THE SYSTEMATIC USE OF BETWEEN-SESSION ACTIVITIES
IN SHORT-TERM PSYCHODYNAMIC-INTERPERSONAL PSYCHOTHERAPY
FOR DEPRESSION

A Thesis in
Psychology
by
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Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Master of Science

August 2008
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ABSTRACT

Although the use of between-session activities or “homework” has traditionally been associated with cognitive-behavioral therapy, there is growing evidence that therapists of diverse orientations are incorporating it into their practice. However, whereas there is strong evidence to support the use of homework in CBT, there are currently no known studies exploring its use with other types of therapy. The author reports results from a preliminary study of homework in psychodynamic-interpersonal psychotherapy for depression using one intensive case study. Theoretically relevant rationale for incorporating between-session activities into psychodynamic therapy are enumerated, results of the present study are discussed, and suggestions for future research are presented.
TABLE OF CONTENTS

List of Tables........................................................................................................... v
List of Figures ............................................................................................................ vi
Acknowledgements .................................................................................................. vii

Introduction .............................................................................................................. 1
  Research on the Effectiveness of Homework in Psychotherapy ......................... 3
  Homework in Psychodynamic Psychotherapy ....................................................... 5

The Present Study ................................................................................................... 9
  Goals ....................................................................................................................... 9
  Hypotheses ........................................................................................................... 10

Methods.................................................................................................................. 10
  The Patient .......................................................................................................... 10
  Treatment ........................................................................................................... 11
  The Therapist .................................................................................................... 12
  Measures ............................................................................................................ 13
  Procedure ........................................................................................................... 16

Results..................................................................................................................... 17
  Beck Depression Inventory Scores .................................................................... 18
  Between-Session Activities Questionnaires: Quantitative Results..................... 20
    Discussion of New Between-Session Activities for the Coming Week .......... 20
    Patient’s Engagement in Between-Session Activities During the Past Week ... 26
    In-Session Discussion of Between-Session Activities from the Past Week ... 31
  Between-Session Activities Questionnaires: Qualitative Results...................... 34
    Discussion of New Between-Session Activities for the Coming Week .......... 34
    Patient’s Engagement in Between-Session Activities During the Past Week ... 37
    Discussion of New Between-Session Activities for the Coming Week .......... 40

Discussion ............................................................................................................... 41
  Evidence for the Compatibility of Between-Session Activities with Psychodynamic Psychotherapy ................................................................. 42
  Additional Observations from Comparisons of the BSAQ and BDI Across Time ... 44
  Limitations and Recommendations for Future Studies ....................................... 49

References ............................................................................................................... 51

Appendix A: Between-Session Activities Questionnaire: Client Pre-Session ........ 55
Appendix B: Between-Session Activities Questionnaire: Client Post-Session .... 57
Appendix C: Between-Session Activities Questionnaire: Therapist Post-Session .. 60
LIST OF TABLES

Table 1: Patient and therapist descriptions of new between-session activities (BSAQ: CPOST 8 & BSAQ: TPost 17) ..................................................................................................................35

Table 2: Patient and therapist descriptions of the relevance of new between-session activities to current issues in treatment (BSAQ: CPost 14 & BSAQ: TPost 23) ......36

Table 3: Patient and therapist descriptions of patient's engagement in between-session activities (BSAQ: CPre 3 & BSAQ: TPost 5) ........................................................................38

Table 4: Patient and therapist descriptions of reasons why patient's did not do (all of) what was discussed (BSAQ: CPre 3 & BSAQ: TPost 5) .........................................................39

Table 5: Patient and therapist descriptions of their discussion of between-session activities from the past week ........................................................................................................41
LIST OF FIGURES

Figure 1: Beck Depression Inventory (BDI) scores from pretreatment through session 6.................................................................18

Figure 2: Patient and therapist perceived relevance of discussed activity plotted with next session’s BDI...........................................................24

Figure 3: Patient and therapist perceived potential helpfulness of discussed activity plotted with next session’s BDI.......................................25

Figure 4: Patient and therapist reports of patient's level of engagement in discussed activities over past week plotted with BDI..........................30

Figure 5: Patient and therapist perceived helpfulness of past week’s activity plotted with BDI.................................................................31

Figure 6: Patient and therapist perceived helpfulness of discussion plotted with next session’s BDI............................................................34
ACKNOWLEDGEMENTS

I am honored to have had the opportunity to collaborate with a number of wonderful individuals throughout the course of this project and to have had the valuable support and encouragement of many others.

First, I would like to thank my thesis advisor, Louis Castonguay, whose insight and guidance have been invaluable throughout this experience and with whom I hope to collaborate on many future projects. His dedication to the field of psychotherapy process research and to psychotherapy integration has been, and continues to be, an inspiration.

I would also like to thank my other committee members, Ken Levy and Cathleen Moore, for their methodological suggestions and other constructive comments during the development of the project, as well as for their encouragement.

I am indebted to both Alissa Yamasaki, who acted as the therapist in the project, and to Mary Boutselis for supervising the treatment. I cannot thank them enough for their contributions, without which this study simply would not have been possible.

I also owe a special thanks to Michael Barkham for his permission to use audiotapes of therapy sessions from the Second Sheffield Psychotherapy Project for the purposes of training the therapist. These materials were extremely helpful in facilitating the training and in helping the therapist prepare for her work in the project.

Finally, I would like to thank my friends and family for their ceaseless support, patience, and encouragement when it was most needed. Their faith in me has meant more than I can express.
The Systematic Use of Between-Session Activities in Short-Term Psychodynamic-Interpersonal Psychotherapy for Depression

Introduction

In cognitive-behavioral therapy (CBT), between-session activities – also known as “homework” – are thought to play an important role in promoting the generalization of learning that takes place within the treatment setting to the patient’s life outside of treatment. Homework is seen as providing opportunities for learning and ongoing reality testing (see Goldfried & Padawer, 1982), practicing new cognitive or behavioral skills, implementing solutions to problems, and providing both patient and therapist with ongoing feedback regarding the patient’s progress in therapy (Ledley & Huppert, 2006; and Beck & Tompkins, 2006).

Goisman (1985) has described homework as “the most generic of behavioral interventions – and one that greatly and immediately distinguishes behavior therapy from psychoanalysis” (p. 676). Likewise, both Blagys and Hilsenroth (2002) and Goldfried, Castonguay, Hayes, Drozd, and Shapiro (1997) identify the use of between-session activities as one of the main distinguishing features between CBT on the one hand, and psychodynamic and interpersonal therapies on the other.

Despite the fact that it has been associated with and popularized by CBT, however, homework is by no means used exclusively by cognitive or behaviorally oriented practitioners. Whereas treatments informed by psychodynamic theory tend not to place the same emphasis on the use of homework as their cognitive-behavioral colleagues (e.g. Luborsky, 1984; Strupp & Binder, 1984; and Hobson, 1985), some authors have actively encouraged the use of homework in psychodynamic psychotherapy at least in some cases (e.g. Carich, 1990; Halligan, 1995; Stricker, 2006a, 2006b, Wachtel, 1993). Indeed, the use of homework can even be traced back to
Freud, who wrote, “The pure gold of analysis [might be freely alloyed with] the copper of direct suggestion” (Freud, 1918, as cited in Strupp & Binder, 1984, p. 8) and who suggested to his phobic patients that, once they had worked through their conflicts in analysis, they should venture out into the world and face their fears (Freud, 1952). Thus, rather than seeing homework as a feature that distinguishes cognitive-behavioral from psychodynamic therapies, some theorists have argued that the acquisition and development of “adaptive skills” through between-session activities is, in fact, a common feature of the two (Badgio, Halperin, & Barber, 1999).

Furthermore, there is mounting evidence that practitioners who identify themselves as psychodynamic are making use of homework in their practice. A 1999 New Zealand study found that 98% of all therapists surveyed (N = 221) reported using homework with their patients (Kazantzis & Deane, 1999). As we might predict, therapists who identified CBT as their primary theoretical orientation (57% of the sample) reported using homework more often than those who identified primarily with some other orientation. It is noteworthy, however, that those who identified primarily with those other orientations (e.g. family-systems, humanistic, interpersonal, or psychodynamic) still reported using homework in nearly half of their sessions (48% as opposed to 66% for CBT practitioners). Another study, conducted with German psychotherapists, found that 100% of practitioners surveyed – 26% of whom identified their primary orientation to be psychodynamic – reported using homework assignments at least some of the time (Fehm & Kazantzis, 2004).
Research on the Effectiveness of Homework in Psychotherapy

Not only is there reason to believe that practitioners of varying theoretical backgrounds are making use of homework assignments, but increasing evidence exists, at least within the cognitive-behavioral literature, that doing so has a positive effect on therapeutic outcome.

At first glance, experimental studies of the effects of homework on treatment outcome (all of which have been conducted within the context of cognitive and behaviorally oriented therapy) have produced largely inconsistent results. Some investigations have shown that treatments including the use of homework led to greater improvement than treatments not including homework (e.g. Harmon, Nelson, & Hayes, 1980; Kazdin & Mascitelli, 1982; and Marks, et al., 1988), whereas others found no significant differences between groups assigned homework and those not (e.g. Blanchard, Nicholson, Radnitz, et al., 1991; Blanchard, Nicholson, Taylor, et al., 1991; Kornblith, Rehm, O’Hara, & Lamparski, 1983). Kazantzis (2000) conducted a meta-analysis examining the effect sizes of such studies, however, and found that most of them had surprisingly low power. This analysis found the mean power for studies with small effects to be 0.09, that for studies with medium effects to be 0.32, and that for studies with large effects to be 0.58, as compared to the 0.80 recommended by Cohen (1962). This means that, assuming such an effect exists, even in those studies in which large effects were found, the researchers had, on average, only given themselves a 58% chance of obtaining a significant result. Those studies which found small or no effects gave themselves even less of a chance of obtaining significant results.

To avoid the problem of low power, Kazantzis, Deane, and Ronan (2000) conducted a meta-analysis investigating the effects of homework assignment and compliance on treatment
outcome. From 11 experimental or quasi-experimental studies (N = 375), they concluded that the inclusion of homework assignments in treatment led to significant positive effects on outcome (r = 0.36; 95% CI = 0.23 – 0.48). Furthermore, this was found to be a homogenous effect size, indicating that, across all samples (with different diagnoses and presenting problems) and across all types of homework examined, treatment including homework produced greater improvement than did treatment not including homework. Additionally, these authors found that the extent to which patients complied with therapists’ assignments of homework was positively correlated with outcome (r = 0.22; 95% CI = 0.22 – 0.22; N = 1327). Whereas this finding is only correlational, it is consistent with the hypothesis that treatments incorporating the use of homework (to the extent that it is completed) lead to greater improvement than treatments that do not.

Naturally, we should question whether compliance with homework leads to further improvement, or whether further improvement actually increases the patient’s likelihood of completing homework assignments. Burns and Spangler (2000) found that depressed patients who completed the most homework (in CBT) showed the greatest improvement (average effect size of 14 – 16 BDI points) and that the severity of depression had no effect on homework compliance. Their findings would suggest that some factors other than severity of depression (e.g., personality characteristics of the patient, therapist’s presentation style of homework assignments) are responsible for patients’ homework compliance. In conjunction with the correlation between homework compliance and improvement, this finding would further support the assertion that the use of homework assignments – when they are completed by the patient – likely lead to greater improvement in outcome.
Whereas Kazantzis, Deane, and Ronan (2000) did not intend to focus exclusively on studies of cognitive and behaviorally oriented treatments, all studies that met their inclusion criteria – and were thus included in the meta-analysis – were of cognitive-behavioral treatments. In fact, despite the strong evidence to support the use of homework in cognitive and behavioral therapies, and despite evidence suggesting that it is being used across orientations, there is currently no known empirical support for its use in psychodynamic, interpersonal, or humanistic treatments. An obvious next step in understanding the effects of homework in psychotherapy is to move beyond the theoretical constraints of one orientation and examine the efficacy of homework in non-CBT oriented therapies.

Homework in Psychodynamic Psychotherapy

Although studies such as the ones conducted by Kazantzis and Deane (1999) and Fehm and Kazantzis (2004) suggest that practitioners of psychodynamic psychotherapy are making use of homework, it is unclear whether they have clearly articulated reasons for doing so that fit within their theoretical framework. Are they merely borrowing a useful technique from their cognitive-behavioral colleagues, or does psychodynamic theory give them reason to believe that the use of homework will enhance treatment?

Some practitioners and theorists may argue that, quite to the contrary, suggesting or recommending such activities to the patient would be detrimental. A central reason for traditional psychodynamic therapists’ avoidance of direct suggestions is the emphasis placed on maintaining neutrality, which is thought to facilitate insight gained from the exploration of the therapeutic relationship. As Wachtel (1993) explains,

Many psychodynamic therapists . . . striv[e] to intervene as little as possible and to reveal as little as possible about themselves in order to assure that the patient
cannot attribute his experience of the therapist to something really about the therapist and that he must therefore accept that the reaction comes from within him. (p. 54)

The use of homework – which implies making a suggestion or recommendation – requires the therapist to reveal a bit of him or herself through taking a more active role. In doing so, the therapist introduces information to which patients could attribute their reactions, potentially making it more difficult for them to recognize the transferential nature of these reactions.

Wachtel goes on to suggest, however, that the maintenance of complete neutrality – besides being impossible (patients may respond as much to a therapist’s inaction as to her action) – is not necessary. He says, “There is always some basis in reality for our experiences. And there is always a significant contribution that reflects the active, constructive nature of all perceptual processes” (p. 55, italics in original). He argues that because all reactions, even those that are highly influenced by transference, are grounded to some extent in reality, suggesting that this is not so, in fact, does a disservice to patients, who could benefit from a more nuanced understanding of their vulnerabilities: “We learn more about our psychological proclivities when the role of ongoing events in eliciting the transference reaction is taken into account than when it is omitted or denied” (p. 59, italics in original).

Traditional psychodynamic theorists might also argue that the suggestion of between-session activities may cause patients to lose sight of the main objective of therapy: namely, to gain insight, usually through introspection. Stricker (2006a) elaborates on this position:

Psychodynamic psychotherapy traditionally places emphasis on the introspective activities of the patient and the relationship between the patient and the therapist. To assign homework would seem to deviate from this framework because it places the therapist in the role of an active and directive authority, and it directs patients’ attention away from the therapeutic interaction and their own internal processes toward the area outside the treatment room. (p. 220)
However, as Stricker (2006a) also goes on to argue, even the most traditional psychodynamic treatments have incorporated their own brand of homework, for instance asking patients to remember or even write down their dreams and then discuss these dreams in therapy. Writing down dreams – or paying attention to emotional reactions or interpersonal dynamics throughout the week – may, in fact, enhance, not detract from, patients’ understanding of their internal processes.

Responding to the concern that using homework requires therapists to take a more active role, Stricker (2006b) suggests that psychodynamic psychotherapists often make use of “quasi-homework assignments” or “implicit homework assignments” (p. 102) as opposed to making explicit suggestions, thus remaining relatively nondirective. For example, he says, therapists often make such comments as, “I wonder what would have happened if you had...” and clients can, and often do, interpret these statements as suggestions. Even when patients do not interpret these as suggestions, a new activity or a new way of acting has still been brought to their attention, and they may decide on their own to give it a try.

Stricker also argues that, while psychodynamic theory has traditionally viewed change in a linear direction with insight leading to subsequent behavior change, many contemporary practitioners and theorists would agree that this process is actually cyclical so that behavior change can also lead to insight (Stricker, 2006b; see also Gelso & Harbin, 2006). Stricker notes that according to this model, which he describes as three-tiered, a change in any tier – behavioral, cognitive-affective, or unconscious – should reverberate throughout the system and lead to changes in other tiers as well. Within this model, therefore, homework could potentially accelerate change, especially when insight has not led to subsequent changes in the other tiers or
when patients are having difficulty achieving insight (see also Schottenbauer, Glass & Arnkoff, 2006).

Wachtel (1993) likewise argues in favor of a more reciprocal view of change, pointing out that patients’ attempts to make changes in their lives outside of therapy not only result in these changes _per se_, but also provide them with new perspectives from which to view their lives and their difficulties, which, in turn, lead to “insights that are a _product_ of change rather than its cause” (p. 51, italics in original). He therefore maintains that direct suggestions from the therapist can actually serve to promote insight and thus augment the work that is done in session:

Insight. . . is enhanced. . . by the patient’s being helped to take new actions in the world that bring him into a different position vis-à-vis his conflicts and provide a new vantage point from which to view himself and his feelings and aims. The synergistic interaction between achieving insight and taking active steps to change troubling life patterns renders anachronistic some formulations of the therapeutic process that cast the therapist solely in the role of furthering understanding and that eschew any other kind of assistance as interfering with that superordinate aim. It is the _refusal_ to offer any other kind of assistance that impedes the fuller development of self-understanding. (pp. 48-49, italics in original)

In addition to the points made by Wachtel and Stricker, there may be other theoretically driven advantages to using homework in psychodynamic therapy. In Nelson, Castonguay, and Barwick (2006), we delineate a number of transtheoretical rationales for using homework. Although we argue that any of these rationales could apply to therapy from almost any theoretical orientation, some of these seem particularly relevant to psychodynamic therapy. For instance, homework can give patients opportunities to engage in therapeutic work in different contexts outside of therapy, thus helping them learn to approach situations outside of therapy as they have been encouraged to do so in session. By focusing on the relationship between the therapist and the patient, psychodynamic therapists ultimately hope to impact the patient’s relationships with others outside of therapy. Homework can be especially helpful in allowing
patients to try out new ways of relating with others and thus to generalize what they have learned
to do with the therapist to their other relationships.

Additionally, although a major focus of many psychodynamic therapies is the
relationship between the patient and the therapist, as in all therapy the goal is for the patient
eventually not to need the therapist – that is, essentially, to become his or her own therapist.
Thus, because homework also encourages patients to engage in therapeutic work without the
therapist present, it can help them begin to use what they have learned in therapy (e.g. the ability
to explore and uncover potential unconscious motivations) in future times when the therapist is
not there to guide them.

The Present Study

Goals

The purpose of the present study was to conduct a preliminary exploration of the
systematic use of between-session activities in psychodynamic psychotherapy.

First, the study aimed to address the question of whether homework is compatible with
psychodynamic treatment: Is it possible for therapists practicing psychodynamic
psychotherapy to make use of between-session activities in a systematic manner and still provide
effective treatment? Likewise, is it possible for therapists to make use of between-session
activities in a manner that remains theoretically consistent with psychodynamic therapy?

The second aim of the present study was to address the question of whether the results of
such treatment are comparable (at least equivalent and at best favorable) to empirically supported
psychodynamic therapies that do not explicitly and/or systematically make use of homework.
Due to the early termination of the patient and the infeasibility of recruiting further patients and therapists for this study, the second question cannot be answered at this time.

**Hypotheses**

We predicted that it would be possible for therapists practicing psychodynamic psychotherapy to make systematic use of homework while still providing effective treatment. We also predicted that it would be possible for therapists to make use of homework in a way that was theoretically consistent with psychodynamic therapy. Finally, we predicted that this treatment would be at least as effective as – and potentially even more effective than – empirically supported psychodynamic therapies that do not explicitly and systematically make use of homework.

**Methods**

*The Patient*

Participants were recruited from the Pennsylvania State University Psychological Clinic. To be considered, participants were required to meet three inclusion criteria: (1) a primary diagnosis of Major Depressive Disorder according to criteria of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; American Psychiatric Association, 2000), (2) a score of 21 or greater on the Beck Depression Inventory (BDI-II, Beck, et al., 1996), and (3) an age of between 18 and 65 years old. Participants likewise could not meet the following exclusion
criteria: (1) current substance abuse or dependence, (2) a history of psychotic symptoms, and (3) a previous adequate trial of psychodynamic therapy within the past five years.¹

One patient was selected to take part in the present study. The patient was a single, heterosexual, European-American male in his early 20s. An undergraduate student at Penn State, he had recently transferred from another university and, at the time of intake, was in his first semester since this transition. His complaints included depressed mood, anhedonia, fatigue, increased need for sleep, decreased ability to concentrate, feelings of worthlessness, and recurrent thoughts of death (although no suicidal thoughts or intent). During intake, the patient was diagnosed with Major Depressive Disorder. He had no history of substance abuse problems or psychotic symptoms, and had no previous experiences in psychotherapy. He had never taken any psychotropic medications and did not begin medication during this course of treatment. The patient’s BDI score prior to beginning treatment was 30, a score indicative of severe depression.

Treatment

The treatment used in the present study was Psychodynamic-Interpersonal (PI) Therapy based on Hobson’s Conversational Model (Hobson, 1985). This model incorporates psychodynamic, interpersonal, and experiential components. It places emphasis on the relationship between patient and therapist as a means of understanding and resolving interpersonal difficulties that play a role in the development and maintenance of depression. This treatment was selected based on the fact that it is one of the few psychodynamic treatments that have been evaluated in randomized control trials, and thus are recognized as empirically

¹ A “previous adequate trial” of psychodynamic therapy was defined as at least 12 sessions in length and meeting criteria delineated by Hilsenroth, et al., (2005), in which the authors present the Comparative Psychotherapy Process Scale (CPPS), differentiating between PI therapy and CBT as well as enumerating distinctive features of each.
supported treatments (ESTs) for depression (Follette & Greenberg, 2005). Furthermore, because previous studies (e.g. Shapiro, et al., 1994) have been conducted using this treatment, there are already established effect sizes that could be used as a point of comparison for overall effectiveness between PI therapy with and without the addition of between-session activities.

Treatment was also based on a manual (Nelson & Castonguay, 2007) describing the incorporation of between-session activities into PI therapy. This manual discusses types of between-sessions activities intended to address different processes that can be assumed to be therapeutic, especially in PI therapy (e.g. facilitating insight, facilitating emotional deepening, facilitating corrective experiences and continued reality testing or working through via behavioral activation) and gives examples of such types of activities and how they might be suggested to the patient.

Sessions were 50 minutes long, video-taped and audio-taped, and held once weekly. Treatment was intended to last a total of 16 sessions. However, due to unknown circumstances, the patient discontinued his participation in the treatment after 6 sessions. The circumstances surrounding his termination will be discussed further below.

The Therapist

The therapist for the present study, an Asian-American female in her early 30s, was a post-doctoral level psychologist practicing as a Senior Research Technician at the Penn State Psychological Clinic. She had substantial previous training in psychodynamic psychotherapy and underwent further training specifically in PI therapy. This training involved reading and discussing Hobson’s manual on PI therapy (Hobson, 1985) and related documents (e.g. an unpublished manual used by Shapiro, et al. (1994) in the Second Sheffield Psychotherapy
Project) and the aforementioned additional manual describing the incorporation of between-session activities into PI therapy. Training took place weekly for approximately 15 weeks, and also involved listening to and discussing audio recordings of PI therapy sessions from the Second Sheffield Psychotherapy Project.\(^2\)

Throughout the course of the treatment, the therapist was supervised by a licensed clinical psychologist who was a member of the clinical faculty at Penn State and who had extensive training in psychodynamically oriented therapy. After the therapist had begun seeing the patient, she met with the supervisor and the author once weekly to discuss the case and receive supervision.

**Measures**

The Anxiety Disorder Interview Schedule, Fourth Edition, Penn State Version (ADIS-IVPSU) is a semi-structured clinical interview assessing symptomology pertaining to the various Axis I diagnostic categories described in the *DSM-IV-TR* (American Psychiatric Association, 2000). The ADIS-IVPSU is based on the Anxiety Disorder Interview Schedule, Fourth Edition (ADIS-IV; Brown, Di Nardo, & Barlow, 1994), which was designed to assess the presence of anxiety disorders as well as mood, somatoform, substance use disorders based on the *DSM-IV* criteria. It also includes brief screening modules for psychotic and conversion symptoms. The Penn State University version of this instrument incorporates additional modules which assess for disorders not included in the ADIS-IV (e.g. eating disorders) and incorporates additional questions in modules that were not as well developed in the original (e.g. psychotic disorders).

\(^2\) Used with permission from Michael Barkham, University of Leeds.
The ADIS-IV (and the ADIS-IVPSU) is designed to facilitate differential diagnosis between *DSM-IV* disorders (thereby providing categorical assessments), while also providing dimensional assessments through the use of 0-8 clinician rating scales and regular inquiries about symptom severity and frequency. The ADIS-IVPSU takes approximately 2-3 hours to complete, depending on the complexity of the pathology.

Although no known psychometric data currently are available for the ADIS-IV, the Lifetime Version of the ADIS-IV (ADIS-IV-L) has been found to have fair to excellent inter-rater reliability (κ’s ranging between .56 and .81) with the exception of Dysthymia, which has poor inter-rater reliability (κ = .22 as principle diagnosis and κ = .31 as principle or additional diagnosis) (Brown, Di Nardo, Lehman, & Campbell, 2001). The inter-rater reliabilities for constructs most relevant to the present study are as follows: Major Depressive Disorder, good (κ = .67) as principle diagnosis and fair (κ = .59) as additional or principle diagnosis; and alcohol and substance use disorders, excellent (κs = .82 and .83, respectively) as lifetime diagnoses (Grisham, Brown, & Campbell, 2004). No known psychometric data is available for the inter-rater reliability of psychotic disorders. When the inter-rater reliability of these constructs is assessed dimensionally rather than categorically, the ADIS-IV is found to have even greater inter-rater reliability. Ratings of symptom severity for Major Depressive Disorder, for instance, have been found to have very good reliability (κ = .74) (Grisham, Brown, & Campbell, 2004). Although there is no known psychometric data available for test-retest reliability of the ADIS-IV, its predecessor, the ADIS-Revised, has been found to have moderate to excellent test-retest reliability with correlation coefficients between .43 and .82 (Di Nardo, Moras, Barlow, Rapee, & Brown, 1993).
The Beck Depression Inventory, Second Edition, (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item, self-report measure assessing the presence and severity of symptoms of depression as defined by the DSM-IV. The BDI-II takes approximately 5-10 minutes to complete. Each of the 21 items is rated on a 4-point scale between 0 – 3. Overall scores are determined by summing the scores of all the items and can thus range from 0 – 63. Scores ranging from 0 – 13 are considered indicative of minimal or no depression; those from 14 – 19, mild depression; those from 20 – 28, moderate depression; and those from 29 – 63, severe depression.

The BDI-II is widely used to measure severity of depressive symptomology and it has been demonstrated to have high internal consistency with psychiatric outpatients, yielding a coefficient alpha of .92 (Beck, Steer, Ball, & Ranieri, 1996), as well as a variety of other populations. Test-retest reliability has likewise been found to be high, yielding a correlation coefficient of .93 (Beck, Steer, Ball, & Ranieri, 1996).

Between-Session Activities Questionnaires: Before each session (beginning with the second session), the patient was asked to fill out the Between-Session Activities Questionnaire: Client Pre-Session (BSAQ: CPre, developed by the author)\(^3\), which asks questions about the patient’s engagement in between-session activities since the previous session. The BSAQ: CPre asks the patient to answer some questions using a Likert scale (e.g. “To what extent did you do what was discussed?”) and others with open-ended responses (e.g. “If you did anything related to what was discussed, what specifically did you do?”)

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\(^3\) See Appendix A.
Following each session the patient was asked to fill out the Between-Session Activities Questionnaire: Client Post-Session (BSAQ: CPost, developed by the author)\textsuperscript{4}, which asks about the patient’s discussion of previous activities with the therapist in session and about any new between-session activities that were discussed for the coming week. Although the second portion of the BSAQ: CPost (which pertains to the discussion of new activities) was completed after all sessions including session 1, the first section (which pertains to the discussion of previous activities) was completed beginning at session 2. As with the BSAQ: CPre, the BSAQ: CPost asks the patient to answer some questions using a Likert scale (e.g. “How helpful do you think your discussion of the activity with your therapist was?”) and others with open-ended responses (e.g. “Please described how [the discussed activity] relates to current issues in therapy.”). Also following each session, the therapist was asked to fill out the Between Session Activities Questionnaire: Therapist Post-Session (BSAQ: TPost, developed by the author)\textsuperscript{5}, which asks the therapist equivalent questions to those included in both the BSAQ: CPre and BSAQ: CPost.

\textit{Procedure}

As part of regular intake procedures, all patients seeking treatment at the Clinic are given the ADIS-IVPSU diagnostic interview prior to beginning treatment. The ADIS-IVPSU was used in the present study to assess both depressive symptomology as well as other potential areas of psychopathology and to establish diagnoses. The ADIS-IVPSU was given prior to commencing treatment (as part of pre-treatment screening) and was intended to be given at the end of

\textsuperscript{4} See Appendix B.  
\textsuperscript{5} See Appendix C.
treatment as well. However, due to the patient’s premature termination, this was not possible.\textsuperscript{6} The pre-treatment interview was administered by an advanced doctoral student who acted as staff therapist in the clinic.

During recruitment, patients who met criteria for the study based on the results of the ADIS-IVPSU interviews were flagged after intake and invited to undergo further assessment to see if they qualified to participate in the study. After being invited to participate in this screening, the patient was then given the BDI-II to assess the severity of his depressive symptoms. In addition to being used in pre-treatment screening, the BDI-II was also be given prior to each therapy session. It was intended that the BDI be given at the end of treatment as well, but, due to the patient’s early termination, this was not possible.

The BSAQ questionnaires were completed by both the patient and the therapist at each session as described above.

\textbf{Results}

Due to the fact that the patient discontinued his participation in the treatment prematurely (after only 6 sessions), many of the previously proposed analyses cannot be done. Basic

\begin{footnote}
\textsuperscript{6} After the patient indicated in a phone message to the therapist that he did not intend to return to therapy, the author attempted to contact him – first by phone and later by letter – to ascertain why he had terminated treatment and to find out if he would be willing to complete the post-treatment measures. Unfortunately, the patient did not respond to any of these communications. Based on the content of his discussions with the therapist both in the last session and in a phone conversation (which took place after the last session but before he indicated that he was ending treatment), it is believed that he ended treatment because he chose not to return to Penn State for the spring semester and therefore most likely moved back to his hometown. The last session he attended was in the week before he left to go home for winter break, and at that time he indicated that he intended to make an appointment when he returned. However, when he called after the break, it was first to say that he still had not registered for classes and therefore did not know when he would be able to meet, and later to say (without giving a reason) that he would not be making another appointment.
\end{footnote}
statistical analyses of the available data will be presented, and graphical representations will be used to discuss trends in the data, that – while not statistically significant – are suggestive of relationships between different variables and may inform hypotheses for future studies.

Beck Depression Inventory Scores

As mentioned above, the patient’s BDI score at pretreatment was 30, indicative of severe depression. With some fluctuation, the trend in BDI scores is, overall, downward (that is, improving), and, at the time of the last session (session 6), his score was 17, indicative of mild depression (see Figure 1). Between pretreatment and session 1, the patient’s BDI score dropped 10 points from 30 to 20, most likely due to expectancy effects. Although the BDI rose again to 27 at session 2, it then began a relatively steady decline over the course of the next four sessions.

Figure 1: Beck Depression Inventory (BDI) scores from pretreatment through session 6
One of the most promising and widely accepted methods for investigating clinically significant change was developed by Jacobson and Truax (1991), who proposed two criteria for assessing clinical significance: first, the treated population must move from a theoretically dysfunctional population to a theoretically functional one, and second, the change must be reliable. In order to fulfill the first criterion, the treatment population mean (or in this case, the individual patient’s score) at pre-treatment must be more than two standard deviations above the general (i.e. “functional”) population mean and must move, by the end of treatment, to within two standard deviations of this mean. Ogles, Lambert, and Sawyer (1995) establish the cutoff point for being within two standard deviations of the general population mean as 13.46 on the BDI. The patient in the current study had a BDI score at pre-treatment (30) that was well above this cutoff; however, his BDI score when he left treatment (17) was also above this cutoff. Therefore, the first criterion was not met.

The patient’s change in BDI scores over the course of the treatment does, however, meet the second criterion – that of reliability. Reliability is calculated using the Reliable Change Index (RCI): if the RCI is greater than 1.96, one can conclude that the change from pre- to post-treatment is not merely a result of random fluctuations in scores, but rather due to a true shift in functioning (Jacobson & Truax, 1991). To meet this criterion, the change in BDI scores over the course of treatment must be greater than 9 points (Ogles, et al., 1995). Therefore, because the patient’s BDI scores over the course of treatment decreased by 13 points, this change can be assumed to be indicative of a real change in functioning rather than mere random fluctuation in scores.
Between-Session Activities Questionnaires: Quantitative Results

As previously mentioned, both the patient and the therapist were asked to fill out questionnaires (the BSAQ: CPre, BSAQ: CPost, and BSAQ: TPost) at each session assessing different aspects of the use of between-session activities. Each of the questions in these questionnaires will be discussed briefly in turn, and patient and therapist responses to analogous questions will be compared.

Several of these questions were also selected for further analysis. These questions were selected based on the author’s belief that they most closely reflected aspects of the use of between-session activities that were most likely to predict therapeutic change. Although the patient’s premature termination of therapy limits the number of data points, thus making a time-series analysis infeasible, a graphical representation of patient and therapist responses to questions alongside the patient’s BDI scores over time may suggest trends in the data that, while not statistically significant, may inform hypotheses for future research in this area.

First, we will discuss questions pertaining the patient’s and therapist’s discussion of new between-session activities for the coming week. Next, we will discuss questions pertaining to the patient’s engagement in between-session activities during the past week. Third, we will discuss questions pertaining to the patient’s and therapist’s in-session discussion of between-session activities from the past week.

Discussion of New Between-Session Activities for the Coming Week

Question 7 of the BSAQ: CPost asks the patient, “In the session you just had, did you and your therapist discuss any between-session activities that you could do between now and the next time you meet? (NOTE: Between-session activities can include anything you might do between
sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)” The question asks for a yes/no response. The patient responded, “Yes,” to this question on five out of the six applicable sessions.

Question 16 of the BSAQ: TPost is equivalent, asking the therapist, “In the session you just had, did you and your client discuss any between-session activities that s/he could do between now and the next time you meet? (NOTE: Between-session activities can include anything the client might do between sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)” The therapist responded, “Yes,” to this question on six of the six applicable occasions. Thus the therapist and patient agreed that between-session activities for the coming week had been discussed in five out of six sessions, and in the one session where they disagreed, the therapist indicated that between-session activities had been discussed while the patient did not.

Question 9 of the BSAQ: CPost asks the patient, “On the following scale, please indicate the degree to which you contributed to the development of this idea.” The question asks the patient to respond using a Likert scale where 1 is, “Not at all,” 3 is, “Moderately,” and 5 is, “Completely.” The patient’s mean response across the five applicable sessions was 2.80 (SD = 1.30).

Question 19 of the BSAQ: TPost is equivalent, asking the therapist, “On the following scale, please indicate the degree to which the client contributed to the development of this idea.” Using the same scale, the therapist’s mean response across the six applicable sessions was 2.83 (SD = 1.17).

Question 10 of the BSAQ: CPost asks the patient, “On the following scale, please indicate the degree to which your therapist contributed to the development of this idea.” Using
the same scale mentioned for the previous question, the patient’s mean response across the five applicable sessions was 4.00 ($SD = 1.00$).

Question 18 of the BSAQ: TPost is equivalent, asking the therapist, “On the following scale, please indicate the degree to which you contributed to the development of this idea.” Using the same scale, the therapist’s mean response across the six applicable trials was 4.00 ($SD = 0.63$).

Question 11 of the BSAQ: CPost asks the patient, “To what degree did you feel that you and your therapist collaborated in developing the idea?” Using the same scale, the patient’s mean response across the five applicable sessions was 3.20 ($SD = 1.00$).

Question 20 of the BSAQ: TPost is equivalent, asking the therapist, “To what degree did you feel that you and your client collaborated in developing the idea?” Using the same scale, the therapist’s mean response across the six applicable sessions was 2.17 ($SD = 0.75$).

Question 12 of the BSAQ: CPost asks the patient, “If your therapist made a suggestion or recommendation, how direct/indirect was her suggestion/recommendation?” Using a Likert scale, where 1 is, “Very indirect,” 3 is, “Moderately direct,” and 5 is, “Very direct,” the patient’s mean response across the five applicable sessions was 3.20 ($SD = 1.30$).

Question 21 of the BSAQ: TPost is equivalent, asking the therapist, “If you made a suggestion or recommendation, how direct/indirect was your suggestion/recommendation?” Using the same scale, the therapist’s mean response was 4.17 ($SD = 1.17$).

Question 13 of the BSAQ: CPost asks the patient, “To what extent does this activity seem relevant to current issues in therapy?” Using a Likert scale where 1 is “Not at all relevant,” 3 is, “Moderately relevant,” and 5 is, “Very relevant,” the patient’s mean response across the five applicable sessions was 3.60 ($SD = 1.14$).
Question 22 of the BSAQ: TPost is equivalent, asking the therapist, “To what extent does this activity seem relevant to current issues in therapy?” Using the same scale, the therapist’s mean score across the six applicable sessions was 4.67 ($SD = 0.82$).

Question 15 of the BSAQ: CPost asks the patient, “How helpful do you believe such an activity could be?” On a Likert scale where 1 is, “Not at all helpful,” 3 is, “Moderately helpful,” and 5 is, “Very helpful,” the patient’s mean response across the five applicable sessions was 3.60 ($SD = 0.55$).

Question 24 of the BSAQ: TPost is equivalent, asking the therapist, “How helpful do you believe such an activity could be?” On the same scale, the therapist’s mean score across the six applicable sessions was 3.83 ($SD = 0.75$).

Questions 13 and 15 of the BSAQ: CPost and questions 22 and 24 of the BSAQ: TPost – which pertain to the perceived relevance and the perceived potential helpfulness of the activity – were selected for further analysis. The patient’s and therapist’s responses to each of these questions are plotted over time alongside the patient’s BDI scores at the beginning of the following session$^7$.

Question 13 of the BSAQ: CPost and question 22 of the BSAQ: TPost ask the patient and therapist, “To what extent does [the discussed] activity seem relevant to current issues in therapy?” Figure 2 depicts both patient and therapist responses to this question over time, as well as the patient’s BDI scores (lagged by one session) over time. Recall that, because the

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$^7$ We have chosen to plot the question responses alongside BDI scores from the following session for two primary reasons. First, the BDI was completed by the patient prior to each session; therefore, his responses on this measure were recorded prior to any in-session discussion of new activities. Second, we might expect these aspects of the use of between-session activities – their perceived relevance and potential helpfulness – to be most predictive of BDI scores at the following session.
patient indicated that he did not believe that new between-session activities had been discussed in session 4, he did not answer this question on that occasion.

Although the therapist’s and patient’s ratings of perceived relevance were in the moderate and slightly below moderate range (3 and 2 respectively on the 1-5 scale) at the session 1, these ratings began to rise with session 2 (therapist 5, patient 4) and remained relatively high throughout the remainder of the treatment. The therapist’s ratings remained in the high range (5) for sessions 2 – 6, whereas the patient’s fluctuated between moderate (3) and high (5).

Coinciding with the change between low/moderate ratings at session 1 and higher ratings at session 2 was an 8-point decrease in the patient’s BDI score, the largest between-session decrease over the course of treatment. Rating remained relatively high over the course of the remaining sessions while the BDI continued to decrease gradually.

Figure 2: Patient and therapist perceived relevance of discussed activity plotted with next session’s BDI.
Question 15 of the BSAQ: CPost and question 24 of the BSAQ: TPost ask the patient and therapist, “How helpful do you believe such an activity could be?” Figure 3 depicts patient and therapist responses to this question over time as well as the patient’s BDI scores (lagged by one session) over time.

Similar to what was observed with patient and therapist ratings of relevance, both of their ratings of potential helpfulness began at session 1 in the moderate range (3). From session 1 to session 2, these ratings both increased (therapist 5, patient 4) and remained in the moderately high range (4) over the next few sessions. This increase in both the patient’s and therapist’s ratings of potential helpfulness coincided with the same 8-point drop in the BDI mentioned above. Both therapist and patient continued to rate potential helpfulness in the moderate (3) to moderately high (4) range through the remainder of treatment, as the BDI continued to decrease gradually.

Figure 3: Patient and therapist perceived potential helpfulness of discussed activity plotted with next session’s BDI
Patient’s Engagement in Between-Session Activities During the Past Week

Question 1 of the BSAQ: CPre asks the patient, “In last week’s session, did you and your therapist discuss any between-session activities that you could do between then and today’s session? (NOTE: Between-session activities can include anything you might do between sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)” This question asks for a yes/no response. The patient responded with “Yes” to four out of five sessions for which this question was applicable. (As with all questions referring to previous sessions or activities, this question is not applicable to the first session.) The one session for which the patient indicated that no between-session activities had been discussed was the same session for which he responded as such in the BSAQ: CPost.

Question 1 of the BSAQ: TPost asks the therapist an analogous question: “In last week’s session, did you and your client discuss any between-session activities that s/he could do between then and today’s session? (NOTE: Between-session activities can include anything your client might do between sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)” Again, this question asks for a yes/no response. The therapist responded with “Yes” on five out of the five sessions for which this question was applicable.

Question 2 of the BSAQ: CPre (which is only answered if the response to question 1 was “Yes”) asks the patient, “To what extent did you do what was discussed?” The questions asks the patient to respond using a Likert scale, where 1 is, “Not at all,” 3 is, “Partly,” and 5 is, “Completely. The patient’s mean response to this question across the four sessions for which it was applicable was 4.25 (SD = 0.05).
Question 4 of the BSAQ: TPost is analogous, asking the therapist, “To what extent did the client do what was discussed?” On the same scale as mentioned above, the therapist’s mean response across the five applicable sessions was 3.80 ($SD = 1.64$).

Question 5 of the BSAQ: CPre asks the patient, “If you did at least part of what was discussed, how helpful do you think the activity was?” Again, the patient is asked to use a Likert scale, where 1 is, “Not at all helpful,” 3 is, “Moderately helpful,” and 5 is, “Very helpful.” The patient’s mean response to this question across the four applicable sessions was 3.00 ($SD = 0.00$).

Question 7 of the BSAQ: TPost is equivalent, asking the therapist, “If the client did at least part of what was discussed, how helpful do you think the activity was?” Using the same scale, the therapist’s mean response across the five applicable sessions was 3.00 ($SD = 1.22$).

Question 6 of the BSAQ: CPre asks the patient, “Did you engage in any activities relevant to therapy that you and your therapist did not discuss in last week’s session? (This might include activities that were not previously discussed or activities discussed earlier in therapy but not in last week’s session.)” This question asks for a yes/no response. The patient answered, “No,” to this question at all of the five applicable sessions.

Question 9 of the BSAQ: TPost is equivalent, asking the therapist, “Did you and the client discuss any activities relevant to therapy that the client engaged in this past week but that were not discussed in last week’s session? (This might include activities that were not previously discussed or activities discussed earlier in therapy but not in last week’s session.)” The therapist responded, “Yes,” to this question on two out of the five sessions for which it was applicable. Thus, on two occasions, the therapist and patient disagreed in their answers to this
question with the therapist indicating that the patient did engage in between-session activities that had not been previously discussed and the patient indicating that he had not.

Question 8 of the BSAQ: CPre (which is only answered if the response to question 6 was “Yes”) asks the patient, “To what extent was this activity related to suggestions/discussions of between-session activities made previously in treatment (not in last week’s session)?” The question asks the patient to respond using a Likert scale where 1 is, “Not at all related,” 3 is, “Moderately related,” and 5 is, “Completely related.” Because the patient responded, “No,” to question 6 at all sessions, this question was not applicable on any occasions.

Question 11 of the BSAQ: TPost is equivalent, asking the therapist, “To what extent was this activity related to suggestions/discussions of between-session activities made previously in treatment (not in last week’s session)?” Across the two occasions for which this question was applicable, the therapist’s mean response (using the same scale) was 3.50 ($SD = 2.12$).

Question 10 (which is also only answered if the answer to question 6 is, “Yes”) of the BSAQ: CPre asks the patient, “To what extent does this activity seem relevant to current issues in therapy?” The question asks the patient to respond using a Likert scale where 1 is, “Not at all relevant,” 3 is, “Moderately relevant,” and 5 is, “Completely relevant.” Again, because the patient indicated that he did not believe that he engaged in any between-session activities that had not been discussed in the previous session on any occasions, this question was never applicable.

Question 13 of the BSAQ: TPost is analogous, asking the therapist, “To what extent does this activity seem relevant to current issues in therapy?” Across the two occasions for which this question was applicable, the therapist’s mean response (using the same scale) was 5.00 ($SD = 0.00$).
Question 11 of the BSAQ: CPre (which is only answered if the answer to question 6 is, “Yes”) asks the patient, “How helpful do you think the activity was?” The question asks the patient to respond using a Likert scale, where 1 is “Not at all helpful,” 3 is, “Moderately helpful,” and 5 is, “Very helpful.” Again, because the patient responded, “No,” to question 6 on all occasions, this question as never applicable.

Question 14 of the BSAQ: TPost is equivalent, asking the therapist, “How helpful do you think the activity was?” The therapist’s mean response (using the same scale) across the two applicable sessions was 4.5 ($SD = 0.71$).

Questions 2 and 5 of the BSAQ: CPre and questions 4 and 7 of the BSAQ: TPost – which pertain to the degree to which the patient engaged in between-session activities and the perceived helpfulness of these activities – were selected for further analysis. The patient’s and therapist’s responses to each of these questions are plotted over time alongside the patient’s BDI scores at the beginning of the same session.

Question 2 of the BSAQ: CPre and question 4 of the BSAQ: TPost ask the patient and therapist, “To what extent did you [the client] do what was discussed?”  Figure 4 depicts both patient and therapist responses to this question over time, as well as the patient’s BDI scores over time.

The patient’s ratings of his own level of engagement began in the moderately high range (4), peaking at session 3 with a high rating (5), and continuing in the moderately high (4) range for the remainder of treatment. The therapist likewise began with high ratings (5), which remained high through session 4; however after this, the therapist’s ratings of the patient’s level of engagement decreased to moderately low (2) for the last two sessions. The session at which
the patient reported the highest level of engagement coincided with the 8-point drop in the BDI mentioned previously.

![Graph showing BDI and Perceived Level of Engagement over sessions](image)

**Figure 4:** Patient and therapist reports of patient's level of engagement in discussed activities over past week plotted with BDI

Question 5 of the BSAQ: CPre and question 7 of the BSAQ: TPost ask, “If you [the client] did at least part of what was discussed, how helpful do you think the activity was?”

**Figure 5** depicts both patient and therapist responses to this question over time, as well as the patient’s BDI scores over time.

The patient’s ratings of how helpful he found the activities in which he did engage between sessions were consistently in the moderate range (3) across all sessions. The therapist’s ratings of helpfulness fluctuated more, however. These ratings began in the moderately high range (4), peaking at session 3 in the high range (5), and returning to moderately high (4) at session 4. This peak in the therapist’s perception of helpfulness coincided with the previously
mentioned 8-point drop in the BDI. However, in sessions 5 and 6, the therapist’s ratings of helpfulness dropped to moderately low (2).

![Graph](image)

**Figure 5:** Patient and therapist perceived helpfulness of past week’s activity plotted with BDI

**In-Session Discussion of Between-Session Activities from the Past Week**

Question 1 of the BSAQ: CPost asks the patient, “If, during last week’s session, you and your therapist discussed any between-session activities that you could do between then and today, were they discussed again today?” This question asks for a yes/no response. The patient responded, “Yes,” to all four occasions for which this question was applicable. (It was not applicable to session 1 and it was not applicable to the session following that in which he indicated that no between-session activities had been discussed.)

Question 2 of the BSAQ: TPost is equivalent, asking the therapist, “If [in last week’s session, you discussed any between session activities that the client could engage in between then and today], where they discussed again today?” Again, this question asks for a yes/no
response. The therapist responded, “Yes,” to this question at five out of the five applicable sessions.

Question 3 of the BSAQ: CPost asks the patient, “How helpful do you think your discussion of the activity with your therapist was?” The question asks the patient to respond using a Likert scale where 1 is, “Not at all helpful,” 3 is, “Moderately helpful,” and 5 is, “Very helpful.” The patient’s mean score across the four applicable sessions was 3.5 ($SD = 1.00$).

Question 8 of the BSAQ: TPost is equivalent, asking the therapist, “How helpful do you think your discussion of the activity with your client was?” Using the same scale, the therapist’s mean response was 3.00 ($SD = 1.22$).

Questions 4, 5, and 6 of the BSAQ: CPost refer to the discussion of activities that the patient may have engaged in over the course of the past week but that weren’t discussed in the previous session. Because the patient indicated that he did no such activities, none of these questions are applicable.

Question 15 of the BSAQ: TPost asks the therapist about the discussion of activities that the patient engaged in over the course of the past week but that weren’t discussed in the previous session. The question asks, “How helpful do you think your discussion of the activity with your client was?” The question asks the therapist to respond on a Likert scale where 1 is “Not at all helpful,” 3 is, “Moderately helpful,” and 5 is, “Very helpful.” The therapist’s mean response to this question across the two applicable sessions was 4.00 ($SD = 1.41$).

Question 3 of the BSAQ: CPost and question 8 of the BSAQ: TPost – which pertain to the perceived helpfulness of the in-session discussion of already completed activities – were selected for further analysis. The patient’s and therapist’s responses to each of these questions
are plotted over time alongside the patient’s BDI scores at the beginning of the following session.

Question 3 of the BSAQ: CPost and question 8 of the BSAQ: TPost ask the patient and therapist, “How helpful do you think your discussion of the activity with your therapist [client] was?” Figure 6 depicts both patient and therapist responses to this question over time, as well as the patient’s BDI scores (lagged by one session) over time.

There is complete agreement between the ratings of the patient and the therapist across sessions 2 – 4. They both began at session 2 by rating the helpfulness of their discussion as moderate (3). They then both rated their discussion at session 3 to be high (5) and their discussion at session 4 to be moderate (3). The patient’s ratings remained in the moderate (3) range for the remainder of sessions, while the therapist’s ratings dropped to moderately low (2) for the last two sessions. The session at which both patient and therapist rated their discussion as most helpful followed the 8-point drop in BDI that has been previously discussed (that is, this discussion was of the activity that took place during the week where most change occurred).

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8 As with the questions pertaining to the discussion of new activities for the coming week, we have chosen to plot these question responses alongside BDI scores from the following session for two primary reasons. First, the BDI was completed by the patient prior to each session; therefore, his responses on this measure were recorded prior to his discussing the past week’s activities with his therapist. Second, although we might expect his actual engagement in between-session activities to be most relevant to the present week’s BDI, we would also expect his discussion with the therapist – which may bring about new insight regarding the activities – to be most predictive of BDI scores at the following session.
Between-Session Activities Questionnaires: Qualitative Results

In addition to the questions discussed above, all of which require either categorical responses (yes/no) or responses on a Likert scale, the BSAQs also ask both the patient and the therapist for open-ended descriptions of activities and discussions. Responses to these questions will be described briefly. We will also identify some themes that arose in the responses and provide examples.

Discussion of New Between-Session Activities for the Coming Week

Question 8 of the BSAQ: CPost and question 17 of the BSAQ: TPost follow the question of whether or not new between-session activities for the coming week were discussed in the current session. These questions (which are only answered if the answer to question previous question was, “Yes”) asks both the patient and the therapist, “If so, what was discussed?”
Themes that arose from these questions include increasing social contacts (e.g. patient’s response: “Joining a club.”), trying to be more open in relationships (e.g. patient’s response: “Finding times in relationships when I could let people in.”), and observing how different types of interpersonal interactions affect his mood (e.g. therapist’s response: “Observe how mood is affected by interactions with family over Thanksgiving.”). For a comparison of the patient’s and therapist’s responses by session, see Table 1.

**Table 1: Patient and therapist descriptions of new between-session activities (BSAQ: CPOST 8 & BSAQ: TPost 17)**

<table>
<thead>
<tr>
<th>Session</th>
<th>Patient</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>“Thinking about future, joining a club.”</td>
<td>“(1) Consider the possibility that fears of future might be focus of treatment, as they might be contributing to depression; (2) try joining a club to meet people.”</td>
</tr>
<tr>
<td>Session 2</td>
<td>“Think about relationships with family over Thanksgiving.”</td>
<td>“(1) Observe how mood is affected by interactions w/ family over Thanksgiving, and (2) try to be ‘laid back’ in interacting with mom.”</td>
</tr>
<tr>
<td>Session 3</td>
<td>“Finding times in relationships when I could let people in.”</td>
<td>“Client might observe current interactions of being ‘laid back’ and try to identify opportunities for being more open in these interactions.”</td>
</tr>
<tr>
<td>Session 4</td>
<td>No response</td>
<td>“To be open to or to try talking more openly with identified friend through direct attempts to call/email &amp; with new coworkers.”</td>
</tr>
<tr>
<td>Session 5</td>
<td>“Look for times when I divert direct personal questions.”</td>
<td>“The possibility that he uses humor to deflect focus from himself, and that it might cause him to miss opportunities to be open &amp; let people know him in the moment. Asked him to be aware of when this might be occurring over the week.”</td>
</tr>
<tr>
<td>Session 6</td>
<td>No response</td>
<td>“Trying to be more himself (not so &quot;linear&quot; in conversations) and observing how others react to this.”</td>
</tr>
</tbody>
</table>
Question 14 of the BSAQ: CPost and question 23 of the BSAQ: TPost follow the question of how relevant the activity seems to current issues in therapy. These questions ask the patient and therapist to, “Please describe how it relates to current issues in therapy.” Themes that arose from these responses include causal links between the patient’s lack of meaningful relationships with others and his depression (e.g. client’s response: “My problems may be caused by relationships or lack thereof.”) and how his own interpersonal style may keep others at a distance (e.g. therapist’s response: “If patient can increase awareness of how he contributes to keeping distant from others, he will be better able to actively change the interpersonal process maintaining his depression.”). For a comparison of the patient’s and therapist’s responses by session, see Table 2.

**Table 2: Patient and therapist descriptions of the relevance of new between-session activities to current issues in treatment (BSAQ: CPost 14 & BSAQ: TPost 23)**

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>“Some of the depression may come from fear of future, thinking about it may help define the problem.”</td>
<td>“Client reported worries that becoming a math teacher might not be what he wants to pursue, and also fears that he may end up having a life like his uncle.”</td>
</tr>
<tr>
<td>Session 2</td>
<td>“My problems may be caused by relationships or lack thereof.”</td>
<td>“We talked today about his style of interaction (‘laid back’) with people, and how his interactions with family might promote main fears &amp; feelings of inability to be treated as an adult. Both of these (style &amp; family interactions) might serve to promote depression.”</td>
</tr>
<tr>
<td>Session 3</td>
<td>“Not letting people in may be giving me problems.”</td>
<td>“Client feels skeptical that our focus (on trying to be more open in friendships) would be difficult to make use of because he does not have current friends, and observing/looking for possible opportunities might help to lesson skepticism and increase agree between client and therapist about focus and area for change.”</td>
</tr>
</tbody>
</table>
Session 4  No response  “Client has pattern of not disclosing/being open in relationships, and attempting to be more open may help him to recognize how he can improve his mood through changing this pattern.”

Session 5  “I divert people, I don't let them really know me.”  “If client can increase awareness of how he contributes to keeping distant from others, he will be better able to actively change the interpersonal process maintaining his depression.”

Session 6  “Try out & notice things talked about during sessions.”  “Client seems to keep himself limited to being ‘linear’ in relationships, which prevents him from being ‘himself’ & comfortable with others, which is likely to contribute to his lack of close relationships.”

Patient’s Engagement in Between-Session Activities During the Past Week

Question 3 of the BSAQ: CPre and question 5 of the BSAQ: TPost follow the question of the extent to which the patient engaged in between-session activities that had been discussed in the previous session. These questions ask the patient and therapist, “If you (the client) did anything related to what was discussed, what specifically did you (s/he) do?” Themes that arose from these responses include observations of interactions outside of session (e.g. patient’s response: “Looked at my relationships with my family.”), trying out new ways of being with others and observing differences in how this makes him feel (e.g. therapist’s response: “He tried being ‘laid back’ with family and also as aware that his mood lowered for the time he was with family (vs. with friends).”), and looking for opportunities to have different types of relationships (e.g. patient’s response: “Tried to find relationships that work both ways, that people will ask me & listen.”) For a comparison of the patient’s and therapist’s responses by session, see Table 3.
Table 3: Patient and therapist descriptions of patient's engagement in between-session activities (BSAQ: CPre 3 & BSAQ: TPost 5)

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Patient (Not applicable)</th>
<th>Therapist (Not applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2</td>
<td>“Went to a meeting for a group &amp; thought about what futures I fear.”</td>
<td>“Attended a meeting to get involved with a student group, and thought about fears he had, particularly related to fears of not having meaningful relationships.”</td>
</tr>
<tr>
<td>Session 3</td>
<td>“Looked at my relationships with my family.”</td>
<td>“He tried being ‘laid back’ with family and also was aware that his mood lowered for the time he was with family (vs. with friends).”</td>
</tr>
<tr>
<td>Session 4</td>
<td>“Identified a friend as one opportunity to be more open. Also thought about the possibility with his mom and at work.”</td>
<td>“He found that there were many barriers to this (e.g. people might be busy) – and then felt depressed by this &amp; even less interested in reaching out to people.”</td>
</tr>
</tbody>
</table>

For a comparison of the patient’s and therapist’s responses by session, see Table 4.
<table>
<thead>
<tr>
<th>Session</th>
<th>Patient</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(Not applicable)</td>
<td>(Not applicable)</td>
</tr>
<tr>
<td>2</td>
<td>“I could've researched more groups to join.”</td>
<td>“Client completed homework fully, but didn't expand a lot about his fears in session – so I was a bit unsure how much he thought about it (which is why my rating for #4 went from 4 to 5).”</td>
</tr>
<tr>
<td>3</td>
<td>No response</td>
<td>No response</td>
</tr>
<tr>
<td>4</td>
<td>No response</td>
<td>No response</td>
</tr>
<tr>
<td>5</td>
<td>No response</td>
<td>“Didn't get to talk to them much because of work circumstances (may have been other reasons, but I didn't push him).”</td>
</tr>
<tr>
<td>6</td>
<td>No response</td>
<td>“He found that there were many barriers to this (e.g. people might be busy) - and then felt depressed by this &amp; even less interested in reaching out to people.”</td>
</tr>
</tbody>
</table>

Question 7 of the BSAQ: CPre and question 10 of the BSAQ: TPost follow the question of whether the patient engaged in any between-session activities over the course of the week that were not discussed in the previous session. These questions ask, “If so, what specifically did you (s/he) do?” Because the patient responded with, “No,” to the previous question on all occasions, this question was not applicable for him. The therapist responded, “Yes,” to the previous question on two occasions. Her responses include, “In addition to observing himself with family, he also did so with friends,” and “Client attempted to repair relationship with mom by apologizing. Also called friend to vent and ended up getting support & advice re: mom.”

Question 9 of the BSAQ: CPre and question 12 of the BSAQ: TPost follow the question of the extent to which activities that the patient engaged in that weren’t discussed in the previous
session were related to previous discussions or suggestions. These questions ask, “If at all related to discussions or suggestions made previously in therapy, what was previously discussed/suggested?” Again, because the patient did not indicate that he had engaged in any such activities, this question was not applicable on any occasions for him. An example of the therapist’s responses to this question is, “His efforts are consistent w/ discussion about this pattern of not being open w/ others and the possibility that increasing his openness might improve mood.”

Discussion of New Between-Session Activities for the Coming Week

Question 1 of the BSAQ: CPost and question 3 of the BSAQ: TPost ask about the discussion of between-session activities from the previous week. Question 1 of the BSAQ: CPost asks the patient, “If, during last week’s session, you and your therapist discussed any between-session activities that you could do between then and today, were they discussed again today?” Question 3 of the BSAQ: TPost, which follows a question of whether previously discussed between-session activities were discussed again in the current session, asks, “If so, what was discussed?” The themes that arose from these responses are similar to those arising from other questions: observations about the patient’s interactions with others between sessions (e.g. patient’s responses: “Observing relationships with family and how they affect mood” and “My relationships with people that are receptive and how they help.”), patterns in the patient’s style of interaction that may contribute to his difficulties (e.g. patient’s response: “Generally, how I react when conversations get more focus shifted to me.”), and opportunities for having different types of interactions (e.g. therapist’s response: “Looking for opportunities to be more
open in relationships & being aware of when he uses humor to deflect.”) For a comparison of the patient’s and therapist’s responses by session, see Table 5.

Table 5: Patient and therapist descriptions of their discussion of between-session activities from the past week

<table>
<thead>
<tr>
<th>Session</th>
<th>Patient</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>(Not applicable)</td>
<td>(Not applicable)</td>
</tr>
<tr>
<td>Session 2</td>
<td>“If I did them or not.”</td>
<td>“Identified what had he done b/w sessions, including specifics about each part of the homework (joined group, thought about fears - esp. related to uncle.”)</td>
</tr>
<tr>
<td>Session 3</td>
<td>“Observing relationships with family and how they affect mood.”</td>
<td>“Attempts to take a ‘laid back’ approach with family, which led to agitation. Also how he felt with regard to mood in these interactions.”</td>
</tr>
<tr>
<td>Session 4</td>
<td>“My relationships with people that are receptive &amp; how they help.”</td>
<td>“Being aware of possible opportunities (relationships) where client could be more open in relationships.”</td>
</tr>
<tr>
<td>Session 5</td>
<td>No response</td>
<td>“Whatever or not client had found opportunities at work to make connections/be a bit more open.”</td>
</tr>
<tr>
<td>Session 6</td>
<td>“Generally, how I react when conversations get more focus shifted to me.”</td>
<td>“Looking for opportunities to be more open in relationships &amp; being aware of when he uses humor to deflect.”</td>
</tr>
</tbody>
</table>

Discussion

In conducting this study, we had two aims. First, we wanted to determine whether the use of between-session activities could be compatible with psychodynamic psychotherapy and whether therapists practicing psychodynamic forms of treatment would be able to systematically make use of between-session activities while still providing effective treatment. Second, we hoped to compare the results of such treatment to the results of other empirically supported psychodynamic psychotherapies that do not explicitly or systematically make use of between-
session activities to see if there were any evidence that the addition of such activities may improve upon these treatments.

Due to the patient’s premature discontinuation of treatment, we are unable to answer this second question. We do, however, have sufficient evidence to address the first question. First, we will discuss this evidence. Then, we will make some tentative observations about the results of the therapist’s and patient’s responses to the BSAQ questionnaires and the patient’s BDI scores. Finally, we will conclude with recommendations for future studies that might continue in this line of research.

Evidence for the Compatibility of Between-Session Activities with Psychodynamic Psychotherapy

The results of the present study demonstrate that it is possible for a therapist to practice psychodynamic psychotherapy incorporating between-session activities and still provide effective treatment. The results of the BSAQ questionnaires act as a manipulation check, demonstrating that (1) the therapist made suggestions for between-session activities at every session, (2) the patient recalled suggestions being made at nearly every session, (3) the patient actually engaged in between-session activities most of the time, and (4) these activities were perceived by both the therapist and the patient as being highly relevant to current issues in treatment. At the same time, the patient’s BDI scores dropped by 13 points over the course of the six sessions, moving from 30 (severe depression) to 17 (mild depression), and meeting criteria for reliable change. Thus a psychodynamic treatment incorporating between-session activities resulted in significant patient improvement over the course of only six sessions. Although the patient’s BDI indicates that he was still mildly depressed when he left treatment for unknown reasons, we might reasonably expect that, had he continued on the same trajectory, he
would have met both criteria for clinically significant improvement had he remained in treatment for the full 16 sessions.

By incorporating between-session activities into a psychodynamically oriented therapy, one might argue that we have merely lifted a technique from one orientation and added it to another. This would certainly be true of the types of between-session activities that the therapist recommended were those associated with other forms of treatment (e.g. asking the patient to practice Progressive Muscle Relaxation, identify automatic thoughts and replace them with rational responses, or schedule pleasurable activities) and there were no theoretically consistent (i.e. psychodynamic) rationale for recommending them.

The results of the BSAQ questionnaires demonstrate, however, that the types of activities that the therapist recommended and in which the patient engaged were highly consistent with the very issues being discussed in treatment. Furthermore, in their responses to open-ended questions, the therapist and patient describe the activities in more detail and discuss their relevance, laying out rationale for how these activities might forward their in-session work. These responses make clear not only that the therapist had theoretically relevant reasons for making the suggestions she did, but also that these suggestions were perceived by the patient as being consistent with the treatment.

For example, one primary issue that the therapist and patient discussed frequently in their sessions was the patient’s lack of close, meaningful relationships. He often described feeling that other people enjoyed talking to him because he was a good listener, but that they rarely showed interest in knowing more about him. In their sessions, the therapist and patient discussed how the patient’s interpersonal style of being “laid back” or “just going with the flow” and his use of humor to deflect personal questions might be keeping others at a distance, as well as
discussing potential unconscious motivations for having this style (e.g. fear of getting hurt because of past experiences). These are the primary themes not only of the treatment as a whole, but also of the between-session activities they discussed. The patient was encouraged to observe different types of interactions, notice how he felt during these interactions, look for opportunities to be more open in relationships with others, and consider how he might be contributing to his difficulties. Furthermore, the observations of each session by the author suggest that, far from detracting from the here-and-now focus of PI therapy and the importance of the therapeutic relationship, these activities both grew out of discussions about the therapeutic relationship and also provided opportunities for exploring how the patient’s interpersonal patterns might be affecting their relationship.

Additional Observations from Comparisons of the BSAQ and BDI Across Time

Although statistical analysis of variables over time is not feasible due to the limited number of data points, we can make some tentative observations of the relationships between different variables related to the use of between-session activities and depressive symptomology. While not based in statistical analysis, these comparisons remain informative and may help generate hypotheses for future studies.

As previously mentioned, we might expect the initial drop in the patient’s BDI scores (between pretreatment and session 1; see Figure 1), due to expectancy effects: simply knowing that he was about to start treatment may have given him a sense of hope or may have led him to feel more positive about himself for having taken such a step to begin addressing his difficulties. Between the first and second sessions, his BDI score went back up, although remaining slightly lower than it had been at pre-treatment. This also might be expected: hope may not have been
enough to sustain the initial improvement, or the patient may have begun to have more realistic expectations of therapy (that change does not occur right away, that it requires effort, etc.), so the BDI moved back in the direction of its baseline. While such changes are very real and we should not underestimate the importance of expectancy as a means of facilitating change, it is unlikely that the fluctuations in the BDI between pretreatment and session 2 are due to specific events in the therapy (e.g. interactions with the therapist, the therapist’s specific interventions, or insight gained from in-session discussion).

The decrease in the patient’s BDI scores between sessions 2 and 3, however – which was the most substantial between-session decrease – is more likely to reflect a response to such events, including between-session activities, and therefore warrants further exploration. First, we will describe briefly the content of discussions surrounding the recommendation of between-session activities for this session (based on the author’s observations of the sessions as well as the questionnaire results presented), and then we will discuss the relationships between relevant variables during this time frame.

In session 2, the therapist and patient discussed the possibility that he could observe interactions with his family over the upcoming Thanksgiving break and notice how his mood might be affected by these interactions. This suggestion grew out of a discussion of the patient’s interactions with family members (and others) and how his own interpersonal style (trying to be “laid back”) might be contributing to the difficulties he had in establishing meaningful interpersonal relationships – something they had identified as contributing to his depression. This theme went on to become a major focus of the remainder of treatment. Actually observing these family interactions between sessions 2 and 3, the patient noticed that he felt more depressed and agitated while interacting with family members than he did with friends, and, in
session 3, he and the therapist discussed the effect of different types of interpersonal interactions and relationships on his mood.

It is interesting to note that both the therapist and the patient rate the relevance (see Figure 2) and potential helpfulness (see Figure 3) of between-session activities discussed in session 1 (to be carried out between sessions 1 and 2) as being moderate to slightly lower than moderate. Compare this to their ratings of these variables at session 2, however, where both of them rate relevance and potential helpfulness as being much higher. At the same time, between sessions 2 and 3 – following this increase in perceived relevance and potential helpfulness – the patient’s BDI dropped by 8 points, the most significant between-session improvement across the treatment.

Furthermore, although the patient rated his engagement in between-session activities as relatively high throughout the course of treatment (see Figure 4), his highest rating of engagement occurred at session 3 (describing his engagement between sessions 2 and 3). The therapist’s ratings of his engagement – which had been high in the previous session as well – likewise remained high at this session. What’s more, although the patient’s ratings of actual helpfulness of between-session activities were moderate over the course of the treatment, the therapist’s ratings peaked at session 3, indicating that she saw his engagement in these activities between sessions 2 and 3 as having been extremely helpful (see Figure 5). Finally, although both patient and therapist perceived their discussion of past between-session activities as having been moderately helpful at all other sessions, both of them rated their discussion at session 3 as being extremely helpful.

Thus, we have evidence that between sessions 2 and 3: (1) the patient engaged in between-session activities that both he and his therapist viewed as highly relevant to current
issues in treatment and which they both saw as having a high potential for being helpful to him, (2) he reported engaging in these activities to a greater extent than on other occasions, (3) the therapist perceived his engagement in these activities to have been particularly helpful to him after the fact, and (4) they both agreed that their subsequent discussion of his experience was extremely helpful. These findings are consistent with the theory that between-session activities which have higher levels of perceived relevance and potential helpfulness, which produce greater levels of engagement, and which lead to more fruitful in-session discussions are more likely to contribute to positive change, assertions we have made elsewhere (Nelson, Castonguay, and Barwick, 2006; and Nelson & Castonguay, 2007).

Although the period between sessions 2 and 3 stands out as a time when we see the greatest improvement along with the highest levels of those factors we would expect to lead to improvement, other sessions are notable as well. With a very slight raise in the BDI between sessions 3 and 4, the patient then continued to report decreasing depressive symptomology until the last session before he discontinued treatment.

Although we hypothesize that the patient’s decision not to return to therapy was based on a decision not to return to Penn State for the next semester rather than because of a dissatisfaction with therapy, we should at least consider the possibility that some of our findings might have predicted his choice not to return. Although his depressive symptoms were decreasing relatively steadily, he was not asymptomatic at the time of his last session, thus making it seem unlikely that he did not return because he felt that he no longer needed treatment. Likewise, because he was showing signs of improvement, it is similarly unlikely that he discontinued treatment because he did not believe that therapy was helpful.
The most notable changes in the sessions leading up to the patient's discontinuation of treatment are to be found in the therapist's ratings of the patient's degree of engagement in activities, the helpfulness of past activities, and the in-session discussion of past activities. While the patient's ratings of these variables remain relatively steady across sessions (at least moderate and sometimes high), the therapist's ratings of these variables – which were, in some cases, higher than the patients toward the beginning of treatment – began to decline so that in the last two sessions, she rated all of these variables at 2 on a scale of 1-5. Interestingly, her ratings of relevance and potential helpfulness for new activities for the coming week remained high even as her ratings of these other variables decreased. Also interesting is the fact that, in one of these sessions, the patient indicated that no between-session activity had been suggested, and in the other, he indicated relatively a high level of engagement and moderate helpfulness.

In her responses to the BSAQ’s open-ended question about reasons why the patient may not have fully engaged in the discussed activities for these sessions, the therapist wrote that the patient perceived there to be many barriers to completing the activity (in both cases, trying to be more open in his interactions with others by relating with them differently), for instance other people being busy, or work schedules making it difficult to find time to spend with people. Although these may have been very real barriers, it is also possible that the patient was feeling pushed to make changes and take risks that seemed overwhelming to him or that he did not feel that he was ready to take. If this were the case, it is possible that he chose to discontinue the treatment as a way of alleviating the anxiety produced by thinking about making such changes. Again, the circumstances surrounding his discontinuation of treatment point to other factors as being significant in his decision; however, there may have been many contributing factors, and fear of taking new risks may have been one.
Limitations and Recommendations for Future Studies

As stated previously, one of the most significant limitations of the present study comes from the fact that the patient was only seen for 6 sessions rather than the intended 16, and that he therefore did not complete other measures intended to track his progress over the course of treatment. We are therefore unable to carry out much of the analysis we had planned as well as unable to answer the second question we had posed – how the results of a psychodynamic psychotherapy incorporating between-session activities would compare to the results of other psychodynamic therapies that have been empirically supported and that do not explicitly or systematically make use of between-session activities.

Even if the patient had remained in treatment for the full 16 sessions and had completed all intended measures including follow-up measures, the present study would have been limited in that it is a single case study and therefore may have limited generalizability.

Despite its significant limitations, however, the present study serves well as a pilot study, to be followed by continued investigation of the presented treatment. Future studies will recruit more clients who will complete the full 16 weeks of treatment. Case studies provide important information about the therapy process, complementing that which can be learned from larger scale studies; however, due to their limited generalizability, it will be important to replicate the procedures by completing several case studies. If the results of such replicated single case studies are promising, a larger scale randomized control trial could be done comparing the effectiveness of PI therapy with and without the incorporation of homework.

Other areas for future research include investigations of the various aspects of the use of between-session activities most predictive of positive change (e.g. perceived relevance,
perceived helpfulness, degree to which the therapist and patient collaborate in developing an idea, etc.). Such research would move beyond the question of whether or not the addition of between-session activities improves treatment and begin to ask how it is beneficial and what factors are most likely to increase its benefits. Other foci might include investigations of the incorporation of between-session activities in other forms of therapy, such as other psychodynamic treatments, process/experiential therapy, and various forms of existential and humanistic therapies. Such studies would contribute to the exploration of between-session activities as a potential common factor, challenging the commonly held belief that it is an orientation-specific technique.
References


Appendix A:
Between-Session Activities Questionnaire:
Client Pre-Session

1. In last week’s session, did you and your therapist discuss any between-session activities that you could do between then and today’s session? (NOTE: Between-session activities can include anything you might do between sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)
   Yes ___ No ___ (If “No,” skip to question 9.)

2. To what extent did you do what was discussed?
   Not at all  Partly  Completely
   1 - - - - - - - - 2 - - - - - - - - 3 - - - - - - - - 4 - - - - - - - - 5

3. If you did anything related to what was discussed, what specifically did you do?

4. If you did not do what was discussed or did only part of it, was there a reason why you did not do (all of) what was discussed? (e.g. Did you forget? Did something get in the way? Did it seem unhelpful?)

5. If you did at least part of what was discussed, how helpful do you think the activity was?
   Not at all  Moderately  Very
   Helpful  Helpful  Helpful
   1 - - - - - - - - 2 - - - - - - - - 3 - - - - - - - - 4 - - - - - - - - 5

6. Did you engage in any activities relevant to therapy that you and your therapist did not discuss in last week’s session? (This might include activities that were not previously discussed or activities discussed earlier in therapy but not in last week’s session.)
   Yes ___ No ___ (If “No,” skip to end.)

7. If so, what specifically did you do?
8. To what extent was this activity related to suggestions/discussions of between-session activities made previously in treatment (not in last week’s session)?

1 - Not at all 2 - Moderately 3 - Related 4 - Completely Related

9. If at all related to discussions or suggestions made previously in therapy, what was previously discussed/suggested?

10. To what extent does this activity seem relevant to current issues in therapy?

1 - Not at all 2 - Moderately Relevant 3 - Completely Relevant

11. How helpful do you think the activity was?

1 - Not at all 2 - Moderately Helpful 3 - Very Helpful
Appendix B:  
**Between-Session Activities Questionnaire:**  
**Client Post-Session**

**Section 1: Discussion of Previous Between-Session Activities** (Beginning with second session):

1. If, during last week’s session, you and your therapist discussed any between-session activities that you could do between then and today, were they discussed again today?  
   Yes ___  No ___ (If, “No,” skip to question 4.)

2. If so, what was discussed?

3. How helpful do you think your discussion of the activity with your therapist was?  
   Not at all 1 - 2 - 3 - 4 - 5  
   Helpfully

4. If, over the course of the past week, you engaged in any between-session activities that had not been suggested/discussed in last week’s session, were they discussed today?  (This might include activities that were not previously discussed or activities discussed earlier in therapy but not in last week’s session.)  
   Yes ___  No ___ (If, “No,” skip to section 2.)

5. If so, what was discussed?

6. How helpful do you think your discussion of the activity with your therapist was?  
   Not at all 1 - 2 - 3 - 4 - 5  
   Helpfully
Section 2: Discussion of New Between-Session Activities (Beginning with first session):

7. In the session you just had, did you and your therapist discuss any between-session activities that you could do between now and the next time you meet? (NOTE: Between-session activities can include anything you might do between sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)
   Yes ___  No ___  (If “No,” skip to end.)

8. If so, what did you discuss?

9. On the following scale, please indicate the degree to which you contributed to the development of this idea:
   1 - - - - - - - 2 - - - - - - - 3 - - - - - - - 4 - - - - - - - 5
   Not at all  Moderately  Completely

10. On the following scale, please indicate the degree to which your therapist contributed to the development of this idea:
    1 - - - - - - - 2 - - - - - - - 3 - - - - - - - 4 - - - - - - - 5
    Not at all  Moderately  Completely

11. To what degree did you feel that you and your therapist collaborated in developing the idea?
    1 - - - - - - - 2 - - - - - - - 3 - - - - - - - 4 - - - - - - - 5
    Not at all  Moderately  Completely

12. If your therapist made a suggestion or recommendation, how direct/indirect was her suggestion/recommendation?
    1 - - - - - - - 2 - - - - - - - 3 - - - - - - - 4 - - - - - - - 5
    Very      Moderately      Very
    Indirect  Direct           Direct

13. To what extent does this activity seem relevant to current issues in therapy?
    1 - - - - - - - 2 - - - - - - - 3 - - - - - - - 4 - - - - - - - 5
    Not at all  Moderately  Completely
    Relevant    Relevant  Relevant

14. Please describe how it relates to current issues in therapy:

________________________________________________________________________

________________________________________________________________________
15. How helpful do you believe such an activity could be?

1 - Not at all  |  2 - Moderately  |  3 - Very Helpful
               |                  | Helpful
Helpful       |                   | Helpful
Appendix C:  
Between-Session Activities Questionnaire:
Therapist Post-Session

Section 1: Discussion of Previous Between-Session Activities (Beginning with second session):

1. In last week’s session, did you and your client discuss any between-session activities that s/he could do between then and today’s session?  (NOTE: Between-session activities can include anything your client might do between sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)
   Yes ___  No ____  (If, “No,” skip to question 7.)

2. If so, were they discussed again today?  
   Yes ___  No ___

3. If so, what was discussed?

4. To what extent did the client do what was discussed?
   Not at all 2 Partly 4 Completely

5. If the client did anything related to what was discussed, what specifically did s/he do?

6. If the client did not do what was discussed or only did part of it, was there a reason why s/he did not do (all of) what was discussed?  (e.g. Did s/he forget?  Did something get in the way? Did it seem unhelpful?)

7. If the client did at least part of what was discussed, how helpful do you think the activity was?
   Not at all 2 Moderately 4 Helpful
   Helpful  Very Helpful
8. How helpful do you think your discussion of the activity with your client was?

1 - Not at all                          2 - Moderately                          3 - Very

Helpful                              Helpful                              Helpful

9. Did you and the client discuss any activities relevant to therapy that the client engaged in this past week but that were not discussed in last week’s session? (This might include activities that were not previously discussed or activities discussed earlier in therapy but not in last week’s session.)

Yes ___  No ___ (If, “No,” skip to section 2.)

10. If so, what was discussed?


11. To what extent was this activity related to suggestions/discussions of between-session activities made previously in treatment (not in last week’s session)?

1 - Not at all                          2 - Moderately                          3 - Completely

Related                               Related                               Related

12. If at all related to discussions or suggestions made previously in therapy, what was previously suggested/discussed?


13. To what extent does this activity seem relevant to current issues in therapy?

1 - Not at all                          2 - Moderately                          3 - Completely

Relevant                              Relevant                              Relevant

14. How helpful do you think the activity was?

1 - Not at all                          2 - Moderately                          3 - Very

Helpful                               Helpful                               Helpful
15. How helpful do you think your discussion of the activity with your client was?

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<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Very</td>
<td></td>
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<tr>
<td>Helpful</td>
<td>Helpful</td>
<td>Helpful</td>
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**Section 2: Discussion of New Between-Session Activities:**

16. In the session you just had, did you and your client discuss any between-session activities that s/he could do between now and the next time you meet? (NOTE: Between-session activities can include anything the client might do between sessions that is relevant to treatment AND can include both direct suggestions/discussion and indirect suggestions/discussion.)

Yes ____  No ____  (If “No,” skip to end.)

17. If so, what did you discuss?

18. On the following scale, please indicate the degree to which you contributed to the development of this idea:

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<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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19. On the following scale, please indicate the degree to which the client contributed to the development of this idea:

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<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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20. To what degree did you feel that you and your client collaborated in developing the idea?

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<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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21. If you made a suggestion or recommendation, how direct/indirect was your suggestion/recommendation?

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<tbody>
<tr>
<td>Very</td>
<td>Moderately</td>
<td>Very</td>
<td></td>
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<tr>
<td>Indirect</td>
<td>Direct</td>
<td>Direct</td>
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</tbody>
</table>
22. To what extent does this activity seem relevant to current issues in therapy?

1 - Not at all  2 - Moderately  3 - Completely Relevant

23. Please describe how it relates to current issues in therapy:

_________________________________________________________________________

24. How helpful do you believe such an activity could be?

1 - Not at all Helpful  2 - Moderately Helpful  3 - Very Helpful