A Naturalistic Study of the Effectiveness of a Four-Session Format: The Brief Psychodynamic Intervention

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This study examined the effectiveness of the Brief Psychodynamic Intervention (BPI). The BPI is a 4-session intervention aiming at (a) developing an optimal plan to resolve the patient’s crisis situation through the use of an initial dynamic interpretation and its working through, (b) providing information on indications for further therapeutic interventions, and (c) furthering the development of early alliance. First, a pre–post design indicated that the BPI was effective in reducing symptom impairment with effect sizes of 0.38 for the SCL-90R Global Severity Index, 0.47 for the Hamilton Anxiety scale, 0.69 for the Hamilton Depression scale, and 0.26 for the Social Adjustment Scale Global Adaptation Score. A cross-sectional design comparing 61 patients who had completed the BPI with 61 patients on a waiting-list group indicated that the treatment accounted for ($\eta^2$) 17% of the variance in outcome. [Brief Treatment and Crisis Intervention 5:368–378 (2005)]

KEY WORDS: Brief Psychodynamic Intervention, BPI, effectiveness, outcome, brief therapy, intake, intervention, psychodynamic.

Brief psychotherapies have gained in popularity in recent years. Since the early works of Alexander and French (1946), Balint (1971), Bellak and Small (1968), Davanloo (1978), and Sifneos (1977), numerous short-term dynamic therapies (STDT) have been suggested for a wide range of disorders (e.g., Eglau, 1992; Leon, 1987; Magnavita, 1993; Moley, 1987; Oldham, 1988; Rockwell, 1987; Strupp & Binder, 1984). Efforts to obtain significant improvement in patients in a short period of time are the result of numerous factors. Aside from the many social causes and the well-known pressures from government and private agencies to reduce the costs of therapeutic interventions, many other factors have contributed to the proliferation of STDTs, including an increase in the number of individuals recognizing their need for therapeutic...
help, the limited financial resources of many patients or institutions, various crisis situations, a need for prevention in mental health, and the patients’ growing expectations to improve significantly and fast.

Results from the early studies of Balint (1971) and Malan (1963, 1976) supported the effectiveness of STDT. However, in a meta-analytic review of 19 studies, Svartberg and Stiles (1991) found that brief dynamic therapies achieved a small effect size and that at 6 months follow-up it was no more effective than a waiting list. Furthermore, their findings suggested that STDT was significantly less effective than the treatments with which it was compared. On the other hand, Crits-Christoph’s (1992) meta-analytic review of 11 studies indicated that STDT produced effect sizes of 1.10 for target symptoms, 0.82 for general symptoms, and 0.81 for social adjustment. These dissimilar results are thought to be due to the inclusion criteria for each of these meta-analyses. Unlike Svartberg and Stiles, Crits-Christoph examined studies where treatment manuals were employed.

More recently, the meta-analytic review of Anderson and Lambert (1995) of 26 STDT studies showed that STDT was effective, with a general effect size of 0.71 relative to a waiting-list control group. They also demonstrated that STDT produced a small effect size of 0.34 relative to minimal treatment conditions, and no differential effectiveness relative to alternative treatments. However, the studies examined in their meta-analysis included therapies of up to 40 weeks duration. This is also the case for the meta-analyses conducted by Crits-Christoph (1992) and Svartberg and Stiles (1991). With the exception of some studies in highly specialized fields (e.g., Miller, 2000; Thom, Sartory, & Johren, 2000), little is known about the effects of ultrabrief therapies, although accumulating evidence on the effectiveness of short-term therapies has recently drawn clinical attention to what Bloom (2001) refers to as the “extreme case”—therapeutic interventions based on one single session. Even though additional controlled outcome studies are needed, preliminary findings suggest that single-session psychotherapy may be effective in achieving diverse clinical goals (for a review, see Bloom, 2001). Other ultrabrief models include the two-plus-one model, which has been shown to be effective with patients suffering from subsyndromal depression (Barkham, Shapiro, Hardy, & Rees, 1999). Nonetheless, information on the effectiveness of ultrabrief therapies is scarce.

This paper first aims at presenting an ultrabrief psychodynamic intervention that addresses the dynamic and systemic processes at work in individuals and in the therapeutic settings. Finally, it reports preliminary results on its effectiveness.

The Brief Psychodynamic Intervention

The Brief Psychodynamic Intervention (BPI), previously referred to as the Brief Psychodynamic Investigation, was developed in Lausanne, Switzerland. Details on the BPI technique are available elsewhere (Gilliéron, 1987, 1989a, 1989b, 1994, 1997; Gilliéron & de Roten, 1996). In summary, the BPI is a crisis intervention that focuses on both the patient’s conscious and unconscious reasons or motives for consultation. The main objectives of the BPI are to develop an optimal plan to resolve the patient’s crisis situation through the use of an initial dynamic interpretation and it’s working through. As such, it is not unlike the two-plus-one model (Barkham et al., 1999). When additional treatment is required following the BPI, this four-session format has the advantage of allowing the clinician to assess the patient’s resources for psychotherapeutic treatment and to further the development of the early alliance.
As such, it is in agreement with the American Psychiatric Association’s practice guidelines for the evaluation of adults (American Psychiatric Association [APA], 1996).

A BPI first involves a 10- to 15-min telephone call from the assigned therapist to his patient. This call entails a brief exploration of the patient’s difficulties and explains the general format of the BPI. As the sessions begin, the BPI involves rapidly drawing up a psychodynamic hypothesis pertaining to the crisis experienced by a patient. This hypothesis is based on the dynamic relationship established between the therapist and the patient at the very early stages of the intake interview (pretransference). It is also based on the patient’s present crisis, his personality organization, and his core relationship patterns (Luborsky, 1998). Using this information, the therapist works on an intervention in the form of an interpretation. This interpretation should address (a) the present crisis experienced by the patient and the relational context in which the symptoms have appeared, (b) the necessary change with which the subject is confronted as a result of the crisis, (c) the intrasubjective conflict the subject must face as a consequence of the crisis and if he or she is to resolve this crisis, and (d) the meaning of the symptoms as compromise formations. This initial interpretation is given at the end of the first intake session or at the very beginning of the second session. Sessions 2 and 3 involve working through this initial interpretation with the patient. Finally, the last session is used to reflect on the three previous sessions and draw conclusions. This last session is also used to decide if further treatment is required and, if so, to determine what kind of treatment would be most beneficial to the patient. A recent manual guides this four-session method of intervention. When the technique is rigorously applied, almost no dropouts occur (Gilliéron & de Roten, 1996).

Method

Patients

The complete sample included 122 self-referred outpatients from the Adult Psychiatry Outpatient Unit of the University of Lausanne (Switzerland). All subjects were assigned to a BPI. The general criteria for participation in the study included 17–60 years of age and a minimum of one diagnosis related to anxiety, depression, or personality disorders. Exclusion criteria included organic or delirium disorders, substantial alcohol or drug dependence, psychotic or bipolar disorders, mental retardation, and antisocial personality disorder.

Of the complete sample \( (N = 122) \), the first 61 patients (hereafter referred to as the “treated group”) had already completed the BPI. The treated group included 24 men (39%) and 37 women (61%) with a mean age of 29.13 \((SD = 9.18)\). Most of these patients were seeking therapeutic help for mood (62.3%) or anxiety disorders (36.1%), and occasionally for eating (4.9%), sexual (4.9%), or substance-abuse-related (3.3%) disorders. Some comorbidity was detected as the mean number of Axis I diagnoses was two disorders. Finally, 38% presented a Cluster C personality disorder on Axis II.

The other 61 patients (hereafter referred to as the “waiting-list group”) had just recently started a BPI and had not yet completed it. Unlike the patients from the treated group, those from the waiting-list group were asked to fill out questionnaires sent to them by mail immediately after their first call for an appointment, and hence approximately 1 month before the first appointment. As such, these patients had already benefited from the routine BPI telephone call, which lasts from 10 to 15 min, and from the first BPI session. Forty-four percent of the patients were women. The mean age was 32.38 \((SD = 11.21)\). These patients were seeking therapeutic
help for mood (86%) or anxiety disorders (36.3%), and occasionally for eating (9%), sexual (4%), or substance-abuse-related (3.1%) disorders. Once again, some comorbidity was detected as the mean number of Axis I diagnoses was 1.5 disorders. Finally, 43% presented a Cluster C personality disorder on Axis II.

Reliability of the clinical diagnoses in both groups was established on a subsample of 36 patients using the Guided Clinical Interview (Perry, 1995). It was shown to be satisfactory with a $\kappa = 0.65$ for Axis I and $\kappa = 0.54$ for Axis II.

**Therapists**

The BPIs were conducted by three female and seven male therapists from the Adult Psychiatry Department of the University of Lausanne. One therapist was a licensed psychologist, whereas the other nine were licensed psychiatrists. All had had prior training in BPI. Five were considered to be senior therapists with a minimum of 5 years of experience in BPI, whereas the remaining five were considered to be junior therapists with less than 5 years of experience in the technique. However, the therapists from both groups had much experience in the practice of psychodynamic therapy with a mean of 19 years of experience (ranging from 8 to 38 years). Furthermore, the therapists were assessed using the BPI Adherence–Competence scale (Tadic & Despland, 2001). Despite small differences in competence between the junior and the senior therapists, all therapists were shown to be highly competent in BPI (Tadic, Drapeau, de Roten, Solai, & Despland, 2003).

**Instruments**

The patients from the first wave (the treated group) were asked to fill out the SCL-90R (Derogatis, 1994) immediately before the intake session and after the last session. The second wave of patients (waiting-list group) was required to fill out the symptom checklist soon after their first call to set an appointment and hence 1 month before the first of the BPI sessions, as well as immediately before their BPI intake. The SCL-90R includes 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (*not at all*) to 4 (*very much*). Although the instrument includes 10 subscales, this study only made use of the Global Severity Index (GSI; score ranging from 0 to 4), which refers to the mean rating across all items.

The Hamilton Depression (HAMD—21 items) and Anxiety (HAMA—21 items) scales were also administered to 31 of the 61 treated patients by experienced clinicians. This was done immediately before the first session and right after the last session. Unfortunately, because the HAMD and the HAMA were added to the protocol at a later time, data are not available for the complete sample.

The Social Adjustment Self-Rated scale (SAS-SR; Weissman & Bothwell, 1976) is a 54-question self-rated scale used in order to assess a patient’s interactions with his environment. The scale addresses an individual’s functioning and level of satisfaction in various social roles, including work, leisure, family, children, intimate relationships, and material situation. A score ranging from 0 (*good adjustment/satisfaction*) to 5 (*bad adjustment/satisfaction*) can then be calculated for each of these six subscales. However, as few patients in this study had children or a spouse, we analyzed all subscales individually with the exception of the ones related to children and to intimate relationships. The Global Adaptation Score was also computed as a mean across all items. The SAS-SR was given to the treated patient group at intake and after the fourth session.

**Study Design and Data Analysis**

This study was partly longitudinal and partly cross-sectional. The longitudinal aspect of the
design involved examining change for 61 patients before and after a BPI. A paired-samples $t$ test was used in order to assess the significance of change on all measures for the group of 61 patients who had completed a BPI. Hence, the tests were computed to compare beginning-of-treatment (immediately before the first session) and end-of-treatment. Furthermore, within-subjects effect sizes (WESs) were calculated in order to quantify the importance of change on all measures. As change in means was the focus of the intervention, effect sizes were calculated by subtracting the $t_1$ mean from the $t_2$ mean and dividing this difference in means by the pooled standard deviation.

In order to facilitate comparison with other outcome studies, the proportion of patients within nonclinical norms for the GSI was computed. The upper nonclinical cutoff was set at two normal population standard deviations above the normal population mean. As Derogatis (1994) suggested a normal population mean of 0.31 ($SD = 0.31$), we considered a score of 0.93 to be the cutoff between clinical and nonclinical cases. Tingey, Lambert, Burlingame, and Hansen (1996) have also suggested a GSI mean of 0.19 ($SD = 0.16$) for an asymptomatic or very healthy and high-functioning sample (see also Hilsenroth, Ackerman, & Blagys, 2001). The proportion of subjects scoring within the mean plus 2 $SD$ of this second cutoff was also computed to determine how many subjects could not only be considered as nonclinical cases but also be considered as high-functioning and psychologically healthy cases.

For the HAMD and HAMA scales, cutoff scores were set at 2 $SD$ above the normal population mean (Hinz & Schwarz, 2001). For the depression scale, a cutoff score of 9 was used to distinguish depressed subjects from normal population norms. For the anxiety scale, the cutoff score was determined to be 11. These scores were used to determine the proportion of patients entering normal population norms.

Finally, the cutoff score for the SAS global score was also set at 2 $SD$ above the normal population mean (Weissman, Pursoff, Thompson, Harding, & Myers, 1978). Hence, a cutoff score of 2.25 was used to determine the proportion of patients within normal population norms.

The cross-sectional aspect of the study involved comparing the 61 patients who had completed a BPI (treated group) with a group of 61 patients who had just recently started a BPI (waiting-list group). These last patients were first put on a waiting list and assessed 1 month before the beginning of the BPI and again immediately before the intake session. Because a BPI involves four weekly-held sessions, comparing change in the treated group in 1 month of psychodynamic intervention with change in 1 month while on a waiting list became possible (these last patients did, however, receive the routine telephone call from their assigned therapists).

First, a $t$ test was used to determine if the two groups were different at $t_1$ on the SCL-90R GSI. Because the groups were significantly different, we used a more conservative approach and applied the multivariate analogue of the analysis of covariance model (ANCOVA) using pretreatment assessments as covariates in order to compare both groups at $t_2$. To compare both groups individually, the WESs were also calculated for the waiting-list group. Finally, the eta square was used to assess between-subjects effect size. The eta-square indexes the percentage of total variance explainable by differences in the independent variable (in this case, the BPI).

**Results**

**Change in the treated group**

Results indicated that the GSI was significantly lower at the fourth session than at intake,
\[ t(60) = 3.94, p = .001, d = -0.38 \] (see Table 1).

When comparing the treated patients’ GSI with the scores suggested for a normal population, results showed that 55.7% of the patients were already within nonclinical norms before the intake session. After the fourth session, 70.5% of the patients had reached scores indicating healthy functioning. Furthermore, 26% of the patients already fell within 2 SD of the asymptomatic and very high-functioning psychologically healthy norms (Tingey et al., 1996) before beginning the BPI. This proportion was of 42.6% at the end of the BPI.

Significant improvements were also found on the HAMA and HAMD scales. For the Anxiety scale, the 31 patients assessed had a mean score of 9.87 (SD = 6.87) at intake and a mean score of 6.83 (SD = 6.09) after the fourth session, \[ t(30) = 2.35, p = .02, d = 0.47. \] Fifty-five percent of the patients had an anxiety score within population norms before the BPI. This proportion increased to 84% after the BPI. For the depression scale, the same 31 patients had a mean intake score of 11.32 (SD = 6.68) and a score of 7.12 (SD = 5.55) after the fourth session. This difference was also significant, \[ t(30) = 3.80, p = .001, d = 0.69. \] Fifty percent of the subjects had a score within population norms before the BPI. This proportion increased to 77.5% after the BPI.

Regarding the SAS-SR, results showed that patients improved in terms of global adaptation with scores significantly lower at the end of the BPI than at intake, \[ t(53) = 2.54, p = .01, d = -0.26 \] (see Table 1). At the beginning of the BPI, 65% of the patients already fell within 2 SD of the general population mean. This proportion increased to 76% after the fourth session. Family-related satisfaction had also improved following the BPI, \[ t(52) = 2.70, p = .009, d = -0.37. \] No significant change was found in adaptation related to work, leisure, and material situation.

**Comparing the Treated and the Waiting-List Groups on the SCL-90R GSI**

One month after their initial call and hence immediately before their intake interview, the waiting-list group had already shown significant improvement on the GSI (see Table 2). Their GSI score had significantly decreased from a mean of 1.12 (SD = 0.58) to a mean of 0.99 (SD = 0.62), \[ t(60) = 2.72, p = .009; d = -0.22. \] When comparing both groups, results from the ANCOVA showed that the two groups were significantly different at time 2, \[ F(1, 121) = 12.45, p = .001, \eta^2 = 0.17, \] with the waiting-list group scoring higher than the treated group. As such, they suffered from greater symptom expression.

### Table 1. SCL-90R GSI and SAS Means and Standard Deviations at Intake and After the BPI

<table>
<thead>
<tr>
<th></th>
<th>Intake</th>
<th>Session 4</th>
<th>(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSI (SCL-90R)</td>
<td>0.90 (0.48)</td>
<td>0.71 (0.52)</td>
<td>-0.38**</td>
</tr>
<tr>
<td>SAS-SR total</td>
<td>2.04 (0.39)</td>
<td>1.93 (0.48)</td>
<td>-0.26*</td>
</tr>
<tr>
<td>SAS-SR work</td>
<td>1.91 (0.54)</td>
<td>1.80 (0.62)</td>
<td>-0.19</td>
</tr>
<tr>
<td>SAS-SR family</td>
<td>2.04 (0.40)</td>
<td>1.87 (0.53)</td>
<td>-0.37*</td>
</tr>
<tr>
<td>SAS-SR leisure</td>
<td>2.17 (0.58)</td>
<td>2.08 (0.63)</td>
<td>-0.15</td>
</tr>
<tr>
<td>SAS-SR material</td>
<td>1.78 (1.18)</td>
<td>1.81 (1.21)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Note. GSI = Global Severity Index; SAS-SR = Social Adjustment Self-Rated scale.

*\(p = .01\). **\(p = .001\).

### Table 2. Pre-Post Data on the SCL-90R GSI for the Treated (n = 61) and the Waiting-List (n = 61) Groups

<table>
<thead>
<tr>
<th></th>
<th>(t_1)</th>
<th>(t_2)</th>
<th>WES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GSI</td>
<td>GSI</td>
<td>GSI</td>
</tr>
<tr>
<td>Treated group</td>
<td>0.90 (0.48)</td>
<td>0.71 (0.52)</td>
<td>-0.38**</td>
</tr>
<tr>
<td>Waiting-list group</td>
<td>1.12 (0.58)</td>
<td>0.99 (0.62)</td>
<td>-0.22*</td>
</tr>
</tbody>
</table>

Note. WES = within-subject effect size; GSI = Global Severity Index.

\(t_1\): assessments at time 1. For the treated group, \(t_1\) is right before the intake interview. For the waiting-list group, \(t_1\) is 1 month before the BPI. \(t_2\): assessments at time 2. For the treated group, \(t_2\) is after the last BPI session. For the waiting-list group, \(t_2\) is right before the intake interview.

*\(p = .01\). **\(p = .001\).
Discussion

Overall, the patients who completed a four-session BPI showed significant improvement on most measures. As indicated by change on the GSI, they suffered less from symptomatic impairment following the ultrabrief therapy. After the BPI, there were 27% more patients within the nonclinical range of the GSI than at intake. Furthermore, the proportion of patients falling within the norms for psychologically healthy and high-functioning individuals jumped from 26% before the BPI to 42.6% at the end of the BPI.

Significant improvement was also found on the HAMA and HAMD scales (n = 31). The effect size for anxiety was 0.47, with a greater effect size of 0.69 for depression. Fifty-five percent of the patients had an anxiety score within population norms before the BPI. This proportion increased to 84% after the BPI. Fifty percent of the subjects had a depression score within population norms before the BPI, whereas this proportion was of 77.5% after the four sessions.

Patients were generally better adapted after the BPI as indicated with the SAS-SR. The effect size was 0.26 after the four sessions. Sixty-five percent of the patients already fell within 2 SD of the general population mean at intake. This proportion increased to 76% after the fourth session. Improvement in the patient’s capacity for better social adaptation was mostly visible in regards to family matters. This was the only scale where significant improvement was found, with an effect size of 0.37 at termination.

A simple pretest–posttest design is a non-experimental design that falls short of establishing any causal hypothesis between the treatment and the patients’ improvements. As such, it fails to address such threats to the validity of the results as regression to the mean and maturation processes. However, the cross-sectional aspect of this study, with its use of a control group, suggests that improvement in the treated sample was not solely related to variables external to the treatment or to spontaneous remission. Comparisons between the two groups showed that the treatment accounted for 17% of the variability in the outcome, with the treated patients demonstrating greater improvement. Nonetheless, the waiting-list group improved significantly on the SCL-90R GSI without receiving the treatment. In this latter group of patients, a telephone call from a trained therapist, setting an appointment, and knowing that professional help was available seemed to bring some relief in symptom impairment. This suggests that clinicians must give much care to the early moments of case management, including to the routine telephone call they make to set initial appointments. This improvement is consistent with other findings and can possibly be related to the effects of patient expectancies and hopes (Howard, Kopta, Krause, & Orlinsky, 1986; Kirsch, 1999; see Hubble, Duncan, & Miller, 1999, for a review).

Unfortunately, in this study, the subjects’ precrisis level of functioning is not known, and it is most likely that the intake assessments only reflect the patients’ state of crisis. As such, any improvement should be seen as a return to their usual baseline-level functioning (Pavan et al., 2003). This is nonetheless in agreement with the theory behind the BPI. This theory, which is based on psychoanalytic and systemic concepts, states that a crisis situation is the result of a disturbance in the balance of a patient’s interpersonal life organization (Gilliéron, 1994, 1997). Patients in crisis struggle with self-esteem issues in regards to their diminished ability to manage the crisis and their distorted representations of others as the cause of this
crisis. When patients request therapeutic help and meet with a mental health professional, they must overcome their fears of criticism and rejection by the therapist in order to share and explain their difficulties.

This process was evident in studying coping and defense mechanisms during the BPI. Using this same sample \( (n = 61 \) treated patients), Drapeau, de Roten, Perry, and Despland (2003) found that as the patients experienced the therapists’ support and openness, their use of narcissistic defenses decreased. Furthermore, as the therapists diffused the patients’ sense of threat associated with the crisis, the patients’ use of defense mechanisms tended to decrease.

By providing the patient with a dynamic interpretation as early as the end of the first session, the process engages the patient to take a critical look at his or her situation, which in turn requires less experiencing of the anxiety related to the crisis. As such, the experience of support and relief early in the process appears to enable the patient to minimize the distress associated with the crisis in the service of examining and discerning patterns leading to or related with the crisis. As such, the BPI appears to have an effect on state. It does not intend to bring about any trait change in the patients, an objective that is unachievable with such an ultrabrief therapy.

However encouraging these findings may be, many limitations to this study must be kept in mind. These include incomplete data on the HAMA and HAMD scales and the absence of a control group for these two measures, the use of a naturalistic design, and the absence of data on the patients’ precrisis level of functioning. Furthermore, the long-term effects of the BPI remain unknown. We are currently collecting follow-up data on the treated sample, with assessments 3, 6, and 12 months after termination. This will enable us to determine if improvement is maintained or if additional improvement is achieved as a result of a so-called incubation effect associated with dynamic therapies (Bateman & Fonagy, 2001; Blomberg, Lazar, & Sandell, 2001; Sandell et al., 2000). This will help determine if patients require further treatment or if the BPI is, in some cases and of itself, sufficient. Furthermore, because the BPI also aims at providing information on indications for further therapeutic interventions, we are currently validating an instrument (Currat & Despland, 2001) that will enable clinicians to assess specific areas addressed during the BPI and that could help predict a patient’s response to further treatment. Left for further intervention will be to determine which patients will only need a BPI and which require longer term treatment.

Conclusion

This study examined change in descriptive measures in patients who completed a four-session ultrabrief dynamic intervention. It involved both a pre–post and a cross-sectional design with a control group. Our findings suggest that a BPI is effective in helping patients overcome a crisis situation, reducing their symptomatic impairment, and helping them return presumably to a precrisis level of functioning. One of the first advantages of BPI, aside from reducing psychological impairment, is that such results can be achieved in a short period of time while respecting practice guidelines for psychiatric evaluation (APA, 1996). Also, it may serve as an anticipatory socialization process known to positively influence the quality of further therapeutic processes (Hoehn-Saric et al., 1964; Strupp & Bloxom, 1973). Finally, our findings suggest that a telephone call by a trained therapist can be helpful in reducing some symptoms in patients. This clearly suggests that clinicians must give great attention to what they usually do in a routine manner.
Acknowledgment

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