the generalizability of their findings to “real life” settings. We have designed a research project to help fill this gap.

Research Questions

The primary goals of this research are to (1) describe the patients seen in the Program for Psychotherapy (PFP), (2) assess change in patients’ symptomatology and functioning over the course of long-term
psychodynamic treatment, (3) explore what change can be attributed to the treatment intervention or, conversely, what lack of change can be attributed to it, and (4) compare our results with benchmark studies done using different psychotherapeutic approaches. We will discuss these goals in turn after a brief description of the Program for Psychotherapy, the setting in which this research will be conducted.

The PFP is a long-term adult psychodynamic psychotherapy clinic in the Outpatient Department of Psychiatry at the Cambridge Health Alliance. The PFP has traditionally been both a service and a training site and is now in the process of evolving to include a research program as well. The PFP services the Cambridge community and surrounding towns, as well as local universities, drawing patients age 18 to 65+ with a wide range of diagnoses and diverse ethnic and socioeconomic backgrounds. The training program includes psychiatry, psychology, and social work fellows who have all completed their formal graduate education and are immersed in advanced study of long-term psychodynamic psychotherapy. Other clinicians in the PFP are licensed psychologists, social workers, and clinical nurse specialists.

Given the breadth of the population the clinic serves and the nature of long-term psychotherapy, it has historically been a challenge to assess the characteristics of the patient population and evaluate the progress patients make in treatment. This study is one of the first to undertake this task by initially studying “who we actually see” at the clinic. To accomplish this goal, clinicians will be asked to be familiar with the SCID I and SCID II scales, which will inform their standard initial intake evaluation.

Patients report anecdotally that they “feel better” or describe ways in which they “get better” from their psychotherapy. This study will allow us to assess more carefully what these changes are (or are not) by having patients complete a series of standardized assessment tools widely used in research of this sort. Not only will we track patients’ progress of lack thereof; we will also note at what rate changes occur. For example, Howard et al. (1993) assessed pattern of change and found several stages: very soon after beginning therapy, patients experienced remoralization; some time later they experienced less distress accompanied by an improvement in symptoms; about a year later relationship changes were evident; and, much later, personality changes were evident.

We will also begin to explore connections between therapy and change. One aspect of therapy that has distinguished psychodynamic
psychotherapy from some other therapeutic approaches has been psychodynamic clinicians’ attention to the therapeutic relationship. Patients will be asked to complete the Working Alliance Inventory and to respond to an open-ended question asking what patients think is helpful or not helpful about their treatment. To ensure that what each clinician is doing is actually considered psychodynamic psychotherapy, therapists will be asked to complete the View of Therapy Q-Sort (Rohrburgh and Shoham 1997), which asks therapists about their views of therapy and sorts responses into different schools of thought.

Since we are not in a position to create a nontreatment control group at this time, as we consider it unethical to refuse therapy to some patients while offering it to others, we will compare our results to benchmark studies using other therapeutic modalities, (e.g., cognitive-behavioral therapy) and assessing both initial change and enduring change. We will ask patients to complete packets of questionnaires at four-month intervals.

Methods

Participants. There are two categories of participants in this study: (1) new patients coming to the PFP for their initial outpatient psychotherapy session (and then remaining as participants during the course of their treatment) and (2) the clinicians in the PFP. We expect to collect data on approximately 60 patients and 25 clinicians over the course of the next year. The therapists in training will be postdoctoral psychology fellows, psychiatry fellows, and postgraduate social work fellows supervised by a licensed psychologist, psychiatrist, or social worker. All other clinicians will have achieved independent licensure in their field.

Procedures. Therapists will receive information about this study in a group meeting with the primary investigators. At this session we will provide them an overview of the study goals and procedures and orient them to questionnaires that they will be asked complete if they choose to participate in the study.

All new patients will receive information about the study from their individual therapist once they set up their initial appointment. Potential participants will be asked to come in forty-five minutes before their first appointment and will be met by a research associate or fellow, who will give them a study packet describing the study. The
patient will complete the packet in the waiting room and return it to the research associate or fellow.

A follow-up letter will be sent to participants before the four-month follow-up to remind them about the study and prompt them to arrange a meeting with the research associate or fellow if they would like to continue their participation.

After receiving the data from both the patient and the therapist, we will combine them in a database, including only a subject ID number and the data. Information combining the name of the patient, the therapist, and the ID number will be kept in a separate file for any other studies we may conduct in which we may try to predict outcome based on patient characteristics at Time 1. The data and the disk on which the data are entered will be kept in a locked filing cabinet. A copy of the informed consent will be kept in a locked drawer as well. Only the primary investigators, co-investigators, and trained research assistants will have access to this file.

Measures. Patients will be asked to complete the Beck Depression Inventory II (Beck, Steer, and Brown 1996), Symptom Checklist–90 (Derogatis 1977), State Trait Anxiety Inventory for Adults (Spielberger, Gorsuch, and Lushene 1970), SF-12 (version 2) Inventory of Interpersonal Problems (Horowitz et al. 1988), Rosenberg Self-Esteem Scale (Rosenberg 1965), Working Alliance Inventory (Hovarth and Greenberg 1989), a health questionnaire (Ware, Kosinski, and Keller 1996), a question about what they find helpful or not helpful about their therapy, and a demographic sheet.

Clinicians will be asked to complete the Views of Therapy Q-sort and consult the checklists from the Structured Clinical Interview for DSM-IV, scales I and II (First et al. 1997a,b), as a guide when diagnosing patients.

REFERENCES


Rebecca Drill
Program for Psychotherapy
Macht Building
Cambridge Health Alliance
1493 Cambridge Street
Cambridge, MA 02139
Fax: 617–665–1744
E-mail: rdrill@challiance.org