The Northwestern/Chicago Psychotherapy Research Program[1]

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I. Aims of the research program.

Our research program has had two major goals. The first is an intensive investigation of the process of psychotherapy, that is, what happens in therapy or within the therapeutic environment (both inter- and intra-personally, both within and between sessions) and how such processes are related to therapeutic effectiveness. The second is to gather information on the psychotherapy service delivery system: who uses psychotherapy, under what circumstances, in what manner, etc.

A grant-supported study of long-term psychotherapy is the umbrella project under which all other studies are being conducted. Although the sub-studies in our program are as varied and diverse as the individuals involved, using the Therapeutic Process/Service Delivery distinction, investigations can be grouped into general subcategories. One area of process research is generated by a generic model of psychotherapy (Orlinsky & Howard, 1987b). The experiences of the participants in therapy has been another major area of research--both intra-session (e.g., the affective environment) and inter-session (e.g., being aware of therapy between sessions) experiences have been investigated. Pre-therapy determinants of the process of treatment (e.g., symptoms, social support, psychological assets for intensive therapy) is another general category of research. All of this process research has been conducted with the goal of elucidating the determinants of effective therapy, a goal demanding integration of process and outcome measures.

Our research program has also focused intensively on the psychotherapy service delivery system, and these studies can also be grouped into general subcategories. Of course, these categories overlap somewhat with the process research. One area of interest has been in predicting treatment duration (service utilization) and/or treatment effectiveness using an early-therapy measure, such as the quality of the early therapeutic bond or the initial level of symptomatic distress. Interest in the relationship between length of treatment, phases of therapy, and treatment effectiveness culminated in a prospective, long term study aimed at

uncovering the relationships between determinants, phases and effectiveness of shorter- versus longer-term treatment. Other projects, completed and current, will be described below, including a project to compile data from the best existing surveys of the service delivery system.

In what follows, we will report on past, current and future studies. We will describe the research methods and instruments that have been used and developed for our research program, and also some of the problems that have arisen as the program has developed, and how these problems have been and are being confronted. First, we would like to describe the mechanics of the program and how methods have developed over the past years.

II. Overall methods.

Northwestern Memorial Hospital's Institute of Psychiatry in downtown Chicago is home to the research program. The Institute houses one of the busiest community mental health centers in the country. Among the various programs within the Institute are an Eating Disorders Program, an Older-adult Program, an Aftercare Program, a Chemical Dependence Program, and several inpatient units. The psychotherapy research program is coordinated by Kenneth Howard, Ph.D., and is located in the outpatient Psychotherapy Program. In a typical year this Program accepts over 500 new patients into individual psychotherapy.

The patients who enter the Institute's Psychotherapy Program are highly selected. In order to become a patient in this program, one must first call the clinic. A brief phone interview is conducted by an intake worker who inquires into the nature of the problem, determines whether or not the person seems suitable for intensive individual psychotherapy and then arranges a screening interview. The screening interview is conducted by a clinician (usually a psychology or psychiatry trainee) and takes one to two hours. If the screening interviewer concludes that the patient is suitable for intensive psychotherapy (rather than some other treatment or some other Program), a summary of the interview is sent to the Director of the Psychotherapy Program (Michael O'Mahoney, Ph.D.) who assigns a therapist. The therapist contacts the patient to arrange for the first session.

Two-thirds of the patients in the Psychotherapy Program are female and 85% are 20-39 years old. Eighty-three percent are not currently married and 57% are employed full time (another 14% are students). The patients tend to be fairly well-educated: 83% have at least some college education--26% have attended graduate school.

At any one time there are about 80 therapists in the Psychotherapy Program. The majority of these are in some stage of training--psychology practicum students, psychology interns and psychiatry residents-- although most have had considerable additional experience. Sixty percent of the therapists are psychologists, 29% psychiatrists, and 11% social workers. Ninety-four percent are 20-39 years of age; 54% are male and 54% are married. Eighty-three percent of the therapists at the Institute have had personal therapy.

The orientation of the Institute is psychodynamic: supervisors espouse this therapeutic approach, case presentations follow this model, and attempts are made to conceptualize each case from this perspective.

Previous to any data collection, informed consent is obtained and research identification numbers (to maintain confidentiality of patients) are assigned. Since research questions are approached from the participant observer perspective, numerous questionnaires and inventories are given to the patients (either before or after sessions). For example, in the study of long-term psychotherapy, patients are expected to complete one set of questionnaires (that is mailed to them) previous to their screening appointment, another set after their screening appointment, a set after each of their first seven sessions, and another set every two or three months thereafter. Of course, all of this occurs previous to data cleaning, coding, entry, compilation and analysis. In the past, all of these steps were done by undergraduate work-study students or graduate students who were collecting data for their Masters' theses or Doctoral dissertations. With recent funding by NIMH, a project coordinator (Elizabeth Bankoff, Ph.D.), a project administrator (Mary Hortatsos), a programmer/data analyst (Bruce Briscoe) and graduate and undergraduate research assistants have been hired and the cooperation of the support staff at the Institute has been obtained. The procedures and instruments of the long term study will be presented later.

III. Major research accomplishments to date.

Data collection at the Institute has been fairly intensive since the mid 1980s, and the amount of data available is extensive. The program is now in its fourth wave of collection, a wave defined as a specific, coherent set of questionnaires. The first wave consisted of Therapy Session Report data collected for a dissertation by Renée Marshel in 1982-83. The second wave began in 1983 and ended in 1985 and consisted of questionnaires completed by patients after the initial screening interview and after each of the first six therapy sessions. The third wave, introduced in 1985 and just recently completed, saw numerous questionnaires revised or replaced, and it resembled the second in that extensive data were collected after each of the early sessions. The fourth and current wave of data collection will be described in detail below. The research findings to be presented are all based on data collected in the first through third waves.

Much of the work presented below has been based on two models: the dosage model (Howard, Kopta, Krause & Orlinsky, 1986) and the generic model of psychotherapy (Orlinsky & Howard, 1987b). In a meta-analysis (Howard et al., 1986), a lawful positive linear relationship between dose (log of number of sessions) of psychotherapy and percent improvement (normalized) was demonstrated. The study showed that 8 sessions is the Median Effective Dose of individual psychotherapy and that by 26 sessions an Effective Dose of 75% is obtained. The dosage model has been important in helping to define shorter (e.g., 8 sessions or less) versus longer-term (e.g., 26 sessions or more) treatment, a conceptualization that has been important to numerous studies.

The generic model of psychotherapy (Orlinsky & Howard, 1987b) has also generated considerable research attention. This model postulates that certain input variables, process events and outcome realizations are common to all therapies. The generic model distinguishes five major process components: (1) the therapeutic contract, which specifies the terms under which therapy is to be carried out; (2) therapeutic interventions; (3) the therapeutic bond; (4) personal self-relatedness, which is how the individual manages self-directed aspects of social encounter; and, (5) therapeutic realizations, which represent the yield of the therapeutic process (e.g.,

insight, catharsis, etc.). The generic model offers a conceptualization of the interrelationships among input, process and outcome variables, providing a theory of psychotherapy that can guide empirical investigation.

As with the models just mentioned, there is one particular process instrument that deserves special mention. The questionnaire that has been used most consistently in the psychotherapy research program is the Therapy Session Report, or TSR, developed by Orlinsky and Howard (1966; see also Orlinsky & Howard, 1987a). This instrument requires 10 to 15 minutes to complete and is designed as a general survey of the experiences patients have in individual psychotherapy. The TSR has been included in each wave of studies.

One general grouping of studies conducted concerns the process of psychotherapy. As noted, the generic model of psychotherapy identifies five process variables: the therapeutic contract, therapeutic interventions, the therapeutic bond, self-relatedness and therapeutic realization. One of the preliminary studies of this model investigated the therapeutic bond, which is composed of three aspects: working alliance, empathic resonance, and mutual affirmation. Saunders, Howard and Orlinsky (1986) developed scales to measure these concepts. The scales were found to be internally consistent and were predictive of patients ratings of session quality. Saunders (1988a) confirmed the prediction that the rated quality of the bond in an early session (session 3) would be predictive of therapeutic effectiveness. There was also some evidence that patients who have high working alliance scores (i.e., seem to be putting considerable effort into their role as patient) but have low mutual affirmation and empathic resonance scores do more poorly.

The generic model suggests specific interrelationships among the components of psychotherapeutic process. Kolden (1988) constructed self-relatedness, therapeutic realizations and immediate post-session outcome measures from the TSR. Using these and the therapeutic bond scales, he found that the propositions of the generic model held up well under scrutiny. Winfrey (1988) found that successful shorter-term patients had the highest scores on the therapeutic bond. Moreover, if the therapeutic bond declined from the third to the eighth session, treatment tended to fail.

Using the Therapeutic Procedures Inventory, (Orlinsky, Lundy, Howard, Davidson & O'Mahoney, 1987), McNeilly and Howard (1988) obtained descriptions from supervisors of ideal sessions of therapy of a psychodynamic orientation. The integrity of the treatment could thus be monitored. Item profiles representative of ideal early and late sessions of therapy completed by supervisors at the Institute indicated that it is possible to identify a guiding ideology and that it is possible to further describe this ideology by what is not done in a psychotherapy session. Additionally, results indicated that ideal early sessions differ from ideal late sessions (see also Newman, Kopta, McGovern, Howard, & McNeilly, 1988).

Carone (1986) investigated patient and therapist perceptions of the patient's presenting symptoms and functioning in an effort to evaluate the degree of consensus in the dyad in the early phase of therapy. She found that healthier, treatment-wise, educated, young patients and their therapists tended to agree in their perceptions. However, after six sessions, agreement tended to occur when therapists lowered their estimation of patients' problems to match patients' perceptions, suggesting that agreement during the early phase of therapy may reflect a mutual minimization of problems rather than a collaborative understanding. In a similar study, Frommelt (1988a,b) studied the widely held belief that treatment is generally more successful if the participants accept and work toward similar goals. After conducting a survey of the session-by-session psychotherapy goals of outpatients and therapists, she found that dyads tended to have different views of what goals were important at different times in treatment but did agree that gaining insight, talking about concerns and establishing a therapeutic relationship were important. Results suggested that goal congruence was correlated with the participants' ratings of progress but only moderately related to treatment outcome.

In another study, Saunders and Howard (1987) investigated the patient's perception of the affective environment of an early session and its relationship to treatment effectiveness. The two feeling sections of the TSR ("How did you feel during this session?" and "How did your therapist seem to be feeling?") were combined and factor analyzed. The six resulting factors were all significantly related to the patient's rating of in-session

progress but were not substantially predictive of treatment duration or outcome. When the sample was categorized according to treatment duration, however, there was a relatively strong correlation between affect and outcome when therapy was brief (less than 8 sessions) and very little correlation when treatment was relatively lengthy (more than 26 sessions).

Robinson (1988) compared the demographic characteristics and early therapeutic process of patients who underwent successful "naturally occurring short-term psychotherapy" (9-25 sessions) with those of patients who underwent successful treatment that lasted 26 sessions or more. She found that successful shorter-term patients were more likely to be males, married and employed, and were less likely to have had previous therapy. Successful longer-term patients were more likely to be concerned about (in session 3) being lonely, isolated, worthless and unlovable and were more likely to be concerned about angry feelings and fearful experiences. Successful shorter-term patients were more likely to report seeing the therapist as cheerful, pleased and optimistic and as receiving more encouragement from the session.

Tarragona and Orlinsky (1988) investigated the impact of the therapy session on the patient. Specifically, they looked at the relationship between patients' experiences in the therapeutic session (operationalized with the patient TSR) and their therapy-related experiences during the week following the session (operationalized with the Intersession Experience Questionnaire [Orlinsky & Tarragona, 1986]). Over 80% of the patients had thoughts, feelings, memories or images of therapy between sessions, and such "intersession experiences" were most frequent when people were facing a difficult situation and were feeling bad. Patients' imagery about the therapist frequently evoked feelings of acceptance and confidence. Patient ratings of the therapeutic bond were positively correlated with feeling remoralized between sessions, suggesting that intersession experiences are related to the quality of the alliance.

Pre-therapy determinants of process and outcome have also been investigated. Daskovsky (1988) investigated the relationship between patients' psychological assets (level of object relations, capacity to delay gratification, willingness to engage in treatment, degree of distress, and

psychological mindedness) for psychotherapy and patients' capacity to enter into a therapeutic relationship, remain in therapy and benefit from treatment. He developed scales to measure these pre-therapy assets. One finding indicated that level of the therapeutic bond in the third session and ratings of object relations at intake were inversely related. This finding was interpreted as indicating that some patients (those with poorer object relations) may need the therapeutic relationship "too much" and may idealize the therapist during this early phase of treatment. Results also indicated that capacity to delay gratification, willingness to engage in treatment and psychological mindedness were all predictive of dosage. Capacity to delay gratification, willingness to engage in treatment and level of object relations were significant predictors of outcome.

There have been a number of studies investigating correlates of initial (pre-therapy) symptomatic distress, measured using symptom checklists similar to the SCL-90R (Derogatis, 1977). Kolden and Howard (1988) examined the relationship between presenting symptoms and ultimate length of treatment. Results indicated that symptoms of hostility were most predictive of discontinuation in treatment. A different study was prompted by epidemiological research that indicates that a sizable minority of individuals who visit mental health professionals do not exhibit significant psychic distress or qualify for a psychiatric diagnosis. Noel (1988) tried to determine the extent to which such individuals are seeking self-fulfillment (in contrast to problem resolution) by examining differences between presenting problem statements for the most and least distressed outpatients. Results indicated that types of presenting problems and initial level of distress were relatively independent.

Another pre-therapy patient characteristic that has been researched is dysfunctional attitudes and dysfunctional interpersonal attitudes. Kolden (1988) used the Dysfunctional Attitudes Scale (Weissman, 1979) and other available measures to examine the relationship between stress, dysfunctional attitudes and depression in a group of outpatients. Beck's model of depression predicts that dysfunctional attitudes are potentiated by stress and lead to clinical depression. In this study it was found that stress and

dysfunctional attitudes were related, but dysfunctional attitudes did not seem to be uniquely characteristic of depressives.

The psychotherapy service delivery system has also been investigated in our program. For instance, it is known that the majority of psychotherapy patients are "early terminators" or "dropouts" in that they do not remain in therapy for the prescribed amount of time. There are two prevailing beliefs about such patients: that they leave treatment dissatisfied and remain in psychological distress; or, conversely, that they got what they wanted from this brief contact. In a study by Schwartz and Howard (1988), telephone interviews were conducted with persons who were scheduled for an intake appointment at the Psychotherapy Program but who declined treatment previous to the third therapy session (44% of the patients). These persons had either (a) not shown for the intake, (b) came to the intake but did not have a session of psychotherapy, or (c) had one or two session of psychotherapy. Of the first group (the no-shows), about 50% had entered treatment elsewhere and only 11% had done nothing about their problems. Of the latter two groups, those patients who had only completed a screening interview or had attended one or two sessions of therapy and then terminated (dropouts), 32% had entered therapy elsewhere within three months of their initial contact with the Institute. Overall, of no-shows and dropouts, fully 40% had entered treatment elsewhere; only 9% were functioning at a low level and had not entered psychotherapy. One patient indicated that she had benefited from her limited contact with the Institute. The major lesson is that early terminators are not necessarily rejecting psychotherapy but may be selecting treatment at an alternative setting.

In another study investigating determinants of early termination of treatment, Noel and Howard (in press) investigated the impact of being assigned to a different clinician for treatment than the clinician who conducted the initial interview. They found that a higher proportion of patients who were assigned a different therapist than the screening therapist did not return for a first session of psychotherapy. However, patients who were screened by one clinician and treated by another were more likely to remain in treatment beyond eight sessions. One implication of these findings is that the existence of some barriers to entry into psychotherapy serve to

deflect less needy or less motivated patients. This is analogous to findings that insurance coverage serves to lower entry barriers to treatment but is not related to level of use (e.g., Knesper, Belcher & Cross, 1988).

A study conducted by Brown (1988) sheds more light on utilization of outpatient mental health services. Using survival analysis to achieve a better description of individual patterns of use, he examined individual treatment episodes at the Institute. About 82% of patients who proceeded beyond the initial screening interview remained in treatment after 4 sessions, 64% after 8 sessions, and 48% after 16 sessions. Results indicated that HMO (vs. non-HMO) patients were no less likely to become long-term patients and, in fact, were less likely to terminate between the tenth and twenty-fourth sessions.

IV. Research in progress

Noel (1988) utilized the system of classifying patients responses to an open-ended question (completed by patients prior to the initial screening interview) about their reasons for seeking therapy. Developed by Yoken (1988), the system includes six main categories of problems (Emotionalness, Self-Concept, Interpersonal Relationships, Achievement, Physical Complaints and Trauma). It appears to be reliable and is being assessed for validity. Such information about problems will be useful in planning treatment, assessing outcome, and defending the inclusion of psychotherapy services in third-party payment programs.

There is considerable evidence that the patient's earliest feelings toward the therapist are important precursors of the therapeutic bond. Bankoff (1988) is investigating the ways in which social support (operationalized using the Social Support Questionnaire [Bankoff, 1985]) affects the earliest phase of the bonding process. Initial findings based on a sample of 24 patients suggests that social support does influence the development of the therapeutic bond but in a fairly complex way. That is, whether the influence is positive, negative or neutral seems to be dependent on the source and quality of the support.

Extending her earlier work, Carone (1986, see above) is investigating the hypothesis that agreement in the dyad may be less important than awareness of the two perspectives, i.e., explicit awareness of both discrete and overlapping elements of patient and therapist viewpoints. The various

indices of consensus will be related to the quality of the therapeutic relationship and therapeutic progress.

The most comprehensive work being conducted at the program, of course, is the long-term study, which was recently awarded a five-year grant from NIMH. One rationale for this study is the consistent epidemiologic research that indicates that, although the median length of treatment is 5-8 sessions (Garfield, 1986), a small minority of the persons who make a "mental health visit" in a year use the great majority of the outpatient mental health visits provided in that year (Taube, Kessler & Feuerberg, 1984). Although this small group of longer-term patients constitutes the bulk of psychotherapeutic practice, because their treatment covers a considerable span of time and because they are a small fraction of those who enter treatment, these cases are difficult to study in clinical settings which do not have both a large patient population and a commitment to providing long-term treatment. Accordingly, longer-term psychotherapy has received little attention in the research literature. Northwestern Memorial Hospital's Institute of Psychiatry has both a large patient population and a commitment to long-term treatment. The focus of our study is an investigation of (a) the distinctive clinical and demographic characteristics of successful and unsuccessful shorter- and longer-term patients, (b) the early therapeutic experiences of successful and unsuccessful shorter- and longer-term patients, and (c) changes in therapeutic process (i.e., phases of therapy) over the course of successful and unsuccessful longer-term treatment.

All Psychotherapy Program patients are asked to participate in the study. After an individual is given an appointment for a screening interview, the phone intake worker informs the project administrator who mails the person the first set of questionnaires. On the day of the screening interview, after registration, prospective psychotherapy patients are brought to the research office where they are informed of the research project, asked to sign an informed consent for participation, and given the second set of questionnaires (post-screening interview questionnaires). Subsequent questionnaire sets are distributed by the cashier, the one person in the Institute, besides the therapist, the patient will definitely be in contact with before every appointment. The cashier is informed of the need to give a

particular patient a particular questionnaire set via an automated "warning" system that has been established on the Hospital's financial information computer. Patients are instructed to complete the questionnaires as soon after the specified session as possible. The instruments are intended to assess extent and type of pathology, pathology proneness, environmental stress, readiness for treatment and therapeutic experience.

The study is unusual in the amount of information now required of the therapists. After the screening interview, the interviewer (and the therapist) will provide DSM III-R diagnoses (Axis I, II, IV, V), plus Level of Functioning and Global Assessment Scale ratings (consult Table 1 for references). Therapists will complete the Therapeutic Procedures Inventory and the Therapeutic Contract Questionnaire--Session Form regularly, at 10-week intervals. As it is necessary to have reliable and valid diagnoses of patients, interviewers have been trained in use of the Structured Clinical Interview for DSM III-R (SCID-IIIR; Spitzer, Williams & Gibbon, 1988) to provide this.

"Treatment integrity" has become a frequently heard phrase in psychotherapy research lately, underpinning the very real need to ensure that planned treatments are implemented. As a means of assessing the conformity of each treatment with the guiding orientation of the clinic, the Therapeutic Procedures Inventory will be completed by therapists at various points in treatment. In addition, supervisors will rate supervisees' sessions on the skillfulness of their case handling.

The progress of the process of therapy will also be assessed from the patient's perspective. The TSR will be completed by patients after each of the first, third, fifth, sixth, and every tenth session thereafter. In addition, the Inter-session Experience Questionnaire (see above) will be filled out at the same time.

With regard to measures of outcome, the patient will complete numerous inventories (see Table 1) after some early sessions, every 10 sessions thereafter, and at termination. Patients will also rate the success of their treatment and the amount of change they have experienced. Also at termination, the therapist will provide DSM III-R diagnoses and rate the success of therapy, the amount of patient change, Level of Functioning, and

Global Assessment Scale. Table 1 presents a brief summary of the input, process and outcome measures currently being used at the research project.

Insert Table 1 about here.

V. Programs planned for the future

Research on the psychotherapy service delivery system is multifaceted and complex, and the research program has begun to embrace the issue in earnest. An attempt is currently underway to synthesize epidemiologic surveys that are relevant to the utilization of psychotherapeutic services. Of particular interest are surveys concerned with (a) the potential patient population, (b) the real patient population, (c) the service providers and (d) utilization patterns. Data tapes from the Epidemiologic Catchment Area (ECA) survey and other surveys are being compiled at Northwestern University's Computer Center under the direction of our programmer/data analyst. To construct an adequate archive of data on patients who receive at least six sessions of individual psychotherapy, aggregation across surveys is necessary.

Yoken is working on the analysis of questionnaire data regarding patients' and "normal" controls' experiences of feelings such as anxiety, sadness and anger. One focus is the change in emotional differentiation over the course of therapy. Yoken is also collecting data from both patients and therapists to investigate their respective levels of emotionality, activity and sociability. Additionally, she is analyzing data (patient and therapist TSRs) investigating the role of emotional attunement between patient and therapist as it relates to outcome.

Conron will extend the work of Daskovsky (1988--see above) by investigating the patient's experience of the therapist in relationship to the patient's level of psychological functioning (e.g., level of object relations, delay of gratification, etc.). The hypothesis is that lower functioning patients have more intense interpersonal needs that they attempt to defend against or gratify in treatment, whereas higher functioning patients will have a more

balanced experience that includes a realistic desire to achieve psychological health.

McNeilly will be investigating the hypothesis that DSM III-R diagnoses are not optimally relevant for categorizing patients treated in outpatient settings. Diagnoses will be compared with presenting problems, symtoms, life functioning, duration of treatment, and treatment outcome. She is particularly interested in differences between patients who qualify or do not qualify for Axis I diagnoses.

Saunders will use the Process of Seeking Therapy Questionnaire (Saunders, 1988b) to investigate the routes that people use to enter therapy (including previous treatment) and how they make this decision. The questionnaire is based on the work of Kadushin (1969) and Veroff and colleagues (e.g., Veroff, Kulka, & Douvan, 1981), and findings will be compared to those of the larger samples.

VI. Nature of the research organization

The following is a list of current team members and their roles: Elizabeth Bankoff, Ph.D. (Northwestern University), project coordinator; Mac Brachman, M.A. (University of Chicago), investigator; Bruce Briscoe, Data Analyst/Programmer; Kevin Brown, M.A. (NU), investigator; Beth Carone, Ph.D. (NU), investigator; Jane Conron, M.A. (NU), investigator; David Daskovsky, Ph.D. (NU), investigator; Christine Davidson, Ph.D. (NU), co-Principal Investigator; Norma Davilla, M.A. (UC), investigator; Alix Derefinko (NU), graduate research assistant; Marge Epstein, M.A. (UC), investigator; Michael Horowitz, Ph.D. (NU), investigator; Judith Gillard-Kaufman, M.A. (De Paul University), investigator; Eve Gordon, (NU) graduate research assistant; Ann Horn (NU), graduate research assistant; Mary Hortatsos (NU), Project Administrator; Kenneth Howard, Ph.D. (NU), Principal Investigator; Sheryl Jones (NU), graduate research assistant; Marta Lundy, Ph.D. (University of Illinois, Chicago), investigator; Mark McGovern, Ph.D. (NU), investigator; Cheryl McNeilly, M.A. (NU), investigator; Susan Noel, M.A. (University of Wisconsin, Milwaukee), investigator; Michael O'Mahoney, Ph.D. (NU) co-Principal Investigator; Fred Newman, Ph.D., (University of Illinois, Chicago), investigator; David

Orlinsky, Ph.D. (UC) co-Principal Investigator; Kevin Perry, B.A. (NU), investigator; Janet Robinson, Ph.D. (NU), investigator; Stephen Saunders, M.A. (NU), investigator; David Schwartz, M.A. (NU), investigator; Margarita Tarragona, M.A., (UC), investigator; LaPearl Winfrey, Ph.D. (NU) investigator; Carol Yoken, Ph.D. (Loyola University of Chicago), investigator. Our team also includes six undergraduate research assistants.

VII. Relation to other research organizations

The goals of the program are investigated (for the most part) from the perspective of the "participant observer." Which observational perspective one uses is a crucial methodological issue that has been discussed in more detail elsewhere (Orlinsky and Howard, 1986) and it is generally agreed that multiperspective work is necessary. Our work complements the work conducted at sites emphasizing nonparticipant observers, such as the Berkeley, Penn or Vanderbilt psychotherapy projects.

The relevance of specific studies to clinical training and practice has been discussed in more detail in the publications and presentations themselves. The relevance of the long-term project is worth reiterating. Again, the longer-term patients are the minority of those who seek treatment but constitute the bulk of clinical practice. It has been documented elsewhere that they create a disproportionate impression on mental health professionals (Cohen & Cohen, 1984). An understanding of the stages of both process and outcome of this group is clearly significant.

VIII. Advantages and disadvantages of team research

In order to conduct clinical research in a natural setting, there must be a clear and consistent commitment from the clinical administration. While such support is obviously a necessary condition, it is by no means sufficient. The cooperation of patients and therapists cannot be presumed, regardless of official policy. Our experience has taught us that in order to gain such cooperation, therapists must be confident that the research procedures are respectful of clinical phenomena and do not interfere with the treatment function. While there are no certain solutions to this confidence/cooperation problem, we have found that making and keeping a firm commitment to not interfere with a patient's treatment is essential. For example, as tangible

evidence of this commitment, we make it clear that we will honor any request from a therapist to withdraw a patient from any research procedure.

A serious research commitment from the clinical administration is also necessary for gaining and maintaining the cooperation of patients. Of course patient participation is voluntary; but the greater the clinic administration's commitment is to the research enterprise, the more likely it is that patients' cooperation will be obtained. Two factors seem to account for this. First, when initially soliciting patients' research participation, such participation can be presented more as a routine, expected part of clinic procedure, and less as a "favor" to the researchers. Second, the greater the administration's commitment, the greater the cooperation of the clinic's support staff (e.g., registration personnel, intake workers, cashier). The support staff helps to create an atmosphere that ongoing research is part of the regular clinic procedure.

The Psychotherapy Program is part of a busy Community Mental Health Center and site for large training programs in Psychiatry and Psychology. The research enterprise had to gradually become an integral part of the ongoing clinical work, with each research element (e.g., questionnaire, rating scale) being explicitly accepted by the staff and training programs.

The first problem, indeed, was the staff's initial resistance to the planned "intrusion" of the first research protocols into their, heretofore, almost entirely unencumbered, "office-practice" treatment relationships. The Psychotherapy Program and the rest of the Institute had had a long-established, psychodynamically-oriented, respect for the sanctity of the therapist/patient relationship, and it was essential that the research program be respectful of this value system and to gradually reassure and eventually win over the staff and training leadership. This task was accomplished by having a senior member of the research team in attendance at the weekly staff meetings, having each proposed research protocol reviewed and accepted at these meetings and keeping the training directors appraised of each new development. This was, at first, a very slow process with many months of planning occurring before any data were collected. The effort, however, seems to have been well spent in that the ongoing data collections

are now an integrated, "normal" Program procedure with good cooperation from supervisors, therapists and patients.

Another problem involved integrating a research diagnostic procedure, SCID-IIIR, into the existing clinical intake procedures of the Program. Our initial plan was to modify the Program's diagnostic and treatment-planning "screening" process to provide this research data. It became apparent that this plan would too greatly distort the clinical elements of this important entry process. Consequently, the screening interview was left intact with its clinical and training focus and a separate research diagnostic interview was included early in the patient's entry experience. This interview is conducted by a member of the research team and patients are paid a token honorarium of $10.00 for their time and effort.

The major advantage of team research stems from the fact that the naturalistic study of psychotherapy is very complex and usually extends over a fairly long period of time. The team approach allows for the sharing of data collection and data management duties. A particular investigator may have research responsibilities that do not bear directly on his or her own study, while other investigators are dealing with data for that particular study. In addition, all studies require the presence of an investigator at intake to obtain informed consent. Since each investigator has a range of other obligations (classes, administrative duties, clinical responsibilities, etc.), it would not be possible for a single investigator to be present for all scheduled screening interviews.

The major draw-back of a team approach is the time required to nurture the development of each investigator's ideas. Since we place no theoretical restrictions on our investigators, we are often challenged by new approaches. It should be clear from our description, that there is a wide range of current projects. Thus, effort has to be dedicated to keeping the team cohesive and ensuring that each member feels valued. Our approach has been to have a weekly two-hour research team meeting. This meeting provides a forum for the development of research questions, instrument construction, pilot testing and the like.

There is a feeling of genuine respect, cooperation and open sharing of ideas in our group. Overall, we have been able to create and maintain a spirit of enthusiastic curiosity and a dedication to empirical inquiry.

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Table 1.

Instruments in the Northwestern/Chicago Psychotherapy Research Program

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Input (Patient and Therapist Characteristics) Instruments

General measures:

DSM III-R Axis I, II, III, IV, & V ratings from SCID (Spitzer et al., 1988)

Presenting Problems (patient self-report; see Yoken, 1988)

Extent and type of psychopathology measures:

Symptom Checklist (patient self-report; adapted from Derogatis, 1977)

Interpersonal Symptoms (patient self-report; adapted from Horowitz et al., in press)

Current Life Functioning (patient self-report; Howard, 1988)

Level of Functioning (Carter & Newman, 1980)

Global Assessment Scale (Endicott et al., 1976)

Pathology proneness measures:

Dysfunctional Attitudes Scale (patient self-report; adapted from Weissman, 1979)

Self-esteem (patient self-report; Rosenberg, 1979)

Coping Style (patient self-report; adapted from Tobin et al., in press)

Environmental stress measures:

Life Stress Inventory (patient self-report; adapted from Holmes & Rahe, 1967)

Social Support Scales (patient self-report; Bankoff, 1985)

Readiness for treatment measures:

Therapeutic Experience (patient self-report)

Readiness for Treatment Questionnaire (patient self-report)

Process of Seeking Therapy Questionnaire (patient self-report; Saunders, 1988b)

Process Instruments

Therapeutic Contract Questionnaire-Session and Segment Forms (therapist report; Orlinsky, et al., 1986)

Therapeutic Procedures Inventory (therapist report; Orlinsky et al. 1987)

Therapy Session Report (patient self-report; Orlinsky & Howard, 1966)

Closeness to Therapist Questionnaire (patient self-report)

Inter-session Experience Questionnaire (patient self-report; Orlinsky & Tarragona, 1986)

Outcome Instruments (change on input instruments also used as an outcome measurement)

Patient Rating of Improvement Scale

Therapist Rating of Improvement Scale

Independent Rating of Improvement Scale

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