

## **Effectiveness of Psychodynamic Psychotherapy With Older Adults: A Longitudinal Study**

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*Using a longitudinal, time-series design, this effectiveness study analyzed archival data collected as a routine part of clinical services and program evaluation at a community mental health clinic utilizing psychodynamic therapy with older adult clients (N = 106) in its Seniors Program. An empirical measure, the Outcome Questionnaire 45.2, was used to track progress and to examine the nature of change over time at 3-month intervals across 12 time points. The effect size was large (ES = .8) and participants showed little deterioration. Findings suggest that older clients can and do benefit from psychodynamic treatment offered in this format.*

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Despite increased attention to mental health and aging in the United States and evidence that older adults can make good use of psychological treatments with few age-related differences in outcomes, many geriatric mental health issues remain untreated and psychotherapy with older adults continues to be underutilized (Crystal, Sambamoorthi, Walkup, & Akincigil, 2003;

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Henderson, 2010; Hollon et al., 2005; Lynch & Smoski, 2009; Pincus, Duberstein, & Lyness, 2007). While recent literature reviews and meta-analyses of evidence-based psychological treatments for older adults have documented that cognitive-behavioral and reminiscence therapies—and, to a lesser degree, interpersonal therapy (IPT)—are effective, gaps in evidence remain, in part, because other treatments have received less research attention (Gatz, 2007; Pincus et al., 2007; Samad, Brealey, & Gilbody, 2011; Zalaquett & Stens, 2006). Psychodynamic therapy, the focus of this article, is one of the “less studied” treatments for older adults.

## PSYCHODYNAMIC TREATMENT AND ADAPTATION WITH OLDER ADULTS

As the earliest of the contemporary, dominant forms of psychotherapy and beginning with Freud, psychodynamic treatment’s history is long and complex. Psychodynamic theory originated as drive theory and developed in quite disparate ways (Stone, 1997). Its evolution includes theoretical directions as divergent as Klein’s object relations, Mahler and Bowlby’s attachment theory, Kohut’s self psychology, and current models of intersubjectivity (Stolorow, 1995). The central, defining characteristics of current psychodynamic approaches to practice include seven core features within an overall social learning model of psychotherapy (Shedler, 2010a): (1) emphasis on affect, (2) exploration of attempts to avoid distressing thoughts and feelings (attention to resistance and defenses), (3) identifying and working with recurring interpersonal “themes and patterns” (p. 99) or what dynamic clinicians might call *enactment*, (4) attention to the past and a developmental focus, (5) attention to interpersonal relations (i.e., object relations and attachment), (6) attention to the therapy relationship as something potentially therapeutic and as a driver of change in itself, and (7) an invitation to explore one’s fantasy life (i.e., free association).

In a recent interview, Shedler (2010b) elaborated on these characteristics as simply “truths of the human condition with which clinicians of any sort have to take account,” such as the human tendency to form and to repeat relational patterns, often without reflecting on how adaptive or maladaptive these might be at different life stages.

The seven core features of psychodynamic therapy still apply when working with older adults. Modifications should be primarily based on “medical and contextual factors” instead of “limitations in the psychological potential of change” (Nordhus, 2008, pp. 180). For example, clinicians should be prepared to be more flexible with scheduling; accommodate age-related issues including sensory impairments (e.g., hearing, vision), physical disabilities, and transportation needs; and be more active and less formal to establish the therapeutic alliance (Nordhus, 2008).

## EVIDENCE BASE FOR PSYCHODYNAMIC TREATMENT WITH OLDER ADULTS

A recent meta-analysis of psychotherapy and related psychosocial interventions for adults aged 60 years and above noted that more controlled studies of psychodynamic interventions for older adults were needed “before final recommendations on their use or non-use would be possible” (Pinquart et al., 2007, p. 652). The authors also recommended that research be conducted in “real world” settings using community-based psychotherapists. Zalaquett and Stens (2006) similarly noted the limited evidence for brief dynamic treatment for clients over 55 diagnosed with depression or dysthymia and emphasized the need to look at dynamic treatments where the clinicians had adequate training and an investment in the treatment. Finally, Hollon and coworkers (2005) noted that in controlled trials of major depression, “dynamic psychotherapy typically was viewed as a comparison condition for a more valued intervention” (p. 458), and may not have been adequately implemented. Specific to the geriatric literature, in two studies, CBT was not more effective than brief dynamic treatment (defined as 15 or fewer sessions) (Hollon et al., 2005).

This study was designed to examine (1) if older adults can benefit from psychodynamic treatment delivered by dynamically oriented, trained, and committed community-based clinicians; (2) if so, with what kind of course, trajectory, and effect size; and (3) how these effect sizes correspond to those reported in the literature for more established treatments, specifically cognitive and reminiscence therapies.

## METHOD

### Procedure

We conducted a secondary data analysis of archival data collected at a community mental health clinic that serves older adults in its Seniors Program. These data, which include Outcome Questionnaire (OQ) 45.2 scores for clients collected at 3-month intervals, are used to inform clinical care at an individual level and to track broader outcomes as part of the clinic’s research program. The data—which were collected as part of a larger study of 1,050 adult clients looking at both the course of change in, and outcomes associated with, psychodynamic psychotherapy—were collected at 3-month intervals, over 20 time points, beginning with 106 clients aged 60 to 89 years at baseline and ending with 2 clients at 57 months. Thus, we adopted a longitudinal, time-series design with a two-level model using multi-level statistical modeling. We created a mixed model utilizing the 12 time points during which 10 or more older adults were represented (see Table 1). We also used

**TABLE 1** Number of OQ 45.2 Observations at Each Time Point with 10 or More Participants

	Observations Per Period	Minimum Score	Maximum Score	Mean OQ Score	Standard Deviation
Baseline	106	14	132	70.08	24.04
3 months	106	00	123	63.45	23.08
6 months	75	27	133	63.51	22.96
9 months	58	23	127	62.55	20.36
1 year	46	19	108	59.15	22.67
15 months	31	25	121	61.26	20.74
18 months	25	15	133	64.12	25.37
21 months	22	00	126	59.68	26.16
2 years	20	25	142	65.80	22.50
27 months	18	23	143	65.78	24.60
30 months	15	28	132	60.87	25.12
33 months	11	33	117	59.82	22.65

an autoregressive covariance structure, which Field (2009) recommends for mapping longitudinal or time series data. The study received University IRB approval and clients gave informed consent as part of their intake at the clinic.

### Sample and Inclusion Criteria

The sample was comprised of 106 clients, aged 60 and older, representing approximately 10% of the annual clinic population. We chose 60 years of age because it is consistent with the geriatric mental health literature (Henderson, 2010); our data broke out well using this distribution; and decades often serve as psychological points of reflection, with 65 being a somewhat artificial, historical marker of retirement (J. McLeod, personal communication, January 25, 2011). The age of participants ranged from 60 to 89 years ( $M = 67$ ). Sixty percent of the participants were women and 75% had a college or graduate education. Forty-four percent were married, 24% were divorced or separated, 18% were single, 10% were widowed, and 6% were in non-married partnerships. Fifty-one percent were currently employed, 8% were unemployed and looking, and 40% were unemployed. The mean reported income was \$42,862. Most participants identified as Caucasian (89%) and 98% identified English as their primary language. By comparison, in 2010, Americans age 65 and over were 57% women, 22.5% had a bachelor's degree or higher, 57% were married, 12.4% were divorced or separated, 4.5% were single, 26.5% were widowed, 17.4% were working or actively seeking work, mean reported income was \$20,485, and 80% identified as Caucasian (Administration on Aging, 2011). The therapies were open-ended. Length was not predetermined, but was tailored to meet the needs of each individual.

## Setting

The data were collected from 2003 to 2008 at a Midwestern community outpatient mental health clinic which served at that time, on average, more than 700 clients annually. During the time data were collected, clinic staff included 16 full time therapists and 15 graduate trainees from psychology and social work, as well as third and fourth year psychiatric residents and three staff psychiatrists. The clinic, which is psychodynamic in its practice orientation, has three primary foci: offering quality care for uninsured and underinsured clients who would not otherwise receive care, providing training for graduate students and community practitioners, and conducting research. In collaboration with university-based researchers, the clinic has developed an increasingly sophisticated research agenda over the last 13 years. The clinic provides weekly interdisciplinary supervision where psychodynamic psychotherapy is the “common language spoken” by psychiatrists, psychologists, and clinical social workers as well as monthly individual supervision with the executive medical director, a practicing clinician. On-site psychiatrists provide both psychotherapy and medication management. The treatment is psychodynamic in nature, with weekly sessions as the dominant standard of care. The staff is also highly trained in psychodynamic psychotherapy, bringing a large degree of treatment allegiance to this theoretical perspective, drawing strongly on attachment and object relations theories. This sense of a strong, shared, theoretical orientation across clinicians bore out as well in a separate, unpublished qualitative study, in which all staff clinicians were interviewed in regard to how they both conceptualize and treat clients at this clinic. The clinic is one of the original community mental health clinics in the country, founded in 1954, and both began with and has carried forward a strong, relationship-based and psychodynamically informed practice orientation since its inception.

## Psychodynamic Treatment With Older Adults in the Study Setting

Clinicians in the study setting conduct a broad, psychodynamic assessment and provide a specific DSM (psychiatric) diagnosis for each client. Although clinicians give attention to development—asking about how a client’s particular history has potentially shaped present conflicts and concerns—work with older adults is particularly present-focused, especially at the beginning of treatment, when the presenting concern is often framed as a concrete one, and/or a decision to make (B. Mantell, personal communication, March 11, 2011). Consistent with the literature on psychodynamic approaches with older adults (Shedler, 2010a; Nordhus, 2008), the clinicians understand the psychotherapeutic relationship as one where more long-standing relational patterns are likely to be enacted, and view these patterns as potential sources of information with which to better understand and assist clients

with their presenting concerns. As part of the assessment, clinicians consider the degree to which each client might benefit from a supportive versus a more exploratory therapy, along a continuum of care. That is, clients are assessed in terms of variables such as their internal capacity and individual ability to tolerate affect, to lead a session, and to sit with silence. Clinicians may be more or less conversational and therapies may be more supportive or exploratory depending on each client's needs. In keeping with Gabbard (2005) and others, most therapies will be somewhere along this continuum and consist of elements of both. Clients' strengths and vulnerabilities are similarly assessed, and clinicians frequently use Knight's (2004) *maturity-specific challenge model* to aid in their overall case conceptualizations.

Older clients typically present with a concrete concern such as a relationship issue with an adult child or a status change (financial, retirement, a change in health, or an identified loss), and often underreport symptoms. Clinicians recognize that, sometimes, underlying the concrete concern is a concurrent or longer-standing issue that is identified and worked with as the treatment unfolds. Client fears regarding death and questions of legacy, a limited sense of time, and other related existential questions are also common themes (B. Mantell, personal communication, March 11, 2011). In keeping with psychodynamic treatment's emphasis on the relationship (Shedler, 2010a), clinicians seek to really know and to convey genuine care and concern for each client and their individual situation.

Because the clinical picture for older adults can change quickly in terms of mental, physical, functional, or cognitive status, assessment of these issues and of medication use is ongoing. Individual case consultations often take 30 to 60 minutes during weekly supervisory meetings of the interdisciplinary teams, which include social workers, psychologists, and at least one psychiatrist (who contributes clinically as well as pharmacologically). Treatment, overall, is seen as interdisciplinary, multifaceted, and tailored to each individual.

## Measure

The OQ 45.2 is a 45-item client-administered questionnaire developed by Lambert and colleagues (2004) to measure outcomes with particular relevance to dynamic therapy. Its use has become widespread, and in Utah it is mandated for agencies receiving state funding. The OQ uses a 5-point Likert scale and provides an overall score (ranging from 0 to 180 points) as well as three subscale scores, specific to symptom distress, interpersonal relations, and social role functioning. Higher scores represent more psychiatric distress, with 63 representing a clinical cut-off or measure of caseness. Clients scoring above 63 are seen as warranting treatment in contrast to community norm scores, which average 45. The instrument has strong psychometric properties and has been normed on psychiatrically well community populations, as well

as on students in college counseling centers, EAP clients, clients in outpatient mental health centers, and psychiatric inpatients. It has also been tested for reliability across gender, race, and ethnicity. Alpha coefficients for internal consistency range between .84 and .93 and test-retest reliability is .84 for OQ Total scores. The OQ speaks to recovery (a score in the range of community norms), to clinically reliable change, and to deterioration, the latter being defined as a 14 or greater point increase in total score (Lambert et al., 2004). The OQ has also been normed on age ranges from 18 to 80, finding no correlation between test score and age (Lambert, Gregersen, & Burlingame, 2004). We found the intraclass correlation of the OQ45, which is a good estimate of the reliability of the total scale, to be about .78 for our particular sample.

### Data Analysis

We used SPSS 18.0 (Cary, NC) to conduct a two level, linear mixed model analysis where scores were nested within people, with attention to variables such as age, gender, and medication as interclass effects. Time was treated as a fixed and random effect with the other potential moderating variables (see patient characteristics below) treated as fixed effects. People were allowed to vary in both their intercept or where they began treatment (all participants had a baseline score), and in their slope, or how they recovered over time. This resulted in the best statistical model fitting. We chose a curvilinear (nonlinear) model of recovery, assuming that change in psychotherapy is not linear and that there would be potentially wide variation over time and across potential moderating variables (Lambert et al., 2004).

### Power Analysis

Statistical power was analyzed using Optimal Design version 2.0. Statistical power in HLM growth curve models is influenced by the sample size, the number of repeated measures, and the anticipated effect size. The sample size of 106 combined with a repeated measure with 12 time points yielded an estimated statistical power of .51 (51%) to capture a moderate effect size ( $\delta = .40$ ). This result should, however, be interpreted with caution due to the complexity of applying a power analysis to a multilevel design—particularly in light of differing sample sizes across levels—and the presence of intraclass correlations (Bickel, 2007). Others have pointed to the complexity of applying this method to longitudinal designs, where a power analysis must “take into consideration within-subject variance” (Vinnars, Barber, Noren, Gallop, & Weinryb, 2005). While the power in this analysis is modest, it should be noted that power applies when a study fails to find a result (i.e., in a type II error). The strong effect size and significant findings in this study suggest that power considerations did not limit the possibility of detecting a meaningful effect size.

## RESULTS

### Participant Characteristics

The mean baseline total OQ score for participants was 70 (SD = 24). Initial scores ranged from 14 to 132. On average, participants attended 33 sessions (SD = 44). The median number of visits was 15 and the modal number was three. Primary diagnoses included adjustment disorder (20%), dysthymia (19%), major depression (31%), anxiety disorder (14%), personality disorder (6%), and substance abuse or dependence (alcohol, cannabis, opioid, and polysubstance) (5%). Thirty-two percent had a second diagnosis, which included dysthymia, mood disorders, and anxiety. Sixteen percent had a psychiatric hospitalization and 69% of the 55 participants who reported on use of psychiatric medications used medication as part of their treatment, a slightly higher percentage than the clinic average of 63%.

### Caseness

Sixty-two (58.5%) participants at baseline met criteria for caseness (a total OQ score at or above 63), in contrast to 68% of participants under age 60 in the larger study. At 3 months, 57 participants (53.8%) met criteria; at 6 months, 40 of 75 (53.3%) met criteria; and at 9 months, 29 of 58 (50%) met criteria. The number of participants still in treatment reporting at or above caseness increased significantly at 12 months to 29 of 46 (63.0%). This is in keeping with findings from the larger data set and may suggest that people who improve are more likely to end treatment. At 2 years, 9 of 20 (45.0%) participants met criteria; at 3 years, 7 of 9 (77.8%) met criteria; at 4 years, 4 of 7 (57.1%) met criteria; and at 5 years, no participants were on record. These trends paralleled the larger clinic sample, with the most significant change happening during the first 3 months of treatment. With older adults, though, the lowest percentage of clients moving below caseness happened at 9 months, one time point earlier than for the larger sample.

### The Mixed Model

A mixed effects model was estimated using the mixed model procedure.

The Level 1 specification was:

$$Y_{it} = \beta_{0i} + \beta_{1i}t + \beta_2(OLDER) + r_i$$

This specification asserts that the score for person  $i$  at time  $t$  is the combination of a baseline score (intercept  $\beta_{0i}$ ) plus a cumulative linear growth  $\beta_{1i}$  over time 0 through  $t$ , plus a fixed constant difference in baseline score  $\beta_2$  due to a participant's age. This coefficient shifts the overall level up or down

depending on whether one is an older adult or not. (An initial model was run to test whether there was moderating effect of the variable OLDER and time, which would have indicated qualitatively different growth trajectories, but this model was not statistically significant).

The Level 2 specification was:

$$\beta_{0i} = \gamma_{00} + u_{0i}$$

$$\beta_{1i} = \gamma_{10} + u_{1i}$$

This specification asserts that the first two coefficients in the Level 1 model are free to vary among persons. In other words, the overall growth rate is believed to consist of an overall mean growth rate plus or minus an individual's deviation from the overall mean. In addition, the repeated measurements were assumed to have a heterogeneous first degree autoregressive error structure. Thus there were a total of six parameters including the autoregressive parameter.

All of the coefficients in the mixed model were statistically significant. Of primary importance was the finding that model coefficient  $\beta_2$  was statistically significant ( $p < .05$ ), indicating that older adults tended to begin treatment as less symptomatic than non-older, with a mean intake OQ score (baseline) of 68.98, versus 75.28 for the broader sample; i.e., the significant level effect of OLDER means that older adults reported being less symptomatic by an average of just over 6 points at intake.

The full model was followed up by an analysis of the patterns of change of the older adults alone ( $N = 106$ ). Here, the focus was on the growth curve itself rather than the moderating effects of age. The researchers fit both a linear and a curvilinear component to capture acceleration and deceleration in growth.

The Level 1 specification was:

$$Y_{it} = \beta_{0i} + \beta_{1i}t + \beta_{2i}t^2 + r_i$$

The coefficients in this model are the same as those of the first analysis, except here the  $\beta_2$  coefficient was a fixed effect to model the quadratic effect of time squared. The squared term was not specified as a random effect in the Level 2 model to avoid difficulties in estimating an over fitted model with highly correlated coefficients.

The Level 2 specification was:

$$\beta_{0i} = \gamma_{00} + u_{0i}$$

$$\beta_{1i} = \gamma_{10} + u_{1i}$$

Older adults made significant change over time,  $F(1, 283.1) = 21.02$ ,  $p < .01$ . They tended to trend down in OQ total score at a rate of  $-2.98$  points per three month interval in the model where time was treated as both a fixed and random effect and to stay longer than participants in the broader clinic sample who averaged 20 visits.

### Effect Size

The overall effect size, representing the strength of treatment effect was relatively strong, at  $.8$  ( $59.15$  to  $70.08/\text{MSE} = -.8$ ) and was larger than the complete data set's overall effect size of  $-.6$ . Effect size calculations for the  $d$  statistic sometimes call for the pooled treatment and control group standard deviation in the denominator (Lipsey & Wilson, 2001), and elsewhere for the square root of the within-group variance (Hunter & Schmidt, 2006). The latter recommendation seemed reasonable in the present case because the residual error reflects the error variance after removing between group variance effects, and this study is examining several such potential between-group moderators. However, it should be noted that this technique may be understood as giving the most optimistic estimate, of the effect size. So, following Hunter and Schmidt (2006), and Howell (2008), we used the square root of the MSE term as the within-subjects error for computing effect sizes. The formula is:

$$d = \frac{M_{\text{post}} - M_{\text{pre}}}{\sqrt{\text{MSE}}}$$

where  $M_{\text{po}}$  is the mean of the post-test,  $M_{\text{pre}}$  is the mean of the pre-test, and MSE is the mean squared error (residual estimate in the ANOVA output table).

### Clinically Reliable Change

At 3 months, 30 of 106 participants (28.3%) had made clinically reliable change in relation to their baseline score (measured by a decrease in total score of 14 or more points). At 6 months, 21 of 75 participants (28.0%) had made clinically reliable change; at 9 months, 15 of 58 (25.9%) had done so; and at 1 year, this number was 20 of 46 (43.5%). These percentages were in keeping with trends in the larger data set, regardless of age.

### Deterioration

The rate of deterioration was relatively low and decreased with time throughout the first year of treatment. At 3 months, 13 of 106 participants (12.2 %) scored 14 or more points higher than at baseline; at 6 months, 12 of 106

(11.3%) had done so; at 9 months, that number decreased slightly to 8 of 75 (10.7%); and at 12 months, only 3 of 58 (5.2%) showed evidence of deterioration. At 2 years, 2 of 20 (10%) had deteriorated, and after that cells fell below 20 participants per time period. On average, 5% to 12% of participants showed evidence of deterioration over the course of the first year.

## Moderating Variables

### GENDER

Gender did not exert an effect on either level (intercept, or baseline) or in the slope of recovery. Nor was the interaction between time and gender statistically significant,  $F = .05$  (1, 21.31),  $p = .82$ .

### MEDICATION

Medication appeared to exert an effect on where participants began treatment, with medicated participants beginning treatment 9 points higher than those who did not use medication. However, due to the large standard error of the coefficient and the small sample size, the effect was not statistically significant. Participants made significant progress, but not in a statistically unique way,  $F = .26$  (1, 23.90),  $p = .62$ .

### NUMBER OF SESSIONS

The number of treatment sessions did not affect participants' average baseline score or the trajectory of their recovery,  $F = 1.65$  (1, 28.17),  $p = .21$ .

### INITIAL SYMPTOM SEVERITY

Participants with an initial OQ score at or above 93 began treatment, on average 35.70 points higher (99.02 versus 63.32 for those whose initial score was under 93)—a statistically significant difference in intercept,  $F = 73.78$  (1, 108.86),  $p < .01$ . Participants in the severe group appeared to progress at a stronger rate of change (an additional  $-.77$  at each time point, over and above the overall rate of  $-3.11$  points per 3-month interval), however, likely due to the large standard error of the interaction coefficient, and the smaller sample size of the older adult only sample, this additional change component was not statistically significant  $F = .60$  (1, 28.12),  $p = .44$ .

### MAJOR DEPRESSION

The diagnosis of major depression exerted a moderating effect in terms of where participants began treatment but not on how their treatment

progressed. Participants with a diagnosis of major depression tended to begin treatment as significantly more symptomatic (with a baseline score of 83.02 versus 66.32 in this model). Their score decreased with a slightly stronger negative slope by nearly a half-point per 3-month interval, but not in a statistically significant way,  $F = .70 (1, 382.28)$ ,  $p = .41$ .

## DISCUSSION

Overall, findings from this study suggest that older clients can and do benefit from psychodynamic treatment, when offered in this treatment configuration. This is evidenced by older adults in this sample demonstrating statistically and clinically reliable change, as measured by the OQ 45.2; in our use of multilevel modeling; and in the finding of a relatively strong effect size ( $-.8$ ), larger than the average effect size for the broader sample of 1,050 ( $ES = -.6$ ). It is also suggested in (a) relatively low levels of deterioration (5% to 12%), which remained relatively stable and decreased slightly over the first year of treatment; (b) by the decreasing number of people meeting criteria for caseness similarly throughout the first year of treatment; and (c) in percentages of clients achieving clinically reliable change comparable to national norms for adults (Henderson, 2010; Lambert et al., 2004).

Our findings support those of Garner (2008), James (2008), and Pincuart and colleagues (2007), suggesting that older adults can benefit symptomatically, and can make use of psychotherapy, with an effect size (.80) nearly identical to that found by Pincuart and coworkers (.84 in their study of major depression). However, our sample was relatively small, which Pincuart associated with larger effect sizes. We also lacked a formal control or comparison group. Nevertheless, looking at within versus between group change is often associated with smaller effect sizes.

The finding that this sample tended to stay in treatment longer (i.e., larger average number of sessions) suggests that psychotherapy with older adults may not need to be shortened (Kennedy & Tanenbaum, 2000). It also challenges earlier findings (a) that older adults should be offered shorter treatments first, and (b) that an “optimal” number of sessions lies between 7 and 12 in order to avoid drop-out “observed with increasing number of sessions” (Pincuart et al., 2007, p. 647). Similarly, this study found optimal or maximum change happening later than Hollon’s (2005) findings, which cited 12 to 14 sessions as an optimal length. We did not, however, use chart review or other approaches to look at which clients ended (i.e., formally terminated) versus dropped out. Pincuart and coworkers (2007) pointed to an average dropout rate of 18.9% for older adults in psychotherapy, based on their sample of 50 studies.

Unipolar depressive disorders were common initial diagnoses, but we did not find that those with major depressive disorder (one of the most

common diagnoses for this age group) tended to be younger as Pinquart and associates (2007) did. Although participants diagnosed with major depression tended to begin treatment as more symptomatic in comparison to their peers with other diagnoses, they were generally able to make progress. Participants with more initial symptom severity tended to progress, as well, though not with a unique slope. Power may be an issue here. In the larger sample ( $N = 1,050$ ), participants who began treatment as more symptomatic tended to make even greater gains than those beginning with less symptomology. This is in keeping with national studies as well (Lambert et al., 2004).

In general this study found that both men and women were able to make use of the treatment without statistically significant differences. Participants tended to present as less symptomatic than their younger peers. This may be partially accounted for by the large number of adjustment disorders diagnoses. Social workers in the clinic also observed and contextualized these findings by pointing out that older adults often present with a concrete concern that might be initially conceptualized as an adjustment disorder, and sometime under-report. As treatment progresses, longer-standing and more severe diagnoses, such as major depression, may emerge as part of a broader clinical picture and as the product of a more extended assessment. This suggests a potential clinical implication in that it reminds clinicians to consider this possibility as part of a clinical assessment. Men, in particular, may present as quiet and stoic and underreport. The potential role of stigma associated with a mental health diagnosis should be remembered as well and may be potentiated among this age group. The study's results suggest mental health therapists should not dismiss psychodynamic treatment as a first tier treatment option for older adults because of a mistaken belief that it is too late for older adults to reflect or look back on their lives. The results also remind social workers and other professionals to consider this treatment option for men who, in this study, showed evidence of benefit by way of treatment response.

This study had several strengths and limitations. In terms of strengths, it answered calls for greater attention to treatment allegiance and for studies grounded in community practice (Henderson, 2010; Hollon, et al. 2005). These data are from a clinic and a group of clinicians with investment in psychodynamic treatment, intentionally adapted to this age group. While the study used an empirically validated instrument, weaknesses include both the lack of specificity in the instrument used and the lack of dimensionality, because only one instrument was used. Future studies would likely benefit from the use of multiple instruments for comparison and from more formal fidelity checks in the delivery of treatment, where possible. Future studies would also benefit from parsing age groups even further (i.e., using a median split to compare and contrast "younger older" and "older older"). James (2008) offers the important reminder that older adults do not represent a homogenous group. Our initial subgroup analysis here suggests that,

while both groups improved, the younger group improved more and over a longer period of time. The data also included a fair amount of attrition, as evident in Table 1. While this is a normal and expected part of longitudinal research, it requires statistical accommodation. The mixed model analysis we chose is particularly well suited to data with anticipated attrition and can accommodate missing data by drawing on existing residuals (Field, 2009). We also chose a covariance structure (AR1) in keeping with our longitudinal design. It is also possible that adults with more initial symptom severity are more likely to improve by way of regression to the mean. Though we analyzed attrition using exploratory and descriptive methods, an event history model might be an interesting approach for future research, as it would more formally account for attrition events.

Last, while the clinic consistently tracked intake diagnoses (that is, diagnoses at baseline), we did not have the same access to diagnostic status at posttreatment. With the clinic having since introduced electronic health records (EHR), future studies will be able to do so, which would further strengthen the research design.

Additionally, this site is relatively unique in its treatment configuration. Few community mental health clinics are able to bring the number of resources referenced here (i.e., longer-term treatment when indicated with on-site psychiatrists who are an integral part of the treatment team, and weekly formal supervision operating from a shared theoretical perspective, which serves as both a source of interdisciplinary input into the treatment and also a sort of “real life” practice delivery check). While not a manualized treatment, this study provided an opportunity to look at a relatively “pure” form of psychodynamic treatment practiced in a community setting by clinicians with a strong sense of allegiance to this treatment model. The clinicians delivering this treatment are, as a group, highly trained and provide training for community mental health practitioners in psychodynamic psychotherapy. It is not clear how easily this treatment configuration generalizes more broadly or if it can be replicated. The strong concern for individual clients and strong attention to the therapeutic alliance may operate as nonspecific factors and may contribute to generally positive outcomes independent of clinicians’ theoretical orientation (Duncan, Miller, Wampold, & Hubble, 2009). This treatment configuration, with its positive associated effects, suggests a strong standard of care. Finally, psychodynamic therapy is not inexpensive. Without psychiatric medication, in this setting it costs, on average, \$4,382 per year (based on 33 visits, at \$130.00/session after the initial assessment—priced at \$222.00—with a clinical social worker or licensed marriage and family therapist). Use of medication, with one psychiatric assessment, followed by five visits with a psychiatrist, would add \$1,090.00 to the baseline cost for a total cost of \$5,472.00 in the first year. However, this is less expensive than hospitalization. Diagnoses such as untreated major depression are also associated with higher medical (non-psychiatric) costs

in general. For these reasons, this treatment warrants a closer look and continued attention, both by researchers and by practicing clinicians. This research team included both and is offered as an example of university and community-based research collaboration, with the goal of better understanding how to meet the needs of this particular and increasingly large demographic.

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