

RESEARCH

Fundamental Reflections on Psychotherapy Research and Initial Results of the Naturalistic Psychotherapy Study on Outpatient Treatment in Switzerland (PAP-S)

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Abstract

The paper deals with the current controversy regarding the subject of appropriate and necessary research strategies in psychotherapy, and it takes a clear stand in favour of a naturalistic, process-outcome-oriented research approach (practice-based evidence). Based on the design and the initial results of the PAP-S study, conducted by the Swiss Charter for Psychotherapy, it will be pointed out how useful empirical research can be carried out in psychotherapy.

Key words: Psychotherapy research, research strategies, naturalistic psychotherapy study, process-outcome research, outpatient treatment

Zusammenfassung

Die Arbeit setzt sich mit der derzeitig kontrovers geführten Debatte um angemessene und notwendige Forschungsdesigns in der Psychotherapie auseinander und bezieht eindeutige Position für einen naturalistischen, prozess-outcome-orientierten Forschungsansatz (practice-based evidence). Am Beispiel des Designs und erster Ergebnisse der PAP-S-Studie der Schweizer Charta für Psychotherapie wird aufgezeigt, wie sinnvolle empirische Forschung in der Psychotherapie erfolgen kann.

Schlüsselwörter: Psychotherapieforschung, Wirksamkeit von Psychotherapie, naturalistische, Psychotherapiestudie, ambulante Psychotherapie, Prozess-Ergebnis-Forschung

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All over the world today, psychotherapy is exposed to significant challenges, especially regarding the issue of proving its effectiveness in an appropriate way. Since the beginning of the 1990s, the rationalization and standardization of medicine – and psychotherapy is often seen (erroneously) as a branch of medicine – has been greatly influenced by the so-

called Evidence-Based-Medicine (EBM) movement, which aims at exclusively recognizing empirically supported treatments (EST). The aim is beyond dispute: objective, reliable insight into the effects of medical treatment (here psychotherapeutic) is necessary for the well-being of patients; and state-of-the-art treatment of patients requires scientifically reliable knowledge. The era when great theories and concepts of psychotherapy were drafted is probably over; it is now a question of separating the wheat from the chaff (“evidence instead of eminence”) and of testing the ingredients of psychotherapeutic treatment theories in terms of the specific factors leading to positive effects. There can be no longer any excuse that psychotherapy, like medicine, necessitates an objectively scientific foundation.

Historical Background

A brief historical outline reveals the first efforts to rationalize and standardize medicine. These efforts were characterised by developments in the early 20th century, starting with the Flexner Report (Duncan and Miller, 2006), which called for a unified curriculum for medical training in the USA and Canada. The first randomised controlled trials in medicine only took place directly after the Second World War. And the appointment of the Food and Drug Administration (FDA) in the USA was intended to lead to periodic inspection of the safety and effectiveness of medical intervention procedures (Norcross et al., 2006). The implementation of the medical model to classify mental illness was set into motion by the Boulder Conference in 1949 (Duncan & Miller, 2006), which did not meet with unreserved approval by all. And, today, the decisions made there have turned into a far-reaching problem for psychotherapy – something that will be discussed more in detail later.

Soon after the historic Boulder Conference, the powerful National Institute of Health (NIMH) in the USA, adopted the same principle of methodological research as can be found in pharmaceutical research – the randomised controlled trial (RCT). This move implied that studies had to include manual-guided psychological or psychiatric treatment as well as samples of mental syndromes as defined in the DSM. (Duncan & Miller, 2006). The movement toward “manualization” gained new momentum as the American Psychiatric Association (APA) decided to develop treatment guidelines – starting in 1993 with “major depression” and “eating disorders”.

However, the American Psychological Association (APA, Division 12: Society of Clinical Psychology) tried to distance itself from these psychiatric guidelines, which were supposedly dominated by medicine, and claimed the right of patients to empirically validated treatment. Instead of clinical consensus, the task force of Division 12 gathered regulations that defined manual-guided therapy and the RCT paradigm as indispensable. As a result, there was more opposition than ever to the utilization of the medical model in psychotherapy – a reaction that was apparently entirely intentional and calculated. However, the profound consequences of the “Faustian covenant” (Duncan & Miller, 2006, p. 140) that psychotherapy entered into with the medical model were probably not understood – and, unfortunately, they are still not understood today (Tschuschke, 2005), what will be shown also in what follows.

To assess the rushed, one-sided development of a medicalized, technically-oriented concept of psychotherapy, it is immensely important to consider the evolvement of the market-oriented health care system in the USA – so-called managed care. This “wrong path” in medicine (Reed, 2006, p. 42) aims alone at economically motivated ways of thinking and does not keep in mind the well-being of patients, but cost reduction alone, which has led to the perverse perception in the psychotherapy dispute that psychotherapeutic long-term treatment is unethical (Shaw-Austad, 1996). This view leaves no room for chronically

mentally ill patients for whom therapy success would mean – for instance – simply being able to continue living and by no means a *restitutio ad integrum*¹ (which RCT research exclusively pursues). Actually, the lion's share of the mentally ill population must be considered as having chronic conditions (Reed, 2006).

Controversy regarding psychotherapy research

Although all share a common aim – namely to put psychotherapeutic treatment on the basis of evidence-based science – nevertheless, the means of assessing the effectiveness of psychotherapy methods is indeed highly controversial. Two camps – seemingly irreconcilable – face each other. Exponents of laboratory-oriented psychotherapy research (efficacy studies) adhere strictly to the RCT paradigm, and treat this partial aspect of EBM, which has a more sophisticated application in general, as the quite clearly non-negotiable point and so flagrantly ignore other aspects of EBM (compare with Leichsenring, 2004). Indeed, the proponents of efficacy studies have emphasized time and again (for example: The German *Beirat für Psychotherapie*) that they do not adhere to the RCT paradigm alone (Level I of the EBM schema); however, the actual practice of accrediting therapy methods, and the way that renowned journals handle publications, serve to unmask this argument as hollow and reveal the current practice of applying EBM in psychotherapy as a “perversion of the EBM concept” (Kriz, 2009, p. 95)

In contrast, proponents of a naturalistic form of psychotherapy research (effectiveness studies) disapprove of manualization and the RCT paradigm; they opt for “naturalistic” empirical research in an actual therapy setting that would have to include process-outcome research (compare Tschuschke, 2005).

The arguments for and against RCT-guided, manualized psychotherapy research can be summarized as follows.

RCT Paradigm

Advocates of RCT – almost all studies have been conducted using behavioural and cognitive-behavioural therapy forms – postulate the RCT paradigm as being the only scientifically possible method. According to this research principle, the researcher must make sure that only one variable can be manipulated (the so-called independent variable) and all others must be “controlled”, which means that the influence of the control variables has to be kept constant under both test conditions (the intervention or experimental, and the control). In the so-called “experimental” group (in psychotherapy studies, the treatment technique – or concept), the therapy technique (analogous to the *verum* in pharmaceutical research, where it is the active ingredient in new medication) would be applied as the active ingredient, whereas in the so-called “control” group (for instance, the waiting list group) no therapy, or some specific or unspecific therapy, would be implemented. All other conditions would have to remain the same: for example the dose of treatment (number of sessions), the qualifications and experience of the therapist, the random (blind) distribution of study patients into intervention and control groups, and the mental disorder.

A diagnosis of the disorder has to be clearly possible by means of the DSM or ICD glossaries, which in turn means that one single diagnosis (for example, anxiety or panic disorders, or depression) is involved. Typically, the other therapy components in such

1 *Restitutio in integrum*: Latin – restoration to its original condition

RCT studies are completely masked. The studies are conducted on a pre- and post- basis (sometimes adding studies of the follow-up history), and reveal nothing about the therapy process itself.

To ensure that the therapy technique is, in effect, applied according to an underlying therapy concept (-theory), therapists are trained on the basis of a manual. The so-called 'adherence' of the therapist (loyalty to a manual) is sometimes randomly verified in studies. Manuals are considered a helpful means of describing structural and conceptual limits of treatment. They are supposedly by no means restricted to the implementation of technique but provide the therapist with a means of orientation in observing his adherence to a concept (Addis & Cardemil, 2006). According to the paradigm used in pharmaceutical research, the technique alone that the therapist implements (based on the concept that is to be applied) must be responsible for the psychotherapeutic success. It is clear here that advocates of this approach consider the therapeutic concept and its practical application as the only thing relevant.

A significantly better therapy result for the experimental (respectively intervention) group compared with the control group – most often determined on the basis of symptom reduction – would on these terms indicate that the specific therapy form applied has been scientifically proven: it is “evidence-based”.

Criticism of the RCT Standard

Critics of the RCT paradigm – which is called the “gold standard” of psychotherapy research by its apologists – see a veritable array of points of criticism, which is why the RCT approach is a false path for psychotherapy as a scientific discipline.

- 1 **Research Bias:** It has been proven that there is a highly significant positive correlation (>80) between the preferred therapy model of researchers and the therapy model tested as successful in the studies (Luborsky et al., 1999). RCT research is based up to 90% on behavioural, respectively cognitive-behavioural, therapy methods; it takes place almost exclusively in centres and institutes for behavioural research.
- 2 **Patients rejected by EST study researchers:** Up to two-thirds of all patients (who appear in the therapist's office with anxiety disorders and depression, for example) are excluded from RCT studies because of the rigid diagnostic criteria for inclusion. That is, they are not “pure” enough for the studies in diagnostic terms. The higher the number of rejected patients, the more successful the therapies prove to be (Messer, 2004). Thus, EST studies (all characterised by the RCT paradigm) involve extremely selective patient groups. There is no room for co-morbid patients; thus, the “normal” cases of multiple problems from among the patients who appear in therapists' offices are all factored out.
- 3 **EST Studies scarcely have lasting effects:** EST – respectively RCT – studies examine almost exclusively patients with certain anxiety disorders (phobias, generalised anxiety disorder) and patients with depression. The average patient in these studies retains mild, although clinically significant, symptoms following the treatment applied in an EST study (Westen & Morrisson, 2001). Only about 40% of all patients benefit; in fact, only 37% of the depressive patients do. If the drop-outs are included, then the rate of success is reduced to just 27%. Over 50% of the patients seek therapy anew within two years following EST therapy (Messer, 2004).
- 4 **Impact of Comparative Studies:** Many so-called *bona fide* therapy methods (Wampold, 2001) cannot show that they have participated in RCT studies [or do not want to]. Nonetheless, they have an extensive, solid canon of basic hypotheses that have been

in use for a long time, and that possess a long tradition of empirical research, but they reject the RCT paradigm (for example psychodynamic, person-centred, and family therapy). These are not considered for direct comparison with behavioural or cognitive-behavioural therapies, precisely because they are used to treat mixed disorders (for example maladjustment, major depression combined with anxiety disorder). Yet, if the aforementioned therapy forms are compared with behavioural / cognitive-behavioural therapy forms, then analogous effects appear in 41 of the 49 EST studies (Messer, 2004) listed by the task force (Chambless et al., 1996).

- 5 **Randomization:** It is not that simple to randomly allocate patients to various therapy forms, or to non-therapeutic activities (randomization). In any event, it is possibly unethical. A therapist cannot decline to give direct help to a person who is suffering, and no ethics commission today would tolerate that. Moreover, a great many people have predispositions: they often enough prefer – for whatever reason – specific treatment forms. Besides, scientific-methodological guidelines that are now available offer numerous tests and procedures for determining indication for, and prognosis of, treatment. The results of these tests would bar therapists from leading patients to treatments from which they would most likely not benefit (for example: Eckert, 2009)
- 6 **Control Group Studies:** Based on their RCT paradigm, EST studies want to suggest that all other possible variables that have an impact – except for one independent one, namely the applied therapy – are “controlled”, that is, kept equal under both conditions (intervention and control group), so that no variable other than the independent one can be held responsible for the psychotherapeutic transformation of the patient. Other unknown variables that possibly facilitate the patient’s transformation are excluded as “control” variables. The absurdity of this assumption is evident alone for the fact that, out of 168 living hours per week, a person spends only 1 or 2 in therapy. That means the patient is not under supervision for 166 hours of the week, and that, during this time, he or she is exposed to hundreds of situations and stimuli; and that he or she experiences positive or negative events of a more or less dramatic kind – all of which can influence him or her. And each patient in a study has his or her individual life-universe, incomparable with that of any other person. So, one wonders what is actually being “controlled” in such studies, since nothing in the experience of therapy patients in a study can be “controlled”. Laboratory mice or rats in studies can perhaps be controlled in that they are given only certain foods or medicine, and their general living conditions in their cages remain constant between experiments. Human therapy patients would only then be participants in real “control” studies if they were locked up in a low-stimulus cell and allowed to leave for their two therapy sessions.
- 7 **Manual-guided Therapies:** Duncan and Miller (2006) criticise the manual-guided treatment approach as limiting and not allowing an adequate view of the therapy process. Furthermore, they quote numerous studies that have failed to bring forth statistical proof that manual-guided approaches are superior – and all this with a variance clearing of significantly less than 10% (in cases of therapy success) using the applied therapy technique. There is apparently even empirical evidence that manual-guided therapy can be harmful. It is of significance that psychotherapy researchers representative of behavioural therapy disregard the words of one of the grand old men of behavioural therapy, Aaron T. Beck, who said: “Being able to conduct cognitive therapy using a manual is just as unlikely as it is to perform surgery using a manual.” (Beck, 2000). The therapeutic bond, which is far more important, and the individual needs of the particular patient (of far greater importance in psychotherapy) are ignored; instead, a technical operation is conducted.

However, it is precisely this that is not psychotherapy.

- 8 Analysis of variance and EST – respectively RCT – studies:** There is no dissent among psychotherapy researchers on the matter that the actual technique of therapeutic treatment explains outcome variance only minimally. The highest assumed rate of therapeutic variance is 15% (Assay & Lambert, 1999) and the lowest is 1% (Wampold, 2001). This corresponds to the “*dodo bird verdict*” in therapy research (“All have won and all must have prizes”). This equates to there being no difference in effectiveness among therapy methods as long as professionally experienced psychotherapists and “real” patients are considered in studies. Wampold et al. (1997) examined 277 research studies done between 1977 and 1995 and found no therapy method to be superior. The *Human Affairs International Real-World-Study* (Brown et al., 1999) included more than 2000 psychotherapists and 20,000 patients, respectively clients, and found that the therapy outcomes of the 13 different therapy concepts involved (including medication and family-therapeutic approaches) did not vary. The *dodo bird verdict* – known in the German-speaking countries as the ‘equivalency research paradox of psychotherapy forms’, according to which no psychotherapy concept is generally superior to any other treatment concept – is one of the best verified results of psychotherapy research (Lambert & Ogles, 2004). Since a mere 1-15% variance pertains to the therapy method, but 7% to the therapeutic alliance (which is not examined in EST studies), 40% even to the patient variables (therapy viability, treatment motivation, specificity of the disorder, severity of suffering, etc.) and altogether about 87% to the extra-therapeutic variables (including patient variables) (Wampold, 2001), then we are amazed to ascertain that EST – respectively RCT – studies revolve around the variance of 1-15% (therapy technique), yet completely ignore all other aspects.
- 9 Conclusion:** Not only do EST/RCT studies reveal nothing about psychotherapy, they are, on the contrary, risky, because they are completely misleading. It is precisely EST/RCT studies which render a completely distorted image of professional, serious psychotherapy, because they describe psychotherapeutic reality in a very biased manner:
- in most studies, bias on the part of the researcher leads subconsciously or consciously to manipulated results
 - there are no representative patients who seek therapy; on the contrary, those chosen are just not representative (no external validity)
 - the complex disorders of the “typical” patients who show up in psychotherapeutic offices (co-morbidities) are and have been excluded from RCT research (no external validity)
 - control studies (control of influence-variables) are not possible (thus no internal validity)
 - randomization is in effect not possible. If implemented, it is unethical at the least.
 - placebo control is not possible in psychotherapy (double blind studies all the more so)
 - EST/RCT studies are not superior to *bona fide* studies
 - manual-guided psychotherapeutic treatment cannot make sense and be effective because it makes free, spontaneous intervention impossible and because it takes “standardized” patients as its basis and assesses the therapist’s relationship to the manual as more important than the therapist-patient relationship; and because it looks upon psychotherapy as if it were a surgical technique, a pill that could be administered at the prescribed moment
 - EST/RCT studies cover only those techniques which make up the 1-15% variance of therapeutic outcomes; consequently, EST/RCT studies theoretically give evidence in a dwindling domain of therapeutic effects and suppress 85-99% of possible influences

- interim conclusion: thus, RCT (EST) studies have no validity whatsoever

Thus the following must be put on record: RCT/EST studies are *per definitionem* invalid, in psychotherapy, since they cannot yield valid results – due to the deficits described above. If the 1-15% variance in therapy method is the major discovery of empirical, evidence-based psychotherapy research, then we know nothing of the effectiveness of psychotherapy. We especially lack knowledge about the real ingredients of therapeutic treatment, because we do not conduct process research in order to detect the mechanisms of change.

The medical model is just not suitable for psychotherapy research. RCT studies in psychotherapy research lack sufficient complexity (Henningson & Rudolf, 2000). They do not illustrate the process of change and reveal nothing about the effectiveness of psychotherapy, because the *verum* (the elements of change) results, in effect, from manifold variables during therapy, variables that have to be controlled, which means, specifically: extensive process research must be conducted. Psychotherapy should not pander to the other medical disciplines by surrounding itself with aura of science (an inauthentic one, at that). Psychotherapy has a more complex object of study than pharmaceutical research (for instance); psychotherapy research must be commensurate to its complexity. It cannot settle for the inadequate research paradigm used in the medical field.

Naturalistic Therapy Research (effectiveness studies)

Psychotherapy is highly complex. There is probably no other quasi-medical discipline that is as complex as human cognition and emotion modified through interpersonal relationships and therapeutic work. If only for this reason, implementing a reductionist paradigm such as RCT research is out of the question. The one-variable approach in psychotherapy is absurd.

Elaborate process-outcome research seems to be the only feasible path to take. A systematic, continuous analysis of the highly complex therapy situation – involving numerous patient-therapist pairs and diverse disorders; taking co-morbidity into account; and taking place in the natural setting of authentic psychotherapeutic treatment; without any kind of unnatural restrictions, or constraints; where the initiation of the therapy process or how it manifests itself under the supervision of the therapist as he implements his own treatment concept (method-loyal, eclectic, unspecific) is concerned – could yield reliable information, based on cumulative results regarding:

- the patient (education, age, sex, what prior experiences)
- with such and such a disorder, respectively syndrome
- with such and such a therapist (experience, relevant attributes)
- with a therapist working in what manner
- starting at what point in the treatment process
- due to what kind of relationship history
- and due to what kind of intervention
- who has or has not experienced a lasting change in which areas
- in what form (with which effects)
- and what all these factors have to do with therapy success – respectively failure

Of course, systematically recorded accounts of the therapy sessions (audio, respectively video, recordings), and approved process-outcome measurement methods, as well as trained rating specialists, who could carry out outcome-battery procedures and process ratings objectively as well as reliably, are required. There is no indication whatsoever that

psychotherapy research could be less expensive than research in any other area of medicine. On the contrary – the high complexity level has probably been one of the main factors responsible for the small amount of concrete knowledge that exists in psychotherapy (except for the fact that professional psychotherapy benefits patients more than no therapy), which suggests, otherwise, that research, so far, has contributed no additional insight due to its lack of complexity.

The PAP–S Study:

Eleven psychotherapeutic associations – as well as schools – have come together under the umbrella of the ‘Swiss Charter for Psychotherapy’ (www.psychotherapiecharta.ch) to participate in an empirical, naturalistic study of the effectiveness of their treatments. Before the decision to conduct the study was made in 2004, there were years of deliberation as to whether – and in that case – in what form an evaluation should take place. For three years, extensive planning was carried out in search of a design, until the study was launched in March 2007, scientifically headed by the Department for Medical Psychology at the University of Cologne (headed by: Professor Dr. Volker Tschuschke) and the Department for Applied Psychology at the School for Applied Sciences in Zurich (at that time Professor Dr. Hugo Grünwald; since 2009 Dr. Agnes von Wyl). The study is being financed, in part by the participating institutes, and apart from that with some funds contributed by the Canton of Zurich and a private, anonymous donater.

The PAP–S Study (**P**sychotherapiestudie **A**mbulante **P**sychotherapie – **S**chweiz / Psychotherapy Study of Outpatient Psychotherapy – Switzerland) is designed as a process-outcome study. In addition to a comprehensive battery of tests (tests and objective diagnoses and ratings by experts), the therapeutic bond is evaluated every five sessions (by client report, Helping Alliance Questionnaire, as well as the OQ-45) (for details, see Grünwald et al., 2007). In addition, three random samples of the audio recordings occurring regularly (every session) throughout the therapy are drawn in order to verify the content in terms of adherence to a concept. For the very purpose of enabling this, a rating manual was developed in which each school of psychotherapy had to define and operationalise 10 intervention techniques specific to its school.

Chart 1: Status of the enquiry in May 2009

	Number
Participating associations of the Swiss Charter	11
Cooperating therapists	67
Patients in the study	239
Completed therapies/completed data sets	77/30

Chart 1 shows the preliminary interim analysis (status: May 2009). The aim is to have at least 500 patients in the study so that, on the one hand, an analysis specific to each institution can be carried out and, on the other hand, so that a statistically adequate number of patients per so-called ‘mainstream’ (humanistic, psychodynamic, body-oriented therapy forms) can be obtained, making possible a comparison of the effectiveness of the various therapy approaches based on comparable numbers of patients/clients. The following institutions are participating in the study.

Chart 2: Participating institutions and number of patients (status: May 2009)

Institutions/Associations and their participating Patients	N=239	%
Swiss Association for Transactional Analysis (French) ASTA	30	12.6
Research Society for Process-Oriented Psychology FG-POP	35	14.6
Institute for Integrative Body Psychotherapy IBP	81	33.9
International Association for Existential-Analytical Psychotherapy IGEAP	11	4.6
Inst. for Logotherapy and Existential Analysis, Chur ILE	9	3.8
Institute for Expressive Arts Therapy ISIS	11	4.6
Psychoanalysis PA	6	2.5
Swiss Society for Analytical Psychology SGAP	12	5.0
Swiss Society for Bioenergetic Analysis and Therapy SGBAT	12	5.0
Swiss (German) Society for Transactional Analysis SGTA	16	6.7
Swiss Association for Gestalt and Integrative Therapy SVG(G)	16	6.7

Chart 2 shows that some institutions have so far been better able to arrange for therapists and patients to participate in the study than others. Intensive efforts to involve behavioural and person-centred therapists in the study have so far failed.

Chart 3: Gender of patients (May 2009)

	n	%
female	147	61.5
male	80	33.5
missing	12	5.0
Total	239	100.0

The results in our study come close to the usual two-thirds (female) partition that one gets in psychotherapy. The average age of the patients is 40.1 years (SD = 11.7), lying mostly between 19 and 72 years.

Chart 4: Social class (May 2009)

Highest Level of Education	N	Valid %
without degree	1	0.4
elementary school	17	7.1
apprenticeship and vocational school	90	37.7
apprenticeship with vocational “matura”, academic “matura”, teacher’s college with corresponding “matura”	35	14.6
higher vocational school, technical college	43	18.0
University	42	17.6
missing	11	4.6
Total	239	100.0

All in all, the randomly chosen clientele can be described as slightly above average in terms

of education: over 50% have attended a school of higher education.

Chart 5: Diagnosis at beginning of therapy (May 2009)

ICD-10	Primary Diagnosis	N	Total %
F10-F09	Mental and Behavioural Disorders due to psychotropic substances	4	1.7
F30-F39	Affective Disorders	85	35.6
F40-F48	Neurotic, Stress- and Somatic Disorders	91	38.1
F50-F59	Behavioural Problems with Physical Disorders and Factors	6	2.5
F60-F69	Personality and Behavioural Disorders	24	10.0
F70-F79	Intelligence Disorders	2	0.8
Z00-Z99	Factors which Influence Health and Lead to Health Care Utilisation	4	1.7
Sub-total		216	90.4
missing		23	9.6
Total		239	100.0

Chart 5 shows that more than 80% of the patients so far included in the study have manifest depressive or other neurotic disorders (F30-F59), and – relatively less (about 10%) – manifest personality disorders.

Chart 6 illustrates preliminary treatment results for the outcome battery on a pre-post basis.

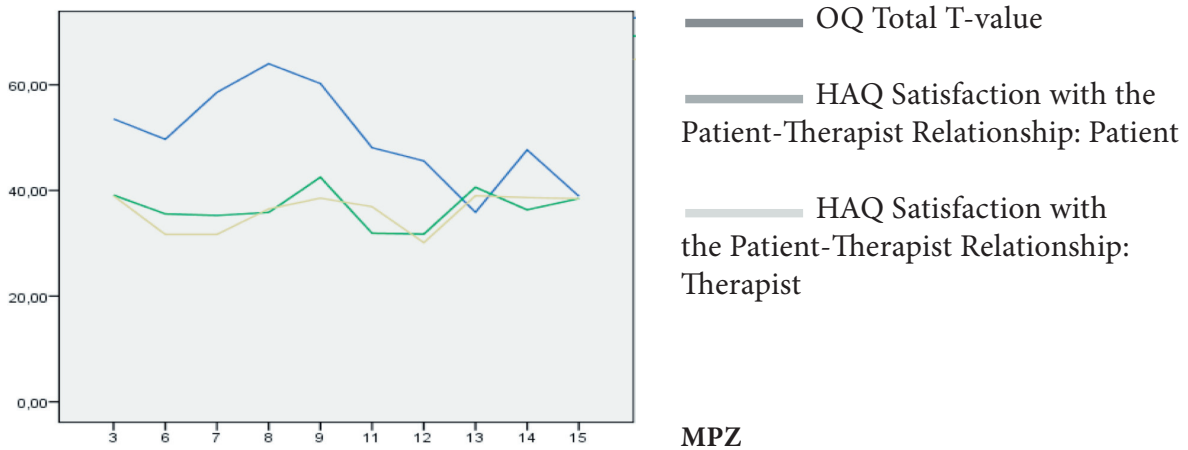
Chart 6: Outcome: Pre – Post (May 2009)

Outcome-Tests	Pre-	SD	Post-	SD	P
BSI (n=29)	0.67	0.40	0.28	0.28	.000
BDI (n=30)	12.59	8.76	5.87	7.00	.000
OQ sym	30.70	11.14	20.74	22.40	.017
OQ ip	14.17	6.13	9.06	7.09	.000
OQ soro	10.96	4.18	8.28	6.00	.015
OQ total (n=33)	55.85	18.35	38.09	31.73	.004
GAF (n=34)	60.73	11.13	76.47	15.02	.000

Where the symptom inventory (BSI) is concerned, the chart shows that the first approximately 30 patients whose treatment had been completed are relatively symptom – free. Yet, a highly significant reduction of all symptoms manifests itself during treatment. The same applies for the depression group (BDI). The *Outcome Questionnaire* (OQ) demonstrates for the most part highly significant improvement where symptoms, social role function and interpersonal dysfunction are concerned. The therapist's assessment (GAF) also shows highly significant improvement of mental function in the case of 34 patients.

OQ-Total value and HAQ-Patient and HAQ-Therapist Relationship Satisfaction

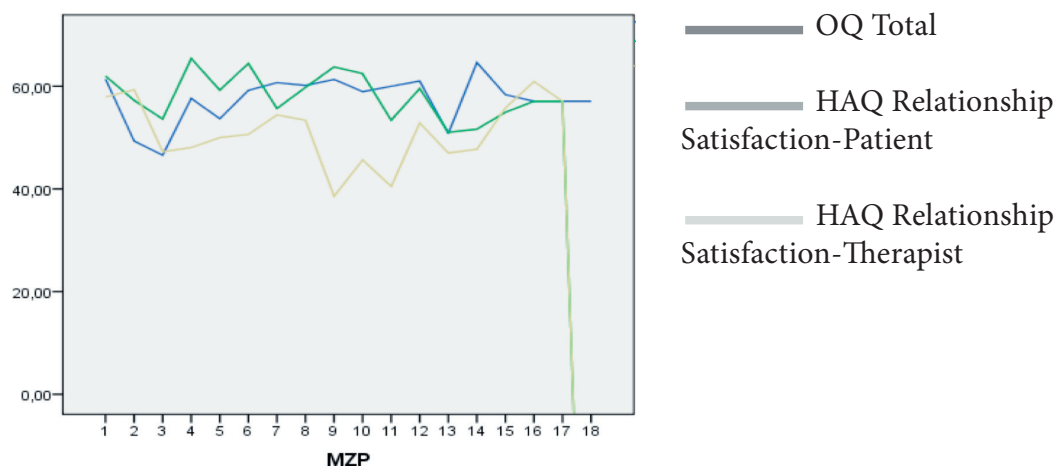
Figure 1: Lessening of discomfort and the therapeutic relationship



Herewith, based on the four above mentioned outcome questionnaires for the various types of treatment, considerable improvement can be demonstrated for 29 of the 34 patients who completed their treatment in its entirety. The sustainability of improvement has to be examined in the follow-up history. Comparative analyses will allow for the evaluation of therapeutic effects related to the various psychotherapeutic concepts. Thus, *time-dose-effect relations*, which also registers noteworthy features of the *therapy process* (therapeutic relationship, lessening of symptoms, etc.), can be observed in order to enable the examination of comparable responsiveness (or lack thereof) of comparable patients to specific therapeutic concepts.

Figure 1 illustrates the relationship between the patient’s and the therapist’s satisfaction (both in connection with the quality of outcome [OQ Test]) based on the example of a therapeutic process. An obvious reduction of symptoms and interpersonal and social improvement throughout therapy are discernible. And that in association with very similar experiences of relationship quality between the patient and therapist! In contrast, figure 2 shows a discrepant experience of the therapeutic relationship between patient and therapist under unimproved therapy quality.

Figure 2: Lessening of discomfort and the therapeutic relationship



These are only two particular cases of the treatments completed so far as scheduled. An essentially more extensive random sample will make it possible to obtain in-depth and differentiated process-outcome correlations involving various therapeutic approaches and comparable patient samples, which will allow for generalizations about comparable effects of outpatient psychotherapeutic treatment in Switzerland.

Thus, our study will make it possible, in view of therapy outcome as well as response time (following how many sessions?) and aspects of therapy process (therapeutic bond, therapist's adherence to a concept), to compare patients with similar – respectively identical – diagnoses in terms of their response to treatment based on differing therapy concepts.

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