

Evaluation of Psychodynamic Psychotherapy in a Community Mental Health Center

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Abstract: This study describes an evaluation of the effectiveness of psychodynamic psychotherapy provided in an outpatient community mental health clinic. The study used a single group pretest-posttest design involving 78 clients. Clinical outcomes included overall psychosocial functioning and quality of life, level of subjective distress, interpersonal functioning and role functioning, measured by the Outcome Questionnaire (Lambert, Hansen, Umpruss, Lunnen Okilshi, & Burlingame, 2000). Clients showed statistically significant improvement from pretest (first sessions) to completion of treatment in overall functioning, and quality of life, level of subjective distress, interpersonal functioning and role functioning. Eighty-five percent of clients made statistically and clinically significant change. Calculation of effect sizes for each outcome found moderate to strong change effects ranging from $d = .4$ to $.9$. The study illustrates a method of intervention research that therapists and agencies can use to integrate practical evaluation methods into their clinical services in order to improve mental health service to clients, to demonstrate the effectiveness of interventions, and to provide data to support coverage for needed services for clients.

The National Institute of Mental Health (NIMH; 1999) and others (Gabbard, Gunderson, & Fonagy, 2002; APA Division 12) have lamented the lack of empirical outcome data provided by psychodynamic therapists and have called for such practitioners to start demonstrating

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their outcomes. Gabbard, Gunderson, and Fonagy (2002) wrote recently about the threat posed to dynamic therapy by not demonstrating such outcomes: "Psychoanalytic psychotherapy is at risk of being sacrificed if scientific methods cannot be developed that will further test its practitioners' claims of efficacy" (p. 505).

Studies that have evaluated the efficacy of psychodynamic therapy compared to wait-list control groups found that various types of brief dynamic therapy had better outcomes compared to a wait-list control group (Chambless et al., 1998; Piper, Azim, McCallum, S. & Joyce, 1990; Shefler & Dasberg, 1989; Winston, Pollack, McCullough, Flegenheimer, & Trajillo, 1991). Two studies reported brief dynamic therapy to be equal in effectiveness compared to cognitive and behavioral therapies in the treatment of geriatric depression and drug abuse (Thompson, Gallagher, & Breckenridge, 1987; Woody, Lubarsky, McLellan, & O'Brien, 1990). Others have found psychodynamic therapy to be equally effective to cognitive behavioral methods in the treatment of depression (Barkham et al., 1996; Crits-Christoph & Mintz, 1992; Shapiro et al., 1990) and anxiety (Svartberg, 1998; Taylor & McClean, 1993). Three studies using longitudinal within subjects designs to evaluate clinical outcomes in client samples with heterogeneous diagnoses reported significant change in symptoms for 50% of the sample (Asay, Lambert, Gregersen, & Goates, 2002; Archer, Forbes, Metcalfe, & Winter, 2000; Kopta, Howard, Lowry, & Beutler, 1994). These gains were maintained at six months and one year follow-up.

Anderson and Lambert (1995) did a meta-analysis of 26 studies that reported treatment outcomes on a range of disorders. They reported large treatment effect sizes for psychodynamic therapy, an average of .85. They note that studies that employed treatment manuals and trained therapists in time limited dynamic therapies produced larger effect sizes.

Meta-analyses of psychodynamic treatment of personality disorders have found consistently large treatment effect sizes of an average 1.29 effect size from an average length of treatment of 1.3 years (Perry et al., 1999). Leichsenring and Leibing's (2003) meta-analysis of 25 studies comparing the effectiveness of cognitive-behavioral treatment and psychodynamic therapy for personality disorders found that both treatments were effective for personality disorders with no significant differences in outcomes based on type of treatment.

Recent reviews (Gabbard, Gunderson, & Fonagy, 2002) have identified the importance of examining moderating and mediating variables that might differentiate psychodynamic therapy outcomes. Studies thus far have looked at age, gender, race, initial symptom severity, initial social functioning, chronicity of diagnosis, the presence or absence

of a personality disorder, and the length of treatment. It appears that initial symptom severity may negatively impact outcome (Taylor & McLean, 1993) as does the presence of Axis II diagnoses (Asay et al., 2002; Taylor & McLean, 1993). Both increase the duration of treatment and the time it takes to make either clinically significant change or to become asymptomatic.

Most research regarding psychotherapy outcomes is efficacy research done in highly controlled research settings with paid subjects and well trained and supervised therapists. They use structured, manualized treatments applied to people with a single psychiatric diagnosis. While strong in design (i.e., providing strong internal validity), questions have been raised about the applicability of the findings from these efficacy studies to "real life" clinical settings (external validity). This is a concern for many clinicians in that the majority of potential research subjects in such efficacy studies, especially those with more than one diagnosis, are often screened out up front (Nathan, Stuart, & Dolan, 2000).

Gabbard et al. (2002) also speak to the difficulty of conducting efficacy research in relation to dynamic psychotherapy and have instead called for effectiveness research, where "baseline, annual, and end of treatment information could be collected on all patients...preferably from the patient's perspective...[this] would provide data that would offer evidence of whether psychoanalytic therapies differ in their effectiveness with different patient groups, techniques, and the timetable and sequence in which change occurs. The results, in turn, would frame more discrete hypotheses and more rigorously controlled outcome studies" (p. 509).

Roseborough's (2004) review of six psychodynamic effectiveness studies reported significant improvement over time for 70% of clients with great variability between studies (Archer et al., 2000; Asay et al., 2002; Barkham et al., 1996; Kopta, 1994; Sandell et al., 2000; Warner, 1998). These naturalistic studies, however, are limited by numerous methodological problems. Measurement issues are often problematic. The variety of measures makes it difficult to compare results to other dynamic studies; several studies utilized outcome measures that have not been psychometrically tested. Small samples, the failure to report treatment effect sizes, and the limited examination of moderating variables have all limited research in dynamic naturalistic studies.

Given the limited research in dynamic therapy, specifically and outpatient mental health services in general, small scale agency based studies are needed to investigate the basic question "Do clients who receive psychodynamic therapy improve over the course of treatment?" (Thyer, 1992). Such efforts are necessary before more sophisticated re-

search efforts are considered that attempt to answer the question "Is dynamic therapy the cause of client improvement?"

The purpose of this naturalistic effectiveness study is 1) to evaluate client improvement in clinical outcomes over the course of psychodynamic treatment provided in a community mental health clinic, and 2) to demonstrate a practical method to develop information about client improvement in treatment using a reliable psychodynamic measure and a simple research design. The research hypotheses are: Ho1 clients will make statistically significant improvement in overall functioning and reduction of symptoms; Ho2 clients will make statistically significant improvement in symptom distress; Ho3 clients will make statistically significant improvement in interpersonal relationships; and Ho4 clients will make statistically significant improvement in social role functioning.

METHODS

Clients

This study used an availability sample of 78 clients who received treatment from Hamm Memorial Psychiatric Clinic in St. Paul, Minnesota. Inclusion criteria for the study included: 1) a DSMIV Axis I disorder, 2) the completion of a course of treatment that included assessment, treatment, and planned termination, and 3) the completion of pre-test (first session) and post-test (end of treatment) outcome measures; in this case the OQ 45.2. Hamm Clinic is a private, non-profit community mental health clinic that provides psychotherapy and psychiatry services as part of therapy, when called for. In addition, Hamm Clinic provides ongoing continuing education and training of interns and community mental health professionals in psychodynamic therapy. Staff therapists who provided treatment in this study were licensed MSW social workers or licensed MA level or Ph.D psychologists. Both are trained and supervised in psychodynamic therapy, which includes weekly group supervision and individual monthly supervision in this model of treatment.

The average client age was 35 years old ($SD=12.42$). Sixty-eight percent of clients were female and 32% male. Thirty-percent were married or partnered, 50% were single, and 20% reported being separated or divorced. Sixty-one percent of clients in this sample were employed. The median income in this sample for those employed clients is \$31,500 annually. Eighty-three percent were Caucasian and 17% were persons of color. Half the sample were college graduates.

Intake diagnoses were clustered into three general categories for the purposes of statistical analysis. A little over half of intake diagnoses (53%) included some form of depression (Major Depression, Depressive Disorder NOS, or Dysthymia). Anxiety disorders, including Generalized Anxiety Disorder, PTSD, and Adjustment Disorders with Anxiety, made up 21% of the diagnoses in the sample, which constituted a second group. The third group, 26%, had adjustment disorders or V-code diagnoses. Half of the clients in the sample received psychopharmacological treatment in addition to dynamic psychotherapy. Almost half of the sample also had diagnosed personality disorders. All of this is largely in keeping with national norms in terms of the diagnoses with which people tend to present in outpatient mental health settings (Andreasen & Black, 2006).

The average length of time a person had had their presenting problem similarly fell into thirds. One third had been symptomatic less than a year. One third had had symptoms for between one and five years, and one-third had symptoms for more than five years. The average length of the presenting problem in this sample was 3.6 years. The average number of treatment sessions received was $M=26$ ($SD=20$). The number of sessions ranged from two to 109.

Treatment Conditions

All clients referred to Hamm Clinic were screened at intake to determine the fit between the client's needs and the services the clinic offers. A support staff gathered information over the phone. An administrative clinician then reviewed all referrals. In potentially complicated cases, a psychiatrist conducted an initial in-person assessment and would make a treatment recommendation.

Hamm's psychodynamic therapy approach is comparable to the procedures outlined by Gabbard (2000). Hamm offers a relationship-based therapy that focuses on 1) fostering a strong working alliance or attachment, 2) the use of the therapist as a good or corrective object, 3) the analysis of transference, and 4) the positive use of the therapy relationship in general. Therapy has three interrelated but discreet stages of treatment.

Phase 1: Beginning Phase Therapy. The goals of this phase are threefold: to make a thorough assessment (both descriptive and dynamic), to socialize the client to therapy, and to establish a strong working alliance. The initial assessment generally takes between one to three sessions, and routinely involves administering the MMPI and order-

ing records from any past mental health providers. The client's initial assessment is presented in a multidisciplinary, consultative team, and a treatment plan is formulated. In keeping with Gabbard's (2000) description of dynamic therapy, both a descriptive Axis I diagnosis and a dynamic diagnosis are made. The latter is seen as evolving throughout therapy and as often requiring an extended assessment. The dynamic diagnosis entails an assessment of the client's history, character, and object relations as evidenced by his or her description of family, work, and relationship history. The sense of self, how the person relates to or uses others, his ability to hold together disparate feelings, etc., are also assessed.

All of the above are carefully assessed in order to predict transference patterns, how the therapy might go, how medication might be interpreted, complied or not complied with, and to determine the most appropriate treatment plan. Hamm offers psychotherapy services along the continuum of Gabbard's (2000) "expressive" and "supportive" models of individual psychotherapy. This assessment and consultation culminate in a written treatment plan, which is reviewed with the client and signed by both therapist and client. An interpretation of the MMPI is read to and discussed with the client in the same time frame, when needed (i.e., in more complex cases, to clarify a diagnosis).

The review of the treatment plan and MMPI can be said to be a pivotal point in socializing the client to therapy. The therapist, while directive in the assessment, will often talk to the client at this point about his or her own "stepping back" and being less directive, inviting the client to be a co-collaborator in the therapy, and helping the client to make this transition to taking more ownership of the content of the sessions. Variations in this exist between therapists in terms of style; however, across the board, therapists assess and make adjustments for clients' differing abilities to tolerate silence, their need for structure, etc., and move between the expressive (insight oriented) and the supportive continuum.

Therapists are trained that therapy begins in the waiting room and work at a good initial alliance through things such as avoiding aloofness and striving to be an empathic observer and partial participant (Gabbard, 2000). Therapists do this primarily by creating a place where patients feel free to talk. This is done through listening and furthering skills, empathically attuned feedback, and by directing parts of the session while "listening to the natural ebb and flow of the patient's thought processes" (Gabbard, 2000). All of this is part of the clinic culture and is in the spirit of creating a good holding environment.

Phase 2: Middle Phase Therapy. The goal of this stage is for the client to get symptom relief, which is seen as, in part, coming through the

experience of being really heard and feeling valued. Often it takes the form of grieving parts of the client's past. The therapist operates at this stage as more of an active listener than as a coach.

This is a discreet phase of therapy where the focus moves toward a working through of transference and resistance (as the client is able) within an empathic context. The therapist at this point will listen for and will often comment on: 1) affect expressed or hinted at, 2) parts of that person's past that might be repeating or playing out in the present (attention to transference), and 3) the therapist's experience of the client's interpersonal style with attention to transference and counter-transference issues. This is often assessed in terms of, "Is what he or she does with the therapist what he or she does out there with other people?" The position of the therapist is that the client can learn to do things differently in order to have fewer negative consequences in his or her interpersonal life. All of this is done with the goal of the client becoming more conscious of his or her psychological life while using the therapeutic experience as a good or corrective emotional experience that the client internalizes and generalizes.

Phase 3: Termination. In this phase of therapy, the therapist overtly helps the client to prepare for the ending, including 1) discussing the client's feelings about the ending, 2) reviewing the learning and growth that took place, as well as any disappointments that were part of the therapy, 2) planning for what may replace therapy for this person, 3) reviewing what the client will take from the therapy experience, and 4) what they see their next work as being. Attention is given to other losses that may come up for the person during termination. The process of ending is valued in itself and the clinic gives value and importance to a sense of a good ending for clients. This is done with the recognition that many people have had previous unplanned, surprising, or traumatic endings. Termination is seen as a chance to do an ending differently.

Attention is thus given to the content of ending (who this person's supports will be, medication management, next steps, etc.) and to the experience or process of ending. This final stage is also sometimes marked by increased therapist self-disclosure that shifts the emphasis to the real relationship as opposed to the analysis of transference. Any further medication management at this point is referred outside of the clinic and any appropriate referrals for aftercare are made.

Research Design and Measures

The study utilized a quasi-experimental pretest-posttest single group design. This design is frequently used when it is impractical to utilize experimental designs that are not possible in many mental health agen-

cies. For instance, a formal control group was not used in this study in that it is known from previous, well-established research (i.e., Hubble, Duncan, & Miller, 1999) that the majority of clients receiving psychotherapy will make improvement over and above those not receiving psychotherapy, regardless of theoretical orientation. Second, by using a paired sample t-test, subjects essentially serve as their own controls (that is, the study looks at aggregate scores for clients entering and completing treatment at the clinic). Finally, the pretest-posttest single group design, however, can be strengthened by use of comparison contrast groups that function as an independent control. In this study, the outcome measure, the Outcome Questionnaire, has a clinical cutoff score and published normed data from community samples that can be used as a contrast in place of a traditional control group. The post score of the treatment group is compared with norms that show clinical significance if it exceeds the normative standard. This method provides some support for causal inference and has been used in other studies (Shadish, Cacon-Moscoso, & Sanchez Meca, 2005)

Each client was given a questionnaire at intake. Data regarding client's age, gender, race, marital status, diagnosis, number of sessions, and length of treatment were obtained by the clinic's management information system. Clients participated in the dynamic psychotherapy provided by the clinic. In addition, some clients were prescribed medication as part of their treatment plan. At completion of treatment, each client completed the questionnaire again.

The outcome measure used in this study was the Outcome Questionnaire-45.2 (Lambert et al., 2000; OQ). Lambert (1983) has recommended monitoring three aspects of the client's life: 1) intrapsychic functioning and subjective distress, 2) quality of interpersonal relationships, and 3) social role performance. The OQ is a client self-report measure that consists of 45 Likert-scale questions and has good reported reliability and validity (Burlingame, Lambert, Reisinger, Neff, & Mosier, 1995).

The measure provides an OQ Total Score and three subscales: Symptoms Distress, Interpersonal Relations, and Social Role Functioning. The Total OQ (scores range from 0-190) assesses the overall severity of psychiatric symptoms and level of psychosocial functioning. It attempts to measure how the client feels inside, how they get along with significant others, and how they function in important life tasks. The Symptom Distress subscale (scores range from 0-100) provides a detailed assessment of symptoms, severity, and level of distress they cause the individual. The Interpersonal subscale (scores range from 0-44) assesses the level of interpersonal conflicts, problems, and functioning. The Social Role subscale (scores range from 0-36) assesses psychosocial functioning in work, social support, and independent living.

The OQ includes a cutoff score that differentiates scores of normal community samples from symptomatic and impaired clinical samples, based on national, epidemiological catchment studies. Cutoffs for the Total OQ: 63; Symptoms Distress: 36; Interpersonal Relations: 15; Social Role: 12. Scores at or below these clinical cutoff scores indicate normal functioning. The OQ also provides a calculation of clinically significant change for each aspect of the measure. The scores for clinically significant change for the Total OQ must change by at least 14 points; Symptoms Distress, 10 points; Interpersonal Relations, 8 points; and Social Role 7 points. Clients in the study completed the OQ at intake and at completion of treatment.

Data Analysis

A paired-samples t-test was conducted on each outcome measure to evaluate whether clients in this sample showed statistically significant improvement from intake to end of treatment. The *d*, a standardized effect size, was used to calculate the magnitude of change for each measure. The percentage of clients reaching the clinical cutoff score and those reaching clinically significant change were calculated using the procedures described by Lambert et al. (2000).

RESULTS

Clients in this sample presented at intake as significantly symptomatic. The mean OQ intake score of 78 placed these scores slightly below the average outpatient clinic score of 83.09 reported in other studies (Lambert et al., 2000).

Total OQ Score Change stats

The results indicate the mean pre-treatment score for the Total OQ, $M=78.15$, $SD=24.43$, was significantly greater than the post-treatment mean $M=57.38$, $SD=25.97$, $t(77)=7.90$, $p < .001$. The *d*, a standardized effect size, was .9, indicating a large change from pre to posttest.

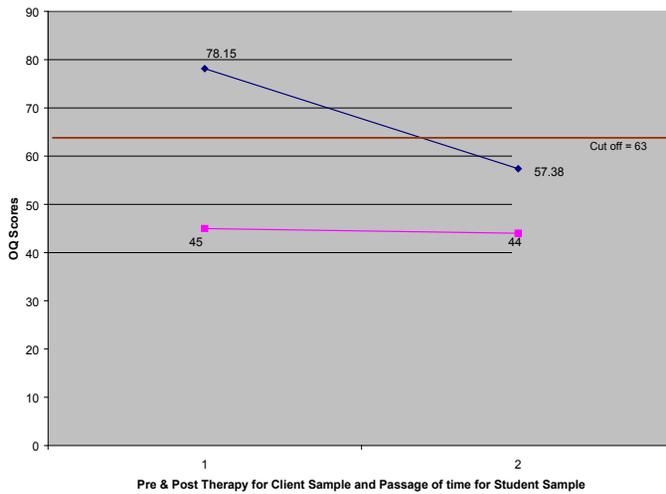


FIGURE 1.

Symptom Distress (SD)

Results indicated a mean pre-treatment score for Symptom Distress, $M=45.91$, $SD=15.93$, was significantly greater than the post-treatment Symptom Distress mean, $M=32.35$, $SD=15.68$, $t(77)=7.86$, $p<.001$. The effect size was .9, indicating a large change from pre to post-treatment.

Interpersonal Relationships (IP)

Results indicated the mean pre-treatment score for Interpersonal Relationship, $M=19.17$, $SD=7.61$, was significantly greater than the post-treatment mean, $M=14.46$, $SD=6.91$, $t(77)=5.24$, $p<.001$. The effect size was .6, indicating a moderate change from pre to posttest.

Social Role Functioning (RF)

Results indicated the mean pre-treatment score for Social Role Functioning, $M=14.35$, $SD=7.33$, was significantly greater than the post-treatment mean $M=10.58$, $SD=5.16$, $t(77)=4.16$, $p<.001$. The effect size was .4, indicating a moderate change from pre to posttest.

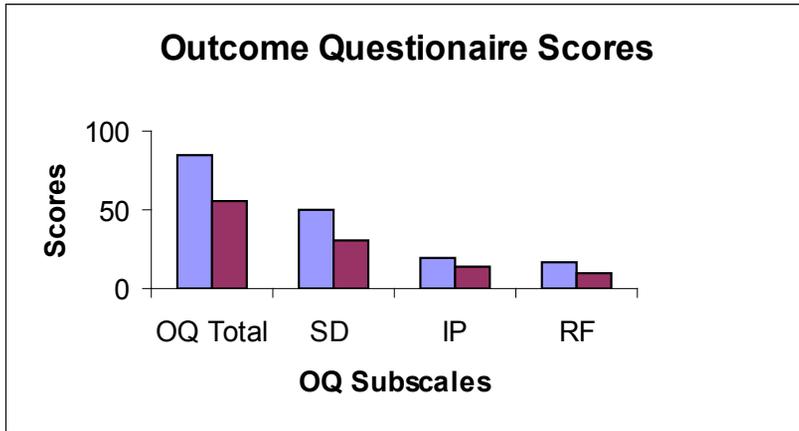


FIGURE 2. Pre-Post OQ Scores

Client Response to Treatment

Eighty-five percent of the sample showed improvement over the course of treatment. Client improvement was measured in terms of (1) clinically significant change, using the statistical norms provided by the OQ itself (summarized in Table 1), in the form of (2) statistically significant change (by way of the paired sample t-tests), and, finally, (3) by way of offering effect sizes, which offer a way of summarizing the strength of a treatment effect in a standardized form. Results for client response to treatment in the form of the total score and for each subscale are represented in Table 1.

Moderating Variables

Potential moderating variables, such as age, income, and number of sessions, were examined for their relationship to the outcome measures by use of a bivariate correlational matrix. There was no significant relationship between income and age on any outcome measure. There was a statistically significant relationship between the number of sessions and improvement in interpersonal relationships. The strength of this relationship, however, was weak (Pearson correlation = .25).

TABLE 1. Client Response to Treatment

Treatment Response	OQ Total Score	Subjective Distress	Interpersonal Relationship	Social Role Function
Full Response: Non-symptomatic	38 % (N = 30)	32 % (N = 25)	36 % (N = 28)	33 % (N = 26)
Clinically Significant Change	19 % (N = 15)	24 % (N = 19)	10 % (N = 8)	3 % (N = 2)
Partial Response	27% (N = 21)	22 % (N = 17)	17 % (N = 13)	18 % (N = 14)
No Change	12 % (N = 9)	19 % (N = 15)	36 % (N = 28)	42 % (N = 33)
Deterioration	3% (N = 3)	2 % (N = 2)	1 % (N = 1)	3 % (N = 3)

Differences in clinical outcomes based on between-group comparisons found no significant differences in any outcome measure based on race, gender, or medication use. There were, however, significant differences in outcomes based on diagnostic category.

Multivariate analysis to test between subjects' effects was significant ($df=3$, $F=3.93$, $p<.01$). Post hoc tests found significant differences in outcomes between subjects diagnosed with depressive disorders compared to subjects diagnosed with adjustment or V Code diagnoses. The mean difference of 20.75, $p<.05$ indicates that subjects with depressive disorders made significantly greater improvement.

DISCUSSION

This study demonstrates that clients receiving psychodynamic therapy made statistically and clinically significant improvements in role functioning, interpersonal relationships, subjective distress, and overall psychosocial functioning and quality of life. A high percentage of clients made improvement in treatment (85%) and, importantly, only three clients got worse during treatment. These positive outcomes are particularly important considering the significant levels of impairment and distress at intake and the brief nature of the intervention.

The findings also add to the literature regarding the effectiveness of dynamic therapy provided by therapists in community settings with more typical multi-problem clients, some of whom had both DSM-IV Axis I disorders and Axis II personality disorders.

The role of moderating and mediating variables in this study is unclear. First, there were no significant relationships or differences between groups based on age, income, race, or gender. Second, results regarding the number of therapy sessions as a mediating variable show a statistically significant, but weak, relationship with outcomes, i.e., more sessions are related to better outcomes. Further research is needed in this area. Third, in this study medication use was evaluated as a moderator of outcomes. There were 29 subjects who received medication at some point in treatment and there were 25 subjects who did not receive medication. Unfortunately, there was missing data on medication use for 24 subjects. Pre-treatment mean OQ total scores were somewhat higher for persons who received medication than those who did not use medication, but there were no significant differences between groups on either the pre-treatment or post-treatment OQ score. The missing data on medication use in this study made it impossible to test medication use as a moderating variable on outcomes. Future studies should examine impact of medication on outcomes. Fourth, there were significant differences in outcomes between depressive disorders and adjustment disorders/V Codes. This difference is likely explained by the greater initial severity of the depressive disorders compared to the adjustment disorders/V Code and statistical regression to the mean.

There are, predictably, several limitations to these initial results. The uncontrolled nature of the research design does not allow for causal inferences about treatment effects and there are potential alternative explanations for the observed improvements. These include maturation and the impact of external events on clients' mental status. Clients are also likely to present for treatment when their situation is at its worst. Subsequent improvement may be due to the natural course of the problem diminishing over time. Similarly, the factor of regression to the mean cannot be ruled out in the current design. Questions might be raised, as well, as to the uniformity of treatment received. Initial findings from this clinic's efforts to define or manualize its treatment point, though, to a fair degree of theoretical uniformity. Finally, the lack of a follow-up period of measurement precludes any understanding of the maintenance of gains over time, and the lack of a random sample allows for potential bias that limits generalizability of the results (Campbell & Stanley, 1963). The clinic is currently in the process of conducting a two-year follow-up study of its outcomes, using the same instrument. Neither the manual nor the follow-up have yet been published.

In order to avoid the limitations of the current study, more rigorous research designs are needed. These could include the use of no treatment or placebo control groups, random assignment, and lengthy follow-up, not all of which are feasible for most mental health clinics.

Ethical and practical issues in providing mental health services to clients also limit the use of randomization, wait lists, and development of control groups. Few clinics have the resources and skills to undertake such research.

In a time of increased demands for accountability, these results offer a potentially important contribution to the field. Few mental health facilities evaluate the outcomes of their services or can provide evidence that clients improve during the course of treatment. Most research studies of psychotherapy are done in the context of grant funded efficacy research. This study is one of the few practitioner-initiated agency-based reports of psychotherapy outcomes.

The study also demonstrates the use of a credible and feasible research method that can be used to empirically evaluate clinical outcomes in community mental health settings. These outcomes can be used to demonstrate that services provided have some degree of empirical support and the data can be used as part of ongoing quality assurance activities that provide data mandated by accrediting bodies and managed care systems.

This practitioner-initiated agency-based study also demonstrates a practical method to develop information about client improvement in treatment using a reliable measure (the OQ-45.2) and a simple research design. The use of group data to analyze statistically significant change from intake to completion of treatment and the examination of single case data to identify categories of client response to treatment on the individual level strengthens the clinical relevance of the research for practice. Continued use of this type of intervention research can be a major step toward improving mental health service to clients, demonstrating the effectiveness of interventions, and providing data to support coverage for needed services for clients.

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