



Practice Study Outpatient Psychotherapy – Switzerland (PAP-S): Study design and feasibility (Revised edition)

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Abstract

In line with the demand for evidence-based medicine, psychotherapy is also expected to demonstrate its effectiveness. For this reason, the Swiss Charta for Psychotherapy, the umbrella organization for psychotherapy education and training institutes in Switzerland, launched a prospective, naturalistic psychotherapy outcome study in 2004. All institutes affiliated with the Charta were invited to participate in the study. In Switzerland a multitude of psychotherapy approaches continue to be practiced. The study therefore also provides a unique opportunity to investigate whether therapists practicing different types of psychotherapy in fact utilize the techniques declared to be specific to their approaches, or whether, for instance, there are just a few techniques that are widely utilized across approaches.

This paper presents the study design and the descriptive data of the baseline survey. Participating were 86 therapists at nine psychotherapy institutes; the therapists recruited 362 patients (238 women, 124 men) aged 17 to 72 years. With regard to the five most important outcome instruments, 80% of the patients had a rating in the dysfunctional range on at least one instrument. Ninety percent of the patients had a diagnosed disorder on Axis I of the DSM-IV. Further analyses of the data will yield outcome and process-outcome results.

Keywords: Psychotherapy, outcome study, prospective naturalistic design, psychotherapy techniques.

Just a few fields of psychotherapy have predominated in psychotherapy research – in both psychotherapy process and outcome research. Cognitive-behavioral therapy is especially strongly represented in randomized controlled trials (RCTs), but psychoanalytic psychotherapy, client-centered psychotherapy, and systemic psychotherapy also have a long tradition in RCTs and other research designs. Other types of psychotherapy have been studied to a lesser extent up to now. With the move towards evidence-based medicine and psychotherapy, all medical treatment methods and also psychotherapy methods are expected to demonstrate their effectiveness. For this reason, the Swiss Charta for Psychotherapy, the Swiss umbrella organization for psychotherapy training institutes and professional associations, launched a prospective, naturalistic psychotherapy outcome study in 2004, Practice Study Outpatient Psychotherapy-Switzerland (PAP-S).

It is not our intention here to discuss the difference between naturalistic studies and RCTs (for a detailed account, see Tschuschke et al., 2009). Instead, we aim to set out the specific potential of a process-outcome study that looks at types of psychotherapy and therapy techniques that have not been examined in the research so far. In contrast to Germany, a number of different types of psychotherapy are still approved in Switzerland. This presents a unique opportunity to study therapy methods that are not a part of the mainstream.

The issue is controversial as to whether psychotherapy is generally effective or whether it is specific factors that lead to treatment effectiveness. Specific factors are usually assigned to a particular psychotherapy model or are seen as specific treatment techniques for use with specific psychological disorders (Pfammatter & Tschacher, 2010). General factors, on the other hand, are implicit factors that are common to all psy-

chotherapies. Lambert and Ogles (2004), for example, proposed the following three categories of general factors: support factors (e.g., therapeutic relationship), learning factors (e.g., insight), and action factors (e.g., practice). It is often said that in psychotherapy practice and psychotherapy research there are two worlds: supporters of the paradox of equivalence – that is, the fact that most reviews of psychotherapy outcome research reveal only small differences in the effectiveness of different psychotherapies (e.g., Stiles, Shapiro, & Elliott, 1986), and supporters of the other view, which holds that there are indeed differences that disorder-specific research approaches uncover (e.g., DeRubeis, Brotman, & Gibbons, 2005). Some researchers have attempted to integrate the two views: Pfammatter and Tschacher (2010) developed a synergistic way of looking at the effect of general and specific factors and emphasized their interplay with characteristics of the disorder and individual patient characteristics. Strauss (2001) reasoned that in addition to general factors leading to therapy effectiveness, specific disorders can also develop their own dynamics, which makes it appropriate to integrate both general and specific interventions.

However, psychotherapy methods and schools do not usually focus on general factors but instead on their specific therapy techniques. It is to be expected that therapists with more experience will work more eclectically (e.g., Jensen, Bergin, & Greavers, 1990). Nevertheless, prospective therapists choose a certain school of psychotherapy because it makes sense to them, because they find it effective as opposed to other forms of psychotherapy, and because they then identify with the school of psychotherapy. A school of psychotherapy usually bases itself on a specific disorder and therapy model and school-specific therapy techniques derived from the model. The nine psychotherapy approaches that participated in the PAP-S are listed in the following, with a brief description of their theoretical underpinnings (according to Schlegel, Meier, & Schulthess, 2011) and listing three selected specific therapy techniques (see Tschuschke et al., 2009).

1. Transactional Analysis

This psychotherapy approach is classified as humanistic and was founded by the early psychoanalyst Eric Berne. Berne combined psychoanalytic and behavioral therapy components on the basis of a humanistic view of humankind that emphasizes each person's unique individuality and potential.

Therapy techniques

- Life Positions
- Communication analyses using structural diagrams
- Script analysis

2. Process-Oriented Psychology

The founder, Arnold Mindell, studied physics and originally trained as a Jungian analyst at the C.G. Jung Institute. In his process-oriented approach, Mindell also integrated group dynamics, spirituality, body awareness, and creative expression

Therapy techniques

- Process work at the edge of awareness

- Integration of processes further from awareness (secondary process) into a person's primary awareness
- Interaction with the inner critic

3. Integrative Body Psychotherapy (IBP)

Founded by Jack Lee in the 1960s, this type of psychotherapy combines various humanistic approaches and influences from Wilhelm Reich. Its focus is somatic experience; in addition, it holds emotions, cognitions, spiritual experience, and behavior to be important.

Therapy techniques

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

4. Existential Analysis and Logotherapy

Viktor Frankl based his logotherapy, or existential analysis (the two terms are used synonymously), on an anthropological view of human beings. On the basis of the philosophical approach of existentialism, humans have freedom of will that is manifested in three dimensions: the spiritual dimension of the person and the dimensions of body and of psyche. In the 1980s, Frankl's followers parted ways with Alfred Längle, one of Frankl's students. One institute in the Frankl tradition and one institute in Längle's tradition participated in the PAP-S.

Therapeutic techniques

- Working on one's relation to life
- Meaning and values in life
- Dereflection

5. Art and Expression-Oriented Psychotherapy

Central techniques in this type of psychotherapy are various forms of expression in all art disciplines. As the basis of these artistic forms of expression, this type of psychotherapy uses psychodynamic, systemic, and daseinsanalytische foundations of psychotherapy as the points of departure; it also incorporates salutogenetic assumptions.

Therapy techniques

- Use aesthetic responsibility
- Heighten perception of the artwork produced
- Defining one's position through the work

6. Analytical Psychology according to C.G. Jung

C. G. Jung, a student of Freud, parted ways with psychoanalysis early on. The reason for this, among other things, was Jung's differing opinions concerning Freud's concept of instinct. Jung's postulated collective unconscious may be seen as an independent development within a depth psychology theory.

Therapy techniques

- Symbol analyses
- Work on complex episodes
- Foster the individuation process

7. Bioenergetic Analysis and Therapy

The roots of this body-oriented psychotherapy approach lie in classical Freudian psychoanalysis. After studying with Wilhelm Reich, Alexander Lowen, the founder of bioenergetic analysis, developed today's concept focusing on the importance of sexual instinct and ego needs. Body-related interventions aim at

helping patients towards awareness of primary needs of infancy and early childhood and resolving issues.

Therapy techniques

- Affect regulation
- Body aspects of the therapeutic relationship
- Body work

8. Gestalt Therapy

Gestalt therapy, the main originator of which is Fritz Perls, was developed in the 1960s, as were many forms of psychotherapy. It can be called a typically integrative psychotherapy approach, as it combines existentialist philosophy, Husserl’s phenomenology, and the foundations of Gestalt theory as developed by Wertheimer and others on the basis of humanistic psychotherapy and psychoanalysis.

Therapy techniques

- Promote awareness of current emotions
- Forster identification
- Exploring behaviors (experiments)

9. Psychoanalytic Psychotherapy

Sigmund Freud was the founding father of psychoanalysis and psychoanalytic psychotherapy. In their more than 100-year history there have been many further developments, including in particular object relations theory.

Therapeutic techniques

- Association (free)
- Interpretation
- Confrontation

The above overview of the different types of psychotherapy indicates that some of the methods listed have many theoretical and technical similarities. For example, body-oriented psychotherapies arose out of both the psychoanalytic and the humanistic tradition. And some of the therapy techniques are explicitly named by several schools of psychotherapy, such as the experimenting with new behaviors in bioenergetic analysis, Gestalt therapy, and also behavioral therapy. In addition to school of psychotherapy-specific therapy techniques, many therapists utilize elements from various continuing education and training courses and work eclectically. For this reason, central research questions of the PAP-S are the following: To what

extent do therapists practicing different types of psychotherapy utilize techniques that are specific to their school of psychotherapy, and are there techniques used in common across schools? It is very possible that formerly psychotherapy school-specific factors have since become common factors. In this paper, however, we focus only on the design of the PAP-S and descriptive information on the therapists and patients.

Methods

Overall Design

In 2004 the Swiss Charta for Psychotherapy launched the prospective psychotherapy outcome study, PAP-S. Nine Charta institutes or therapy schools agreed to participate. In addition, some psychotherapists agreed to participate whose schools of psychotherapy did not participate officially. Participation entailed a financial commitment on the part of the institutes, but the greater part of the costs was covered by a generous bequest from a foundation.

The study was conducted as a naturalistic quasi-experimental study, with adherence to quality standards (see, for example, Leichsenring, 2004). The participating psychotherapists agreed to invite all new patients seeking treatment to participate in the study. Patients consenting to participate were invited to a pre-assessment at one of five regional assessment centers prior to their fifth psychotherapy session. Independent assessors conducted a diagnostic interview using the Structured Clinical Interview for DSM-IV (SKID) and the conflicts and structural level axes of the Operationalized Psychodynamic Diagnosis (OPD). In addition, the patients were given various questionnaires. For process measurements, the psychotherapists audiotaped each therapy session and filled out a checklist on the interventions that they used in that session. Every fifth session, psychotherapists and patients both completed questionnaires. Following the final therapy session, the psychotherapist registered the patient for a post-assessment at the assessment center. A follow-up assessment was conducted at the center one year after the end of psychotherapy. At each of the five regional assessment centers, one coordinator was responsible for the planning of the as-

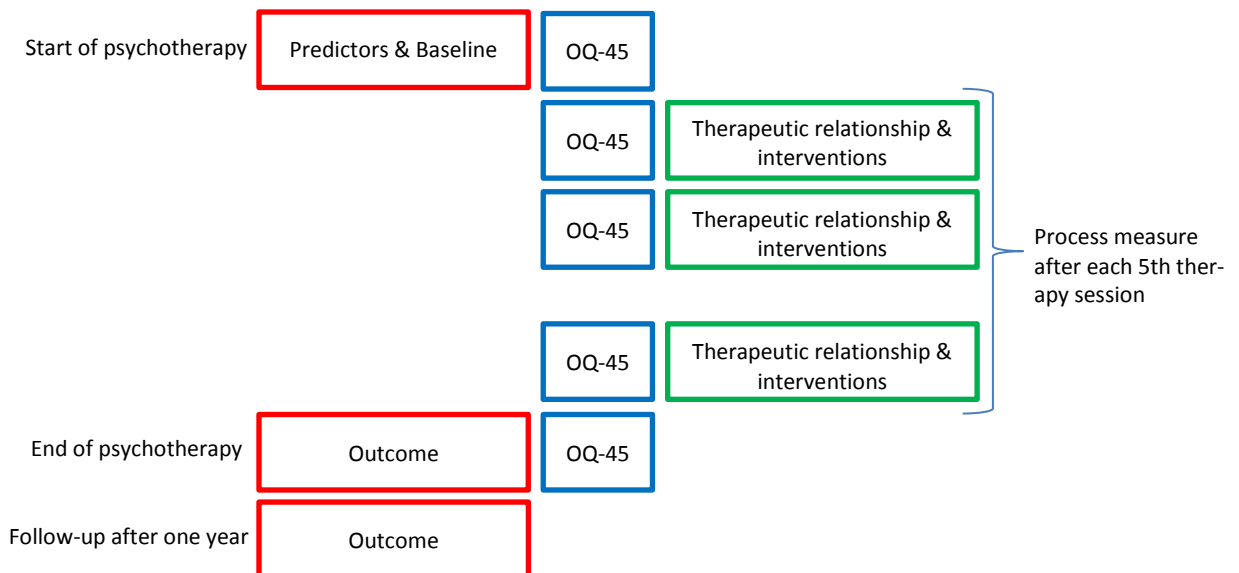


Figure 1: Schematic representation of the study design of PAP-S

sessments. A total of 23 assessors were trained to conduct the pre-, post-, and follow-up assessments. Figure 1 shows the study design. In all cantons in which participating psychotherapists had practices, research applications were submitted to the ethical committees and approved. Two universities served as scientific co-directors of the study. One of them, the School of Applied Psychology of the Zurich University of Applied Sciences, acted as project coordinator. The steering group of the study was made up of the president of the Charta, the scientific directors, and two other persons. Four of the five members of the steering group also work as psychotherapists in four different types of psychotherapy (bioenergetics analysis, Gestalt therapy, systemic psychotherapy, and psychoanalytic psychotherapy).

Sample

Participating Institutes and Therapists

Nine psychotherapy institutes or associations participated in the study:

- 1) Swiss Society for Transactional Analysis (SGTA/ASAT: German-/French-speaking section)
- 2) Institute for Process Analysis (IPA) (formerly FG POP)
- 3) Institute for Integrative Body Psychotherapy (IBP)
- 4) 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 for Analytical Psychology (SGAP)
- 8) Swiss Society for Bioenergetic Analysis (SGBAT)
- 9) Swiss Association of Gestalt Therapy (SVG)

Two psychoanalytic psychotherapists also participated in the study. The SGBAT therapies were complemented by psychotherapies at its sister society in Austria.

A total of 86 psychotherapists agreed to participate in the study (see overview in Table 1). For some psychotherapists some data is missing. Sixty-six percent of the psychotherapists were women; at some of the institutes only women psychotherapists participated, whereas at other institutes, the ratio of female to male psychotherapists was more balanced. The psychotherapists ranged in age from 32 to 77 years; with an average age of 51, they were experienced psychotherapists overall.

Patients

Psychotherapists agreed, over a period of two years, to invite all new patients starting psychotherapy to participate in the study. They maintained a list of patients. Extrapolation of the evaluable data showed that a total of approximately 1,660 patients had been asked to participate in the study; 379 patients agreed. However, 17 patients failed to appear at the pre-assessment; they are not included as study participants. The total sample was therefore 362 patients (see Table 1).

Of the patients, 238 were women and 124 men. Patients' average age was 39.7 years (SD = 11.80); the youngest patient was 17.2 years old and the oldest 72.7 years old (n = 353). On average the SGTA/ASAT had the youngest patients (M = 38.1; SD = 10.88) and ILE the oldest patients (M = 49.8; SD = 9.80).

In a two-year period prior to the current psychotherapy, 232 patients had not been in psychotherapy or outpatient psychiatric treatment; 87 had been in outpatient psychotherapy or psychiatric treatment, and 28 had been in inpatient psychotherapy or psychiatric treatment (n = 347; see Table 2). 91 Ninety-one patients were married; 189 patients lived in a stable relationship (n = 341). Two hundred sixteen patients reported having no children; 137 patients had from 1 to 4 children (n = 353). As their highest educational level attained, 40% had a university degree, 3 had not finished compulsory education. Two hundred sixty-three patients (73%) worked full time or part-time; another 31 patients were in training. Just under 12% of

Table 1: Participating Institutes and Associations, Number of Therapists and Patients, and Demographic Information

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

the patients were unemployed, on sick leave, or retired.

Table 2: Description of Patient Sample at Pre-Assessment

	Number of participants (%)
Sex	
Female	238 (66)
Male	124 (34)
Age in years	
Average age	39.7
Psychotherapy or psychiatric treatment within two years prior (n=347)	
None	232 (66.9)
Outpatient treatment	87 (25.1)
(Partly)inpatient treatment	28 (7.7)
Marital status (n=350)	
Single	189 (54)
Married	91 (26)
Separated/ divorced	62 (17.1)
Widowed	8 (2.3)
Living in a stable relationship	189 (55.4)
Number of children	
No children	216 (61.2)
One child	37 (10.5)
Two children	69 (19.5)
Three children	24 (6.8)
Four children	7 (2)
Educational attainment (n=350)	
No schooling	3 (.9)
Compulsory education	26 (7.4)
Vocational apprenticeship	126 (36)
Matura qualification for university entrance, upper secondary specialized school	52 (14.9)
Professional education and training (PET) colleges, universities of applied sciences	67 (19.1)
University	76 (21.7)
Work situation (n=353)	
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)
Social security/pension	9 (2.5)
Housework	8 (2.3)
Disability pension	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 economical and widely used quality assurance instrument measures important areas of psychotherapy change, including symptom load (25 items), interpersonal relationship functioning (11 items), and social role (9 items). Patients rate the 45 items on a five-point scale (1 = never, 5 = always). The questionnaire is designed for outcome measurement as well as for monitoring

therapeutic progress during the course of therapy. The original version in English has high reliability (overall Cronbach's alpha = .93) and validity (Lambert & Ogles, 2004); the same holds for the German-language version (Lambert et al., 2002).

- **BSI** (Brief Symptom Inventory) (Franke, 2000): The BSI is a short form of the well-known Symptom Checklist (SCL-90). It serves as an economical questionnaire for patients' self-rating of physical and psychological symptoms on the following nine scales: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Patients rate each of the 53 items on a five-point Likert scale of distress from 0 (none) to 4 (extreme).
- **BDI** (Beck Depression Inventory) (Hautzinger, Bailer, Worall, & Keller, 1994): This self-report questionnaire has 21 items capturing affective, cognitive, motivational, somatic, and behavioral components of depression. Patients rate severity on a four-point scale from 0 to 3. Like the original inventory (in English), the German-language version shows satisfactory reliability and validity (Hautzinger et al., 1994).
- **SOC-9** (Sense of Coherence) (Antonovsky, 1987; Schumacher, Wilz, Gunzelmann, & Brähler, 2000): This self-assessment questionnaire examines sense of coherency in terms of three dimensions: comprehensibility, manageability, and meaningfulness. The short version used here has 9 items, with a seven-point response scale from 1 (very often) to 3 (very seldom).
- **K-INK** (*Inkongruenzfragebogen Kurzversion* [short version of the incongruence questionnaire]) (Grosse-Holtforth & Grawe, 2003): The construct of motivational incongruence, which goes back to Grawe's consistency theory, is defined as insufficient goal satisfaction in interaction with the environment, distinguishing between approach and avoidance goals. The five-point response scale ranges from 1 (much too insufficiently) to 5 (completely sufficiently).
- **FMP** (*Fragebogen zur Messung der Psychotherapiemotivation* [questionnaire assessing psychotherapy motivation]) (Schneider, Basler, & Beisenherz, 1989): This questionnaire captures four aspects of motivation for psychotherapy: the patient's perception of illness (distress), general expectations of psychotherapy, experience and attitudes towards psychotherapy, and layman's concept of etiology. The questionnaire contains 47 items that the patient rates on a five-point Likert scale from 1 (completely true) to 5 (not true at all).

b) *Assessment by external assessors*

- **SKID-I and SKID-II** (*Strukturiertes Klinisches Interview für DSM-IV*) (Wittchen, Zaudig, & Fydrich, 1997): These German-language versions of the Structured Clinical Interview for DSM-IV Axis I Disorders and Structured Clinical Interview for DSM-IV Axis II Disorders are efficient and reliable instruments for making DSM-IV diagnoses of mental disorders according to the diagnostic criteria. For the interview the assessor is systematically guided

by open questions and instructions on what questions to ask in what order.

- **GAF** (Global Assessment of Functioning) (Sass, Wittchen, Zaudig, & Houben, 2003): Axis V of the DSM-IV concerns patients' general functioning. The GAF is a numeric scale (1 through 100) for subjective rating of the psychological, social, and occupational functioning of adult patients. Ratings from 91 to 100 indicate superior functioning and no symptoms; ratings from 1 to 10 indicate "persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death".
- **GARF** (Global Assessment of Relational Functioning) (Sass et al., 2003; Endicott, Spitzer, Fleiss, & Cohen, 1976): The GARF is a variation of the GAF for indicating an overall judgement on the functioning of family or partner relationships in terms of affective and instrumental aspects.
- **OPD-2** (*Operationalisierte Psychodynamische Diagnostik*/Operationalized Psychodynamic Diagnosis OPD-2) (Arbeitskreis OPD, 2006), Axes III and IV: Of the five axes on the OPD-2, we used Axis III (conflicts) and Axis IV (structural level). The OPD-2 interview guide aids systematic questioning and assessment of the level of structural integration and rating of unconscious types of conflicts.
- **Videotaping or audiotaping** of pre-, post, and follow-up assessments.

Process Measurement

a) *Self Assessment by the patients*

- **HAQ-S** (Helping Alliance Questionnaire, Patient Version) (Bassler, Potratz, & Krauthauser, 1995):

This German-language version of the HAQ Patient Version captures aspects such as patients' satisfaction with the therapeutic relationship (alliance), broadening of perspectives, intensity of working on problems, and positive and negative emotions during the session.

b) *Assessment by the therapist*

- **HAQ-F** (Gross & Riedel, 1995): Therapist version of the HAQ-S.
- **Intervention checklist:** The intervention checklist was developed for this study. It contains a series of lists of psychotherapeutic method-specific interventions and common interventions in the form of rating scales, which were developed in cooperation with the participating psychotherapy schools/institutes. There is a manual that provides detailed definitions of the intervention techniques. Therapists rated their interventions after each therapy session. As an example, Table 3 shows the list of interventions on the checklist specific to bioenergetics analysis.
- **Audiotaping:** With the patient's consent, all therapy sessions were recorded, starting with the fourth session.

Further Questionnaires

- *Basic documentation of patient's entry into psychotherapy and leaving psychotherapy:* General information on the patient, including age, occupation, employment status, medications, payer, ICD-10 diagnosis code, etc. The treating psychotherapists filled out this survey at the start and end of therapy.
- *Basic documentation of therapist information:* General information on the therapist, such as education and training, professional activities, and so on.
- *Basic documentation of assessor information:* Gen-

Table 3: List of Interventions Filled Out by Participating Therapists: Bioenergetic Analyses

	Not at all	Very often / very intensively
1. I commented on the patient's spontaneous breath / breathing, had the patient observe her own breath, or suggested working with the breath	0 1 2 3 4 5 6 7 8 9 10	
2. I addressed the physical level, had the patient observe patterns of muscular tension, commented on them or explored them, worked with them	0 1 2 3 4 5 6 7 8 9 10	
3. I instructed the patient to translate verbal comments into action, explored them, worked with them	0 1 2 3 4 5 6 7 8 9 10	
4. I suggested or provided instruction for a bioenergetic exercise (sensu Lowen)	0 1 2 3 4 5 6 7 8 9 10	
5. I noted physical signals which I then had the patient transform into motor activity; or I instructed the patient to translate verbal comments into action	0 1 2 3 4 5 6 7 8 9 10	
6. I noted, addressed facial expressions, gestures, body posture and/or suggested changes	0 1 2 3 4 5 6 7 8 9 10	
7. I addressed the patient's affect regulation in a certain area, or attempted to bring about a change in the patient's affect regulation	0 1 2 3 4 5 6 7 8 9 10	
8. I analyzed, explored, or commented on the patient's mental or physical transference	0 1 2 3 4 5 6 7 8 9 10	
9. I provided instruction in experiencing certain aspects of the therapeutic relationship as physical/mental state and/or suggested changes	0 1 2 3 4 5 6 7 8 9 10	
10. I registered the mental and physical countertransference phenomena which the patient experienced and communicated them to the patient or worked with them	0 1 2 3 4 5 6 7 8 9 10	

eral information on the assessor, such as education and training, professional activities, and so on.

Rating Manual for Psychotherapy Treatment Adherence

To be able to rate the interventions of the various types of psychotherapy we developed the *PAP-S-Rating-Manual* for external raters (Tschuschke, Koemeda, & Schlegel, 2013). All institutes and associations participating in the PAP-S were asked to put together up to 10 interventions that are typical and important in their psychotherapy approach. In addition, specific interventions from four types of psychotherapy that did not participate in the study were included in the manual in collaboration with experts: cognitive-behavioral therapy, psychoanalytic psychotherapy, client-centered psychotherapy, and systemic therapy. Finally, common, general intervention techniques were included in the manual; these common techniques were put together in collaboration with the participating institutes and associations and based on the research literature (e.g., Lambert, 2004).

In the manual, the descriptions of the interventions are structured as follows: school/concept, name of the technique, definition, operational criteria, and typical examples. After several revisions, the final manual comprised 100 psychotherapy intervention techniques. The following example from the manual is intervention category 17, breath work.

Breath Work

Definition:

The therapist **comments on the patient's spontaneous breath / breathing**, has the patient observe her own breath, or suggests working with the breath.

Operational Definition:

The therapist:

- focuses on the patient's breathing
- has the patient change her breathing patterns (deepening / slowing / accelerating)
- has the patient perform breathing exercises (possibly accompanied by ideas such as energy, energy build-up, charging, charge distribution, vitality, relaxation, calming down, sympathetic / parasympathetic breathing)

Differentiation:

- 33 (*Teaching Relaxation Techniques*): relaxation techniques encompass **more** than the **breath**.

Typical Examples:

- 1) Therapist: "When you were just telling me about your colleague at work, I noticed that your breathing became very shallow. What was that like for you?"
- 2) A patient tells of a car accident in which her daughter was seriously injured. Her account is repeatedly interrupted by deep sobbing. The therapist touches her back and says, "It was horrible, wasn't it. But try to keep breathing anyway—now—as well as you can."
- 3) Therapist: "Let me suggest that you interrupt your account for about three minutes. While you're silent, put your right hand on your stomach and watch how it moves as you breathe . . ." Then, after three minutes have elapsed: "What did you experience?"

- 4) Therapist: "Take five deep breaths into your chest. What are you feeling now? A little bit light-headed? OK, then push your feet down onto the floor somewhat harder. Good, just like that. What are you experiencing now?"
- 5) Therapist: "Place your hands on your stomach and breathe in such a way that your hands move up when you inhale and move down when you exhale."
- 6) Therapist: "Imagine that this feeling of hopefulness becomes richer with every breath you inhale and disperses in your body every time you exhale."
- 7) Therapist: "When you exhale, imagine that your breath is like sand flowing in an hourglass; it flows through your body. Your feet and legs are slowly filling up with the sand . . ."
- 8) Therapist: "Pay attention to your breath. It seems somewhat shallow to me. Give yourself a little more air and observe how feelings change as you continue telling me about it."

Procedures

The sources of the PAP-S study data were the following:

- 1) Questionnaires completed by psychotherapists
- 2) Questionnaires completed by patients
- 3) Assessments (pre-, post- and follow-up) by external assessors

The 23 assessors were all trained psychotherapists having several years of professional experience. They received training in conducting the SKID-I and SKID-II interviews and the OPD interview and were supervised regularly. They belonged to different schools of psychotherapy.

Pre-measurement: In the first therapy session, the psychotherapist generated an ID number for each new patient. Patients were informed about the study and given an information sheet. By the third therapy session at the latest, patients had to decide if they would participate in the study. If they agreed, they signed a consent form. The psychotherapists registered their patients with the assessment coordinator in their own area, and the assessment appointment was made. The assigned assessor conducted the pre-assessment with the patient usually before the fifth therapy session.

Process measurement: The psychotherapists audiotaped every therapy session. Patients who agreed to participate in the study but did not want the sessions recorded were still included in the study. At the end of each session, the psychotherapist filled out the intervention checklist.

After every fifth session: The psychotherapists gave the patients the HAQ-S and the OQ-45. The patients filled out the questionnaires at the psychotherapists' office and put them into a sealed envelope. The psychotherapists completed the HAQ-F and sent all documents to the project coordinator.

Post-measurements: After the last therapy session, the psychotherapists registered the patients with the assessment coordinator for the region. The coordinator organized the post-assessment by one of the assessors. The project coordinator contacted the psychotherapists and asked for a certain number (usually three) of audi-

otapes of randomly selected sessions. The psychotherapists copied the audiotapes to CD and sent the CD to the project coordinator.

Post-measurement if therapy was discontinued or interrupted: Where possible, post-assessments were conducted also if therapy had been discontinued or interrupted. The psychotherapists had agreed to report discontinuation or interruption of therapy. In some cases, the same procedure could be followed as after a regular end of therapy, and in some cases, the project coordinator planned the post-assessment. A study nurse was responsible for unclear situations, defaulting psychotherapists and assessors, and so on.

Follow-up: One year after the end of therapy the responsible assessor contacted the patient and scheduled the third assessment

Results

DSM IV-Diagnoses

Of 361 patients (one coding was missing), 320 (89%) were given a DSM-IV Axis I diagnosis. On Axis II – Personality Disorders (PD) (N = 327) there were 150 diagnoses (45%), the most frequent (101 diagnoses) being Cluster C (Avoidant PD, Dependent PD, Obsessive-Compulsive PD).

Table 4: DSM-IV Diagnoses

DSM-IV Diagnoses	
Axis I (N = 361)	
Mood Disorder	139
Anxiety Disorder	85
Adjustment Disorder	56
Other Conditions	40
None (V codes)	41
Axis II (N = 327)	
Cluster A (Paranoid Personality Disorder (PD), Schizoid PD, Schizotypal PD)	8
Cluster B (Borderline PD, Histrionic PD, Antisocial PD, Narcissistic PD)	41
Cluster C (Avoidant PD, Dependent PD, Obsessive-Compulsive PD)	101
None	177

Average Scores on the Outcome Instruments at Pre-Assessment

For the instruments BSI, BDI, OQ-45, GAF, and OPD-2 Axis IV ‘structural level,’ Table 5 shows the mean scores and standard deviations at the pre-assessment. The mean score on the BSI was 0.84 (SD = 0.47), and the mean score on the BDI was 15.32 (SD = 9.63). For the BSI and BDI, the cut-off values between functional and dysfunctional follow Hiller, Schindler, Andor, and Rist’s (2011) recommendations. The mean score on the OQ-45 was 63.05 (SD = 22.73). Here we used the cut-off between functional and dysfunctional according to Lambert and Ogles (2004). The mean score on the GAF, rated by external assessors at pre-assessment, was 63.05 (SD = 22.73). Here it should be noted that on the GAF, higher scores indicate higher levels of functioning. For the GAF we used the cut-off of 70 recommended by Jacobi, Uhlmann, and Hoyer (2011). Finally, the mean rating by the external assessors on the OPD-2 Axis IV ‘structural level’ was 1.96 (SD = 0.50).

Table 5: Severity at the Start of Therapy as Assessed by Outcome Instruments and Compared to Cut-Off Values

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

¹ Rated by external assessors at pre-assessment; ² Recommended by Hiller, Schindler, Andor, and Rist (2011); ³ Recommended by Jacobi, Uhlmann, and Hoyer (2011)

Notes: Coding of BSI: 0 = no distress, 4 = high distress; coding of BDI: 0 = minimal depression, 63 = severe depression; coding of OQ-45: higher scores indicate higher degree of disturbance; GAF: 0 = lowest level of functioning, 100 = completely symptom-free; OPD-2 Axis IV ‘structural level’: 1 = high level of structural integration, 2 = moderate level of structural integration, 3 = low level of structural integration, 4 = disintegrated structure.

Table 6 shows that based on the BSI, 62% of the patients had scores at the dysfunctional level, and on the OQ-45, 49% of the patients had scores at the dysfunctional level. On the GAF, which is rated by external assessors, 67% had scores at the dysfunctional level. As the instruments capture different aspects of psychological distress, the table row headed ‘summed’ shows in the functional column the number of patients that had scores at the functional level on all four instruments without exception; this was 67 (19% of the patients participating). The other 294 patients had scores at the dysfunctional level on at least one of the four instruments.

Table 6: Distress/Severity/Symptom Load at Pre-Assessment (Frequency), Shown Separately for Functional or Dysfunctional Scores on the Relevant Outcome.

Instrument	N	Functional	Dysfunctional
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%)
Summed	361	67 ¹ (19%)	294 (81%)

¹ Number of patients who had no scores at the dysfunctional level on any of the instruments.

OPD-2 Axis IV ‘structural level’

Of the 323 patients with whom an OPD interview could be conducted, 14 (4.3%) showed a consistently high level of structural integration in their personality organization, 105 (32.5%) patients showed only slight structural limitations (see Figure 2). All other scores diagnosed structural vulnerabilities: 183 (56.7%) patients had a moderate level of structural integration, and 21 (6.5%) patients had a low level of structural integration. A low level of structural integration means that regulating mental functions are not fully available to the patient.

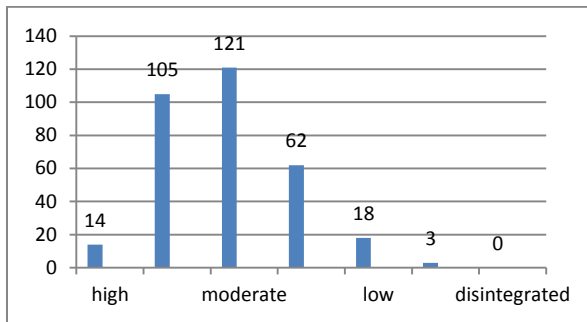


Figure 2: Distribution of OPD-2 Axis IV ‘structural level’ scores, from high to disintegrated (N = 323)

Discussion

A total of 362 patients treated by psychotherapists practicing 10 different types of psychotherapy could be included in the Practice Study Outpatient Psychotherapy - Switzerland (PAP-S). Data collection followed a multi-method, multi-informant strategy – with assessments conducted by external assessors at three points in time (pre-assessment, post-assessment, and follow-up), complemented by process-related data from the psychotherapists and patients collected every fifth therapy session and also audio recordings of the therapy sessions. This design yields answers to questions about common and specific factors in psychotherapy (e.g., Pfammatter & Tschacher, 2010; Strauss, 2001). It will be of particular interest to compare different therapy techniques (promoting identification, interpretation, breath work, etc.; see Tschuschke et al., 2013).

The aim of this paper was to present the study design and procedures in detail and to report descriptive data on the patients and psychotherapists. The patients’ DSM-IV diagnoses were distributed as follows: 89% had an Axis I diagnosis; 45% had an Axis II (personality disorders) diagnosis. And 20% of all patients participating had scores on the outcome instruments at the functional level – that is, they showed few symptoms. For a sample of outpatient psychotherapy patients, it can be expected that approximately 90% will have an Axis I diagnosis. As there were no inclusion criteria regarding the mental disorder, it is to be expected that some participants will have no psychiatric diagnosis.

What may be surprising, however, is the relatively high percentage of personality disorders of 45%. It is very possible that this is connected with the way the diagnoses were made: The diagnoses reported in the PAP-S were made based on a SKID interview and not by a clinician who bases therapeutic steps on the diagnosis. Diagnoses based on structured interviews have sometimes been called epidemiological and diagnoses made by clinicians called clinical (e.g., Ajdacic-Gross & Graf, 2003). It is possible that clinicians would not have made the same high number of diagnoses of personality disorders. Nevertheless, it makes sense to have the diagnoses made by external assessors, so that the study can work with comparable values (see also, for example, Leichsenring, 2004). At first glance, it is also surprising that 20% of the patients had no scores at the dysfunctional level on any of the four outcome measures, which means that their symptoms are not clinically significant. That this percentage is not lower

may be connected with the fact that the patients did not fill out the questionnaires before the intake conversation but only after several therapy sessions. It is to be expected that symptom load had already decreased or was found to be less distressing. This is also supported by the fact that of all of the outcome instruments, the GAF, which was rated by external assessors and focuses on the general level of functioning, showed the highest percentage of scores at the dysfunctional level.

The OPD-2 Axis IV ‘structural level’ shows some scores indicating “not impaired” (36.8%), relatively many that indicated a moderate level of structural integration (56.7%), and a few (6.5%) that indicated a low level of structural integration; the low level means that regulating mental functions are not fully available to these patients. The concept of structure, in addition to symptom load and distress, is an important psychodynamic variable. It was included in the study as an outcome instrument as a way to capture possible structural changes – that is, the increasing integration of those areas that are of central importance in a patient’s psychodynamics (Rudolf, 2002).

A limitation of this study is missing data. With a naturalistic study that works with real psychotherapists and real patients, special effort has to be taken to obtain the most complete data as possible. This holds also for the PAP-S: For the psychotherapists and patients, all the paperwork demanded additional effort. And the patients had to travel to the regional assessment centers to take part in an assessment that lasted two or more hours. Some of the patients asked that the assessment be stopped early, because it was too strenuous to continue. This makes it all the more impressive that most of the patients completed the entire assessment. Despite these limitations, a comprehensive and interesting set of data was successfully generated. Outcome results will be published in future papers, and the many possible process-outcome issues will be answered as fully as possible.

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