

# The Systematic Use of Homework in Psychodynamic-Interpersonal Psychotherapy for Depression: An Assimilative Integration Approach

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Although the use of between-session activities—or homework—has traditionally been associated with cognitive-behavioral therapy (CBT), 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. As a preliminary study, the authors examine the feasibility and effectiveness of an integrative assimilation of homework in psychodynamic-interpersonal psychotherapy for depression. Findings from 3 case studies support the hypothesis that homework can be successfully integrated into psychodynamic therapy in a seamless and theoretically consistent manner. Findings also suggest that, at least within this limited sample of 3 cases, this integrative treatment may be at least as effective as (and possibly more effective than) psychodynamic therapy that does not include homework.

*Keywords:* assimilative integration, between-session activities, homework, psychodynamic-interpersonal psychotherapy, psychotherapy integration

Therapists' systematic and skillful recommendation of between-session activities—also known as “homework”—has emerged as a factor that contributes to the effectiveness of cognitive-behavioral therapy (CBT; Kazantzis, Deane, & Ronan, 2000). Whereas the regular and systematic use of homework (HW) is considered to be a central component of CBT, it is generally not considered as such in most other forms of treatment (e.g., psychodynamic, interpersonal, and humanistic therapies). Thus, although it is possible that the use of HW in these other therapies may also improve their effectiveness, this possibility has not been explored thus far. As a preliminary investigation, the authors take an assimilative integration approach to the systematic use of HW in psychodynamic-interpersonal psychotherapy for depression,

presenting three individual case studies and considering the effectiveness of the proposed integrative treatment.

## Psychotherapy Homework

In CBT, HW is thought to play an important role in promoting the generalization of learning that takes place within the treatment setting to the client's life outside therapy. It is seen as providing opportunities for practicing new skills, implementing solutions to problems, and providing ongoing feedback about client's progress. Goisman (1985) has described HW as “the most generic of behavioral interventions—and one that greatly and immediately distinguishes behavior therapy from psychoanalysis” (p. 676). Despite the fact that it has been associated with CBT, however, HW is by no means used exclusively in this form of therapy. A few authors have actively encouraged the use of HW in psychodynamic psychotherapy, at least in some cases (e.g., Stricker, 2006a, 2006b; Wachtel, 1993). Although certainly not emphasized in traditional psychoanalysis or psychoanalytic psychotherapy, the use of HW can

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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 indicated that he sometimes suggested to his phobic clients that, once they had worked through their conflicts in analysis, they should venture out into the world and face their fears (Freud, 1926/1952). Furthermore, there is evidence that a substantial number of current psychodynamic practitioners are using HW (Kazantzis & Deane, 1999). Nonetheless, most theoretical texts and treatment manuals for psychodynamic therapy do not discuss the use of homework explicitly, and even when they do mention it, they do not typically discuss its regular and systematic incorporation into treatment.

### Defining “Homework”

CBT therapies have traditionally defined HW as a discrete task or activity explicitly prescribed by the therapist to the client in which the client is expected to engage between sessions. Reviews of the HW literature, however, have pointed to a range of definitions of what may constitute psychotherapy HW, calling into question whether it must, by definition, involve overt, observable behaviors and also how explicitly prescribed they must be (Kazantzis, 2000; Nelson, Castonguay, & Barwick, 2007). Kazantzis and Dattilio (2010) suggest that HW be viewed more broadly as a “structural aspect” of therapy that may take different forms within different treatment models. They propose that definitions of what constitutes HW may likewise differ based on a given model’s understanding of the mechanisms that contribute to change. To better understand the prevailing views of HW, these authors surveyed practicing psychologists and found that psychologists from both CBT and psychodynamic orientations identified the recommendation of both observable and nonobservable behaviors (e.g., monitoring emotional reactions or interpersonal dynamics) as “between-session assignments.” These findings point to a definition that is broad and captures any therapist recommendations for ways in which clients might make use of time between sessions to work toward therapeutic goals.

Elsewhere, we have pointed out that there can be varying levels of explicitness or directiveness when it comes to therapist’s recommendations of HW activities (Nelson et al., 2007). Consistent with the more traditional CBT definition, therapists might make very direct recommendations; on the other hand, they might make less directive suggestions that clients may try if they find them to be relevant, or they may even implicitly suggest HW activities by making comments that encourage clients to consider ways in which they might work toward therapeutic goals between sessions. Additionally, we proposed that HW might include not only activities recommended by the therapist but also activities that are developed in collaboration with the client or even completely client-initiated activities that are therapeutically relevant. We argue that these alternatives to direct and explicit prescription may be more consistent with therapies in which relatively more emphasis is placed on the therapeutic relationship or with traditions that discourage the therapist from assuming such a directive or “expert” role.

Based on these assertions, we propose the following transtheoretical definition of HW: *Psychotherapy HW may consist of any activity (including nonobservable activities, such as thinking or observing) that is suggested by the therapist, developed collaboratively by the therapist and client, or developed by the client alone but informed by suggestions or comments made by the therapist, which the client performs between sessions in a conscious attempt to work toward therapeutic goals on his or her own (without the therapist present).*

### Research on the Effectiveness of Homework in Psychotherapy

Not only is there reason to believe that practitioners of varying theoretical backgrounds make use of HW as discussed above, but increasing evidence exists, at least within the CBT literature, that doing so has a positive effect on outcome. In a meta-analysis involving 11 experimental or quasi-experimental studies ( $N = 375$ ), Kazantzis and colleagues (2000) found that the inclusion of HW was associated with significant positive

effects on outcome. Additionally, these authors found that the extent to which clients complied with HW assignments was positively correlated with outcome. However, despite the evidence to support the use of HW in CBT, 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 HW in psychotherapy is to move beyond the theoretical constraints of one orientation and examine the efficacy of HW in non-CBT therapies.

### Homework in Psychodynamic Psychotherapy

Although there is evidence to suggest that psychodynamic therapists are making use of HW, it is unclear whether they are merely borrowing a useful technique from their CBT colleagues or whether psychodynamic theory gives them reason to believe that the use of HW will enhance treatment. Some practitioners and theorists might argue that, quite to the contrary, suggesting or recommending such activities could cause clients to lose sight of the main objective of psychodynamic therapy: namely, to gain insight, usually through introspection. However, as Stricker (2006a) argues, even the most traditional psychodynamic treatments have incorporated their own brand of HW, for instance asking clients to write down their dreams or pay attention to emotional reactions or interpersonal dynamics throughout the week. Such activities may, in fact, enhance not detract from clients' understanding of their internal processes.

Some might also argue that using HW requires therapists to take a more active role than that prescribed by traditional theories. Responding to this concern, Stricker (2006b) suggests that psychodynamic therapists often make use of "quasi-homework assignments" or "implicit homework assignments" (p. 102) while not 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 sugges-

tions. Furthermore, 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 (and reciprocal) so that behavior change can also lead to insight (e.g., Stricker, 2006b; Wachtel, 1993). Wachtel (1993), for instance, points out that clients' 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. In this way, HW could potentially accelerate change, especially when insight has not already led to subsequent changes in affect or behavior or when clients are having difficulty achieving insight.

### The Purpose of the Present Study

The purpose of the present study was to investigate the systematic use of HW in psychodynamic psychotherapy. It can be viewed as an example of assimilative integration, which, as described by Messer (1992), is aimed at improving a particular type of treatment by the selective and cohesive incorporation of practices and views from other systems. Specifically, the authors developed a treatment manual for the integration of HW into a psychodynamic model and, on the basis of three individual case studies, sought to address two questions: (a) feasibility: whether or not it is possible to systematically incorporate HW into the psychodynamic treatment model in a seamless and theoretically consistent manner and in a manner that both therapists and clients experience as consistent with the rest of their therapeutic work and treatment goals; and (b) effectiveness: is this integrative treatment effective in treating clients' presenting problems, and are the results of such treatment comparable (at least equivalent and at best favorable) to empirically supported psychodynamic therapy that does

not explicitly and/or systematically make use of HW?

### Hypotheses

*Hypothesis 1:* The systematic use of HW can be successfully integrated into psychodynamic therapy in a seamless and theoretically consistent manner. Specifically, it was predicted (a) that both clients and therapists would report the use of HW activities in the majority of their sessions, (b) that they would perceive these activities to be directly related to current issues being discussed in therapy, and (c) that clients would report actually having engaged in such activities on most occasions when they had been recommended.

*Hypothesis 2:* Psychodynamic therapy incorporating the systematic use of HW activities will be effective in treating depression. Furthermore, this treatment will be found to be at least as effective as (and possibly more effective than) empirically supported psychodynamic therapy that does not explicitly or systematically make use of HW. It was predicted (a) that clients would no longer meet criteria for MDD at posttreatment follow-up, (b) that they would experience clinically significant change (Jacobson & Truax, 1991) in depressive symptomology from pre- to posttreatment, and (c) that they would experience some decrease in distress related to interpersonal problems. (Because long-standing interpersonal problems often take longer to change than depressive symptoms [Kopta, Howard, Lowry, & Beutler, 1994], it was not hypothesized that criteria for clinically significant change would be met over the course of this 16-session treatment, although such change was assessed.) It was also predicted that effect sizes for changes in depressive symptoms would be at least comparable with and at best favorable to findings from two studies of the same treatment not including the systematic use of HW: The Second Sheffield Psychotherapy Project (SPP2; Shapiro et al., 1994) and The

Collaborative Psychotherapy Project (CPP; Barkham et al., 1996). It was also predicted that the effect sizes for changes in interpersonal problems would be at least comparable and at best favorable to those found in aforementioned studies.

### Method

#### Clients

Three participants were sought for intensive case study. Participants were recruited from The Pennsylvania State University Psychological Clinic and were required to meet three inclusion criteria: (a) a primary diagnosis of Major Depressive Disorder (according to *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision [DSM-IV-TR] criteria), (b) a score of 21 or greater on the Beck Depression Inventory (BDI-II, Beck et al., 1996), and (c) aged between 18 and 65 years. Participants were likewise required to fail to meet the following exclusion criteria: (a) current substance abuse or dependence, (b) a history of psychotic symptoms, and (c) a previous treatment of adequate length (defined as at least 12 sessions) of psychodynamic therapy (assessed using the Comparative Psychotherapy Process Scale [CPPS], Hilsenroth et al., 2005) within the past five years. (No potential participants were actually ruled out based on these criteria.) These criteria were used to maximize the comparability between these participants and those in the comparison studies discussed further below (Barkham et al., 1996; Shapiro et al., 1994). To increase external validity as well as the number of available participants, potential participants were not excluded on the basis of their use of psychotropic medication unless they had either started taking medication or had changes made to their dosages within the 6 weeks preceding the beginning of treatment. Participants who were already taking prescribed medications maintained a constant dosage for the duration of the study.

Client 1 was a European American, heterosexual, single man in his early 50s. He lived alone. He had completed his education through a masters degree and was unemployed for the duration of the study. At in-

take, Client 1 was given two principal diagnoses: Major Depressive Disorder and Avoidant Personality Disorder. He was also given the additional diagnosis of Social Phobia. He had been taking an SSRI for a number of years when he began treatment.

Client 2 was a European American, bisexual, partnered woman in her mid-20s. She lived with her male partner. She had completed her education through a bachelor's degree and was employed throughout the duration of the study. At intake, Client 2 was given the following principal diagnoses: Major Depressive Disorder and Borderline Personality Disorder. She was also given the additional diagnosis of Dysthymic Disorder and a past diagnosis of Post-Traumatic Stress Disorder related to a sexual assault experience. She was not taking any medications for the duration of the study.

Client 3 was a European American, heterosexual divorced woman in her mid-50s. She lived with her daughter, granddaughter, and her daughter's male partner. She was in a dating relationship with a male partner who lived in another state. She had completed her education through a vocational degree (post high-school) and was unemployed and on disability for the duration of the study. At intake, Client 3 was given the following principle diagnoses: Major Depressive Disorder and Posttraumatic Stress Disorder. She also suffered from several physical health conditions. Prior to beginning treatment and for the duration of the study, she was on an SSNRI and had a PRN prescription for a benzodiazepine. She also took medications for high blood pressure and pain management.

## Treatment

Treatment 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 therapeutic relationship as a means of understanding and resolving difficulties in interpersonal relationships that play a role in the development and maintenance of depression. This particular treatment was chosen from among other psychodynamic treatments, because previous studies have

demonstrated support for its effectiveness in treating depression (e.g., Barkham et al., 1996; Shapiro et al., 1994), allowing for a comparison to be made between the efficacy of the present treatment and that of previously documented treatments that did not explicitly or systematically incorporate HW.

The present treatment was also based on a manual developed by the authors, describing the incorporation of HW into PI therapy (Nelson & Castonguay, 2007). This manual discusses the potential benefits of HW (e.g., providing opportunities for raising awareness or achieving insight into interpersonal dynamics, facilitating the consolidation or "working through" of in-session changes or insights, encouraging clients to take an active role in their treatment). It outlines types of HW activities intended to address different processes that can be assumed to be therapeutic in PI therapy (e.g., facilitating insight, emotional deepening, corrective experiences) and gives examples of such types of activities and how they might be suggested to clients (e.g., paying attention to or making note of feelings or interpersonal patterns, trying out different ways of communicating needs in close relationships, journaling, etc.). It also discusses processes and principles of therapeutic change associated with the PI model and how HW can be used to facilitate these processes. Finally, it provides specific guidelines for the use of HW in this treatment model (e.g., regarding the framing of HW, the relationship between HW and in-session work, the importance of helping clients understand the relevance of HW to broader treatment goals, recommendations for how to follow up on HW suggestions, what can be learned from 'non-compliance,' and the importance of remaining attuned to potential impacts of HW on the therapeutic relationship).

Treatment sessions were 50 min long, digitally recorded, and held once weekly for a total of 16 sessions (the same duration of treatment studied in the aforementioned comparison studies).

## Therapists

Therapists were three advanced doctoral students, two in Clinical Psychology, and one in Counseling Psychology. Two were female

and one was male. As part of their training, therapists studied Hobson's (1985) book on PI therapy, the PI manual used in both Sheffield studies,<sup>1</sup> supplemental readings on this treatment model, and the aforementioned additional manual describing the incorporation of HW into PI therapy. They attended weekly training meetings for seven weeks to discuss these manuals and view videotape demonstrations of the treatment before being assigned a client. Once therapists had begun seeing clients, they met weekly with the first author for supervision. In preparation for each supervision session, the first author watched the entire video of the most recent session and took detailed process notes on the session as well as notes related to therapist adherence, guided by a measure of adherence used by Shapiro et al. (1994), the Sheffield Psychotherapy Rating Scale (SPRS; Shapiro & Startup, 1990).

Prior to training and supervising therapists for this study, the first author (an advanced graduate student at the time) had completed a seminar involving extensive reading in psychodynamic therapy and had received formal, supervised clinical training in psychodynamic therapy by a recognized expert in this approach. She had acquired competence specifically in the PI model by reading Hobson's (1985) book as well as the PI manual used in both Sheffield studies and by reviewing supplemental materials provided by Michael Barkham that were used as part of these studies. She had also listened to audiotapes of the therapy from the Sheffield studies, provided by Dr. Barkham. Prior to beginning this study, she conducted a pilot study of this treatment including the integration of HW and received supervision of supervision from a licensed psychologist familiar with the model. Given that she was not yet licensed herself at the time of the study, she continued to receive supervision of supervision throughout, including discussion of treatment adherence.

## Measures

**Anxiety Disorder Interview Schedule for DSM-IV, Lifetime Version (ADIS-IV-L).** The ADIS-IV-L (Brown, Di Nardo, & Barlow, 1994) is a semistructured clinical interview designed to establish reliable diagnoses

of various Axis I diagnostic categories described in the *DSM-IV-TR* (American Psychiatric Association, 2000), including anxiety, mood, somatoform, and substance use disorders and to screen for the presence of other conditions, such as psychotic disorders. Unlike the earlier ADIS-IV-R, the ADIS-IV-L assesses the presence of lifetime disorders and includes a diagnostic timeline, facilitating an accurate assessment of onset, duration, and the temporal sequence of disorders. The ADIS-IV-L also provides dimensional assessments through the use of 0–8 clinician rating scales and regular inquiries about symptom severity and frequency.

The ADIS-IV-L has been found to have fair to very good interrater reliability for constructs most relevant to the present study: Major Depressive Disorder as principal diagnosis,  $\kappa = .67$ ; Major Depressive Disorder as additional or principal diagnosis,  $\kappa = .59$ ; and alcohol and substance use disorders as lifetime diagnoses,  $\kappa = .82$  and  $.83$ , respectively (Grisham, Brown, & Campbell, 2004). Ratings of symptom severity for Major Depressive Disorder have also been found to have very good reliability ( $\kappa = .74$ ; Grisham et al., 2004). However, no data are available for the interrater reliability of psychotic disorders.

For this study, additional modules were used to assess for disorders not included in the ADIS-IV-L (e.g., eating disorders), and additional questions were added in modules that were not as well developed (e.g., psychotic disorders). No data on interrater reliability for these additional modules are available.

**Beck Depression Inventory, Second Edition (BDI-II).** The BDI-II (Beck, Steer, & Brown, 1996) is a 21-item self-report measure assessing the presence and severity of depressive symptoms. Each item is rated on a 4-point scale between 0–3. Overall scores are determined by summing the scores of all items and can range from 0–63. Scores ranging from 0–13 indicate of minimal or no depression; those from 14–19, mild depression; those from 20–28, moderate depression;

<sup>1</sup> We thank Michael Barkham for his willingness to share the manual used in the SSPP (and in the CPP) and as well as several chapters from an unpublished manuscript for use in training the therapists for this study.

and those from 29–63, severe depression. The BDI-II has demonstrated high level of internal consistency and test–retest reliability (Beck et al., 1996).

**Inventory of Interpersonal Problems (IIP-64).** The IIP-64 (Horowitz, Alden, Wiggins, & Pincus, 2000) is a self-report measure assessing interpersonal distress. Each item is rated on a 5-point Likert scale from 0–4. The IIP-64 has six subscales, including “hard to be assertive,” “hard to be sociable,” “hard to be intimate,” “hard to be submissive,” “too responsible,” and “too controlling.” The overall level of distress is obtained by averaging the scores of all items. The IIP-64 has been found to have high reliability and validity (Horowitz et al., 2000).

**Homework assignment and monitoring.** The *Between-Session Activities Questionnaire: Client, Pre-Session* (BSAQ:CPre) the *Between-Session Activities Questionnaire: Client, Post-Session* (BSAQ:CPost), and the *Between-Session Activities Questionnaire: Therapist, Post-Session* (BSAQ:TPost; all developed by the first author) are self-report measures assessing various aspects of HW use. They include some questions that are answered on a 5-point Likert scale (from 1–5) as well as some free response questions. Of particular relevance to the present study are questions related to the discussion/suggestion of HW activities for the coming week, the perceived relevance of such activities to issues being discussed in therapy more generally, and the extent to which clients actually completed previously discussed HW activities.

## Procedures

As part of standard practice at the Psychological Clinic, all new patients undergo an intake interview to establish both Axis I and Axis II diagnoses and to identify goals for treatment. Diagnoses are made by the intake clinician the using the ADIS-IV-L semistructured diagnostic interview and are verified by one additional clinician by watching the video recording of the intake interview. Any discrepancies in intake diagnoses are then discussed between the two clinicians until a consensus diagnosis is reached.

During the recruitment period for this study, any new patients coming in to the Clinic who appeared to meet the study’s requirements following the initial intake interview (i.e., a primary diagnosis of Major Depression and the absence of rule-out diagnoses) were then contacted by phone by their initial intake clinician, told about the study, and given the opportunity to participate in an additional interview to determine their full eligibility, involving the administration of the BDI-II and CPPS (evaluating past treatment experience), which are not part of standard intake procedures.

Not all patients who were contacted chose to come in for the additional screening interview. The few who were contacted and did not come in for further evaluation either could not be reached by phone or indicated that they were no longer interested in treatment at the clinic for various reasons (e.g., lack of transportation, moving out of state). However, all potential participants who expressed interest in the study and who came in for further evaluation ended up meeting the study’s requirements and were thus invited to participate. The intended target number of participants for this study was three. The first three eligible participants elected to participate in the study, after which no further recruitment was done. All three participants read and signed an informed consent (approved by the The Pennsylvania State University Office of Regulatory Compliance). To protect participants’ confidentiality, any information that would allow clients to be identified has either been omitted or made sufficiently general in this paper so as to be nonidentifying.

The BDI-II was administered at pretreatment screening, prior to each therapy session, and at posttreatment follow-up. The IIP-64 was administered at pretreatment screening, at Sessions 8 (midpoint) and 16 (last session), and at posttreatment follow-up. Participants completed the BSAQ:CPre prior to each therapy session and the BSAQ:CPost after each therapy session. Therapists completed the BSAQ:TPost after each therapy session.

Whereas the entire ADIS-IV-L was administered pretreatment (during the standard intake interview, as described above), the mood disorders section alone was given again at posttreat-

ment follow-up<sup>2</sup> to determine whether clients continued to meet criteria for Major Depressive Disorder following their treatment. All post-treatment follow-up interviews were conducted by an advanced doctoral student therapist.

## Results

All three clients met criteria for Major Depressive Disorder using the ADIS-IV-L prior to beginning treatment. Clients 1 and 2 no longer met criteria at posttreatment follow-up, whereas Client 3 still met criteria at posttreatment follow-up.

### BDI-II

The BDI-II scores for the three clients at pretreatment, Session 1, Session 16 (final session), and posttreatment follow-up are presented in Table 1.

**Clinically significant change.** Jacobson and Truax (1991) proposed two criteria for assessing clinical significance: (1) the population must move from a theoretically dysfunctional population to a theoretically functional one, and (2), the change must be reliable. To fulfill the first criterion, the treatment population mean (or in this case, the individual client's score) at pretreatment 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) established the cutoff point for being within two standard deviations of the general population mean on the BDI-II as 13.46. The second criterion, that of reliability, is calculated using the Reliable Change Index (RCI): if the RCI is greater than 1.96, one can conclude with at least 95% confidence that the change is not merely a result of measurement error or a random fluctuations in scores, but rather attributable to a true shift in functioning (Jacobson & Truax, 1991). Ogles and colleagues (1995) established that, to meet this criterion, the change in BDI-II scores must be greater than 9 points.

Client 1's change in BDI-II scores (21 at pretreatment screening and 16 at posttreatment follow-up) did not meet the either criteria set by Jacobson and Truax (1991). In

contrast, Client 2's change in BDI-II scores (28 at pretreatment screening, 0 at posttreatment follow-up) met both criteria. Finally, Client 3's change in BDI-II scores (31 at pretreatment screening and 22 at posttreatment follow-up) did not meet the first criterion but did meet the second.

**Effect size comparison.** Next, the authors used several different methods to compare the effect size across these three cases to those established by previous research of PI therapy that does not explicitly or systematically make use of HW. Both Shapiro and colleagues (1994) and Barkham and colleagues (1996) calculated effect size for the BDI<sup>3</sup> based on pretreatment variability, using what Seidel, Miller, and Chow (2014) refer to as the  $ES_{pre}$ , which standardizes changes in well-being based on the initial variability of the sample of interest and is calculated as follows:

$$ES_{pre} = (M_{post} - M_{pre}) / SD_{pre} = M_{diff} / SD_{pre}$$

As noted by Seidel and colleagues (2014), different methods for calculating effect sizes can vary significantly in their estimations of change. To make a comparison between the effect size of the present sample and that of these much larger samples, the authors first used the same calculation. Using the formula above, the  $ES_{pre}$  for this present sample was 2.73 ( $SD_{pre} = 5.13$ , 95% CI [-0.31, 5.76]), as compared with the effect size found by Shapiro and colleagues (1994) of 2.37 ( $SD_{pre} =$

<sup>2</sup> For Client 1, the post-treatment follow-up took place approximately 2 months after the final session because of difficulties with scheduling. For Clients 2 and 3, the post-treatment follow-up took place within 2 to 3 weeks of the final session.

<sup>3</sup> Although Shapiro and colleagues (1994) and Barkham and colleagues (1996) used the original BDI (Beck & Steer, 1987) rather than the BDI-II, these two measures are quite comparable in terms of their content. The most significant difference between the two is that the original BDI uses a 1-week time reference, whereas the BDI-II uses a 2-week time reference; otherwise, there are only very minor changes in the wording of a few items. Scoring and cutoffs are the same. Therefore, in the absence of other studies using the BDI-II to examine change over time in PI therapy, we believe that a comparison of effect sizes using these two measures is reasonable, especially in the case of a preliminary study such as this one.

Table 1  
BDI-II Scores Across Treatment

Client	Pretreatment screening	Session 1	Session 16 (last session)	Posttreatment follow-up
Client 1	21 (moderate)	27 (moderate)	13 (mild)	16 (mild)
Client 2	28 (moderate)	39 (severe)	2 (minimal)	0 (minimal)
Client 3	31 (severe)	30 (severe)	26 (moderate)	22 (moderate)

6.34, 95% CI [2.02, 2.71]<sup>4,5</sup> and that found by Barkham and colleagues (1996) of 1.61 ( $SD_{pre} = 6.83$ , 95% CI [1.05, 2.16]).<sup>6</sup>

Because  $ES_{pre}$  is based on pretreatment variability ( $SD_{pre}$ ), differences in variability of pretreatment distress can dramatically impact the score. To reduce the likelihood that the calculation might be biased by the peculiarities of any one case within the present sample of only three participants, the authors then followed the recommendations of Seidel (J. Seidel, personal communication, September 14, 2015) and recalculated the  $ES_{pre}$  for this sample and the two comparison studies using a cross-sample  $SD_{pre}$  of 6.10 (the unweighted average of  $SD_{pre}$  across this present sample and the two comparison samples). Using this variation of the  $ES_{pre}$ , the effect size for the present study was found to be 2.29, as compared with the effect size for Shapiro and colleagues (1994) of 2.46, and that for Barkham and colleagues (1996) of 1.79.

Finally, because effect size calculations are impacted by the degree of correlation between pre- and posttreatment measurements, the authors also calculated the  $ES_{RMC}$  (proposed by Dunlap, Cortina, Vaslow, & Burke, 1996, and described in Seidel et al., 2014), where  $ES_{RMC} = d$ :

$$d = t_c [2(1 - r)/n]^{1/2}$$

where  $r$  is the Pearson correlation coefficient for the pretreatment and posttreatment scores, and where

$$t_c = M_{diff} / (SD_{diff} / n^{1/2}).$$

Following this formula, the  $ES_{RMC}$  (or repeated-measures-corrected  $ES$ ) for the present sample was 1.58. (The Pearson correlation coefficient [ $r$ ] between pretreatment and posttreatment BDI-II scores was .04 [ $p = .975$ ]). The comparison studies did not provide sufficient

information to allow for the calculation of the  $ES_{RMC}$ , however, so no direct comparison can be made.

### IIP-64

IIP-64 Total Scores for the three clients at pretreatment screening, Session 8 (midpoint), Session 16 (last session), and posttreatment follow-up are presented in Table 2.

**Clinically significant change.** Safran, Muran, Samstag, and Winston (2005) established the clinical cutoff for the IIP-64 total score to be 1.13. These same authors likewise established the standard error for the IIP-64 to be 0.34. From this, we can calculate that a difference of 0.67 would be required to yield an RCI of 1.96.

Changes in Client 1's IIP-64 total scores (1.30 at pretreatment screening and 1.06 at posttreatment follow-up) met the first criterion for

<sup>4</sup> Shapiro and colleagues (1994) did not report the effect size for changes in the BDI for PI therapy alone (and did not provide sufficient information for this  $ES$  to be calculated) but reported the effect size across both PI and CB treatments. They also reported that CB was found to be slightly more effective (on the BDI) than PI. Therefore, the reported effect size can be assumed to be slightly higher than that for PI therapy alone in this study. Thus comparing the effect size of the present treatment to this effect size of 2.37 results in a more conservative test, given that the effect size of PI therapy alone would have been slightly lower.

<sup>5</sup> This  $ES_{pre}$  (showing the effect size from pre-treatment to end of treatment) was recalculated based on information provided in Shapiro et al. (1994) to make it comparable with both Barkham et al. (1996) and the present study. However, in their paper, Shapiro and colleagues (1994) report the  $ES_{pre}$  from what they call "Assessment 1" (at Session 1 rather than pre-treatment) and end of treatment, which was 1.77 ( $SD_{pre} = 6.75$ , 95% CI [1.46, 2.07]).

<sup>6</sup> Barkham and colleagues (1996) also did not report the effect size for changes in the BDI for PI therapy alone (and did not provide sufficient information for this  $ES$  to be calculated) but reported no significant differences between PI and CB treatments. Therefore, this effect size (across both treatments) can be assumed to apply to the PI treatment in that study.

Table 2  
IIP-64 Total Scores

Client	Pretreatment screening	Session 8 (midpoint)	Session 16 (last session)	Posttreatment follow-up
Client 1	1.30	1.20	(missing)	1.06
Client 2	1.63	1.41	.66	.45
Client 3	2.00	1.64	1.81	1.91

clinically significant change set by [Jacobson and Truax \(1991\)](#), but not the second. Changes in Client 2's IIP-64 total scores (1.63 at pretreatment screening and 0.45 at posttreatment follow-up) met both criteria. Client 3's change scores (2.00 at pretreatment screening and 1.91 at posttreatment follow-up) did not meet either criterion

**Effect size comparison.** As with the BDI, the authors used several different methods to compare the effect size of the IIP-64 across these three cases to the effect sizes established by previous research. First, they calculated the  $ES_{pre}$  using the formula noted above. For the present sample, the  $ES_{pre}$  for the IIP-64 was found to be 1.44 ( $SD_{pre} = 0.35$ , 95% CI [-0.88, 3.73]), as compared with the  $ES_{pre}$  for [Shapiro and colleagues \(1994\)](#) of 1.00 ( $SD_{pre} = 0.45$ , 95% CI [0.72, 1.28]),<sup>7,8</sup> and that of [Barkham and colleagues \(1996\)](#) of 0.74 ( $SD_{pre} = 0.53$ , 95% CI [0.22, 1.25]).<sup>9</sup>

Next, the authors used the same variation of the  $ES_{pre}$  discussed above (substituting the  $SD_{pre}$  with the cross-samples unweighted average  $SD_{pre}$ ), which yielded an effect size of 1.14 for the present sample, as compared with that found by [Shapiro and colleagues \(1994\)](#) of 1.01 and that found by [Barkham and colleagues \(1996\)](#) of 0.88.

The  $ES_{RMC}$  for the present sample was 0.77. (The Pearson correlation coefficient [ $r$ ] between pretreatment and posttreatment IIP-64 scores was 0.61 [ $p = .585$ ]). The comparison studies did not provide sufficient information to allow for the calculation of the  $ES_{RMC}$ , however, so no direct comparison can be made.

**Between-session activities questionnaires.** As previously mentioned, both clients and therapists were asked to fill out questionnaires (BSAQ:CPre, BSAQ:CPost, and BSAQ:TPost) at each session assessing different aspects of HW use. Client and therapist responses to questions pertaining to the discussion of possible

HW activities for the coming week, the perceived relevance of such HW activities to issues being discussed in therapy more generally, and the extent to which clients actually engaged in the previously discussed activities are presented in [Table 3](#).

Both client and therapist measures asked, "In the session you just had, did you and your therapist [you and your client] discuss any between-session activities that you [s/he] could do between now and the next time you meet?" All three clients as well as the therapists for Clients 1 and 2 responded, "Yes," to this question for all but one applicable session (the question did not apply to the final session). Client 3's therapist responded, "Yes" to this question for all applicable sessions.

After asking about the HW activity discussed, both client and therapist measures

<sup>7</sup> [Shapiro and colleagues \(1994\)](#) did not report the effect size for changes in IIP-64 scores for PI therapy alone (and did not provide sufficient information for this  $ES$  to be calculated). These authors report the effect size of 1.00 across both PI and CB treatments. However, they do report that they did not find any significant differences between PI and CB treatments in this regard. Therefore, this effect size (across both treatments) can be assumed to apply to the PI treatment in that study.

<sup>8</sup> [Shapiro and colleagues \(1994\)](#) report the  $ES_{pre}$  from what they call "Assessment 1" (Session 1) rather than pretreatment. Unlike with the BDI (see above), the  $ES_{pre}$  could not be recalculated from pre-treatment to end of treatment, as there were no pretreatment values reported for the IIP-64.

<sup>9</sup> [Barkham and colleagues \(1996\)](#) did not report the effect size for changes in IIP-64 scores for PI therapy alone (and did not provide sufficient information for this  $ES$  to be calculated). They report the effect size of 0.75 across both PI and CB treatments (although our recalculations yielded an  $ES$  of 0.74). They also report that CB was slightly more effective (on the IIP-64) than PI in their sample. Therefore, the reported effect size can be assumed to be slightly higher than that for PI therapy alone in this study. Thus comparing the effect size of the present treatment with this effect size of 0.74 results in a more conservative test, given that the effect size of PI therapy alone would have been lower.

Table 3  
*Client and Therapist Responses to the BSAQ*

Dyad	Discussed HW for the coming week <sup>a</sup> (ratio yes/total)	Relevance of HW to issues in therapy <sup>b</sup> (mean across sessions, scale 1–5)	Extent of HW completion <sup>c</sup> (mean across sessions, scale 1–5)
1			
Client	13/14 <sup>d</sup>	5.00 ( <i>SD</i> = 0)	3.47 ( <i>SD</i> = 1.06)
Therapist	14/15	4.85 ( <i>SD</i> = .38)	4.36 ( <i>SD</i> = 1.08)
2			
Client	14/15	4.93 ( <i>SD</i> = .27)	4.08 ( <i>SD</i> = .95)
Therapist	14/15	4.71 ( <i>SD</i> = .47)	4.42 ( <i>SD</i> = .51)
3			
Client	14/15	4.93 ( <i>SD</i> = .27)	4.13 ( <i>SD</i> = 1.06)
Therapist	15/15	4.40 ( <i>SD</i> = .63)	3.71 ( <i>SD</i> = 1.44)

Note. BSAQ = Between-Session Activities Questionnaire; HW = homework.

<sup>a</sup> “In the session you just had, did you and your therapist [you and your client] discuss any between-session activities that you [s/he] could do between now and the next time you meet?” Responses given as Yes/No. <sup>b</sup> “To what extent does this activity seem relevant to current issues in therapy?” Responses given using a Likert scale (1–5) where 1 is *not at all relevant*, 3 is *moderately relevant*, and 5 is *very relevant*. <sup>c</sup> “To what extent did you [the client] do what was discussed?” Responses given using a Likert scale (1–5), where 1 is *not at all*, 3 is *partly*, and 5 is *completely*. <sup>d</sup> Data for one session were missing.

asked, “To what extent does this activity seem relevant to current issues in therapy?”<sup>10</sup> Using a Likert scale where 1 is *not at all relevant*, 3 is *moderately relevant*, and 5 is *very relevant*, Client 1’s mean response across the 13 applicable sessions was 5.00 (*SD* = 0.00), and his therapist’s mean score across the 14 applicable sessions was 4.85 (*SD* = 0.38). Client 2’s mean response across the 14 applicable sessions was 4.93 (*SD* = 0.27), and her therapist’s mean score across the 14 applicable sessions was 4.71 (*SD* = 0.47). Client 3’s mean response across the 14 applicable sessions was 4.93 (*SD* = 0.27), and her therapist’s mean response across the 15 applicable sessions was 4.40 (*SD* = 0.63).

Both client and therapist measures asked, “To what extent did you [the client] do what was discussed?”<sup>11</sup> Using a Likert scale, where 1 is *not at all*, 3 is *partly*, and 5 is *completely*, Client 1’s mean response across the 15 sessions for which it was applicable was 3.47 (*SD* = 1.06), and his therapist’s mean response across the 14 applicable sessions was 4.36 (*SD* = 1.08). Client 2’s mean response to this question across the 14 sessions for which it was applicable was 4.08 (*SD* = 0.95), and her therapist’s mean response across the 12 applicable sessions was 4.42 (*SD* = 0.51). Client 3’s mean response across the 15 applicable sessions was 4.13 (*SD* =

1.06), and her therapist’s mean response across the 15 applicable sessions was 3.71 (*SD* = 1.44).

Although a more extensive discussion of additional items from this measure, including qualitative items, will be presented in a future study, clients’ and therapists’ descriptions of HW activities in the free response items generally demonstrated theoretical consistency and adherence to the PI model (e.g., reflecting on interpersonal dynamics, paying attention to emotional reactions, journaling about feelings, trying out new ways of responding in familiar interpersonal situations).

## Discussion

The purpose of the present study was to provide a preliminary investigation of the systematic use of HW in psychodynamic-interpersonal

<sup>10</sup> This question was only applicable to sessions in which clients/therapists reported having discussed HW activities for the coming week. It was not applicable to the final session. Likewise, clients did not respond to the question on all occasions in which it would have been applicable.

<sup>11</sup> This question was only applicable to sessions in which clients/therapists reported having previously discussed HW assignments for the week and in which they also reported discussing previously assigned HW in the present session. It was not applicable at Session 1.

psychotherapy for depression. Based on the analysis of three cases, the authors sought to address questions related to the compatibility of HW with this treatment model and the ease of the proposed integration, as well as the effectiveness of this integrative treatment relative to that of psychodynamic-interpersonal treatment that does not explicitly or systematically make use of HW. Overall, the results support the hypotheses regarding these questions.

### Hypothesis 1

The first hypothesis—that the systematic use of HW would be found to be compatible with the provision of psychodynamic-interpersonal therapy—was supported. This conclusion is based on the following observations (detailed further below): therapists provided PI therapy; the treatment included the discussion of HW activities at almost every session; clients reported engaging in HW activities at almost every session; and these activities were perceived by clients and therapists to be highly relevant to the work of therapy more generally.

Although the authors did not complete systematic ratings or have any other observer ratings of therapist's adherence to the PI treatment model, the first author did watch every session in its entirety and took detailed notes guided in part by a measure of adherence designed for previous studies using this treatment model (SPRS; Shapiro & Startup, 1990). Based on her observations, she estimated that the therapists' adherence to the treatment model to be high. For example, in all three cases, therapists focused on understanding problematic patterns in relationships and how these may have been contributing to clients' depressive symptoms; drawing connections between patterns observed in past relationships, current relationships outside of therapy, and the therapeutic relationship as a way of understanding these problematic patterns; deepening emotions in the here-and-now by responding to verbal and nonverbal cues; and understanding clients' wishes and fears in interpersonal relationships, all hallmarks of psychodynamic-interpersonal therapy (Hobson, 1985). Therapists also took a collaborative stance, inviting an atmosphere of mutual negotiation of meaning (making tentative hypotheses, inviting correction of misunderstanding and acknowledging mistakes, and using "I"

and "we" language); made use of understanding hypotheses (statements of how the therapist imagines the client may be feeling), linking hypotheses (statements of how the therapist imagines feelings in session may be related to feelings in other situations both inside and outside of session), and explanatory hypotheses (statements that introduce possible ways of understanding problematic patterns, usually related to some underlying conflict between a wish and a fear); and they made use of emotionally evocative metaphors developed collaboratively with clients (Hobson, 1985). Thus although specific ratings of adherence are not available, it seems reasonable to conclude that the treatment provided was consistent with the psychodynamic-interpersonal model.

Across the three cases, clients and therapists reported that they discussed HW activities for the coming week in almost all sessions. In fact, two of the three therapists reported that such activities were discussed in all but one session and the third reported that they were discussed at every session. Not only did therapists and clients report discussing potential activities for the coming week, but they also indicated that, to a large extent, clients actually engaged in such therapeutically relevant activities between most sessions.

Furthermore, both clients' and therapists' ratings of the relevance of these HW activities to issues currently being discussed in treatment more generally were very high, indicating that they saw the HW as furthering treatment goals and extending the in-session work into the time between sessions. Responses to these questions—about the discussion of HW activities and the perceived relevance of such activities—serve as measure of adherence to the HW manual. These findings suggest that the use of HW was successfully and seamlessly integrated into the psychodynamic-interpersonal treatment model and demonstrate that clients and therapists found it to be theoretically consistent with the rest of their work.

### Hypothesis 2

The second hypothesis—that the treatment would be effective in treating clients' depression and would be at least as effective as (and possibly more effective than) empirically supported psychodynamic therapies that do not ex-

plicitly or systematically make use of HW—was also mostly supported. Again, each aspect of this hypothesis will be discussed in detail below.

All three clients seemed to benefit from this integrative treatment, although to varying degrees. Client 2 appeared to have benefited quite dramatically. Consistent with the authors' hypotheses, at posttreatment follow-up, she no longer met criteria for Major Depressive Disorder. Although her BDI-II scores early in treatment were in the moderate to severe range, by the end of treatment, she was reporting minimal depressive symptoms, and her BDI-II score at posttreatment follow-up was 0. Also consistent with the authors' hypothesis, this client's change in depressive symptoms over the course of treatment met criteria for clinically significant change. What's more, this client also experienced a clinically significant decrease in distress related to interpersonal problems (IIP-64) over the course of this 16-session treatment, thus exceeding the authors' hypothesis in this regard.

Client 1 also failed to meet criteria for Major Depressive Disorder at posttreatment follow-up. However, he experienced less dramatic changes and did not meet criteria for clinically significant change in depressive symptoms from pre- to posttreatment as had been hypothesized. That being said, he reported a 6-point increase in depressive symptoms between pretreatment screening and Session 1, quite to the contrary of what we might expect: previous research on expectancy effects (e.g., Frank, Nash, Stone, & Imber, 1963; Friedman, 1963) would suggest that simply knowing that he was about to start treatment might have given the client a sense of hope or might have led him to feel an increased sense of self-efficacy for having taken such a step to begin addressing his difficulties, thus leading to a decrease in distress. The reasons for this client's increase in depressive symptoms prior to the commencement of treatment are unclear. However, it is worth noting that the change in depressive symptoms from Session 1 (as opposed to pretreatment screening) to posttreatment follow-up is, in fact, large enough to be considered reliable. Taken with the fact that the client's BDI-II scores over the last few sessions hovered around the clinical cutoff, with Sessions 14 and 16 dipping just below, it seems reasonable to say that this change comes close

to meeting criteria for clinical significance. The issue of clinical significance aside, this client nonetheless showed some notable improvements over the course of his treatment, albeit less dramatically so than did Client 2. Client 3 continued to meet criteria for Major Depressive Disorder at posttreatment. However, changes in her BDI-II scores demonstrate a decrease in depressive symptoms that can be considered reliable and which indicate a movement from severe to moderate depression.

The prediction that this integrative treatment would be found to be at least as effective as comparable psychodynamic-interpersonal treatments that did not explicitly/systematically make use of HW was also supported. Effect sizes for changes in depressive symptoms across cases were comparable to those found by Shapiro and colleagues (1994) and Barkham and colleagues (1996). (Comparison of effect sizes recalculated using the cross-sample  $SD_{pre}$  were comparable; on the other hand, comparison of the present study's effect size to that originally reported in each comparison study was actually favorable.) In fact, as noted previously, because the effect size reported by both of these groups of authors included both PI therapy and CB therapy (the authors did not report them separately), and because Shapiro and colleagues (1994) reported that they found CB therapy to be slightly more effective than PI therapy in reducing symptoms assessed by the BDI, the comparison is actually a more conservative one, given that the effect size for PI therapy alone was presumably slightly smaller than the one reported (Barkham et al., 1996, on the other hand, found no significant differences for changes in the BDI across treatments).<sup>12</sup> However, such comparisons must be made only tentatively, given the small sample size for this study and the fact that previous research has suggested that studies with smaller sample sizes are more likely to yield higher effect sizes (Slavin & Smith, 2009).

Likewise, the effect size for the IIP-64 across the three cases is notably larger than those found by both Shapiro and colleagues (1994)

<sup>12</sup> Furthermore, given that the effect sizes for the BDI reported by both studies included both PI and CB treatments, these favorable comparisons are not only to PI therapy that does not explicitly include HW but also to CBT.

and Barkham and colleagues (1996). (This was true both when using the effect sizes originally reported in the comparison studies as well as those recalculated using the cross-sample  $SD_{pre}$ .) As with the BDI, both of these groups of authors also reported effect sizes for the IIP-64 across both treatments (not each treatment individually). Therefore, because Barkham and colleagues (1996) reported that they found CB therapy to be very slightly more effective than PI therapy in reducing interpersonal distress reported on the IIP-64, this favorable comparison is also more conservative, given that the effect size for PI therapy alone was presumably slightly smaller than the one reported (in the case of the IIP-64, Shapiro et al., 1994, found no significant differences between treatments).<sup>13</sup> Nonetheless, as noted above, these comparisons must also be interpreted very tentatively due to the small sample size.

### Limitations and Future Directions for Research

The present study has several limitations. The fact that the study includes only three cases clearly limits the degree to which the observations can be generalized, as noted above. In addition, no variables were manipulated. Larger scale studies (with appropriate statistical power) in which HW inclusion could be manipulated are required for drawing the conclusion that the addition of HW actually improves the effectiveness of psychodynamic therapy. In addition, the absence of a systematic adherence check involving an established adherence measure to ensure that the treatment provided was consistent with the psychodynamic-interpersonal model reduces the strength of some of the conclusions that can be drawn from this study. Although initial diagnoses were established by two clinicians using the ADIS-IV-L (both the intake therapist and a second therapist who viewed a video-recording of the ADIS-IV-L interview), diagnoses at posttreatment follow-up were only established by one clinician (again, using the ADIS-IV-L). Finally, the fact that the BSAQ is a new measure that has not yet undergone psychometric testing is an additional limitation. Keeping these limitations in mind, however, the results of this preliminary study tentatively suggest that this integrative treatment might be at least comparably effective to

the original, and we might further conclude that the possibility that it may improve the effectiveness at least warrants further investigation.

As noted above, HW in psychodynamic therapy should not be presumed to look like HW in CBT or other models. Future research is needed to more fully understand the ways in which HW may be incorporated into this model, how it may contribute to the process of change, and how it may be experienced by clients. To this end, the authors plan to present more process-oriented and qualitative findings from the present study in a future paper.

### Implications for Practice

Although these findings regarding the effectiveness of this integrative treatment must be considered tentatively given the small sample size, it appears likely that the treatment has the potential to be effective in some cases. Psychodynamic practitioners working with clients who seem to be having difficulty translating awareness or insight gained in session into changes outside of session, or who seem to be having difficulty gaining that awareness or insight in the first place, may find it especially helpful to incorporate HW activities into their work.

Psychodynamic therapists who wish to make use of HW in their practices are encouraged to consider doing so systematically; that is, they may wish to consider suggesting HW activities on a regular basis or regularly encouraging their clients to suggest activities themselves. (The occasional use of HW may still be quite helpful, as discussed by Stricker, 2006b, although the present study does not address the degree to which such less systematic use of HW may be experienced as fully integrated into the treatment model by clients.) Therapists are also encouraged to ensure that their recommendations for HW activities are relevant to the treatment more generally and that this relevance is made clear to clients. As always, therapists are encouraged to remain attuned to clients' reactions to their suggestions and address these reactions with clients in a curious and supportive manner.

<sup>13</sup> Similarly, given that the effect sizes for the IIP-64 reported by both studies included both PI and CB treatments, these favorable comparisons are not only to PI therapy that does not explicitly include HW, but also to CBT.

Finally, therapists are encouraged to keep in mind that HW is intended to facilitate and expand upon in-session work, not replace it. Especially within this model of psychodynamic therapy, which places emphasis on the here-and-now experience in session within the therapeutic relationship, therapists should be careful to keep in-session work the primary focus and to be aware of the balance between discussion of HW and discussion of the present experience. It is likely that the discussion of HW can be integrated into the here-and-now work, for instance by focusing on the client's current experience of sharing what happened between sessions with the therapist or by drawing connections between such experiences and dynamics in the therapeutic relationship.

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## El uso sistemático de tareas en la psicoterapia psicodinámica-interpersonal para la depresión: Un enfoque de integración asimilativa

Aunque el uso de actividades entre sesiones, o tareas, ha sido tradicionalmente asociado con la terapia cognitiva conductual (cognitive-behavioral therapy, CBT, por sus siglas en inglés), hay creciente evidencia que terapeutas de diversas orientaciones están incluyendo tareas en su práctica. Sin embargo, aunque hay evidencia fuerte para apoyar el uso de las tareas en CBT, todavía no hay estudios explorando su uso en otros tipos de terapia. Como un estudio preliminar, los autores examinan la viabilidad y la efectividad de una integración asimilativa de tareas en la psicoterapia psicodinámico-interpersonal para la depresión. Hallazgos de 3 estudios de caso apoyan la hipótesis que las tareas pueden ser integradas exitosamente en la terapia psicodinámica en una manera teóricamente consistente sin problemas. Hallazgos también sugieren que, por lo menos dentro esta muestra limitada de tres casos, que el tratamiento integrativo puede tan efectivo como (y posiblemente más efectivo que) la terapia psicodinámica que no incluye tareas.

la integración psicoterapeuta, la integración asimilativa, tarea, entre sesiones actividades, psicoterapia psicodinámico interpersonal

家庭作业在对抑郁症的精神动力学 - 人际心理治疗中的系统使用：一种同化整合方法

虽然治疗访谈之间的活动-比如家庭作业-的应用传统上与认知行为治疗 (CBT) 相关联, 但是越来越多的证据表明具有不同导向的治疗师都将其纳入实践。然而, 虽然有强有力的证据支持在CBT中使用家庭作业, 但目前还没有已知的研究探索家庭作业其他类型心理治疗中的使用。作为初步研究, 作者研究了家庭作业的整合同化在对抑郁症的心理动力-人际心理治疗中的可行性和有效性。来自3个案例研究的结果支持(我们的)假设, 家庭作业可以成功地以无缝的和理论上一致的方式整合到心理动力学治疗中。结果还表明, 至少在这3例的有限样本中, 这种整合性的治疗可能至少与不包括家庭作业的精神动力疗法一样有效(可能更有效)。

心理治疗整合 同化整合 家庭作业 治疗访谈之间活动 心理动力-人际心理治疗

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### Correction to Faerstein, Levenson, and Lee (2016)

In the article “Validation of a Fidelity Scale for Accelerated-Experiential Dynamic Psychotherapy” by Ian Faerstein, Hanna Levenson, and Alexandra C. Lee (*Journal of Psychotherapy Integration*, 2016, Vol. 26, No. 2, pp. 172–185. <http://dx.doi.org/10.1037/int0000020>), the name of Alexandra C. Lee was not included in the article. The online version of this article has been corrected.

<http://dx.doi.org/10.1037/int0000087>