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A systematic literature review: How do patient intersession experiences relate to patient characteristics and the therapeutic processes?

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Abstract

This review systematically explores the associations that patient characteristics and therapeutic processes have with patient intersession experiences. Electronic databases (EMBASE, MEDLINE, PsycINFO, ASSIA) were searched for relevant studies using the application of a range of inclusion and exclusion criteria, including adult only populations and patient intersession experience only. The methodological quality of 15 studies was explored using assessment tools developed for the purpose of this review. Findings suggest that most patients report a range of intersession experiences. Intensity and type of intersession experience were associated with patient personality, diagnosis, phase of therapy, alliance and outcome. Study limitations included small sample sizes, the exploratory nature of some designs and the generalisability of the results. Clinical implications include the association that intersession experiences may have with the therapeutic relationship and treatment outcome, in addition to possible treatment gains post therapy.

Key words: intersession experience; therapy; process; representation

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<http://www.apa.org/pubs/journals/int/index.aspx>

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Within the 2006 special series of the Journal of Psychotherapy Integration, Ronan and Kazantsis summarise research to date on planned between session activities in psychotherapy. They concluded that therapeutic activities in the time between sessions, such as homework, are beneficial to clients. Homework activities are planned and deliberate instrumental between session tasks, yet other therapy related processes are known to occur for patients in the time between sessions. Imagined interactions, fantasies, thoughts, feelings, dreams and images about the therapy or therapist that occur between sessions have been labelled within the literature as an 'intersession experience'. This term is widely used (although mostly within psychodynamic literature) to group the range of mental representations patients have about therapy between sessions (Orlinsky, Geller, Tarragona & Farber, 1993). Whilst patients may create mental representations about a range of people in their life in the time between sessions, intersession experiences are concerned with those related to therapy or the therapist. They are often spontaneous, unobservable and self-reported.

Historical Development

Decades of psychotherapy research have explored processes within sessions and have focussed on the role of the therapeutic relationship. The bond between the patient and therapist is argued to be the most robust predictor of positive therapy outcome across theoretical orientations (Norcross, 2011). Exploring this relationship and wider therapy processes (defined as events that occur within the session, Orlinsky & Geller, 1994), has emphasised the interaction during therapy sessions and how this relates to outcome.

From the 1970s the scope of psychotherapy research broadened to consider processes occurring outside of the therapy session. From this time a number of studies began to focus on patients' mental representations of therapy in the time between sessions. They considered that patients 'take home' in-session processes, resulting in a range of intersession experiences (Orlinsky et al., 1993).

Measures

Two measures have been developed to assess types of intersession experience; however they are self-report and retrospective. The Therapist Representation Inventory (TRI) aims to explore patients' representations of their therapist at a single point in time (Geller, Cooley & Hartley, 1981). It focuses on the complexities of the representations, the sensory modalities and their function for the patient. The TRI comprises of four parts which requests participants to: 1) write a description of their therapist; 2) rate the contribution of a range of factors such as words, pictures and sounds to their conscious experiences of the therapist between sessions (Therapist Embodiment Scale, TES); 3) rate the functions of representations (Therapist Involvement Scale, TIS); 4) rate the vividness of dreams in which therapists appear. Following this, Orlinsky and Lundy (1986) developed the Intersession Experience Questionnaire (IEQ) to explore patient and therapists' between session experiences over the course of therapy. The IEQ asks patients to report the type and frequency of representation, the feelings evoked, the content and situation of the representation, and how much they talked about therapy with others (Orlinsky & Geller, 1994). The IEQ was translated into German language with minor adaptations by Hartmann, Orlinsky, Geller and Zeeck (2003) and labelled the Inter-Session Fragebogen (ISF). Both the IEQ and the TRI examine patient dreams about their therapist as forms of representation. Orlinsky and Geller (1994) suggest that whilst there are some differences between the questionnaires, they can be viewed as complementary and partially overlapping; the main difference being that the TRI is intended to measure intersession experiences at a single point in time, while the IEQ is intended for repeated use across therapy.

Current focus and findings

Orlinsky et al. (1993) suggest that patient intersession experiences reflect in-session interactions and serve as a vehicle for in-session processes to be transferred to patients' lives outside of therapy. Orlinsky and Geller (1994) report that representations may reflect the therapeutic relationship, and comprise of the "psychological connective tissue between successive therapy sessions" (p.23). In addition, they may influence the course of therapy, having significant impact on therapeutic process. An example of this may be a patient's recreation of the therapeutic dialogue to solve a problem outside of session, yet this experience also strengthens the therapeutic relationship within sessions. The forms of patient intersession experience, in addition to the situations in which they are evoked or experienced, have been seen to change over the course of therapy (Bender, Geller & Farber, 1997; Hartmann, Orlinsky, Weber, Sandholz & Zeeck, 2010; Rosenzweig, Farber & Geller, 1996; Zeeck, Hartmann & Orlinsky, 2006), have been reported to continue following termination (Wzontek, Geller & Farber, 1995), and have been associated with treatment outcome (Owen, Quirk, Hilsenroth & Rodolfa, 2012; Hartmann et al., 2010; Hartmann, Orlinsky & Zeeck, 2011; Zeeck & Hartmann, 2005). This suggests that intersession experiences may reflect important aspects of the therapy process.

Bohart and Wade (2013) provide a summary of learning and processing outside of therapy within the latest edition of the Handbook of Psychotherapy and Behaviour Change (Bergin & Garfield, 2013). The definition of intersession experience is outlined and agreed within the literature, however systematically reviewing the findings and methodological quality of studies to date may help to synthesise the factors associated with this phenomena and inform professional practice. Exploring patient intersession experience may increase understanding of the development of the therapeutic relationship, informing how to achieve the best outcomes for patients. It may be that intersession experiences influence outcome through the relationship and therefore clinicians should place greater emphasis in sessions on the processes occurring outside of the therapy session. In addition, it may be that intersession experiences influence whether patients continue to apply and retain skills after therapy completion, predicting long term treatment outcomes.

The following questions are identified:

1. What are the types and prevalence of intersession experience?
2. How are intersession experiences related to patient/therapist characteristics?
3. How reliable are the measures of intersession experience?
4. How are intersession experiences associated with therapy stage and length?
5. How are intersession experiences associated with the therapeutic relationship and treatment outcome?

Given that small teams of psychotherapists from the USA and Germany have conducted most of the previous research, a new perspective on the literature may provide further direction for future research.

Method

The search comprised of electronic database and reference list trawling. Studies were eligible dependent on the following criteria.

Inclusion:

1. Studies with participants who have accessed psychological therapy.
2. Studies that explored patient representations of therapy or therapist between sessions.
3. Peer review and dissertation articles. Dissertation articles were located and considered within the search process (e.g. Nichols, 2011); however they were all excluded on other criteria.

Exclusion:

1. Studies that examined populations outside of adult age range (18 +), as child experiences and development processes were not the focus of this review.
2. Studies that only examined patients' representations about themselves or significant others.
3. Studies that explored in-session representations only.
4. Studies that explored therapist planned between session tasks, such as homework. This review is interested in relational experiences only, such as spontaneous thoughts or feelings about therapy/therapist in the time between sessions.
5. Studies that explored the neuropsychological processes underpinning therapy recall were not included as it is not within the scope of the review.
6. Only English language articles were considered due to practicality. Two key studies were excluded on this basis and is therefore a noted limitation of the review.
7. No date restriction was applied; however database start dates restricted the search.

Electronic Search Strategy

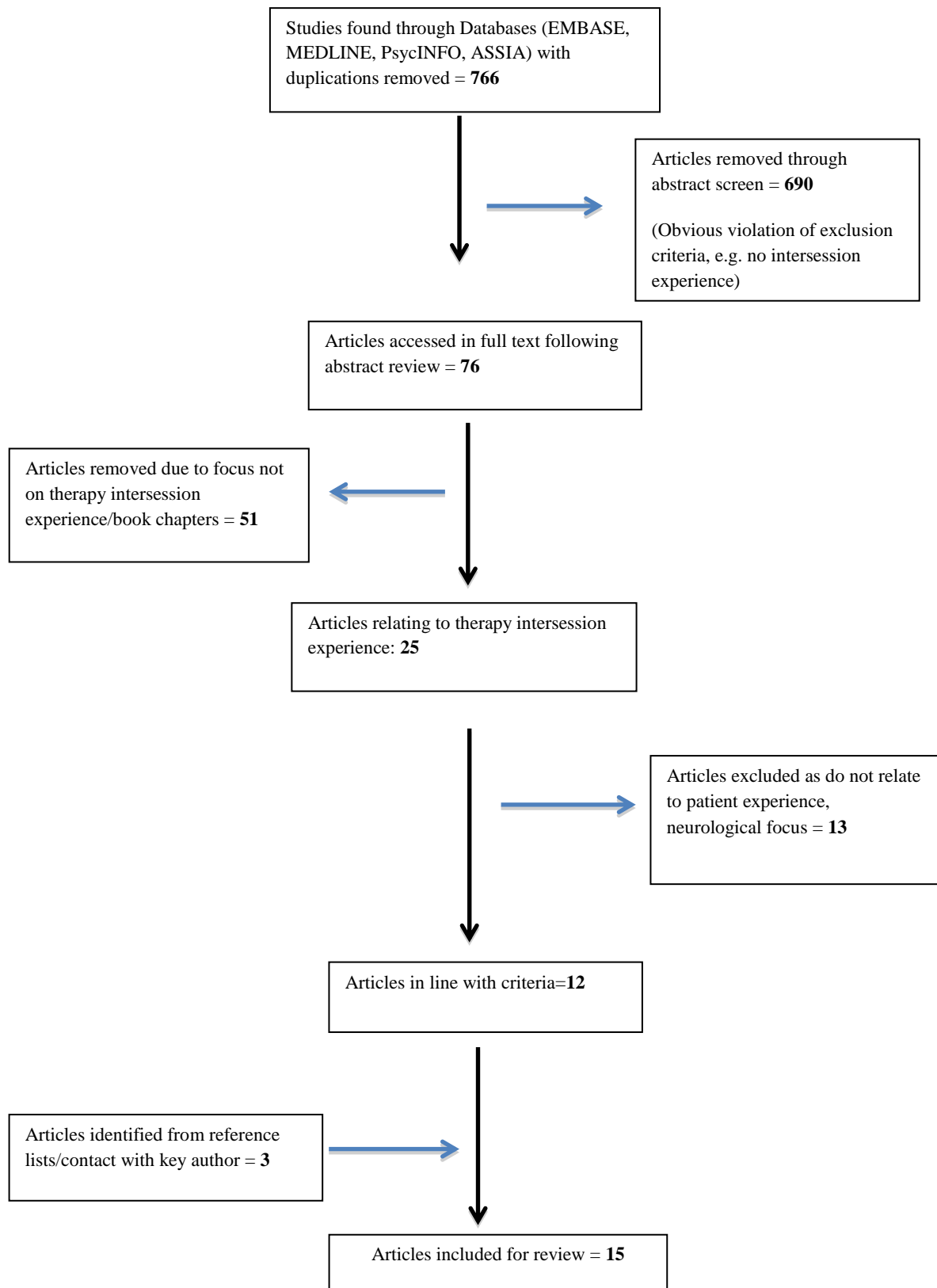
Four databases were searched with the same strategy: EMBASE, MEDLINE, PsycINFO, Applied Social Sciences Index and Abstracts (ASSIA). For date spans and journal numbers per database please see Appendix A.

Three broad concepts were identified in relation to the review; patient, therapy/therapist, and intersession experience. Key terms were searched individually, using Boolean operators to group searches within each concept (OR). They were then combined (AND) to produce a total search number for each database. Key terms used were: intersession experience*, intersession process* mental representation* between session experience*, patient* client*, therapist* therapy. Medical Subject Headings (MeSH) related to the key terms were also identified and exploded. Headings varied however, examples included 'fantasy' as a MeSH for 'mental representation*' (EMBASE), and 'patients/or inpatients/or outpatients/' as a MeSH for 'patient*' (MEDLINE). ASSIA does not have this function and therefore only key terms were used. Please see Appendix B, C, D and E for full search strategies.

Key terms were intentionally broad using known labels for the concept of intersession experience. These terms did not focus on specific themes such as patient characteristics or measures of intersession experience. This was to narrow the search to ensure only patient between session experiences related to therapy were identified, excluding large quantities of unrelated papers.

Where possible, additional limits were applied to reflect the exclusion criteria (e.g. adult only, removal of non-human articles and written in languages other than English). Removal of duplicate articles and a title scan identified 76 articles from the initial 766 located within the search. Articles were re-examined in line with inclusion/exclusion criteria via full text review identifying 12 relevant studies. Given electronic searching alone is not guaranteed to identify all articles (Dickersin, Scherer & Lefebvre, 1995), reference lists of relevant studies were trawled, adding a further three eligible studies for inclusion. A key author in the area was contacted via email who confirmed all relevant papers he was aware of had been located via the search strategy. A QUORUM diagram (Figure 1) details the search process.

Figure 1. Selection.



Data abstraction

Authors, participants, methodology, measures, aims and key findings of papers selected for review are outlined in Table 1.

A range of assessment tools to review the methodological quality of research exists within the literature, each with their limitations. Whilst they can be considered beneficial in reducing subjectivity and improving reliability, the validity of the conclusions they lead researchers to have been widely criticised (Juni, Witschi, Bloch & Egger, 1999). To assess the quality of quantitative studies, a coding frame was developed using an amalgamation of the most relevant elements of two established quality scales within the literature (Critical Appraisal Skills Training, University of Oxford, 2005; Newcastle-Ottawa Scale, Wells et al., 2010). This helped guide the development of the quality assessment tool, but allowed for adaptations in line with the design of studies in the review. This tool contained seven areas of bias (definition; participants; assessment; design; results; generalisability; implications). Sub-questions considered measures, recruitment strategies, statistical reporting and procedure, and aims to reduce bias. The qualitative paper was evaluated based on criteria outlined by Tracy (2010) regarding qualitative best practice. This was adapted in line with the study being reviewed and is consistent with other qualitative assessment criteria (Yardley, 2000). No overall score is provided given that the reduction of a study's quality to a single dichotomous judgement is likely to obscure the important differences between aspects of the study design (Cooper, 2010).

Due to the scope of this review, quality assessment was conducted by one researcher and therefore inter-rater reliability could not be undertaken. Please see Table 2 for the quantitative studies quality results and Table 3 for the qualitative study quality results.

Table 1: Studies examining the properties of patient intersession experiences.

Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
1. Geller , Cooley and Hartley. (1981)	Psychotherapists in therapy n=120 males n =86 females	Quantitative Questionnaire: development of TRI 1. Describe therapist 2. How much they experienced words/sounds/image of therapist when not with them. 3. Vividness of dreams 4. How much therapy had helped	Identify the function and properties of representations	<ul style="list-style-type: none"> • Three forms of representation were identified that make up the TES; The Imagistic Mode, The Haptic Mode, The Conceptual Mode. • High internal consistency between questions on the TES ($\alpha=.69$). • Six functions of representation were identified that make up the TIS; Sexual and aggressive involvement, the wish for reciprocity, continuing the therapeutic dialogue, failures of benign internalisation, creation of therapist introject, and mourning. • Some internal consistency between questions on the TIS($\alpha=.49$) • Continuing the therapeutic dialogue is associated with perceived outcome of therapy*.
2. Rohde, Geller and Farber. (1992)	n=67 Psychotherapists in therapy (n=33 currently in therapy) (n=30 terminated therapy)	Quantitative TRI- part 4 (dreams only)	To explore patient representations of therapists through their dreams.	<ul style="list-style-type: none"> • No significant difference in frequency, mood of dream or success of therapy between those in therapy and those whose therapy has terminated. • Within dream content: 13.4% reported aggressive interactions between patient/therapist, 16.9% reported friendly interactions between patient/therapist, 7.5% reported sexual interactions between patient/therapist.

Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
3 Farber and Geller. (1993)	n=206 patients (therapists accessing therapy) Aged 25-75	Quantitative TRI	What circumstances evoke therapist representations for current/former patients? Does attendance, total number, time elapsed affect types of representation, vividness and positive therapeutic change (outcome)?	<ul style="list-style-type: none"> • Positive therapeutic outcome is associated with a wish to continue the therapeutic dialogue* ($r=.39$) and the vividness of representations* ($r=.27$), but is not associated with the frequency and duration of representations. • Number of years since therapy termination and frequency of representation recall is significantly correlated* ($r=.32$).
4 Orlinsky, Geller, Tarragona and Faber. (1993)	n=276 total sample (206 = therapist patients, 70 = patients) Individual treatment=279 Private=20 Family clinic=27 Couple=25 Family treat=18	Quantitative IEQ and TRI Factor structure	What types of intersession experiences occur and when? What is the dimensionality of intersession experiences?	<ul style="list-style-type: none"> • Over 90% reported having intersession experiences, mostly pre-session. • Good internal consistency of the TRI (ranging from $\alpha=.70$ to $.86$) and the IEQ (ranging from $\alpha = .57$ to $.81$). • Function of representation: a source of emotional support, to master and manage conflict exposed during therapy.

Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
5. Geller and Farber (1994)	n=66 patients/therapist dyads. 29 men 37 women 8 male therapists 18 female therapists	Quantitative TRI	To explore the ways in which patient and therapists gender influences the nature of representations.	<ul style="list-style-type: none"> • Patient/therapist genders did not affect frequency of representations. • Women are more likely to miss male therapist* (t=2.18). • Females hold on to representations for 1minute, males only 30-45 seconds* (t=2.41).
6. Wzontek, Farber and Geller (1995)	n=60 former psychotherapy patients (aged 25-57) 2 groups: therapy for <1year, therapy for >1year	Quantitative TRI– including TIS and TES	Does length of therapy relate to representation? Does termination of treatment relate to representation type and self-perceived improvement? What is the relationship between representation and outcome?	<ul style="list-style-type: none"> • Patients have internalised representations of therapists. • No difference in representations between patients in <1year/>1year of therapy. • No significant difference in representation related to why people terminated therapy. • Greater outcomes post therapy had ‘continuation of therapeutic dialogue’ representations and less benign internalisation.

Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
7. Rosenzweig, Farber and Geller. (1996)	n=8 patients Psychotherapists in therapy. n=88 (n=66 from Geller & Farber, 1982 sample, n=22 doctoral students)	Quantitative Cross sectional design- 3 phases TRI	Differences in themes of representation over 3 stages of therapy. Effect of the representation The associations between forms/functions of representations	<ul style="list-style-type: none"> • Patient in the later stages of therapy use the representation of recreating therapeutic dialogue significantly more to reduce distress** (F=5.69) • Representations of the therapist left patients feeling 'comforted', 'safe' and 'accepted' in the early stages. This increased as therapy progressed.
8. Bender, Farber and Geller. (1997)	n=46 completed at stage 1 n=28 completed at follow up.	Quantitative TRI part 1 ('please describe your therapist').	How do patients conceptualise therapists during first 6 months of therapy. What character pathologies are related.	<ul style="list-style-type: none"> • Paranoid patient symptomatology is negatively correlated to therapist representation* (r = .25)

Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
9. Knox, Goldberg, Woodhouse and Hill. (1999)	n=13 adults long term psychotherapy	Qualitative-CQR methodology	What circumstances to intersession experiences occur, how are they used and how do they influence therapy.	<ul style="list-style-type: none"> • Intersession experiences were triggered by distressing thoughts or thinking about past/future sessions. • They varied between situations and intensity. • Most clients liked the experience and felt they influenced therapy and beyond. • The frequency increased over therapy and clients felt it strengthened the therapeutic relationship.
10. Bender, Farber, Sanislow, Dyck, Geller, and Skodol. (2003)	STDP n=25 BPD n=49 AVPD n=51 OCPD N=59 MDD n=17	Quantitative TRI	Attributes of mental representations of therapists by patients with personality disorders.	<ul style="list-style-type: none"> • STPD had the highest level of intersession experiences including missing their therapists and wishing for friendship, while also feeling aggressive or negative. • Patients with BPD exhibited the most difficulty in creating a benign image of the therapist outside of the session. • Gender, co-occurring Axis I disorders, and amount of individual psychotherapy were significant covariates for a number of analyses.

	Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
11.	Zeeck and Hartmann. (2005)	Anorexic patients n=38 6 weeks of treatment sessions= 344 (German)	Quantitative EDI-II, Stundenbogen (session questionnaire), ISF weight gain as a positive outcome	Are process aspects of the first 12 individual psychotherapy sessions of anorexic patients associated with weight gain (good outcome).	<ul style="list-style-type: none"> • Recreating the therapeutic dialogue was a significant predictor of outcome*** (B= - 1.017) • Negative emotions between sessions predicted poor outcome ***(B= 0.674)
12.	Zeeck, Hartmann and Orlinsky (2006)	n=76 patients diagnosed with NP n=20 patients diagnosed with BP Patient recruited from a day clinic (German).	Quantitative Time series ISF completed before each session. Stundenbogen completed after each session.	Differences in intersession experience How is intersession experience related to therapy phase, outcome and personality?	<ul style="list-style-type: none"> • No differences between BP and NP in intensity of intersession experience overall. • During phase two (weeks 3-6) BP had a higher intensity of intersession experience than NP** (t=2.77) and more negative intersession experiences in all three phases of therapy. • Compared to BP, NP had significantly more positive representations of their therapist in the last stages of therapy** (t=-2.98) and were more likely to recreate therapeutic dialogue between sessions in the first** (t=4.01) and middle stage ** (t= 2.93) of therapy.

Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
13. Hartmann, Orlinsky, Weber, Sandholz and Zeeck. (2010)	n=43 patients with diagnosis of bulimia nervosa treated in inpatient and day clinic (German).	Quantitative Admission, discharge and follow up. SQ ISF Social Adjustment Scale. EDI-II	Patients intersession experience as predictors of outcome Effect size of intersession experience compared to other predictors of outcome	<ul style="list-style-type: none"> • Recreating the therapeutic dialogue with negative emotion relates to poor outcome in initial and mid phase of therapy. • In mid phase High intensity (frequency and duration) of intersession experience predicted good outcome*** ($r^2=.34$) • Alliance was not related to outcome (measured by the EDI-II).
14. Hartmann, Orlinsky and Zeeck. (2011)	n=769 370 Chicago, USA outpatient 399 Freiburg, Germany inpatient and outpatient	Quantitative ISF/IEQ HAQ- German version WAI Therapeutic Bond Scales	Factor structure of IEQ across USA/German population. Relationship between IEQ and alliance as an outcome measure.	<ul style="list-style-type: none"> • Almost identical factor structures on the IEQ ranging from, $\alpha=.50$ to $.89$. • Strong relationships between intersession experience and alliance** (varying in strength $r^2=0.20$ to 0.66) • Positive emotions are strongly associated with good alliance as measured by the HAQ total score *($r^2=.31$) and Therapeutic Bond Scale *($r^2=0.67$). • Positive working alliance was associated with recreating the therapeutic dialogue* ($r^2=.02$), relationship fantasies* ($r^2=.01$), and emotive problem solving* ($r^2=.06$) • Negative therapeutic dialogue and emotions were associated with poor alliance* ($r^2=.02$)

Authors	Sample characteristics	Methodology	Aims/Focus	Key findings
15. Owen, Quirk, Hilsenroth and Rodolfa (2012)	n= 75 patients (student sample)	Quantitative IEQ WAI	Are intersession processes positively associated with patient rated alliance, CB and PI techniques? How much does this vary?	<ul style="list-style-type: none"> • Alliance* (B=0.2) and use of PI techniques in later stages of therapy* (B=0.27) were predictors of engagement in intersession activity. • How patients perceived CB techniques was not significantly related to the amount of intersession experiences reported.

Note. For quantitative studies the following significance indicators are used: * $p > .05$; ** $p > .01$; *** $p > .001$. Eating Disorder Inventory, EDI-II, (Garner, 1991); Working Alliance Inventory, WAI, (Horvath & Greenberg, 1989); Intersession Experience Questionnaire, IEQ (Orlinsky & Lundy, 1989); Inter-session Fragebogen, ISF, (Hartmann, Orlinsky, Geller & Zeeck, 2003); Helping Alliance Questionnaire, HAQ-I, (Alexander & Luborsky, 1986); Therapeutic Bond Scales, (Saunders et al., 1989). Personality Disorder (PD); Neurotic Patients (NP); Borderline Patients (BP); Schizotypal PD (STPD); Borderline PD (BPD); Avoidant PD (AVPD); Obsessive Compulsive PD (OCPD); Major Depressive Disorder, MDD; Psychodynamic/ Interpersonal (PI); Cognitive Behavioural (CB). Consensual Qualitative Research (CQR).

Table 2: Quantitative studies methodological quality.

Study	Definition		Participants			Assessment		Design		Results		Generalisability	Implications
	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Geller et al. (1981)	M	M	N	N	N	Y	N	N	N	Y	Y	N	N
2. Rohde et al. (1992)	M	N	N	M	N	M	M	M	N	M	Y	N	M
3. Geller et al. (1993)	Y	Y	N	M	N	Y	N	N	N	M	N	N	M
4. Orlinsky et al. (1993)	Y	Y	M	M	N	Y	M	N	M	M	N	M	Y
5. Farber et al. (1994)	M	Y	N	M	N	Y	N	M	N	M	Y	N	M
6. Wzontek et al. (1995)	M	Y	M	M	N	Y	M	M	M	M	N	N	M
7. Rosenzweig et al. (1996)	Y	Y	N	M	N	Y	N	N	N	M	N	N	M
8. Bender et al. (1997)	M	N	M	M	N	N	N	N	M	M	N	M	M
10. Bender et al. (2003)	M	Y	M	Y	N	M	N	N	N	N	M	M	M
11. Zeeck et al. (2005)	M	N	M	N	N	M	M	M	Y	N	N	M	N
12. Zeeck et al. (2006)	M	Y	M	M	N	M	M	M	M	M	M	M	N
13. Hartmann et al. (2010)	Y	Y	Y	M	N	Y	Y	Y	M	Y	M	N	Y
14. Hartmann et al. (2011)	Y	Y	M	M	N	Y	Y	Y	Y	M	Y	Y	Y
15. Owen et al. (2012)	M	Y	M	N	N	Y	M	M	N	M	N	M	M

Note.1. Clear definition of concept: Yes, explanation of construct is given and operationalized (using previous literature and clinical examples); Moderate, construct is defined using literature but is somewhat unclear; No, concept is introduced with no clear definition and limited reference to literature. 2. Clear definition of measures: Yes, clear definition (including previous use and examples); Moderate, introduced with some background literature and discussion; No, measure is introduced with no/very limited background. 3. Sample representativeness: Yes, attempts are made to ensure sample is fully representative of the one outlined; Moderate, sample is partially representative of

that outlined (some attempt at ensuring representative, consideration of diversity); No, limited representation. 4. Comparison between/within groups: Yes, appropriate comparison between/within groups; Moderate, some comparisons made; No, no comparisons between/within groups. 5. Power: Yes, power reported; No, power not reported or unknown; 6. Appropriate measure: Yes, measure with full reporting of internal reliability and validity; Moderate, some reporting of internal reliability and validity; No, no reporting of questionnaires reliability/validity. 7. Minimisation of bias: Yes, fully minimised bias (e.g. objective measures, repeated measures); Moderate, some potential bias considered/acknowledged; No, bias not taken into consideration/acknowledged. 8. Confounding variables: Yes, confounding factors fully identified (e.g. acknowledge and control/adjust for confounding factors); Moderate, partially identified (e.g. some acknowledgement); No, not addressed/discussed. 9. Length/follow up: Yes, sufficient follow up or measurement over time, Moderate, some repeated measures through time; No, no follow up/retrospective single account; 10. Statistics: Yes, fully reported in line with APA guidelines (to include all variables discussed, appropriate confidence intervals and effect sizes); Moderate, some results reported (e.g. values and confidence intervals, some effect sizes); No, limited results discussed (e.g. only those significant, few/no effect sizes). 11. Type I/II errors accounted/adjusted: Yes, errors accounted/ adjusted for through further analysis (e.g. Bonferroni corrections, OR not necessary, e.g. exploratory study); Moderate, errors acknowledged; No, not addressed. 12. Generalisability: Yes, fully generalisable to the population studied; Moderate, somewhat generalisable; No, population differs greatly from population of interest. 13. Implications: Clinical implications are clearly defined and directly match the aims/findings of the study; Moderate, some implications are discussed; No, limited/no clinical implications are outlined or unrelated/exaggerated.

Table 3. Qualitative methodological quality

Study	Rich rigour	Reflexivity	Credibility	Contribution/resonance	Ethical clarity	Meaningful coherence
9. Knox et al. (1999)	Y	M	M	Y	M	Y

Note. (1) Rich rigour: yes, a rich description and rationale for the methods and forms of analysis are described/conducted; moderate, limited description or rationale; no, little or no information is provided. (2) Reflexivity: yes, potential bias is reflected upon; moderate, some bias is discussed; no, little or no bias is discussed. (3) Credibility: yes, findings appear credible in line with aims/method; moderate, may be credible but superficial claims are made; no, little or no information to assess. (4) Significant contribution and resonance: yes, significant insights related to intersession experience are discussed; moderate, some insights into intersession experience; no, little or no insights/information discussed. (5) Ethical clarity: yes, ethical issues are detailed and acknowledged; moderate, some consideration of ethical issues; no, little or consideration or discussion. (6) Meaningful coherence: yes, appropriate methods and theory are discussed; moderate, generally appropriate methods are discussed; no, limited or no discussion of methods/theory to assess criteria.

Results

Key findings: types and prevalence

Knox et al. (1999) noted that clients reported a range of intersession experiences. These included invoking a literal recreation of a therapy conversation to cope with an anxiety provoking situation, experiencing dreams about the therapist and talking through what the therapist may say in future sessions. Some participants discussed the idea of intersession experiences as being ‘mini between sessions’ to help manage their distress. This is consistent with quantitative studies which report recreating the therapeutic dialogue as the most common intersession experience (Hartmann et al., 2010; Hartmann et al., 2011; Rosenzweig et al., 1996; Wzontek et al., 1995), in addition to imagined interactions, dreams and images (Geller et al., 1981).

Rohde et al. (1992) assessed the dreams patients have about their therapists, suggesting that dreams may be a window into the representational world. From the original Geller et al. (1982) sample, 67 participants (33%) reported to have dreams about their therapists. Many dreams related to feeling separated or rejected, seduced or antagonised, protective or responsive and receiving praise from the therapist. Findings were only compared for differences between those currently in therapy and those who had terminated.

Key findings: patient/therapist characteristics

Characteristics associated with intersession experiences include gender and personality types. A range of demographic information was collected within all studies however this varied greatly and was generally not incorporated into the analysis.

The gender of patients was not associated with the frequency of intersession experiences; however Geller et al. (1993) noted that women hold on to intersession experiences for longer than men. It is uncertain as to how this was measured given the study was self-report only. Most associated characteristics related to personality types. Bender et al. (2003) found that schizotypal patients had the most intersession experiences throughout all stages of therapy; however they were both positive and negative in tone. Borderline types had the most difficulties in recreating images of their therapist. This is similar to findings by Zeeck et al. (2005) who noted borderline types to have greater negative intersession experiences and difficulties in recreating positive therapeutic dialogue in the time between sessions, whilst neurotic types have significantly greater frequency and intensity of experience. This contrast may relate to neurotic patients’ high levels of anxiety meaning they think through the therapy much more between sessions, and borderline patients’ fluctuations of positive regard for the therapist, resulting in greater negative intersession experiences. Anorexic patients who recreated the therapeutic dialogue with negative emotion were less likely to report positive outcome (Hartmann et al., 2010), however this may be attributable to other factors such as personality. Several studies were exploratory with low participant numbers and a range of potential confounding variables such as therapist/patient characteristics and time in therapy. Hartmann et al. (2010) acknowledge that patients’ other treatment within the large hospital setting could have accounted for the variance of intersession experience, in addition to their small sample size increasing the chance of Type I error.

Some studies reported therapist characteristics, yet in many cases the data was limited to gender and experience, and not used within analyses (Hartmann et al., 2010; Owen et al., 2012; Zeeck et al., 2005; Wzontek et al., 1995). Given representations explored within the TRI and IEQ/ISF are related to therapists and arguably born from an extension of the

relationship to times outside of the session, it is likely that therapist variables may be important and could have impacted on the data obtained.

Key findings: measures

All quantitative studies used formal measures comprising of the TRI or the IEQ. The internal consistency of both measures is reported to be within the acceptable/good range (Geller et al., 1993; Hartmann et al., 2011; Orlinsky et al., 1993; Rosenzweig et al., 1996), however the generalisability of the TRI may be questionable given this was developed with psychotherapists in therapy (Geller et al., 1981). Orlinsky et al. (1993) later examined the validity and reliability of this measure; however the majority of the sample was also therapists accessing therapy. Subsequent studies, such as Geller et al. (1993), Rosenzweig et al. (1996) and Orlinsky et al. (1993) drew from the original Geller et al. (1981) sample to perform further analysis of the data and therefore their findings may be limited in generalisability. Furthermore, both the IEQ and TRI are self-report in addition to being retrospective, however one study did aggregate different time lengths for comparisons (Rosenzweig et al., 1996). Whilst the TRI is intended to measure a single point in time, Bender et al. (1997) repeated this measure across a six month period of therapy. The IEQ, a measure designed to be repeated across therapy, was used at various time points, yet in practice researchers have combined results to reflect different phases of therapy.

Key findings: therapy stage/length

Studies varied in length of therapy, comparisons across therapy stage, and length of follow up. Wzontek et al. (1995) and Geller et al. (1993) noted that patients continue to experience a range of spontaneous thoughts, feelings and images about their therapist in the years following completion; however changes were not tracked over time. When tracked over therapy (Hartmann et al., 2010; Hartmann et al., 2011; Owen et al., 2012; Rosenzweig et al., 1996; & Zeeck et al., 2006), intersession experiences significantly increased, however this may relate to the sample being studied, such as anorexic patients or participants with personality difficulties. Similar findings were noted by Rosenzweig et al. (1996) who sampled psychotherapists in therapy. They reported that positive emotions evoked about the therapy/therapist increased over the course of therapy, and recreating the therapeutic dialogue was associated with reductions in patient distress in later stages of therapy.

Key findings: therapeutic relationship and treatment outcome

The relationship between intersession experience and outcome is a theme within seven studies, measured indirectly through the therapeutic alliance, by self-report of progress, psychometric assessment, or observable measures (such as weight gain in eating disorder populations). Continuation of the therapeutic dialogue correlates significantly with patient self-report of perceived benefit during therapy (Geller et al., 1982; Geller et al., 1993) and post termination (Wzontek et al., 1995). In addition, type and frequency of intersession experience was associated with significant weight gain in patients with anorexia (Zeeck et al., 2005). Intersession experiences that have negative emotions are associated with poor outcome as measured by the EDI-II for bulimia patients in the initial and mid stage of therapy (Hartmann et al., 2010).

Owen et al. (2012) found that the therapeutic alliance, as measured by the Working Alliance Inventory (Horvath & Greenberg, 1989) is positively correlated with the quantity of intersession experiences. In an international study with three treatment conditions, Hartmann et al. (2011) also found that intersession experience associated with positive emotions showed a strong relationship with in session alliance, whereas negative emotions showed a strong

inverse relationship. One qualitative study by Knox et al. (1999) reported that clients liked having intersession experiences, felt they influenced the course of therapy and significantly strengthened the therapeutic relationship.

Key findings: methodological characteristics

Of the fifteen studies within the review, fourteen were quantitative in methodology. Only one qualitative study met the criteria for the review (Knox et al., 1999). One other study was located within the search (Arnd-Caddigan, 2012); however this was excluded due to focussing on therapist intersession experience only.

Quantitative studies (Table 2). The quality of studies varied; selection and recruitment of participants in addition to the sample representativeness ranged from good (recruiting patients from a range of settings) to moderate (only recruiting psychotherapists that were in therapy). Some samples were reported as being “highly ambivalent about being involved in treatment” (Zeeck et al., 2005, p.245) and therefore may have felt pressured to engage. Wzontek et al. (1995) reported postal mailing, potentially resulting in self-selection bias, although later stated some recruitment was through ‘personal networking’. Quantitative study sample sizes ranged from 43-769 and limited demographic information was generally reported. Most studies were retrospective, although four studies did track changes over therapy. All studies used self-report methods.

Several studies considered a range of variables within the analyses yet only small sample sizes were recruited. Only three studies made post-hoc corrections despite the high numbers of analyses, increasing the chance of Type I errors. However, Hartmann et al. (2010), Zeeck et al. (2005) and Zeeck et al. (2006) explicitly state that the study design is exploratory.

Unless reporting correlations, studies did not clearly state effect sizes. Whilst a range of studies highlighted strong associations between intersession experiences and patient/therapy characteristics, correlation and regression do not identify causation and therefore significant findings may be attributable to confounding variables such as therapist factors or the events outside of therapy.

Qualitative studies (Table 3). Knox et al. (1999) was the only qualitative study included within this review. Overall the study’s methodology either fully (yes) or partially (moderate) achieved the quality assessment criteria (Table 3). A strong rationale was provided and the sample representation was good, recruiting therapists to access a range of patients. The study provided a good methodological description, detailing data collection, overall research process, transcription and analysis. To minimise bias, researchers recorded their expectations of the results prior to data collection, however only researcher interpretations were reported rather than direct quotations. The study provided meaningful coherence in achieving what it aims to be about, however some ethical considerations were not reported, such as debriefing participants.

Discussion

This review examined the variation and parameters of patient intersession experiences. Studies identified that patients reported to have intersession experiences about their therapist/therapy. These experiences have been associated with a number of factors outlined

within the review including patient characteristics, therapy length, the therapeutic relationship and treatment outcomes.

Types of intersession experience may differ between individuals based on patient characteristics, for example, borderline types may experience highly negative intersession experiences that could impact on their engagement in sessions (Zeeck et al., 2005). Exploring these experiences within sessions may assist clinicians in understanding some of the barriers to therapy given the focus has historically been on what occurs in the session.

The type and prevalence of intersession experiences may relate to the type of therapy or therapist delivering the sessions. These factors were neglected within all studies. Given intersession experiences are conceptualised as relational experiences, it is likely that therapist variables may influence this phenomenon, with both patient and therapist having intersession experiences (Schroder, Wiseman & Orlinsky, 2009). In addition, all studies focussed on psychodynamic therapy. It is highly likely that patients engaging in other treatment modalities also have intersession experiences. Whilst some studies reported the incorporation of cognitive techniques in some therapy, this remains an area for further research. Furthermore, it may be that intersession experiences reflect what happens inside of the session (Orlinsky et al., 1993) yet comparisons have not been made between intersession experience and in-session content.

The measures of intersession experience have been reported as generally reliable and valid with most studies using either the TRI or the IEQ. Whilst the one qualitative study in this area (Knox et al., 1999) corroborated the quantitative findings, it also provided a richer understanding of how participants made sense of their intersession experiences through capturing their perspective rather than through pre-developed questionnaires. Further qualitative research may provide a greater understanding of the role of intersession experiences in therapy process and outcome.

Given their association to the therapeutic relationship, it may be possible to conceptualise intersession experiences as an extension or mechanism by which the therapeutic alliance is continued or reactivated in the patients' life outside of therapy, reflecting the strength and quality of the patient/therapist bond. Findings suggest that the amount of positive or negative intersession experiences patients have over the course of therapy may be a reflection of how well the therapeutic relationship is developing (Hartmann et al., 2010; Hartmann et al., 2011; Owen et al., 2012; Rosenzweig et al., 1996). Previous research suggests the importance of the quality of the alliance in therapy outcomes (Norcross, 2011). An intersession experience could then be considered as helpful or damaging to the patient and potential therapy outcome, depending on whether it is associated with positive or negative emotions.

Whilst emphasis has been placed on in-session process, the studies reviewed consider the important processes occurring in the typical 167 hours patients have between therapy sessions. This experience appears to be largely neglected by therapists, who typically focus on transference within sessions, yet may provide a valuable insight into how therapy is progressing and influence immediate and long term outcome.

Limitations of the review

The exclusion of two key studies that are not in English language has limited the review findings. Furthermore, both quality assessment tools applied to studies were subjective with

one rater only. In addition, the inclusion of only one qualitative paper may have impacted on the synthesis of findings due to its significantly different methodology and the lack of comparison with other qualitative studies. Despite this, quantitative findings were supported and the exclusion of this study would have ignored key findings. Finally, whilst search terms were limited to broad key phrases related to intersession experience in order to reduce large quantities of unrelated studies, the terminology used may have limited the studies identified to mostly psychodynamic literature.

Recommendations for future research

Firstly, future studies would benefit from greater use of qualitative methods such as interviews or focus groups. For example, studies could explore the underlying meanings that patients and therapists attribute to intersession experiences. Secondly, further exploration of the association between intersession experience and therapy outcome may help to inform clinical practice. Thirdly, further analysis of intersession experience and alliance at time points during therapy may increase understanding of how this process relates to in-session experiences. Fourthly, therapist characteristics and theoretical orientations should be considered, as present studies are limited by exploring only patient characteristics and predominantly psychodynamic therapies. Finally, longitudinal designs may increase understanding of the long term implications of intersession experiences.

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Appendices

Appendix A: Data Spans/Journal Numbers

Database	Dates	Journals
Embase	1980-2013 week 42	8307
Medline	1946- October week 3, 2013	5600
PsycINFO	1806- October week 3, 2013	2521
ASSIA	1987- October week 3, 2013	500+