# Therapists' Interventions in Different Psychotherapy Approaches: Category and Temporal Aspects

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Abstract

This study describes and compares the in-session interventional behaviour of therapists who were clearly affiliated with five different types of psychotherapy: psychoanalysis, Gestalt, transactional analysis, bioenergetic analysis and systemic therapy. To determine the relative occurrence of elements specific to therapists' own, specific to other or common to all types of psychotherapy under investigation, audio-recorded psychotherapy sessions were analysed. A second aim was to investigate if the duration of interactional units were related to certain types of intervention, hypothesizing that longer durations of intervals between therapeutic interventions might indicate higher complexities of processing in patients.

Time-lined verbatim transcripts of 11 therapists' verbal interventions from 137 (complete) psychotherapy sessions with 41 patients were coded according to a specially developed multi-method rating manual with 100 different intervention categories. Therapists used a fairly wide spectrum of different interventions, i.e., they worked eclectically. On average they used rather few techniques from their own type of psychotherapy (9.9%), about twice as many from other types of psychotherapy (18.9%), and mostly non-specific, common techniques (67.3%). Certain types of interventions were indeed followed by time intervals whose duration significantly exceeded that of others. More than two-thirds of psychotherapists' interventions – under naturalistic conditions – were common techniques. About 30% of the interventions, however, were techniques specific to different types of psychotherapy. Among these, we found some interventions to engage patients in activities of a longer duration, which may indicate higher complexities of processing.

*Keywords:* Psychotherapy process, audio-recorded sessions, verbal therapist behaviour, temporal features, categorical features, common factors, specific factors.

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A multitude of psychotherapeutic approaches have emerged and been propagated since the 1960s (see e.g., Lambert 2013a). Eysenck (1952) raised the fundamental question of the effectiveness of psychotherapy and sparked many psychotherapy outcome studies (for meta-analyses see Grawe, Donati, & Bernauer, 1994; Orlinsky, Rønnestad, & Willutzki, 2004, Smith, Glass, & Miller 1980); all concluded that psychotherapy is highly beneficial. Reviews

of comparative outcome studies have demonstrated that different treatment approaches do not differ in effectiveness (Lambert, 2013b; Lambert, Garfield, & Bergin, 2004; Luborsky, et al., 2002; Wampold, 2001). Some researchers doubted these results (Beutler, 1991, 2002; Strauss, 2001) and suggested that the research strategies and methods for finding differences had been inadequate (Budd & Hughes, 2009). Division 12 of the American Psychological Association created criteria for the empirical validation of treatments (Chambless & Hollon, 1998). But as Lambert (2013a) states, the results of research and practice are always tentative, and "reliance on the prevailing research paradigm (randomized clinical trials) has had the organizational effect of distancing some therapies … from being considered as 'evidence based'" (p. 7). Body psychotherapeutic approaches, we think, are still among them.

If the hypothesis of poor methodology were discarded, the general finding of no or very little difference in the outcome of diverse therapies could be due to common curative factors, such as the therapeutic alliance, exploration, support, empathy, and advice, which are used in several or all types of psychotherapy but not emphasized in their theory of change. This possibility was first hypothesized by Rosenzweig (1936) (for common factors, see also Ablon & Jones, 2002; Castonguay, 1993). *Common factors* refer to elements that are shared across most if not all therapeutic modalities. *Specific factors* are theory-specified techniques that proponents of a particular type of psychotherapy have declared as central to their theory of change. According to Lambert (2013b), there is growing evidence to support the hypothesis that there are some specific technique effects and many common interventions across treatments (see also Orlinsky et al., 2004) and that the vast majority of therapists have become eclectic in their orientation. The actual activities therapists engage in overlap to a large degree across theoretically diverse types of psychotherapy. Having reviewed empirical research, Lambert (1992) summarized that 30% of the outcome variation was due to common and 15% to specific factors (see also Lambert, 2013b, p. 200; and for specific factors, see DeRubeis, Brotman & Gibbons, 2005). Researchers have reported on and discussed the relative contribution of common and specific factors (e.g., Weinberger, 1995), Castonguay, Goldfried, Wiser, Raue, and Hayes (1996), Boswell, Castonguay, and Wasserman (2010), Pfammatter & Tschacher (2010) and Pfammatter, Junghan, and Tschacher (2012)). Ulvenes, Berggraf, Hoffart, Stiles, Svartberg , McCullough, … & Wampold (2012) found that the same type of intervention has different effects when comparing the context of one treatment with the context of another.

There have been several attempts to collect active, curative factors in psychotherapy by looking beyond the boundaries of schools (Crits-Christoph, Connolly, Gibbons, & Mukherjee, 2013; Grawe et al., 1994; Orlinsky et al., 2004;). Orlinsky et al. (2004) proposed a "generic model of psychotherapy". Grawe (1995) advocated a general theory of psychotherapeutic change (*"Allgemeine Psychotherapie"*) on the basis of empirically validated active factors. If it is true that psychotherapy is effective and that diverse approaches are equally effective, we still don't know why. At present, three types of psychotherapy are officially recognized in Germany, 22 in Austria, and 60 in Switzerland. These examples demonstrate that researchers and politicians are far from unanimous with respect to what is worthwhile both in regards to financial reimbursement or inclusion in academic psychotherapy curriculums.

Castonguay, Barkham, Lutz, and McAleavy (2013) underlined the "need to build stronger links between research and practice" (p. 86), because the use of empirical information in the conduct of clinical work is clearly imperfect. In Switzerland, following an initiative

by the Swiss Charta for Psychotherapy – the umbrella organization for institutes offering training in psychotherapy – ten institutes agreed to invite their certified practising therapists to have their therapeutic behaviour and effectiveness examined. With this objective— a naturalistic process-outcome study of treatments in outpatient settings— the Practice Outpatient Psychotherapy Study Switzerland (PAP-S), was carried out. Systemic and cognitive behaviour therapists from several Swiss institutes were invited but declined to get involved. Participating therapists were clearly affiliated with specific types of psychotherapy, but treatments were not manualized. The results of the PAP-S have been and will be published in several reports (Crameri, von Wyl, Koemeda-Lutz, Schulthess, & Tschuschke, 2015; Staczan, Schmuecker, Koehler, Berglar, Crameri, von Wyl, & Tschuschke, 2015; Tschuschke, Crameri, Koehler, Berglar, Muth, Staczan, . . . & Koemeda-Lutz, 2014a; and others). All types of psychotherapy examined in the PAP-S, namely Analytical Psychology (C.G. Jung), Psychoanalysis (S. Freud), Bioenergetic Analysis (A. Lowen), Existential Analysis and Logotherapy (V. Frankl), Gestalt Therapy (F. Perls et al.), Integrative Body Psychotherapy (J.L. Rosenberg et al.), Arts and Expression Oriented Psychotherapy (P.J. Knill, et al.), Process-Oriented Psychotherapy (A. Mindell) and Transactional Analysis (E. Berne), on average resulted in positive treatment outcome as measured by the Brief Symptom Inventory (BSI) (Franke, 2000), the Outcome Questionnaire (OQ-45) (Lambert, Morton, et al. 2004), the Global Assessment Functioning Scale (GAF) (American Psychiatric Association, 1989), and Beck's Depression Inventory (BDI) (Hautzinger, Keller, & Kühne, 2006). Effect sizes were moderate to large, $0.78 \leq d \leq 0.99$, following Cohen (1988). No significant differences between types of psychotherapy were found.

The training curricula of all approaches investigated in our study are based on well-elaborated theoretical concepts (Schlegel, 2002; Schlegel, Meier, & Schulthess, 2011), although some of them are not widely known.

The value of using treatment manuals to train therapists and verify their adherence has been strongly advocated by Perepletchikova, Treat, and Kazdin (2007) and Perepletchikova (2009), advocated and questioned by Orlinsky et al. (2004), and questioned by Miller and Binder (2002) and Castonguay et al. (2013), who coined the term "empirical imperialism". *Adherence* means the degree to which therapists deliver the theory-specified techniques. Our study reported here used a "bottom-up-approach" of practice-oriented research, with mutual collaboration between clinicians and researchers. We wanted to examine the interventional behaviour of therapists who had finished their training in a given modality and who worked as clinicians in outpatient settings with as little interference or directives from the research team as possible.

Before data collection started, we asked proponents from different theoretical orientations to name and define their specific intervention techniques and to name and define what they believed to share with other orientations. We were interested in exploring therapists' naturally occurring adherence to their own types of psychotherapy as compared to the amount of eclecticism. In a recent meta-analytic review of 32 studies, Webb, De Rubeis, and Barber (2010) found no overall significant relationship between adherence and outcome.

Early on, during data collection, we found the intervals between audible interventions to vary considerably within sessions. In some parts of sessions, turn-taking between therapists and patients followed faster rhythms, whereas in other parts, time lags between verbal interventions increased. We therefore included the measurement and analysis of time intervals between the onsets of verbal therapeutic interventions, assuming that their

duration was indicative of the complexity of cognitive, affective and somatic processing that each audible intervention triggered. Our question was: Are there types of intervention that systematically engage patients in more complex processing? And if so, what are they? From studies of memory (Sternberg, 1966, 1975) we know that reaction latencies increase with increasing complexities of the task. According to Elliott, Greenberg, Watson, Timulak, and Freire (2013): "depth of experiential self-exploration is seen as one of the pillars of psychotherapy process and change" (p. 515), and has been consistently related to positive outcome.

**Objectives and explorative questions of the present study**

1) Investigate the natural occurrence of different types of interventions (no prescriptions by treatment manuals or research design)
2) Delineate the amount of specificity (adherence to own concept) by therapists in the five types of psychotherapy under examination (according to a Rating Manual, Tschuschke et al., 2014b, see method, Rating Manual)
3) Explore if what therapists retrospectively considered to have been "significant" sessions differed from randomly selected sessions concerning specificity (adherence)
4) Test if there were differences in adherence between sessions from successful and unsuccessful treatments (based on the differences between pre- and post-OQ-45 scores (Lambert et al., 2004)
5) Investigate if the variability of time lags between audible interventions was related to different intervention categories or if their duration varied independently, i.e., if some types of interventions typically slowed down the pace of verbal therapeutic activity and increased the processing demands on patients, this possibly being a crucial prerequisite for therapeutic change (see Roth, 1994; Stern, 2004).

**Method**

***Context: Practice Outpatient Psychotherapy Study – Switzerland (PAP-S)***

Data were collected from 2007 – 2012 as part of a larger process-outcome study, the Practice Outpatient Psychotherapy Study Switzerland (PAP-S) (Tschuschke et al., 2010, 2013; von Wyl et al., 2013), with the participation of 362 patients, 81 therapists, 10 training institutes / types of psychotherapy. Starting in March 2007 cooperating therapists invited new patients to participate. Patients were informed that they would receive therapy whether or not they participated in the study. All patients participating signed an informed consent form, agreeing to have their sessions audio-recorded. Audio-recordings were the maximum of intrusion therapists would tolerate. Although video-recordings would have allowed to additionally observe aspects of nonverbal behaviour and increase the complexity of our observational data, it would have cost losing a considerable number of participating therapists. Our choice was to include a sufficient number of therapists from different types of psychotherapy sufficient for satisfying statistical needs. Patients were told that they would be free to drop out of the study at any time and/or to have audio-recordings of their sessions deleted if they wished. Prior to data collection, the ethical committees in all Swiss cantons in which therapists participated approved the study design and proceedings. The project was funded by the participating institutes and, to a larger part, by an anonymous donor through the Department of Health of the Canton of Zurich, Switzerland. The training institutes signed a contract agreeing to refrain from influencing the scientific evaluation of the data.

To validate therapists' diagnoses and make them comparable within our total sample, patients agreed to participate in additional diagnostic interviews conducted by specially trained clinicians: these included the following: *The Structured Clinical Interview for DSM-IV* (SCID I and II) (First et al., 2003); *Operationalized Psychodynamic Diagnostics* (OPD; task force, 2001); and the *Global Assessment of Functioning Scale* (GAF; American Psychiatric Association, 1989). Interviews were conducted at assessment centres in nine cities in Switzerland at the beginning, at the end and one year after termination of therapy. At each of these assessments, patients filled in a number of self-report questionnaires on depression (BDI), overall symptoms (BSI, OQ-45), and other variables relevant to outcome (see Crameri et al., 2014; von Wyl et al., 2013).

***Subsample for this partial study: sessions, patients and therapists***

Therapists were asked to routinely audio-record all sessions with patients who participated in the study. The rationale for session selection was to cover types of psychotherapy from different main streams: psychodynamic, humanistic, body oriented, and systemic (see Table 1). After termination of therapy, three sessions out of each treatment were randomly selected by the study group, so that neither patients nor therapists knew in advance which sessions would be selected. Tschuschke et al. (2014a) report on an investigation of exclusively randomly selected sessions from therapists following eight different types of psychotherapy and their relationship to outcome.

From preceding analysis (Tschuschke et al., 2014a) we knew that the number of interventions specific to therapists' own approach was surprisingly low (4,3 % $\leq \bar{X}_{specific} \leq$ 27,6 %). We wanted to check if this was different for sessions that therapists, on the basis of their personal notes, retrospectively, qualified as significant for the course of that specific treatment. So, in addition to the 85 randomly selected sessions, we asked therapists to contribute more recordings. Since this was on an uncontracted optional basis, we received additional sessions which were unequally distributed across the factors *types of psychotherapy and therapist* (see Table 2, bold numbers). Four therapists contributed 52 additional sessions from nine patients, which they retrospectively judged to have been significant for the course of treatment.

In the present study, the therapists were all Caucasian: 54.5 % women, 45.5 % men; their average age was 54.8 years (sd = 5.9). Patients were also Caucasian: 58.5 % women, 41.5 % men; their average age was 37.6 years (sd = 10.1).

Patients' DSM-IV diagnoses assessed by external experts in this sample can be taken as representative of our total sample ($Chi^2_{SKID\ I}(4) = 4.62$; $p = 0.33$; $Chi^2_{SKID\ II}(3) = 1.82$; $p = 0.61$)(see table 2a).

Table 2 a
Patients' DSM-IV diagnoses assessed by external experts

| | this sample (%) | total sample (%) |
|---|---|---|
| axis I | | |
| affective disorders | 38.6 | 38.8 |
| anxiety disorders | 12.9 | 25.1 |
| adjustment disorders | 19.4 | 16.0 |
| other disorders | 9.7 | 8.8 |
| no axis I disorder | 19.4 | 11.3 |
| axis II | | |
| cluster A | 0.0 | 3.2 |
| cluster B | 13.0 | 14.5 |
| cluster C | 34.8 | 26.4 |
| no axis II disorder | 52.2 | 55.9 |

***Rating manual***

For the categorization of therapists' interventions by external raters, a rating manual was constructed (Tschuschke et al., 2014b). Proponents of 13 different theoretical orientations, (cognitive behaviourists, systemic therapists and Rogerians included), were asked (prior to the beginning of data collection) to each name and define up to 10 categories of interventions they believed were specific to their type of psychotherapy (specific interventions). We asked these same people to name and define additional intervention categories they believed were also important but not specific to their type of psychotherapy (common interventions). For common intervention techniques we also queried the existing literature (Castonguay, 1993; Grawe, 1995; Orlinsky et al., 2004). Each category was operationally defined. Distinctions from similar categories were included as well as a list of prototypes of therapists' interventions representing that category (for an example, see appendix 1). Some types of psychotherapy share specific techniques (specific, but not unique). We therefore ended up with 100 intervention categories; twenty-five were common to all types of psychotherapy participating, and 75 were specific.

***Transcripts***

Eight students collaborated to prepare time-lined verbatim transcripts of therapists' interventions from audio-recordings (total sessions, N = 137). Three additional students, not familiar with any type of psychotherapy, were then trained to code these transcripts following our rating manual. Units of analysis were therapists' verbal interventions and the time intervals between onsets of therapists' interventions. The raters neither knew the type of psychotherapy the therapists were affiliated with nor the attribution of intervention categories to types of psychotherapy. Frequency counts for each intervention category and percentages of the total number of interventions in each session were computed. The

percentages of common interventions, interventions *specific to therapist's type of psychotherapy,* and interventions *specific to other types of psychotherapy* were added to yield sum scores for these three types of categories.

**Interrater reliability**

***Observer agreement***

Eighty out of 137 sessions were coded independently by two different raters. The average interrater-reliability on a single intervention basis was Cohen's Kappa = 0.68. According to Landis & Koch (1977) this can be qualified as "substantial strength of agreement" (p. 165).

***Therapists' global and detailed self-ratings in comparison with external ratings***

After each session, therapists estimated the extent to which they believed the session to have been specific to their type of psychotherapy (global rating on a scale from 1 to 10) and to what extent they thought they had applied interventions from each of the specific and common intervention categories. Therapists' global ratings as to the specificity of their interventions in a single session (adherence to their type of psychotherapy) varied greatly (range: 0 – 100 %; $\overline{X}$ = 67.5 %; SD = 26.8 %). The external raters' judgments also varied considerably (range: 0 – 61.4 %; $\overline{X}$ = 9.9 %; SD = 9.3 %). Overall, therapists believed the adherence to their own type of therapy to have been greater than external raters detected. Nevertheless, there was a correlation of r = 0.31 ($p < 0.1$; medium effect size according to Cohen, 1988) between therapists' and external raters' global ratings concerning the specificity of interventions in each session. Concerning single (specific and common intervention) categories, therapists' self-ratings and external ratings on average correlated 0.22; $p < 0.01$ (small effect size according to Cohen, 1988).

***Category types and interval duration***

Early during data collection we found considerable variation in interval duration between therapists' verbal interventions. We defined four classes of time intervals (int < 10 sec.; 10 sec. ≤ int < 30 sec.; 30 sec. ≤ int < 60 sec.; int ≥ 60 sec.). To uncover whether all types of interventions were equally distributed across these four interval classes, or if certain types of intervention tended to cumulate in interval classes of longer duration, a cross tabulation of time intervals, and the percent frequencies of each type of intervention in these four classes was set up. Positive (more frequent) and negative (less frequent) deviations from the expected values were computed by $\frac{f_{observed} - f_{expected}}{\sqrt{f_{expected}}}$

**Results**

***Natural occurrence of different types of intervention (Question 1)***

External raters identified, on average, 21 different categories of interventions per session (range: 11 – 34; SD = 4.4); only 9.9% of all interventions were specific to therapists' type of psychotherapy (range: 0.4 – 61.4; SD = 9.3), 67.3% were common interventions (range: 18 – 86.9; SD = 13.5), 18.9% were interventions specific to other types of psychotherapy (range: 6.1 – 59.8; SD = 10.6), and 3.9% of therapists' interventions could not be coded using our rating manual.

In all five types of psychotherapy, three categories of interventions played a dominant role (see Table 3; rating manual category numbers in brackets): *support* (46), *clarifying inquiry* (55), *advice/information* (52). These three categories added up to 61.6% of all interventions. All three are common interventions shared by a variety of types of psychotherapy. An additional 5.7% of interventions were other common interventions, such as *exploring and discussing dysfunctional patterns* (21), *promoting insight for change* (30), *inquiry about emotional experiencing* (8), *expressing empathy* (31).

The relationship between therapists' experience, adherence to own type of psychotherapy and outcome is reported on and discussed in Tschuschke et al. (2014a).

***Amount of specificity (adherence) in each of the five types of psychotherapy (Question 2)***

The frequency of interventions that are specific to therapists' type of psychotherapy was significantly higher in psychoanalytic, bioenergetic and systemic sessions as compared to the frequency of application of such specific interventions in sessions of transactional analysis and Gestalt psychotherapy ($t_{PA}(1; 135) = 12.95$; $p < 0.01$; $t_{BA}(1; 135) = 7.63$; $p < 0.01$; $t_{SYST}(1; 135) = 10.24$; $p < 0.01$). Sessions from transactional analysis and Gestalt did not differ from other sessions with respect to specific interventions from their own type of psychotherapy ($t_{TA}(1; 135) = 1.48$; $p = 0.14$; $t_{GESTALT}(1; 135) = 0.29$; $p = 0.77$).

***Adherence differences between "significant" and randomly selected sessions (Question 3)***

Sessions that therapists had qualified as significant for the course of therapy featured interventions specific to the therapist's type of psychotherapy significantly more often than sessions that had been randomly selected ($\bar{\bar{X}}_{sign} = 11.9\%$ (N=88); $\bar{\bar{X}}_{random} = 6.3\%$ (N=49); $F(1;135) = 12.52$; $p < 0.01$), and they included supportive interventions significantly less often ($\bar{\bar{X}}_{sign} = 37.6\ \%$; $\bar{\bar{X}}_{random} = 55.1\%$; $F(1;135) = 45.95$; $p < 0.01$).

***Adherence differences between sessions from successful and unsuccessful treatments (Question 4)***

OQ-45 pre-scores and post-scores were available for 31 patients. According to Lambert, Morton, et al. (2004), OQ-45 score differences between pre and post exceeding 14 are classified as significantly improved and smaller differences as unchanged or deteriorated. Patients who achieve total scores < 64 are classified as remitted.

On average, patients in our subsample improved their OQ-45-scores by 24.2 points; 54.8% were classified as significantly improved and remitted, 64.5% as significantly improved, 80.6% as remitted, and 35.5% did not improve or deteriorated. There was no significant difference between successful and unsuccessful treatments, regarding the relative frequency of specific interventions ($F(1;116) = 0.11$; $p = 0.74$).

***Temporal aspects of therapeutic interventions (Question 5)***

Looking at the average percent frequencies by which different interventions were delivered and the average percentage of time passing after each type of intervention, the correlation for intervention categories across all sessions was $r = 0.88$; $p < 0.01$ (big effect size according to Cohen, 1988). The more frequently a given type of intervention was applied, the higher the percentage of the total time of sessions was spent by therapist and patient with this type of interventions. Nevertheless, the duration of time intervals between interventions varied considerably within sessions.

From a total of 7,356 minutes of audio-recorded material, adding up from 137 sessions of 53.7 minutes duration on average, we measured a total of 32,773 therapeutic interventions. From an interactional point of view, therapists' "interventions" could, of course, at the same time have been "responses" to what a patient had just said. But for simplicity's sake, in this report we call therapists' utterances "interventions" and patients' utterances "responses". Since we only tracked the onset of interventions, for further analyses we considered intervals between onsets of interventions, each one representing one interactional unit between patient and therapist. More than half of these interactional units (53.1%) lasted less than 10 seconds; 37.5% lasted from 10 to 30 seconds; 7.3% lasted from 30 to 60 seconds. Only 2.1% of all intervention-reaction units were equal to or exceeded 60 seconds. The normal interactional pace (> 90%) seems to consist of intervention-response units shorter than 30 seconds. Only 9.4% of all time lags between intervention onsets was equal to or exceeded 30 seconds.

Table 4 shows intervention categories, for which the observed frequency clearly exceeded the expected frequency in the class of longest time intervals (≥ 60 sec; amount of deviance in descending order).

Correspondingly, these types of interventions were underrepresented in the class of shortest duration (< 10 sec.). Most of these categories were specific interventions.

***Excerpts from 3 sessions and rhythmicity of therapeutic activity***

Three sessions from therapists affiliated with three different types of psychotherapy were randomly selected. They included intervals between onsets of verbal therapeutic interventions of long duration (5:02, 4:10, and 7:24 minutes). Transcripts of therapist and patient utterances around these interaction units can be found in Appendices 2 – 4. A commentary was added to each excerpt. In our opinion these texts support the conjecture that certain interventions work like "small surgery"—after the intervention, mental and psychic "tissue" has to reorganize. And this takes time.

To convey an impression of the variability of time lags between interventions (the rhythmicity of therapeutic activity), the figure in Appendix 5 shows intervention onsets as horizontal lines along the time line of whole sessions. These were the same sessions from which excerpts were taken.

**Discussion**

Psychotherapeutic process cannot be accurately assessed through either therapists' or patients' self-reports alone (Perepletchikova et al., 2007); therefore, we additionally used audio-recordings of sessions, developed a multi-method rating manual, and trained external raters to code category and temporal aspects of therapists' verbal in-session behaviour.

It turned out that under naturalistic conditions therapists applied a variety of interventions. Overall, 67 % were common interventions, and 29 % were specific interventions, only about 10 % from therapists' own types of psychotherapy.

Although the participating therapists were clearly affiliated and identified with different types of psychotherapy, eclecticism was present. All patients received support and encouragement, were asked questions and given advice and information. At maximum, specific interventions from a therapist's type of psychotherapy, as detected by external raters, reached 64% in a single session. On average these interventions were applied more rarely. But the ratio of 60:30, common to specific interventions that we found corresponds well with the ratio reported by Lambert (1992), namely, 30:15.

Psychoanalytic, bioenergetic and systemic therapy sessions each differed significantly from the rest with respect to increased applications of interventions specific to the therapist's type of psychotherapy. Transactional and Gestalt sessions were not distinguishable in this respect. To find out if this result was substantial or accidental, it would need to be replicated.

As foreseeable in a naturalistic study, a considerable number of patients and therapists who had agreed to participate, dropped out, and therapists delivered incomplete data. The Vienna Systemic Institute contributed consecutively recorded sessions but, unfortunately, did not complete outcome measures. Some of the selected audio-recordings lacked sufficient acoustic quality for analysis. And not all of our co-workers completed their transcripts and ratings. Ideally we would have wanted an equal number of audio-recordings from the five types of psychotherapy, an equal number of therapists for each approach, an equal number of patients from each therapist, and three sessions from each treatment, one from the beginning, one from the middle and one from the end of each treatment. Our sample though fell short of the intended size and variable distribution (See Table 2).

Sessions that therapists had identified as significant for the course of therapy included significantly more interventions from the therapist's type of psychotherapy than sessions that had been randomly selected. Therapists' accounts of their interventional behaviour was therefore related to what external raters observed. Accordingly, the correlation between the external raters' and therapists' self-ratings was significant, though far from perfect. Therapists' self-ratings of adherence were considerably higher than external raters' judgments. We suspect that (1) therapists' concepts of treatment adherence included common interventions, and that (2) common interventions prepared the ground for attainment of type of psychotherapy-specific goals. External raters could not know what was on therapists' minds; they only rated manifest verbal behaviour.

Although the authors of the rating manual spent much time and effort to operationally define and distinguish the categories from one another, verbal statements tend to be ambiguous (Watzlawik, Beavin, & Jackson, 2011). If a systemic therapist opens a session by asking, "What may I do for you today?", this could be categorized as *clarifying inquiry,* and, at the same time categorized as a *good parent message* (saying: I am here for you. I am listening). When we constructed our multi-method rating manual, we tried to delineate categories that were mutually exclusive. Empirically, i.e. as measured by interrater reliability and deviances from perfect matches (see Tschuschke et al., 2014), some of them, in fact, overlap.

Successful and unsuccessful treatments according to OQ-45-outcome scores did not differ with respect to the overall *specificity* of applied interventions (adherence). This is in line with the results of Huppert et al. (2001) (see also Lambert & Ogles, 2004) and Webb et al.'s (2010) meta-analytic study, which found no significant relationship between adherence and outcome.

The high correlation between percent frequencies and percentage of time used by patients after different types of interventions means that on average, time intervals between interventions tended to last equally long. However, there were a few types of interventions that in some instances engaged patients in more time-consuming processes (e.g. therapist provides an interpretation, stimulates somatic experiencing, instructs a relaxation technique, guides the patient to focus on breathing; list continued in table 5). Intervals up to 30 seconds made up more than 90% of all therapist-patient / intervention-response units, interactions for which we assumed that patients and therapists had routines in the service of building trust, exchange of information, etc. However, when therapists "hit a nerve",

i.e. asked a question for which the patients had no routine, this took time; the patients had to search for an answer or had to create a novel one. Maybe they had to find words for previously unmentalised sensations, emotions, body states, or opened themselves up to previously repressed memories, or mobilised resistance. We offer three randomly selected examples in the Appendices 2 – 4, to support this assumption.

For example, the category *interpretation*, was – more often than expected by chance – followed by patient activity exceeding 60 seconds. Not all interpretations, of course, were to the point; some may have been delivered at a suboptimal moment, or warded off by a defence; so not every interpretation elicited complex processing.

The result that external raters identified fewer supportive and more specific interventions in sessions that therapists had judged as "significant" for the course of therapy may support the assumption that change occurs when normal routine behaviour is challenged (longer durations of silence being one special type of suspending the regular pace of turn-taking in conversations).

Interventions that – more often than expected by chance – were followed by time intervals exceeding 60 seconds were very often specific interventions. These interventions, we think, are worth pursuing in future research.

**Conclusion**

Nearly two-thirds of therapists' verbal behaviour consisted of encouraging the flow of communication, supporting patients in their exploration and self-esteem, asking questions, and every now and then providing information – independent of the type of psychotherapy. Proponents of different psychotherapeutic approaches should be aware and appreciative of the common ground on which psychotherapy operates. In addition, there seemed to exist specific categories of intervention, that under optimum conditions and in certain moments, and after long preparatory sequences, suspend routine responses. We think they make patients either mobilize resistance and fall silent or hold on, think, sense and feel, query different modules of their brains to contribute elements to a new and creative response. This is how we believe change and growth comes about. Some of these specific intervention categories may have been elaborated by main-stream psychotherapy approaches, whereas others originate in types of psychotherapy that have been marginalized in past decades. These specific interventions deserve, as our data recommend, further investigation.

The study results demonstrate that therapists affiliated with approaches that lacked "empirical validation" according to Division 12 of the APA were also effective. The results of the present study advise that if we were striving for a "generic model" of psychotherapy as wide a diversity of different approaches as possible should be considered for integration. This is recommended because the investigation of temporal patterns revealed remarkable rhythmic variability in therapists' activity especially connected to specific interventions from different approaches.

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**Tables**

*Table 1 Types of psychotherapy / institutes (a subsample of the PAP-S study)*

| Type of psychotherapy (institute) | Founder | Anthropological background/concept of human being | Main theoretical orientation/school |
|---|---|---|---|
| **Bioenergetic analysis** (SGBAT/DÖK) | Alexander Lowen (1958) | Patients are seen as psychosomatic entities. Somatic self awareness, emotional experiencing, body movement and interaction aim at dissolving character defenses and changing dysfunctional relational patterns. | Body-oriented psychotherapy |
| **Gestalt therapy** (SVG) | Perls, Hefferline, and Goodman (1951) | Focus is on the experiential present moment and on process (what is happening) over content (what is being talked about). Human beings know themselves against the background of their relationships with others. Enables the patient to become more fully alive and relies on the client's potential for self-healing. | Humanistic psychotherapy |
| **Psychoanalysis** (PSZ/DaS) | Sigmund Freud (1895 – 1945) | The therapeutic setting is seen as a laboratory situation, where transference of unconscious conflicts, mostly remnants from the past, onto the therapist is invited, in order to free conflicts from repression and to make them accessible to change. | Psychodynamic psychotherapy |
| **Systemic therapy** (SIW) | Virginia Satir (1988) | Problems can be solved by changing interactional patterns in the system - family, couple, group. The interpersonal construction of reality is one of the core concepts. | Systemic therapy |
| **Transactional analysis** (SGTA/ASAT) | Eric Berne (1967, 2001) | Stimulates patients' growth in the context of an empathic, facilitative relationship. Four levels of analysis: structural (ego states), transactional (interpersonal relationships), game (patterns of behavior) and script (attitudes, decisions in life) | Humanistic psychotherapy |

For more recent conceptualizations, see:
[1] Koemeda-Lutz (2002), Heinrich-Clauer (2011),
[2] Hartmann-Kottek (2008)
[3] List (2009)
[4] Brandl-Nebehay (1998)
[5] Hennig & Pelz (2007)

**Appendix 1**
Example from rating manual (Tschuschke, Koemeda-Lutz, & Schlegel, 2014b)
Category 8: **Focus on emotional experiencing**

Definition
Therapist's questions aim at exploring patient's quality of experiencing, sensations, feelings. Beliefs, appraisals, explanations or assumptions are not areas of inquiry. Therapist guides patient to focus on her / his present experiencing, sensations, feelings (which the patient supposedly has conscious access to).

Operationalization
Therapist
- asks about present state of being
- asks about present quality of experiencing
- clarifies on an emotional level

Differentiation
↔ (19) shifting focus of attention to present emotion of which the patient supposedly is unconscious
↔ (55) clarifying inquiry: exploration of facts, events, cognitions, not emotions.

Examples
1) How do you experience this? How do you feel about it?
2) You explained to me the way this happened and why Mr. F. did what he did, but I would like to know how you feel about it.

*Table 2*

| type of psychotherapy | Psychoanalyis | | | | Bioenergetic Analysis | | | | | | | Transactional Analysis | | | | | | | | | | | | Gestalt Therapy | | | | | | | Systemic Therapy | | | | | | | | | | total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| therapists | A | | B | | C | | | | D | | E | F | | | | | G | H | I | | | | | J | | | | | | | K | | | | | | | | | | 11 |
| patients | a1 | a2 | b1 | b2 | c1 | c2 | c3 | c4 | d1 | d2 | e1 | f1 | f2 | f3 | f4 | f5 | g1 | h1 | i1 | i2 | i3 | i4 | i5 | i6 | j1 | j2 | j3 | j4 | j5 | j6 | j7 | k1 | k2 | k3 | k4 | k5 | k6 | k7 | k8 | k9 | k10 | 41 |
| no.analyzed sessions | 1 | 1 | **7** | 3 | **10** | **11** | **18** | **13** | 1 | 1 | **2** | 2 | 3 | 3 | 3 | 3 | 3 | 2 | 1 | 1 | 1 | 3 | 2 | 3 | 2 | 2 | 2 | 2 | **4** | **4** | **4** | 1 | 3 | 1 | 1 | 2 | 3 | 1 | 3 | 3 | 1 | 137 |
| no. "sign." sessions | | | 4 | | 7 | 8 | 15 | 10 | | | 2 | | | | | | | | | | | | | | | | | | 2 | 2 | 2 | | | | | | | | | | | 52 |

**Sample** - 4 nested factors: type of psychotherapy, therapist, patient, session - bold numbers include randomly selected and "significant" sessions.

*Table 3*

Average percentage of the 10 most frequent intervention categories for five types of psychotherapy (manual numbers in brackets)

| Gestalt | % | | Bioenergetic analysis | % | | Psychoanalysis | % | | Systemic therapy | % | | Transactional analysis | % | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Support (46) | 39,9 | | support (46) | 39,3 | | support (46) | 25,8 | | support (46) | 49,4 | | support (46) | 58,8 | |
| Inquiry / exploration (55) | 17,8 | | inquiry / exploration (55) | 10,5 | | inquiry / exploration (55) | 16,7 | | inquiry / exploration (55) | 10,8 | | inquiry / exploration (55) | 8,8 | |
| Information / advice (52) | 7,6 | | information / advice (52) | 4,9 | | interpretation (27) | 8,8 | ** | information / advice (52) | 10,7 | | information / advice (52) | 4,1 | |
| Self-disclosure (78) | 4,0 | | somatic experiencing (56) | 3,9 | ** | empathy (31) | 6,6 | | construction of possibilities (38) | 4,6 | ** | insight (30) | 3,5 | |
| Emotional experiencing (8) | 2,3 | | focus on breathing (17) | 3,4 | ** | insight (30) | 6,0 | | humour (12) | 3,6 | | empathy (31) | 2,5 | |
| Dysfunctional patterns (21) | 2,3 | ** | insight (30) | 3,4 | | information / advice (52) | 4,6 | | focus on breathing (17) | 3,0 | * | emotional experiencing (8) | 1,7 | |
| Insight (30) | 2,2 | | empathy (31) | 3,2 | | dysfunctional patterns (21) | 4,5 | | insight (30) | 1,5 | | script (81) | 1,4 | ** |
| Role playing (76) | 2,1 | ** | dysfunctional patterns (21) | 2,7 | | emotional experiencing (8) | 3,5 | | metaphors (65) | 1,4 | ** | unconscious emotion (19) | 1,2 | |
| Interpretation (27) | 1,8 | * | emotional experiencing (8) | 2,3 | | confrontation (60) | 2,5 | ** | construction of reality (39) | 1,3 | ** | therapeutic goals (89) | 1,2 | ** |
| Mirroring (92) | 1,8 | * | interpretation (27) | 2,0 | * | affect regulation (2) | 0,4 | * | therapeutic goals (89) | 1,2 | | ego states (48) | 0,9 | ** |

** specific to the therapists' type of psychotherapy: M = 9.9 % (Gestalt: 7.6 %; BA: 12.4 %; PA: 16.6 %; Syst: 7.8 %; TA: 5.3 %); * specific to other types of psychotherapy, blank: common intervention

*Table 4*

Means, standard deviations and ranges

| | Psychoanalysis | | | Bioenergetic analysis | | | Systemic therapy | | | Gestalt therapy | | | Transactional analysis | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *M* | *SD* | *Range* | *M* | *SD* | *Range* | *M* | *SD* | *Range* | *M* | *SD* | *Range* | *M* | *SD* | *Range* |
| Number of interventions per session | 92,0 | 36,5 | 55,0 - 170,0 | 223,0 | 82,9 | 83,0 - 567,0 | 231,0 | 86,2 | 66,0 - 394,0 | 323,0 | 93,9 | 188,0 - 495,0 | 352,0 | 74,7 | 200,0 - 519,0 |
| % supportive interventions | 25,8 | 16,9 | 8,2 - 61,7 | 39,3 | 16,3 | 1,2 - 77,3 | 49,4 | 8,9 | 34,9 - 69,9 | 39,9 | 12,8 | 18,1 - 63,1 | 49,4 | 8,9 | 34,9 - 69,9 |
| % interventions specific to own approach | 16,6 | 8,5 | 5,7 - 32,0 | 12,4 | 12,0 | 0,4 - 61,4 | 7,9 | 4,2 | 1,0 - 13,7 | 7,6 | 6,7 | 0,6 - 22,5 | 5,3 | 2,5 | 0,8 - 9,0 |
| *OQ-45-Diff*$_{post\text{-}pre}$ | 27,2 | 0,6 | 27,0 - 29,0 | 22,0 | 19,4 | -7,0 - 52,0 | | | | 24,5 | 14,4 | -1,0 - 42,0 | 30,3 | 25,0 | -11,0 - 82,0 |

*Table 5*

Interventions more frequently succeeded by time intervals ≥ 60 seconds than expected by chance
(distances from expected frequency - last column on the right: in descending order)

| Intervention category | Manual no | Specific to | Int < 10 sec | 10 sec ≤ int < 30 sec | 30 sec ≤ int < 60 sec | Int ≥ 60 sec |
|---|---|---|---|---|---|---|
| Interpretation | 27 * | PA | -10.1 | 4.7 | 13.0 | 7.2 |
| Somatic experiencing | 56 * | BA; G; IBP | -6.7 | 4.2 | 4.9 | 6.9 |
| Relaxation technique | 33 * | VT; IBP | -0.1 | -0.9 | -0.9 | 6.2 |
| Focus on breathing | 17 * | BA; IBP | -2.9 | 1.8 | 1.2 | 5.0 |
| Integration of interpretation | 29 * | PA | -2.1 | -0.6 | 4.5 | 4.5 |
| Transference | 90 * | PA; AP; BA | -2.6 | 1.2 | 2.5 | 3.6 |
| Diagram of communication | 59 * | TA | -1.0 | 0.1 | 1.1 | 2.8 |
| Insight | 30 | C; IGEAP | -9.6 | 8.1 | 6.1 | 2.8 |
| Emotional experiencing | 8 | C | -3.1 | 2.6 | 1.2 | 2.2 |
| Body exercise | 58 * | BA | -4.2 | 3.2 | 3.1 | 2.1 |
| Imagination | 50 * | AP | -3.0 | 3.3 | -0.3 | 2.0 |
| Empathy | 31 | C; GT | -2.3 | 1.6 | 1.7 | 1.9 |
| Dysfunctional patterns | 21 | C; G; TA | -6.6 | 4.7 | 6.5 | 1.8 |
| Purposeful frustration | 42 * | G | -0.1 | 0.1 | -0.9 | 1.8 |
| Invitation to identification | 49 * | G | -4.0 | 2.4 | 4.7 | 1.5 |
| Working with metaphors | 65 * | SYS | -5.5 | 3.4 | 6.3 | 1.4 |
| Confronting a defense | 1 * | PA | 0.1 | -0.2 | -0.3 | 1.2 |
| Focus on ego states | 48 * | TA | -1.4 | 1.8 | -1.0 | 1.2 |

**Appendix 2**
Excerpt from transcript

| **Psychoanalytic session** | | | |
|---|---|---|---|
| **Onset** | **Interval duration** | **Intervention category (IC)** | **Text (T = therapist; P = patient)** |
| 00:41:00 | 00:00:57 | 27 | T: Well, you mean … I must repeat this once again… this urge for independence could also have something to do with not having to owe anything to anyone. |
| 00:41:17 | | | P: Mhm. (8 seconds of silence). But I simply believe that not everything is so … well, of course, one could read anything into it now … that I put myself through my studies at the university, that I owe my parents nothing, um, maybe this was somehow the trigger, but not actively, well, I don't know, I was not conscious of it, that when I let someone pay for something for me that I would then feel indebted. I think … maybe it's also … |
| 00:41:57 | 00:01:16 | 27 | T: Okay, … may I just … this would now be, well, you just tended to reject it, so you could take it instead of a hypothesis, that is, it could be that putting yourself through university on your own is concretely related to not wanting to owe your parents anything. |
| 00:42:18 | | | P: Yes, well, I don't say that this can't be true. I simply say it was not an active decision … well, it was not … but yes, it was an active decision. Maybe it was … I come back now and draw a connection to self-confidence. Perhaps my self-confidence is so low that it's like I have to give myself self-confidence, in the sense that … I have always accomplished everything all by myself and have never owed anything to anyone. Even if I am not the best, the smartest, the prettiest person and so on, anyway, everything I am and everything I have, I managed alone … even if I am not aware of it, even if there is no self-assurance (the patient now has a whiny voice)… nevertheless! |
| 00:43:13 | 00:00:09 | 8 | T: Just now something is moving you intensely, strongly … what is it? |
| 00:43:16 | | | P: Yes! Don't know … (sniffs) |
| 00:43:22 | 00:00:21 | 31 | T: This is maybe such a moment, I don't know, when it gets hot in a way |
| 00:43:26 | | | P: (sniffs) These are exactly the questions that put something in motion. I can't say. I don't feel anything. That is, it's not … I simply feel something coming out … but I don't feel any sadness, I don't feel any anger. |

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|---|---|---|---|
| 00:43:43 | 00:00:07 | 8 | T: Yes, sure, but you feel it is intense, or I perceive it as something intense.<br><br>P: ... |
| 00:43:50 | 00:05:02 | 60 | T: And then I embarrass you a bit with my question, because you like to be someone who gives an answer, or, well, because you like to be someone who knows things a bit. And then I confront you, well confront or stress you, well … it happens that by my question you become aware that something happens inside you that you don't understand and don't have a grip on and can't control so easily. |
| 00:44:22 | | | P: Mhm (8 seconds silence) Now that's a funny subject, touches on a completely different small section of my life. Just today, once again … I still have no answer on that NZZ thing. This makes me a bit angry. Because I call them, and have to send a CV within 2 hours, send in my application within 24 hours. Then within 48 hours I write on how motivated I am. Why do they set a Friday deadline, because they say they are interested, because then on Friday she said, well, she had other candidates, whom she wanted to see next Wednesday. It would then be decided by Friday, if there would be a second round with the CEO, and who would be invited to this. So why did everything have to be immediately, if they then took their time for another week. And I see this all as negative, you know, this is probably going to turn out to be nothing. And that really pisses me off. Because it ruins another chance to get away from Zurich. So I don't believe … because I have the feeling with this job … well, there was a job that I really wanted…and because I am disappointed that I didn't get it. And now with this NZZ job it's more that… I think it's too bad, well, it really looked as if I could quit my job before the end of this month to get away from Zurich, and now again it still isn't happening, now again I have to wait another month. It's a little bit like … yeah … for a different reason.<br>But in any case, as I was walking here, I was thinking that everything that has happened in my life … the good things happened unconsciously, the good decisions … that is, I didn't go after them intentionally. There are things that I really worked towards, going to Australia … although … the distinction now gets a bit difficult. Sometimes I feel that Australia was unintentional, and sometimes I feel that Australia was deliberate. So, the decision to go down there with my boy-friend was |

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| | | | somehow conscious and then it didn't work out and pursuing it was conscious, but what was unconscious or accidental, for example … or lucky circumstances, was that I went to visit my colleague in Australia, as you know, and found out that this exchange opportunity even existed. So this was somehow not quite so intentional. It was good luck. And, for instance, in the past, well, in the past I always defined myself … I was born on the 1st Advent Sunday … a huge child of good fortune. And there are many things in life where I used to always say it is just good luck that it is that way, just good luck that it happened, just good luck, good luck, good luck. And as I was walking here, I was thinking that I hadn't seen the NZZ job advertised and I applied for it but rather it just came my way, so to speak. And that's why I thought, and this is now absolutely superstitious, and I am actually not superstitious, but … this with the NZZ will work out for sure, because everything that just fell into my lap in the past, through good fortune, worked out. And whenever I really wanted something badly, it didn't work out. Or only with a lot of effort. And concerning being conscious or unconscious of certain things, I somehow feel that the things I am not conscious of are the things that make me happy. And when I do something intentionally, I must put enormous effort into it to make it work, I need to struggle enormously … and then it also works out eventually. I am cold. Um … well, I am actually having rather confusing thoughts. The moment you said that you noticed that there were unconscious things in my life, the hot stuff, feelings or emotions, come up. And in that moment I wondered whether that's true. Am I afraid of the unconscious, of stuff that I cannot control? And that's why my answer emerged the way it did. No, that's not actually true, because actually I feel that very many things that happened to me without my intention were good things. |

Commentary: First the therapist (minute 41:00) suggests that the patient's urge for independence could be connected to wanting to avoid any kind of obligation to anyone (intervention category IC27). This patient seems to "digest" (8 seconds of silence) what the therapist just said. She then mildly rejects the therapist's proposition ("this is not the whole story; one could interpret anything …"). She then concedes that this motive might have caused her behaviour, but not actively, she hadn't been conscious of it. Then, 57 seconds later, the therapist repeats her interpretation (IC27). Now the patient opens up more to what the therapist is saying and adds another link. It could be connected to her low self-esteem, and that trying to be independent could be compensation. The therapist notices that she is moved to tears and addresses her feeling (IC8). The patient confirms and then doubts it. The therapist empathically remarks

that this is one of those delicate moments. And the patient sniffs and confirms that she is being moved by the questions. But at present she neither feels sadness nor anger.

At minute 43:43 the therapist repeats that there is something strongly affecting the patient (IC8), at least she perceives it as something intense, and she goes on to confront (IC60) the patient with the fact that there exist things within herself that she doesn't understand and can't control, although she is a person who likes to be in control. Again the patient pauses (8 seconds), and then for the next 5 minutes recollects several events and life decisions and finally revisits and differentiates her image of herself as being a lucky person, turning it into: Good things happen to her. But when she has strong needs and wishes or works enormously hard for things, she often fails. She wants to get away from Zurich but doesn't get the job that would enable her to leave. She comes to question one of her core beliefs: If I really want something, I won't get it. And she realizes that unconscious stuff in her life is connected to "hot" emotions. She finally asks herself if she is afraid of her unconscious and concludes that she is not.

Through cognitive analysis, quite autonomously, she comes up with her own conclusion, which in relevant aspects differs from that of her therapist. Premature or mature autonomy? This patient seems to be caught between achieving an insight and defending her habitual ways.

**Appendix 3**

Excerpt from transcript

| **Gestalt session** | | | |
|---|---|---|---|
| **Onset** | **Interval duration** | **Intervention category (IC)** | **Text (T = therapist; P = patient)** |
| 00:14:21 | 00:00:09 | 21 | T: What is the function of you, when you start to want to say something, mentioning that I, of course, would say something different? |
| 00:14:28 | | | P: No, no, it doesn't have to be different. It can also be confirming. |
| 00:14:30 | 00:00:10 | 46 | T: From your point of view, yes. |
| 00:14:32 | | | P: Yeah, yes, no, no … see, you are looking a bit critically at me right now |
| 00:14:40 | 00:00:20 | 20 | T: It is a specific wording you have there… |
| 00:14:45 | | | P: It is not really … Actually, I just said something that is in fact clear, which will be the case anyhow, right? Well, um, what I really don't need to say. |
| 00:15:00 | 00:00:13 | 20 | T: Well, I don't know. I am only asking, how, um, how come you talk like that. What the function of that is … |
| 00:15:11 | | | P: I actually don't know either. I could just as well come straight to the point. |
| 00:15:13 | 00:00:06 | 46 | T: Yes. |

| | | | |
|---|---|---|---|
| 00:15:16 | | | P: It would in fact … |
| 00:15:19 | 00:04:10 | 27 | T: It sounds as if you want to cover your back somehow. Is it something sensitive you are about to say? |
| 00:15:24 | | | P: No! No, no! Actually, I don't, don't know either. It's curious, in fact … not necessary, that I, as an introduction, mention, well, I will now just say it like it is (laughs), or as I see it, or, as it went. Um … Yeah, on the one hand, it's connected with my position that I had there. Well, I was something like … um … the project leader, among other things. In fact, it was a bit of all, project leadership and analysis, programming, that is, a bit of everything, really, but also leading projects. I wanted to develop more in that direction there, um, um … somehow these were also things that I noticed over time that I don't enjoy doing very much, and that I then postponed doing these things a bit, neglected them somewhat, anything that was project management and tracking, such as where do we stand, what actions do we need to take. Yeah, actually I didn't really totally, um, love doing those things, but I never, basically, um, communicated that directly, that is, I actually communicated it more in the sense that my handling of these tasks was a bit shabby and I took care of other things instead. Well, I see actually the mistake that I made, that basically I should have communicated more clearly, about that too, um … I would prefer to take care of technical matters and that stuff. And administrative stuff, I would prefer that, well, that someone else would do it, I mean, that I be provided with a person who takes care of that, so that I can attend more to the technical tasks and things that I prefer to do and where I see myself a bit more, that I can take care of those things, you see?<br>And so, in that sense I didn't really do that and then, all the same did a bit of everything, and so I did some of the things a bit poorly or, well, neglected them a bit, and because of that, of course … well, because of that there was a bit of friction, yes friction, true, I failed to meet some deadlines and so I got blamed for that, basically, um … Somehow I think that I provoked it a bit, basically, so that it ended, that it ended like that. But I basically didn't get sufficiently involved. And later, somewhere in this whole game, um … as I was responsible, I lost a bit by it all, didn't I? |
| 00:19:29 | 00:01:20 | 46 | T: Mhm |
| | | | P: With him it was, well … basically, he is the type of … who actually … you can really be frank with him, discuss things, also argue, and, and … um … yeah, you can really get involved there. And I realize, I somehow |

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|---|---|---|---|
| | | | didn't do enough of that and kind of slid more and more into the role. I actually preferred then … yeah … to not … um … yeah, to have as little to do with him as possible. So that's what I most liked to do. I didn't want an open confrontation. And … yeah … and so somehow … I basically felt like a loser in the whole thing, you know? |

Commentary: In this session the therapist asks his patient (minute 14:21 seconds) what the function of his assumption is that he, the therapist, would "naturally" have a different opinion (IC21: Exploring a dysfunctional pattern). A minute later (15:19), after having pointed out the patient's style of communication (IC20, twice) and supporting the patient in what he said (IC 46, twice), the therapist provides an interpretation: It sounds as if you were safeguarding yourself. Is there something sensitive that you want to communicate?

The patient vigorously denies: No! No, no! In the following 4 minutes and 10 seconds he tries to ward off admitting that he neglected the core tasks in his job and probably therefore got fired. He most likely does not understand why he did that and supposedly has no idea how to change his dysfunctional behaviour. He denies and camouflages this insight towards himself but also the confession to the therapist, by using lots of paraphrases, filler words like "really", "actually", "basically", "well", and "um", hardly ever getting to the point of what he is trying to say. In the periphery of his consciousness he recollects what his goal had been (development) but that he experienced unpleasant feelings while trying to act accordingly. Instead, he sought out vicarious activities, e.g. took care of the technical tasks that interested him more. He would have needed assistance, but he never communicated this to his superiors. Instead he acted out and sought friction by missing meetings and deadlines.

After these 4 minutes and 10 seconds the therapist utters a supportive "Mhm". And the patient goes on for another minute and 20 seconds that indeed his boss would have been open to discussion but that he, the patient, withdrew and avoided confrontation and by consequence became a victim of the whole situation. At this point, he gained insight into his own responsibility for what happened, which is a prerequisite for opening up to possibilities of change.

**Appendix 4**

Excerpt from transcript

| **Bioenergetic session** | | | |
|---|---|---|---|
| **Onset** | **Interval duration** | **Intervention category (IC)** | **Text (T = therapist; P = patient)** |
| 00:40:06 | 00:00:12 | 57 | T: Yeah, and please take a position that feels adequate to you. Okay? (therapist laughs) This was the position to start with that I had recommended, but … |
| 00:40:13 | | | P: True, but like this I feel very exposed. |
| 00:40:18 | 00:07:24 | 46, 56 | T: Yes, mhm, oh, then I shouldn't … then I'll come over to the other side. Better? Okay like this? More or less? More or less, okay. Mhm. |

| | | | |
|---|---|---|---|
| 00:47:42 | | | P: Very effective this (incomprehensible word) … this kind of contact. |
| 00:47:48 | 00:00:12 | 46 | T: Mhm. Hm. |
| 00:47:54 | | | P: As if … uh … this calmness. |
| 00:48:00 | 00:00:28 | 46 | T: Mhm. |
| 00:48:05 | | | P: Really very strong now, this image, that if … uh … my reaction to people who go away, my … well, people mainly, my aloneness, it is this contraction and clenching my teeth, and then I somehow manage, but it is always this … |
| 00:48:28 | 00:00:17 | 31 | T: Losing your ground, no external holding. Is that it? |
| 00:48:30 | | | P: Yes, and then I pretend … I really notice that when sleeping I often … really lie like this or that my arm gets numb when I lie on it, which never happens when G [her husband] is there … |
| 00:48:45 | 00:00:03 | 31 | T: Well, it is as if you have to hold yourself, right? |
| 00:48:46 | | | P: Yes, and that this is very strong … |
| 00:48:48 | 00:00:19 | 92, 46 | T: When you are alone or feel alone. Yes. Mhm. |
| 00:48:55 | | | P: And it is really this image of the … Capricorn … which doesn't, that I don't … well, it is an image … all around … |
| 00:49:07 | | 31 | T: … which provides you with a shelter, gives you grounding. |

Commentary: In this session we don't know what the patient is processing during the 7 minutes and 24 seconds of silence. What can be heard from the audio recording is that the therapist motivates her patient to change positions. At first the patient feels too much exposed; both therapist and patient then rearrange themselves. The patient is invited to observe body sensations, feelings, thoughts or images that come to her mind. She seems to be familiar with this kind of experiencing, because although no explicit instructions are given, she retreats into silent awareness. The patient, who normally speaks quite fast and is very eloquent, seems to have a hard time finding words when she decides to come back to verbal communication. She says that the way she has been touched is very effective. She retrieves the words and memories only very slowly, trying to make sense of her experience. She suspects that her contracted body and clenched teeth may be connected with people abandoning her, and that when sleeping her arm gets numb when her husband is not there. She mentions the Capricorn (an image that had emerged during her preceding session, and which represents protection and security for her). Her utterings are slow and not very cohesive. The therapist encourages, supports her (IC46) and makes empathic remarks (IC31). The patient is gradually giving meaning to what she just experienced.

**Appendix 5**

Figure: Interventional rhythmicity in 3 different sessions – each horizontal line represents the onset of one therapeutic intervention (y-axis: time line in minutes) Transcript excerpts cover the sequences which are marked by brackets (on the y-axis)