



## The PAP-S (Practice of Ambulant Psychotherapy-Study), Switzerland Study Design and Feasibility

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### Abstract

In compliance with the requirements of evidence-based medicine, psychotherapy needs to demonstrate its effectiveness no less. For this purpose, the Swiss Charta of Psychotherapy, the umbrella organization of psychotherapeutic education and training institutes in Switzerland, launched a prospective, naturalistic psychotherapy outcome study in 2004. All member institutions of the Charta were invited to participate. There is quite a number of different co-existing types and subtypes of psychotherapy in Switzerland. The study is therefore a unique opportunity to particularize whether therapists from different schools do in fact apply techniques which are markedly specific to their types of psychotherapy, or whether, for instance, there are some which are employed widely, i.e., in various therapeutic disciplines.

This article focuses on presenting the study design and the descriptive data of the baseline survey. 86 therapists from nine different psychotherapeutic institutes participated. They recruited a total of 362 patients (238 women, 124 men) aged between 17 and 72. With regard to the five most important outcome instruments, 80% of the patients had a rating in the dysfunctional range on at least one of them. Ninety percent of the patients exhibited a DSM-IV Axis I disorder. Further analyses of these data will yield further outcome and process-outcome findings.

*Keywords:* Psychotherapy, outcome study, prospective naturalistic design, psychotherapeutic techniques.

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Psychotherapy research, i.e., outcome as well as process research, has been dominated by but a few psychotherapeutic modalities. Randomized controlled trials (RCTs) have been the province of Cognitive Behavioral Therapy, but also Psychoanalytic Psychotherapy, Client-Focused Psychotherapy and Systemic Therapy look back on a longstanding research tradition of RCT- and other study designs. Other psychotherapeutic specifications have been scientifically investigated to a lesser extent. Since medicine and psychotherapy are required to deliver evidence-based proves of efficacy, the individual psychotherapeutic procedures are obliged to do so, too. For this purpose, the Charta of Psychotherapy, the Swiss umbrella organization of psychotherapeutic training institutes, trade associations and professional organizations, has launched a prospective, naturalistic psychotherapy outcome trial in 2004.

This is not the place to discuss the difference between naturalistic and randomized-controlled studies (for further reading see Tschuschke et al., 2009). The purpose of this paper is to expound the specific potential of a process outcome study of those psychotherapeutic schools and their therapeutic techniques which, to date, have hardly been investigated. As opposed to Germany, in Switzerland, a number of various psychotherapeutic procedures are authorized. This provides us with an excellent opportunity to subject those procedures to academic scrutiny which are not part of the mainstream.

The question whether psychotherapy is generally efficient, or whether there are specific factors that account for efficacy is being discussed controversially. Specific factors are usually associated with certain psychotherapeutic models, or understood as specific therapeutic skills applied to certain mental disorders

(Pfammatter & Tschacher, 2010). Active factors implicit in any psychotherapy are usually considered 'general'. Lambert and Ogles (2004), for example, suggest the following three categories under which general factors may be subsumed: supportive factors (e.g., the therapeutic relationship), learning factors (e.g., insight), and action-related factors (e.g., exercises). It is often argued that psychotherapeutic practice and research are divided in two 'worlds': one adheres to the so-called paradox of equivalence, i.e., to the fact that various meta-analytic studies have identified small differences only, concerning the efficacy of different psychotherapeutic schools (i.e., Stiles et al., 1986). The other view holds that you do find differences as soon as you pick out disorder-specific research approaches for comparison (e.g., De Rubeis et al., 2005). There are various authors who seek to integrate these two points of view: Pfammatter and Tschachner (2010) are presently developing a synergistic outlook on the efficacy of both factors emphasizing that these interact with disorder-related parameters and patients' individual features. Strauss (2001) argues that, apart from general active principles, specific disorders can develop their own dynamics which, in the long run, calls for a combination of both approaches.

Psychotherapeutic methodologies and schools usually do not focus on general active factors but on their specific therapeutic skills. Therapists are bound to become more & more eclectic over time as they gather more and more experience (e.g., Jensen et al., 1990). Nevertheless do prospective therapists opt for a certain therapeutic direction because a particular one seems sensible to them and they deem it to be more effective than others which leads them to the identification with their specific option. A therapeutic school normally relies on a specific disorder and therapy model and bases their specific therapeutic techniques upon them. In the following, we will briefly describe the theoretical backgrounds (according to Schlegel et al., 2011) and a selection of three particular psychotherapeutic skills of those schools which took part in the PAP-S (see Tschuschke et al., forthcoming).

### 1. Transactional Analysis

This therapeutic approach, which has been classified as humanistic, goes back to the early psychoanalyst Eric Berne. He integrated psychoanalytic elements and some of Behavioral Therapy on the backdrop of a humanistic idea of man which pays tribute to the human being's unique individuality and potential.

#### *Therapeutic Techniques*

- The concept of life positions
- Communication work according to diagram
- Script analysis

### 2. Process-Oriented Psychology

Its founder, the physicist Arnold Mindell, had originally been trained as a Jungian psychoanalyst at the C.G. Jung-Institute. He blended group-dynamics, spirituality, body awareness, and creative expression in his process-related approach.

#### *Therapeutic techniques*

- Working at the process boundary

- Unfolding what is on the edge of awareness (secondary process)
- Interaction with the inner critic

### 3. Integrative Body Psychotherapy (IBP)

Founded by Jack Lee Rosenberg in the 1960ies, this therapeutic modality merges various humanistic approaches with influences from Wilhelm Reich. It focusses on bodily experience and holds cognitions, spiritual experience, and behavior relevant.

#### *Therapeutic techniques*

- Working on character and protective style (agency)
- Energetic boundaries
- Self-help techniques

### 4. Existential Analysis and Logotherapy

Viktor Frankl based his Logotherapy or Existential Analysis (terms mostly used interchangeably) on an anthropological view of the human being. On the basis of existential philosophy, man is supposed to possess free will which manifests in the mindset of the three-dimensionality physicalness, psyche, and mind. In the 1980ies, the followers of Victor Frankl and his student Alfred Längle went different directions. In the PAP-S, one training institute in Frankl's tradition as well as one in Längle's are included.

#### *Therapeutic techniques*

- Working on the relationship with life
- Meaning and value orientation
- Dereflection

### 5. Art and Expression-Oriented Psychotherapy

The vital skills of this therapeutic specification are various forms of expression by multiple artistic means. The psychotherapeutic foundation of these is psychodynamic, systemic, and daseinsanalytical and it integrates salutogenetic assumptions.

#### *Therapeutic techniques*

- Employing artistic-aesthetic responsibility
- Sensitizing perception towards one's creative work
- Defining one's (work-related) position

### 6. Analytical Psychology according to C.G. Jung

C.G. Jung, Freud's pupil, disaffiliated from psychoanalysis in its early days. One of the reasons for this disagreement was Jung's very different approach to Freud's instinct concept. The postulate of a collective unconscious may be seen as an independent branch of development within depth-psychological theory.

#### *Therapeutic techniques*

- Working with symbols
- Working with complex-episodes
- Enhancing the individuation process

### 7. Bioenergetic Analysis and Therapy

This body-related approach is rooted in Freud's classic psychoanalysis. In the wake of Wilhelm Reich, Alexander Lowen, the founder of Bioenergetic Analysis, developed the concept as it is used today, to which the sexual instinct and the ego-needs are central. Body-related interventions aim at reviving the primary needs of infantine stages and at curing them.

#### *Therapeutic techniques*

- Affect regulation
- Embodied aspects of the therapeutic relationship
- Body exercises

### 8. Gestalt Therapy

Gestalt Therapy, the most prominent founder of which was Fritz Perls, evolved in the 1960ies as many other humanistic psychotherapies did. It may be seen as a typically integrative school of therapy, as it combines existentialist philosophy, Husserl's phenomenology, and the basic principles of Gestalt theory (Wertheimer et al.) on the basis of humanistic psychotherapy and psychoanalysis.

#### Therapeutic techniques

- Directing awareness to present emotion
- Asking the client to identify
- Exploring behavior

### 9. Psychoanalytic Psychotherapy

Psychoanalysis and Psychoanalytic Psychotherapy go back to Sigmund Freud, their founder. In its history of more than 100 years, several developments have taken place, the most important of which was the embracement of the significance of object relations.

#### Therapeutic techniques

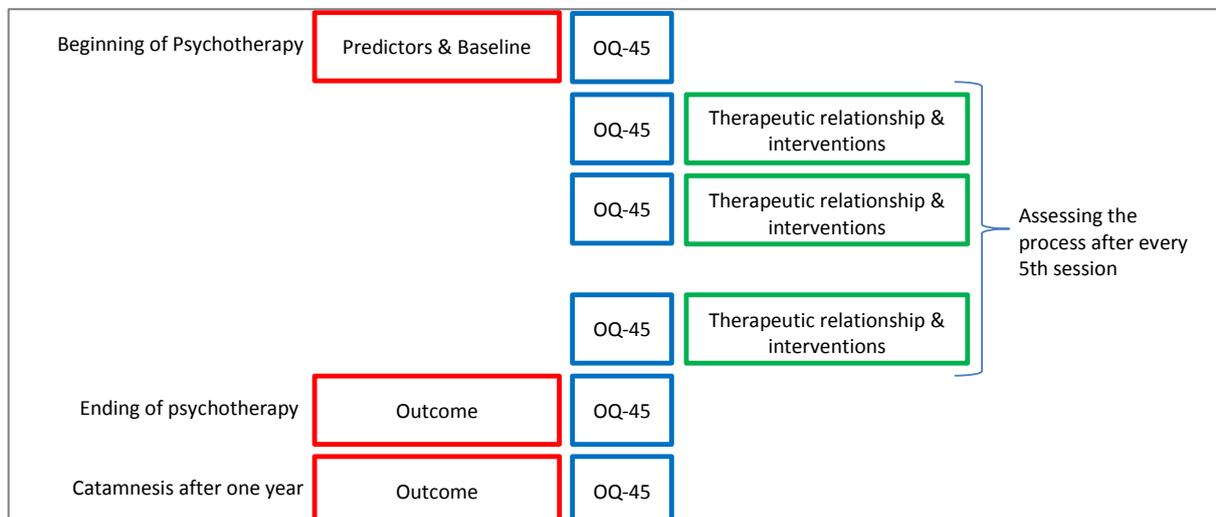
- (Free) association
- Interpretation
- Confrontation

The above overview gives a glimpse of how much theories and techniques of some of the mentioned methods overlap. It gives us an idea, for example, of how body-related approaches have emerged from psychoanalytic as well as from humanistic traditions. Some therapeutic techniques are explicitly stated by a number of schools, e.g., *experimentation with new behavior* by Bioenergetic Analysis and Therapy, Gestalt Therapy, and Behavioral Therapy. Many therapists have come to work in an eclectic way by integrating various method-specific techniques as well as new elements from their continuing education. The PAP-S has therefore ventured on investigating the extent to which therapists of different provenance resort to techniques that claim to be specific to their schools, and whether there are others which are used widely. It is well possible that some active factors which used to be school-specific have become general. In this article, however, we will solely focus on the study design and give descriptive information on the partaking therapists and patients.

### Methodology

#### General Design

In 2004, the Swiss Charta of Psychotherapy launched a prospective outcome study. Nine Charta institutes or therapeutic schools, respectively, warranted their participation. Additionally, some psychotherapists took part, the schools of whom did not participate officially. Partaking entailed financial obligations for the institutes, but the major share of the accruing costs was covered by a generous endowment from a foundation. The study was naturalistic and quasi-experimental. Quality standards were closely observed and tried to be duly met (see e.g., Leichsenring, 2004). The therapists who had declared their participation committed to inviting every new patient who was seeking help to contribute. If patients consented, they were called upon to undergo pre-assessment in one of the five regional assessment centers before their fifth session. Independent assessors would conduct a diagnostic interview which tried to establish the psychiatric diagnosis via SKID-interviews on the one hand, and assess the axes *structure* and *conflict* from OPD-diagnostics on the other. In addition, patients were given various questionnaires. In order to monitor the process, the therapists recorded each session and filled in a checklist that reviewed the interventions thereafter. The therapists as well as the patients completed questionnaires after every fifth session. After the last therapy session, therapists enrolled their patients for a post therapy check. One year after the closing session, a catamnestic investigation was carried out by and in the assessment center. One particular person planned for and coordinated the assessments across all five regional centers. All in all, 23 assessors were trained to conduct the pre-, post-therapy as well as the catamnestic assessments. Graph 1 gives an overview of the entire design. In all cantons in which the participating therapists had their offices, applications for ethical approval were filed. The scientific study was co-conducted by two colleges. One of them, the department of Applied Psychology of the ZHAW (Zurich College of Applied Sciences) coordinated the project. The leading committee of the study consisted of the President of the Charta, the scientific management and two further individuals. Four of the five members of



Graph 1: Schematic Representation of the PAP-S Design

the leading committee are also practicing psychotherapists who belong to four different specifications (Bioenergetic Analysis, Gestalt Psychotherapy, Systemic Therapy, Psychoanalytic Psychotherapy).

**Sample**

*Partaking Institutes and Therapists*

Nine psychotherapeutic institutions/associations contributed:

- 1) The Swiss Society of Transactional Analysis (German and French section; SGTA/ASAT<sup>1</sup>)
- 2) Institute for Process Work (IPA, formerly FG-POP)
- 3) Institute for Integrative Body Psychotherapy (IBP)
- 4) The International Society for Existential-Analytic Psychotherapy (IGEAP)
- 5) Swiss Institute for Logotherapy and Existential Analysis (ILE)
- 6) European Foundation of Interdisciplinary Studies (EGIS)
- 7) Swiss Society of Analytical Psychology (SGAP)
- 8) Swiss Association for Body Psychotherapy (SGBAT)
- 9) Swiss Association for Gestalt Therapy and Integrative Therapy (SVG)

tients had been approached. 379 of them had given their consent of whom 17 did not show up for pre-assessment and therefore dropped out of the study. The complete sample thus encompassed 362 subjects (see table 1).

238 of the test subjects were women, 124 men. Their age average was 39.7 years (SD = 11.80), the youngest being 17.2, the oldest 72.7 years (n = 353). Die SGTA/ASAT had the lowest age average patients (M = 38.1; SD = 10.88), ILE the highest (M = 49.8; SD = 9.80).

232 patients had not been in therapy or psychiatric outpatient treatment before the present one in two years, 87 had been in psychotherapeutic care as outpatients, and 28 had been in (partly) inpatient psychotherapeutic or psychiatric care (n = 347; see table 2). 91 patients were married, and a total of 189 patients were living in a steady relationship (n = 341). 216 stated to be childless; 137 patients had between one or four children (n = 353). 40 % of the patients had graduated from university, 3 patients had not completed compulsory schooling. 263 (73%) were working fully or part time, while 31 were in professional trainings. Just under 12% were unemployed, on sick leave, or had retired.

**Table 1:** Contributing Institutes and Associations, numbers of therapists and patients, demographic data

Institute	Therapist					Patient				
	Age					Age				
	N	% female	M	SD	Range	N	% female	M	SD	Range
<b>SGTA/ASAT</b>	14 (13)	69.2	55.3	9.76	42-77	63 / 61	62%	38.1	10.88	21-65
<b>IPA</b>	10	50	51.4	4.67	39-56	61 / 61	57%	42	10.98	20-67
<b>IBP</b>	20 (19)	57.9	48	8.00	35-65	83 / 82	69%	40.7	10.82	19-64
<b>IGEAP</b>	6 (5)	100	52.4	9.59	38-64	19 / 18	89%	41.2	12.23	25-71
<b>ILE</b>	2	100	52.1	8.16	46-58	13 / 10	77%	49.8	9.80	28-63
<b>EGIS</b>	3	100	56	6.99	51-64	16 / 16	87%	36.9	11.93	19-56
<b>SGAP</b>	6 (4)	50	60.1	4.82	53-64	13 / 12	38%	36.8	15.21	20-70
<b>SGBAT</b>	14	71.4	49.9	7.00	38-60	49 / 48	71%	36.7	12.49	17-65
<b>SVG</b>	9	66.7	44.8	9.92	32-60	35 / 35	54%	38.5	11.14	19-64
<b>Psychoanalysis</b>	2	50	56.3	4.58	53-60	10 / 10	79%	38.5	18.91	20-73
<b>Total</b>	81	66.7	51	8.52	32-77	362 / 353	66%	39.6	11.80	17-73

<sup>1</sup> Abbreviations of German denominations.

Two therapists from an analytic school also took part in the study. The SGBAT was supplemented by therapists from its affiliate society in Austria.

In total, 86 therapists, of whom table 1 gives an overview, pledged their participation.

Some data are still outstanding. 66.7% of the contributors were female. Some institutions fielded female therapists only, whereas from others, the male/female ratio was more balanced. The therapists' ages varied between 32 and 77 years, the average being 51, which indicates that the therapists were fairly experienced.

*Patients*

The therapists committed to inviting all new patients to participate over a period of two years and to run a list of those whom they had asked. The extrapolation of the evaluable data unveiled that, in total, 1660 pa-

**Table 2:** Description of patients during pre-assessment

	No. of Participants (%)
<b>Sex</b>	
Female	238 (66)
Male	124 (34)
<b>Age in years</b>	
Average Age	39.7
<b>Psychiatric/psychotherapeutic treatment over the last 2 years (n = 347)</b>	
none	232 (66.9)
outpatient treatment	87 (25.1)
(partly) inpatient treatment	28 (7.7)
<b>Marital status (n = 350)</b>	
single	189 (54)
married	91 (26)
separated/divorced	62 (17.1)
widowed	8 (2.3)
living in a steady partnership	189 (55.4)

<b>Number of children</b>	
no children	216 (61.2)
one child	37 (10.5)
two children	69 (19.5)
three children	24 (6.8)
four children	7 (2)
<b>Professional training (n = 350)</b>	
none	3 (.9)
compulsory schooling	26 (7.4)
apprenticeship	126 (36)
university-entrance diploma, teacher-training College of Applied Science, Advanced Technical College	52 (14.9)
university	67 (19.1)
university	76 (21.7)
<b>Work Situation (n = 353)</b>	
full time	148 (41.9)
part-time	115 (32.6)
currently in training	31 (8.8)
unemployed	19 (5.4)
on sick leave	18 (5.1)
on widow's annuity, retired	9 (2.5)
housewife/husband	8 (2.3)
disability pensioner	5 (1.4)

## Instruments

### Result Measurement

#### a) Self-Assessment of Patients

- **OQ-45** (Outcome Questionnaire; Lambert, Burlingame, Umphress, et al., 1996; Lambert, Hannöver, Nisslmüller, et al., 2002): This very economical and widely used instrument insures the quality of psychotherapeutic progress in areas such as symptom-related distress (25 items), interpersonal relationships (11 items), and social role (9 items). All 45 items of this self-report scale are assessed by a five-grade response scale (1 = never, 5 = always). It estimates the client's degree of disturbance at the outset and over the course of treatment. The reliability of the original English version is very high (the overall Cronbach's alpha being .93) as is its validity (Lambert & Ogles, 2004); the German version is equally reliable (Lambert et al, 2002).
- **BSI** (Brief Symptom Inventory; Franke, 2000): The BSI is the short version of the well-known SCL-90. By this effective questionnaire, participants rate to which extent they have been bothered by physical and psychological symptoms. Its nine subscales are designed to assess the following symptom groups: Somatization, obsessive compulsive disorder, interpersonal sensitivity, depression, anxiety, aggressiveness/hostility, phobic anxiety, paranoid ideation and psychoticism. Each of the 53 items is graded by the 5-point Likert-scale (0-4), which stretches from 'not strong at all' to 'very strong'.
- **BDI** (Beck Depression Inventory; Hautzinger, Bailer, Worall, et al, 1994): This 21 questions self-assessment questionnaire is supposed to identify the affective, cognitive, motivational, somatic, and relational components of depression as well as their severity. Each question has a set of at least four possible answer choices, their intensity ranging from 0-3. Just as the original, the German version is satisfyingly reliable as well as valid (Hautzinger et al., 1994).
- **SOC-9** (Sense of Coherence; Antonovsky, 1987; Schumacher, Wilz, Gunzelmann & Brähler, 2000): This self assessment questionnaire examines the sense of coherence by looking to three components: comprehensibility, manageability, and meaningful-

ness. The brief version used in the PAP-S has 9 items with seven-point response scales (spanning from 'very often' (1) to 'very rarely' (7)).

- **K-INK** (Short version of Incongruence-Questionnaire; Grosse-Holtforth & Grawe, 2003): The construct of motivational incongruence which goes back to Grawe's theory of consistency. Incongruence is defined by the unsatisfactory realization of motivational goals ('approach and avoidance goals') in the interaction with the environment. The Likert-type scale (1-5) extends from 'far too little' (1) to 'completely sufficient' (5).
- **FMP** (Questionnaire of psychotherapeutic motivation; Schneider, Basler, Beisenherz, 1989): This tool attends to four aspects of treatment motivation: Illness experience (distress), general expectations from treatment, experiences of and attitudes towards psychotherapy, and lay concept of etiology. The 47 items are rated by a 5-step Likert-scale ranging from 'totally true' (1) to 'not true at all' (5).

#### b) Assessment by an external assessor

- **SKID-I und -II** (Structured Clinical Interview for DSM-IV; German by Wittchen, Zaudig & Fydrich, 1997): This interview is an efficient and reliable instrument for clarifying diagnostic criteria of various mental disorders as classified by DSM-IV. SKID-I relates to the DSM-IV axis I and SKID II to axis II accordingly. The assessor is systematically guided through the interview by open-ended questions and by pointers to the progression of questions.
- **GAF** (Global Assessment of Functioning; Sass, Wittchen, Zaudig & Houben, 2003): The general level of functioning of a patient is diagnosed along axis V of DSM-IV. It is a numeric scale (0 through 100) rating the social, occupational, and psychological functioning of patients whose scores are often given as a range. A range between 100 and 91 points to an excellent performance and to freedom of symptoms. Scores between 10 and 1 are defined as a „constant risk of harming oneself and others OR as the inability to meet minimal standards of personal hygiene OR as at risk of committing suicide with a clear intention to die”.
- **GARF** (Global Assessment of Relational Functioning; Sass et al., 2003; Endicott, Spitzer, Fleiss & Cohen, 1976): GARF is a variation of the GAF-Scale to indicate an overall judgment of the functioning of a family or another ongoing relationship and the degree to which the family/relationship meets the affective or instrumental needs of its members.
- **OPD-2** (Operationalized Psychodynamic Diagnostics; OPD Study Group, 2006) Axis 3 and 4: Out of the 5 OPD-axes, axis 3 (conflicts) and 4 (structural level) are considered. An interview guideline induces the systematic inquiry into the structural level and the assessment of unconscious conflict types.
- Video- or audio-taping of pre-, post- und follow-up (catamnestic) assessments.

### Process Measurement

#### a) Self Assessment by Patients

- **HAQ-S** (Helping Alliance Questionnaire; German by Bassler, Potratz & Krauthauser, 1995): This ques-

tionnaire considers aspects such as satisfaction with the therapeutic relationship, the expansion of perspectives, the thoroughness with which problems have been worked through as well as positive and negative emotions during the session.

*b) Assessment by the treating therapist*

- **HAQ-F** (Gross & Riedel, 1995) is the therapists' Version of the HAQ-S.
- **Intervention Sheet:** The so-called intervention sheet which had been developed specifically for this study involves a series of method-specific and general interventions with concomitant rating scales. The partaking institutions had set up this sheet collaboratively adding a manual with detailed definitions of those interventions. The therapist assesses his/her interventions after every therapy session. Table 3 gives an example of such an intervention list (Bioenergetic Analysis and Therapy).
- **Audiotaping:** Starting with the fourth, all sessions were recorded with consent of the patient.

**Manual rating adherence to therapeutic concept**

This rating manual has been developed for the extra-neous evaluation of interventions from different psychotherapeutic schools (Tschuschke et al., forthcoming). All participating institutes and associations were summoned to put together up to ten key interventions of their therapeutic orientation. School-specific interventions from non-partaking therapeutic modalities were added by the author of the manual in collaboration with experts from cognitive Behavioral Therapy, Psychoanalytic Psychotherapy, Client-Centered Psychotherapy, and Systemic Therapy. Finally, so-called general interventions were added in collaboration with the partaking institutions and associations, and some were gleaned from literature (e.g., Lambert, 2004).

The following structure served as the foundation for the description of these psychotherapeutic interventions: Name, definition, operational criteria, and the way of anchoring. After several revisions, the manual settled on a number of 100. In the following, we will exemplify 'breath work'.

**Table 3:** List of interventions for partaking therapists (example from Bioenergetic Analysis and Therapy)

	Not at all	Very often/ very intensely
1. Commented on/asked client to observe/worked with spontaneous breathing	0 1 2 3 4 5 6 7 8 9 10	
2. Commented on/asked client to observe/worked with bodily sensations / patterns of muscular tension	0 1 2 3 4 5 6 7 8 9 10	
3. Commented on/explored/worked on relationship between verbal communication and physical process	0 1 2 3 4 5 6 7 8 9 10	
4. Suggested/encouraged bioenergetic exercises according to Lowen	0 1 2 3 4 5 6 7 8 9 10	
5. Perceived body signals and had them translated in motor activity and/or encouraged transfer from verbal expressions to action	0 1 2 3 4 5 6 7 8 9 10	
6. Was aware of/addressed facial expressions, gestures, body postures and/or encouraged change of these	0 1 2 3 4 5 6 7 8 9 10	
7. Addressed affect regulation of patient in a certain area and tried to achieve pattern change	0 1 2 3 4 5 6 7 8 9 10	
8. Analyzed/explored/commented on psychically and somatically experienced transference	0 1 2 3 4 5 6 7 8 9 10	
9. Gave instructions of how to experience certain aspects of the therapeutic relationship as somato-psychic condition and/or encouraged change	0 1 2 3 4 5 6 7 8 9 10	
10. Became aware of/communicated/worked with mentally and somatically experienced countertransference phenomena	0 1 2 3 4 5 6 7 8 9 10	

**Further Data Entry Forms**

- *Basic documentation of patient on entering/leaving therapy:* General information on patients such as age, profession, ability to work, medication, benefactor, IDC 10-diagnosis, etc. as recorded by the treating therapist at the beginning and at the closing of the therapy.
- *Basic documentation of therapist's data* such as professional trainings, other professional engagements, etc.
- *Basic documentation of assessor:* general information on the assessor such as professional trainings, other professional engagements, etc.

**Breath Work**

*Definition*

The spontaneous **breath/breathing of the patient is commented by the therapist** or s/he has the patient observe his or her own breathing or s/he encourages a work sequence with breath/breathing.

*Operational*

The therapist addresses

- The patient's breathing pattern or
- has the patient change his or her breathing pattern (breathing more deeply/slowing down/accelerating his or her breath)

- encourages breathing exercises (possibly verbally accompanied with notions such as energy, energy build-up, charge (build-up), charge distribution, vivacity, relaxation, calming down, sympathetic/parasympathetic breathing)

*Differentiation from relaxation techniques*

Relaxation techniques include elements other than breathing

*Examples of Anchoring*

- 1) Th: When you just told me about your colleague at work I noticed that your breathing had become very shallow.
- 2) A patient speaks about a car accident in which her daughter was seriously injured. She often interrupts her report by heavy sobbing. The therapist touches her back and says, "It was horrible, wasn't it. Try to still go on breathing if possible."
- 3) Th: "I suggest that you interrupt your report for about three minutes and are silent while you place your right hand on your belly and feel your breathing movements ..." After the three minutes have passed: "What did you experience?"
- 4) Th: „Take five deep breaths into your chest. What do you feel now?" "I am slightly dizzy in my head." "Okay, then press your feet a little more strongly onto the floor. Yes, that's right. What are you aware of at the moment?"
- 5) Th: „Place your hands on your belly and inhale in a way that your hands rise when you inhale and sink when you exhale."
- 6) Th: „Imagine that this feeling of confidence/hopefulness enriches with every breath you take and distributes in your whole body while you exhale."
- 7) Th: „Imagine that your breath trickles through your body as sand does in an hourglass. Your legs and feet are slowly filling with sand ..."
- 8) Th: „Watch your breathing. It looks shallow to me. Allow yourself to take in more air and notice how your feeling changes while you continue sharing your story with me."

**Procedure**

The PAP-S-data were assembled from the following sources:

- 1) Questionnaires completed by therapists
- 2) Questionnaires completed by patients
- 3) Assessments (pre-, post- und catamnestic) by external assessors

All 23 assessors were professional psychotherapists of longstanding experience from different psychotherapeutic schools. They underwent a specific training and were supervised regularly when executing SKID-I and II, and the OPD-interviews.

*Pre-Measurement:* In the first therapeutic session, every new patient was assigned an ID-number by his/her therapist. The patients were informed about the trial and received an information sheet. They were asked to make up their minds before the fourth session whether they would contribute to the study or not. If their answer was affirmative, they signed an informed consent form. The therapists registered their patients at the assessment-coordinator of their area, and an appointment for the assessment was arranged. The

patient was allocated a certain assessor who did the pre-assessment, usually before the fifth session.

*Process-Analysis:* The therapists audiotaped every session (digital recording). Patients who declined the recording were nonetheless included in the study. After the session, every therapist filled in an intervention sheet.

*After every fifth session:* Therapists handed out the HAQ-S, the individual session sheet, and the OQ-45 to their patients. The patients filled in these questionnaires on the premises and sealed them in an envelope. The therapists completed the HAQ-F and sent all documents to the project coordinator.

*Post-Measurement:* After the very last therapy session, the therapists registered their patients once more at the assessment coordinator of their region. She was the one who was organizing the post-assessment. The project coordinator's office contacted the therapists and asked for a certain number (usually 3) of randomly selected audio-taped sessions. The therapists burned them on CD and sent them to the coordinator.

*Post-Measurement in case of discontinuation or interruption of therapy:* Post-measurements were undertaken in either case where still possible. The therapists had committed to reporting cases of discontinuation or interruption of therapy. With some patients, the procedure could be kept up just as with regular therapy endings, and with a few others, it was the project coordinator's office who planned for post-assessment. A study nurse took care of unclear situations, defaulting therapists, assessors, etc.

*Follow-Up/Catamnesis:* One year after therapy ending, the responsible assessor contacted the patient and scheduled the third assessment.

**Results**

*DSM IV-Diagnoses*

Out of 361 patients (one of whom had not been coded), 320 (89%) got a DSM IV axis I-diagnosis. On the axis II, i.e., personality disorders (N = 327), 150 diagnoses (45%) were ascertained. Cluster C (101 mentions) which covers self-conscious and insecure, dependent, and obsessive-compulsive personality disorders was represented most frequently.

**Table 4: DSM IV-Diagnoses**

DSM IV-Diagnoses	N
Axis I (N = 361)	
affective disorders	139
anxiety disorders	85
adaptive disorders	56
other	40
none (V-Codings)	41
Axis II (N = 327)	
cluster A (paranoid personality, schizoid p., schizotypic personality)	8
cluster B (Borderline-p., histrionic p., antisocial p, narcissistic personalities)	41
cluster C (self-conscious and insecure, dependent and obsessive-compulsive personalities)	101
none	177

*Average Scores of Outcome-Instruments at Pre-Assessment*

For the instruments BSI, BDI, OQ-45, GAF, and the OPD-axis 'structure', the average scores and standard deviations from pre-assessment are displayed below (Table 5). The average score of the BSI was at 0.84 (SD = 0.47) and the average of BDI at 15.32 (SD = 9.63). The cut-off-values between the functional and the dysfunctional realm of BSI and BDI follow the recommendations of Hiller, Schindler Andor, and Rist (2011). The average score of OQ-45 was 63.05 (SD = 22.73). Here, the cut-off value between functional and dysfunctional areas relates to the standards of Lambert and colleagues (2004). The GAF mean value as ascertained by the external assessors during pre-assessment, was 63.05 (SD = 22.73). It is important to note that in the case of GAF, higher scores reflected a better functional level. The suggested cut-off value of 70 was adopted from Jacobi, Uhmman und Hoyer (2011). Finally, the mean value of OPD-axis 4 (structural axis) as determined by the external assessor was 1.96 (SD = 0.50).

**Table 5:** Strain at the beginning of therapy as calculated by the outcome measuring instruments and as compared with boundary values

Instrument	N	M (SD)	Cut-Off Value functional vs. dysfunctional realm
BSI	342	0.84 (0.47)	0.56 <sup>2</sup>
BDI	343	15.32 (9.63)	14.29 <sup>2</sup>
OQ-45	355	63.05 (22.73)	63
GAF <sup>1</sup>	361	62.56 (13.59)	70 <sup>3</sup>
OPD Axis 4 <sup>1</sup>	323	1.96 (0.50)	

<sup>1</sup> At pre-assessment by extraneous assessors; <sup>2</sup> Suggestions by Hiller, Schindler Andor, & Rist, 2011; <sup>3</sup> Suggestion taken from Jacobi, Uhmman & Hoyer, 2011.

Key to codification system: BSI: 0 = no distress, 4 = high distress level. BDI: 0 = not depressive; 63 = very depressive. OQ-45: the higher the score the more pronounced the impairment. GAF: 0 = minimal functional level; 100 = complete freedom of symptoms; OPD-Axis 4, Structure: 1 = good structure, 2 = moderate structure, 3 = low structure, and 4 = disintegrated.

Table 6 shows that, according to BSI, 62% of the patients were dysfunctional, according to BDI the percentage amounted to 46% only. GAF, which had been carried out by external raters, counted 67% in the dysfunctional section.

**Table 6:** Distress at pre-assessment (frequency), subdivided in functional and dysfunctional by the relevant outcomes instruments

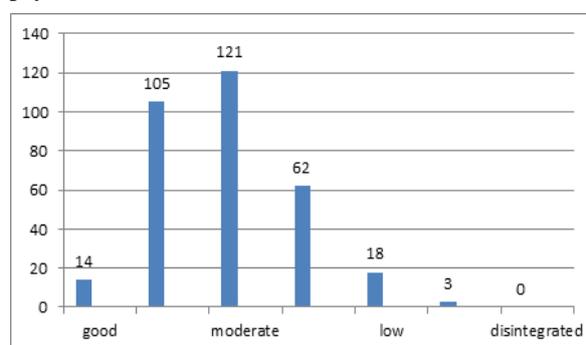
Instrument	N	Functional Area	Dysfunctional Area
BSI	342	129 (38%)	213 (62%)
BDI	343	186 (54%)	157 (46%)
OQ-45	355	183 (51%)	172 (49%)
GAF	361	117 (32%)	244 (67%)
Accumulated	361	67 <sup>1</sup> (19%)	294 (81%)

<sup>1</sup> This value highlights those 67 testees who were not judged as dysfunctional by any instrument.

The instruments obviously represented different aspects of psychological impairment. The article 'accumulated' pools those patients who were in the functional section as per all instruments (67, i.e., 19% of the participants). The others, i.e., 294 were measured to be dysfunctional by at least one of the measuring instruments.

**OPD-Structural Axis**

Out of the 323 patients who underwent an OPD-interview, 14 (4.3%) displayed good structures and well organized personalities throughout. With 105 (32.5%) of patients, only a slight structural impairment could be observed (see graph 2). All other assessments revealed structural vulnerabilities. 183 (56.7%) were diagnosed as exhibiting moderate, 21 (6.5%) low structures. 'Low structure' indicates that these patients have very limited access to their own psychic functions.



**Graph 2:** Distribution of OPD-structural axis assessments from 'good' to 'disintegrated' (N = 323).

**Discussion**

The PAP-S comprised 362 patients who had been treated by therapists from 10 different psychotherapeutic schools. For data collection, a *multi-method, multi-informant*-strategy including assessments was applied and executed by external assessors at three different points in time (pre-, post- and catamnestic assessments). This was supplemented by process-related data from therapists and patients which had been systematically collected every fifth session, and by audio recordings of therapeutic sessions. This procedure yielded answers on general and specific therapeutic agents (e.g., Pfammatter & Tschacher, 2010; Strauss, 2001). It will henceforth be of specific interest to investigate and compare various therapeutic techniques (request of identification, interpretation, breath work, etc., see Tschuschke et al., forthcoming). The objective of the present article has been to give a detailed description of the study design and procedure, and to submit descriptive data of patients and therapists. The DSM IV-diagnoses of the patients were distributed as follows: 89% of patients were diagnosed on axis I, 45% on axis II (personality disorders). The outcomes instruments diagnosed 20% of the patients to be in the functional segment, i.e., as having few symptoms only. A sample of psychotherapeutic outpatients is therefore expected to have diagnoses on axis I by 90%. Since no inclusion criteria had been stated as to the mental condition, a major proportion of participants without psychiatric diagnoses were predictable.

What was stunning though was the relatively high percentage of personality disorders (45%). It is most probable that this was an artifact brought about by the way they were diagnosed: The diagnoses referred to in the PAP-S had been established on the basis of SKID-interviews and not by a clinician who plans his further therapeutic steps accordingly. Diagnoses ascertained by structured interviews are sometimes called epidemiological, those from clinicians clinical (e.g., Ajdacic-Gross & Graf, 2003), and possibly clinicians would not have arrived at an equally high figure of personality disorders. It makes nonetheless sense to have patients diagnosed by external assessors because in this way, comparable values are obtainable (see e.g., Leichsenring, 2004). It is furthermore surprising, at least at first sight, that none of the outcomes instruments had placed 20% of the patients in the dysfunctional section, which means that their symptoms were clinically irrelevant. This unexpectedly high percentage may have to do with the circumstance that the patients did not complete their questionnaires before the intake interview, but as late as after a few therapy sessions when distress and symptoms had either waned or were experienced as less strenuous. This argument is supported by the fact that, from all outcomes instruments, the GAF, which had been conducted by extraneous assessors and which focuses on the general level of functioning, showed the highest portion of scores in the dysfunctional area.

The OPD structural axis displays some inconspicuous results (36.8%), relatively many with moderate structural levels (56.7%), and only a few (6.5%) with rather low structural levels, the latter being patients with limited psychic functioning. Apart from symptom-related distress, the concept of 'structure' is an important psychodynamic variable and was therefore included in the study as an outcomes instrument that pictures possible structural changes, i.e., the increasing integration of those areas which are particularly meaningful in a patient's psychodynamics (Rudolf, 2002).

One definite shortcoming of the study is the missing data. A naturalistic design that works with 'real' therapists and 'real' patients takes enormous efforts to complete its data set, and the PAP-S was no exception. For therapists as well as patients, the paper work was an additional investment. What is more, the patients had to travel to the premises of the regional assessment centers and sit through the testing for two or more hours. Some patients asked for premature abortion because the participation was too much strain on them. It is thus all the more impressive that most of them took the whole procedure upon them. In spite of the mentioned constrictions, a comprehensive and interesting set of data was generated. Further publications will be dedicated to in-depth outcomes and process outcomes research to find the best possible answers to the copious related issues.

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