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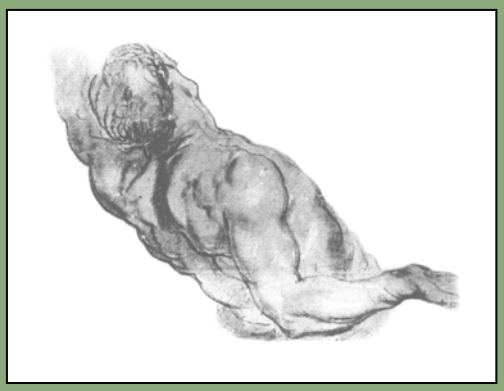

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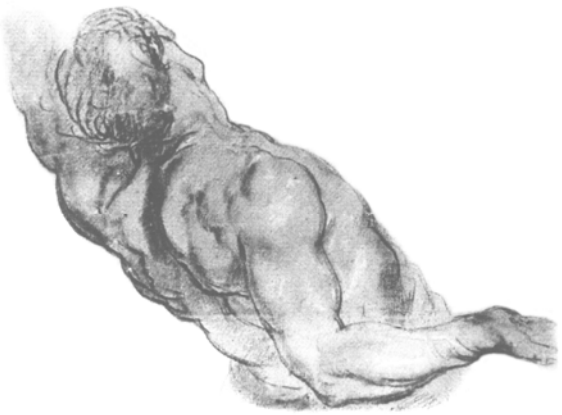

USABP Mission Statement
The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999)

Efficacy of Bioenergetic Therapies and Stability of the Therapeutic Result: A Retrospective Investigation

Christa D. Ventling

Abstract

This article reports on a retrospective investigation of the efficacy of bioenergetic therapy with adults in a private practice setting as well as on the stability of the therapeutic results achieved over time. Sixteen certified bioenergetic therapists of the Swiss Society of Bioenergetic Therapists (SGBAT), provided data on 319 former patients who had terminated their therapies after a minimum of 20 sessions 6 months to 6 years earlier. They were then sent an evaluation questionnaire to be answered anonymously; 290 of them could be reached and 149 (49%) returned it. The questions dealt with the psychic and physical condition, interpersonal and psychosomatic problems and the effect of body work on physical consciousness, cognitive insights and changes in quality of life. Statistical analysis showed significant positive changes in all areas questioned and supports the efficacy of the method. Regarding the stability of the therapeutic result, 107 (75%) patients indicated a stable or even improved condition.

Keywords

Bioenergetics – Consciousness – Efficacy – Efficacy of Bioenergetic therapies – Psychosomatic - Stability

Introduction

The question, "how effective is a certain psychotherapy method ?" is an urgent one. Not only do our patients have a right to know what they are "buying", the politicians dealing with health insurance issues also have a right to know who we are and what we are "selling". The efficacy of psychotherapy is based on the sum of several items, which include, to name but a few, on the therapist's[1] side his formative background, his professional and personal way of bringing into the sessions empathy, knowledge, art and wisdom; and on the patient's side his motivation to want to change things, his ability to make insights and to apply these in everyday life and last but not least as a key issue the relationship between therapist and patient.

As to the question "how does one measure efficacy?" there are basically two approaches possible depending on whether one is interested in the final result of the therapy (outcome quality) or in the quality of the therapy while it is going on (process quality). By means of suitable questionnaires in both cases, one can question the therapist, the patient, or both. There are advantages and disadvantages to each approache and they need careful consideration.

For this study, we were investegating one aspect: the outcome quality of the therapies and the stability of the result obtained. For such an investigation we had to decide, basically, whether we wanted to have our questions answered by former patients or by present patients starting their therapies now. Again, advantages and disadvantages played a role in the decision making, for in any case a large number of patients was required for a good scientific and statistical evaluation. Former patients may be difficult to locate, but the stability of the findings are more reliable. For new patients beginning therapy, the outcome of the therapy is unpredictable, and the question of stability is even more so and may not be answerable for many years. We chose to locate and question former patients.

Let us return for a moment to the above mentioned quality of the therapist. An investigation of the state of well-being of former patients comes originally from many different therapists and raises the question of whether the background and training of these therapists are of matching quality. They must

[1]The terms therapist and patient include both genders.

have similar training to form a consistant basis. Bioenergetic therapists undergo a training prescribed and overseen by international trainers recruited from the staff of the International Institute of Bioenergetic Analysis (IIBA) in New York and trainees graduate with a certification (Certified Bioenergetic Therapist = CBT).

In Switzerland the title "psychotherapist" became legally accepted and protected in 1992, when the CHARTA, an organization composed of a number of psychotherapy schools was created to establish uniform standards for the formation of psychotherapists. As a prerequisite for becoming a psychotherapist in any of the accredited member schools, a University degree in psychology (Masters) or medicine must be obtained followed by a uniform training period of five years with CHARTA-prescribed hours of theory, practice, personal therapy, supervision etc. In this way the CHARTA became the guaranteeing body for quality psychotherapy training. The Swiss Society for Bioenergetic Analysis and Therapy (SGBAT) is a founding member of the CHARTA. SGBAT members have an academic background and a more intensive training than the one offered before through the IIBA.

While the quality of bioenergetic therapists in Switzerland is not questioned anymore, there is, considerable scientific and political pressure to provide evidence of the efficacy of the psychotherapeutic method used. The pressure came from the cognitive-behavioral therapists (Lambert & Bergin 1994; Grawe & Braun 1994, Laireiter 1995), and from Grawe et al. 1994. Grawe (Grawe 1990, Grawe, Caspar und Ambühl 1990a-d) had previously published a very extensive study comparing the efficacies of interactional behavioral therapy (IVT), enlarged-spectrum behavioral therapy (BVT) and client-centered therapy (GT), in individual and group setting. They had gathered an impressive amount of data on the efficacy of each form of therapy relative to the diagnosis of the client. They retested results six months and twelve months after ending the therapy. Their study is probably the first one to take into consideration the stability of the therapeutic result achieved. It has, however, serious drawbacks: clients could neither choose the form of therapy nor the therapist but were randomly assigned, which caused many drop-outs. Statistical comparisons were made with only 15 clients per group, therapy was limited to weekly sessions for less than a year and psychology students in training for cognitive-behavioral psychotherapy were used as therapists albeit under supervision.

Bioenergetic therapists, like the therapists from many other schools, notably the analytical ones, showed their concern and interest in quality evidence first by publishing case reports and vignettes and like most others felt that this was sufficient. In Switzerland, Ehrensperger (1991) demonstrated by presenting individual case vignettes, that Bioenergetic Analysis and Therapy (in the following abbreviated as BAT) is an efficient form of therapy with patients suffering from certain psychosomatic problems (tension headaches, rheumatism, irritable colon). In contrast to Ehrensperger, Amstutz (1992) compared three groups: a BAT group, a group having client centered therapies and a third group learning autosuggestive relaxation techniques (AT). The groups were given a standardized questionnaire before and after therapy (VEV questionnaire by Zielke and Kopf-Mehnert, 1978). Highest and statistically significant positive changes were obtained by the BAT group (49 neurotic patients in therapy for 3-4 years), followed by the GT group (45 patients of undescribed diagnosis in therapy for 9 weeks) and last by the group in AT treatment (32 mostly psychosomatic patients having had 10-35 sessions). Again, this study is deficient in that the groups are not truly comparable. However, it represents a first serious concern about the quality of BAT. One thing became clear in the studies of both Ehrensperger and Amstutz: Bioenergetic therapy is not a short-term therapy.

The first large–scale scientific investigation of the application and efficacy of BAT was carried out by Gudat (1995, 1997) in Germany. His retrospective study was done with 309 patients from private practices. He used the VEV questionnaire as an instrument to measure and statistically evaluate changes between the beginning and the end of therapy, which was approximately 2 years. Data were also correlated with the DMS-III diagnosis. BAT proved to be especially successful for the treatment of neurotic problems, such as anxiety and depression as well as for psychosomatic disorders. A comparison

of the VEV data from BAT with those from cognitive-behavioral therapy (VT), client-centered therapy (GT) or even psychoanalysis showed that BAT was just as efficacious as the other forms of therapy, and this in spite of the fact that differing forms of psychotherapy were applied for very different lengths of therapy. BAT patients were in therapy on the average for 75 hours while those in VT or GT were in treatment for much less time and those in psychoanalysis for much longer.

As to the question, "for how long does the result of the therapy last?" the literature provides practically no answers, yet this question ought to be of utmost concern to therapists. Besides the study of Grawe et al. (1990a-d) mentioned above we found only one article where the question of stability of the therapeutic result achieved was studied: the Jungian Society of Switzerland found that the variable, the ability to work, was stable over a period of six years after the end of therapy (Keller et al. 1997).

In the investigation documented here we provide conclusive evidence that Bioenergetic analysis and therapy is an efficacious form of therapy for patients with mostly neurotic and psychosomatic problems. Furthermore we show that the result achieved is stable for a period of at least 6 months to 6 years after the therapy ended.

Methodology

Data collection

In the spring of 1997 all certified bioenergetic therapists of the Swiss Society of Bioenergetic Therapists who had been working with adult patients in private practices since 1990 or earlier were requested to list all patients they had treated from January1991 until December 1996 and supply age, gender, number of therapy hours, form of payment, diagnosis according to the ICD-10 and main character structure according to Lowen[2] for each patient. This documentation provided us with the total number of patients seen and their socio-demographic data. In August 1997 the same therapists were asked to send a specially designed questionnaire (see at the end of this article) to only those patients who had terminated their therapy after a minimum of 20 hours during the time period of 1991 to 1996.

The Questionnaire

As criteria of the efficacy of a therapy we consider the positive change observed for a number of disturbing or painful parameters in the individual or social surrounding of a patient, as measured between the beginning and the end of the therapy. For criteria of stability we consider the lasting effect of the therapeutic result achieved between the end of the therapy and the present time of questioning. As we wished to measure both criteria at the same time, we needed a suitable questionnaire which would take into account the three time-points needed: 1.before therapy, 2.at the end of therapy, 3.at the time of questioning, which was within the time period of 6 months to 6 years after termination of the therapy. Thus, a comparison of the data from the first two time points gives an indication of the changes achieved during therapy, e.g. the efficacy of the therapy, while a comparison of the data from the last two time points tells us something about the stability of the result achieved.

The most widely used questionnaire within German-speaking Europe, the VEV mentioned above, was not suitable because a) it measures the changes between two time-points only and we did not want to confuse the ex-patients by asking them to fill out the same questionnaire twice, and b) it contains no questions about working with the body which we assumed to be crucial. Thus we resorted to designing our own questionnaire. We took into account the advice of Seligman (1995): to place all questions on a single sheet of paper, to ask for anonymous responses, to add a letter of explanation and a stamped return envelope pre-addressed to a neutral place. According to Seligman, this procedure should assure a reasonable return of at least 25%. We used 5 different colors for the questionnaire in relation to

[2] The data obtained relating to the character structures of Lowen will be published in a separate paper.

the 5 character structures of Lowen (e.g. blue for schizoid, pink for oral etc.). The therapists were to mail them to their former patients in accordance with their dominant character structure.

Statistics.

The relative frequency was calculated for items which could be answered "yes" or "no". For questions to be answered with "poor", "satisfactory", "good" etc. we rated an improvement by one grade with a + and a drop to a lower grade with a -. Thereafter the statistical significance was calculated with the sign test (two-sided questioning, 5% error limitation). For more complex comparisons, the Chi-Square test for dependent samples was used. All statistical programs were available as software "CSS, Statistical for personal computers".

Results

Patient Data

All patient data in this investigation were collected by 16 SGBAT therapists, 7 of them male, 9 female, and 6 of them were psychiatrists (e.g. medical doctors) and 10 were psychologists (e.g. with a Master degree). All of them worked with adults in private practices in the German–speaking section of Switzerland. From January 1991 until December 1996 they treated a total of 1399 patients in single therapy sessions. Of all these patients 319 terminated their therapies after at least 20 sessions. These 319 ex-patients satisfied the requirements for our study; the questionnaire, to be answered anonymously, was received by 290 (90.9%) and returned by 144. Two questionnaires could not be evaluated. The 142 correctly filled out ones correspond to a return of 49%.

Sociodemographic Data

The age distribution of the 319 patients shows 64% between 30 and 50 years, 6% were younger and 16% older. Altogether 14% did not indicate their age. The mean age was 41.6 years, with a minimum of 20 and a maximum of 62.

The distribution of the number of therapy sessions (at one session per week) shows that about half of all the patients required up to 75 sessions, a fourth up to 150 hours and another fourth more than 150 hours. (Mean = 91 hours, Modal= 26-50 hours).

All 319 patients were diagnosed according to the F categories (to the second decimal point) of the ICD-10. However this precision could not be maintained when calculating the frequencies due to very small numbers in some of the categories. Therefore, we resorted to using only F1 - F9. The F4 group (neurotic, stress and somatic symptoms) was the largest represented (58%), followed by the patients of the F6 group (13.5%, personality and behavior disturbances) and those of the F3 group (12.3%, affective disorders). In the F9 group were only 7.5% of the patients (behavioral and emotional disturbances originating during childhood). The remaining 8.6% represented the other F categories. As the questionnaire was answered anonymously an ICD-10 diagnosis was not possible anymore for the 142 returned forms.

The gender distribution of the 290 patients showed 203 women (64%) and 116 men (36%); the same gender distribution of the 142 answering patients was with 77 women (52%) and 55 men (39%) very similar, whereby 10 persons (9%) did not indicate their sex.

Evaluation of the efficacy of Bioenergetic Analysis

A therapeutic goal as motivational aspect

Of the 142 patients asked 122 (86%) said that they had a goal in the beginning of the therapy and 44 (36%) of them indicated they reached it completely. Another 69 (57%) said they reached the goal only partially, and a mere 9 persons (7%) claimed not to have reached it at all.

State of psychological well-being and social competences

Tables 1a and 1b summarize psychological well-being and social competences before and after therapy. Before therapy about half of the patients indicated that their psychological well-being was poor (54%), their self-esteem low (52%) and their self-acceptance poor (49%). A third of all patients judged their assertiveness as poor. At the end of therapy all these variables were improved (highest significance $p<0.001$). Only 2 -5% of all patients declared no improvements.

Table 1a. General feeling and social competence **at the beginning** of BAT (n=142)

Variable	Poor	Satisfactory	Good
	n %	n %	N %
General feeling	77 (54.2)	57 (40.1)	6 (4.2)
Ability to make contact	27 (19.0)	71 (50.0)	41 (28.9)
Ability to work	22 (15.5)	45 (31.7)	72 (50.7)
Self-esteem	74 (52.1)	61 (43.0)	6 (4.2)
Self-acceptance	69 (48.6)	63 (44.4)	8 (5.6)
Assertiveness	49 (34.5)	72 (50.7)	18 (12.7)

Table 1b. General feeling and social competence **at the end** of BAT (n=142). The sign test relates to changes since the beginning of therapy (Table 1a).

Variable	Poor	Satis-factory	Good	Sign-test
	n %	n %	n %	P<
General feeling	3 (2.1)	44 (31.0)	94 (66.2)	0.001
Ability to make contact	3 (2.1)	45 (31.7)	91 (64.1)	0.001
Ability to work	5 (3.5)	27 (19.0)	108 (76.1)	0.001
Self-esteem	5 (3.5)	72 (50.7)	64 (45.1)	0.001
Self-acceptance	6 (4.2)	64 (45.1)	70 (49.3)	0.001
Assertiveness	8 (5.6)	57 (40.1)	73 (51.4)	0.001

Problems of relationships

The most frequent relationship problem encountered among patients was that of partnership. Two thirds of our patients (66%) suffered from these at the beginning of the therapy, another 42.3% indicated problems with parents and another 27.5% had problems with their superiors. After the therapy 41% of the patients indicated an improvement in their partnerships, 21% had better relationships with their parents and even the problems with superiors were improved by 14%. All these changes are statistically highly significant.

Physical sufferings

A relatively high percentage of patients indicated at the beginning of therapy that they suffered physically. Predominant complaints concerned the neck and shoulder area with headaches (40%), followed by sleep disorders (36%). About half of all the patients showed highest significant improvements ($p<0.001$) by the end of therapy with the exception of those complaining of circulatory problems. Of the 20% of all patients requiring a medication at the beginning of the therapy, only 13% did so at the end of the therapy (statistical significance $p<0.04$).

Quality of life

We defined quality of life in accordance with Seligman (1995) as the total of feeling alive, being creative, having friends, living a satisfactory sexual life, loving and respecting oneself by following healthy nutrition and hygiene, being active physically and enjoying hobbies. All these variables (Table 2) improved during the therapy significantly ($p<0.001$). The improvement in the feeling of aliveness was 76%, followed with 44% for creativity and 40% for sexuality. The least change was in personal hygiene (22%).

Table 2. Changes in quality of life **during the therapy** (n=142)

Variable	Unchanged		Better		Worse		Sign-test
	n	%	n	%	n	%	P<
Vitality	34	(23.9)	108	(76.0)	0	0	0.001
Personal Hygiene	111	(78.2)	31	(21.8)	0	0	0.001
Creativity	79	(55.6)	62	(43.6)	1	(0.7)	0.001
Eating Habits	97	(68.3)	44	(30.9)	1	(0.7)	0.001
Sexuality	81	(57.0)	57	(40.1)	4	(2.8)	0.001
Circle of friends	87	(61.3)	44	(30.9)	11	(7.7)	0.001
Physical Activities	86	(60.5)	46	(32.4)	10	(7.0)	0.001
Hobbies	100	(70.4)	40	(28.2)	2	(1.4)	0.001

About the effect of body work

We wanted to know whether our Certified Bioenergetic Therapists actually do body work and if so how the patients reacted to it. 125 (88%) patients acknowledged the body work, but only 70 (56%) of them said that the body work was the reason for gaining new insights; 58 (46%) linked the improved body consciousness to the body work. Only 27 (22%) thought that the positive change in quality of life was due to the body work. However, the experience of body work seemed to be key for the recommendation of the therapist: 124 (87%) of the patents would recommend the therapist, 9 patients had actually indicated that their therapist had not used body work and they therefore would not recommend him/her.

About the stability of the therapeutic result

State of psychological well-being and social competences

Since the termination of the therapy and the time of questioning we see a general and significant ($p<0.001$) further improvement in two thirds of all patients in all areas questioned (see Table 3). Only a mere 3-5% of the patients claimed a worsening of their condition since termination of the therapy.

Table 3. Changes of general feeling and social competence **since** termination of the BAT **until** time of questioning (n=142).

Variable	Unchanged		Better		Worse		Sign-test
	n	%	n	%	n	%	P<
General feeling	28	(19.7)	104	(73.3)	8	(5.6)	0.001
Ability to make contact	45	(31.7)	89	(62.7)	6	(4.2)	0.001
Ability to work	54	(38.1)	77	(54.2)	8	(5.6)	0.001
Self-esteem	35	(24.6)	101	(71.1)	4	(2.8)	0.001
Self-acceptance	37	(26.0)	99	(69.7)	4	(2.8)	0.001
Assertiveness	46	(32.4)	89	(62.7)	5	(3.5)	0.001

Problems of relationship

Since the termination of the therapy and the time of questioning we see also in this area further significant improvements ($p<0.001$)

Physical suffering

Significant improvements ($p<0.001$) were seen also here. Somatic problems which had improved or disappeared during the therapy did not return thereafter or improved even further.

The question of satisfaction with the therapeutic result

Of the 142 patients 107 (75%) said that they were satisfied with the result of the BAT and had no need to enter a second therapy. However, 35 (25%) patients of whom 21 had terminated their BAT between 1990 and 1993 and 14 who had terminated between 1993 and 1996 indicated they have gone into another therapy since. Another bioenergetic therapy was chosen by 6 patients ("with a therapist of the opposite sex from the first therapist "). Of the remaining 29 patients 14 chose another not further specified body psychotherapy, 2 went into psychoanalysis, 8 chose a cognitive therapy and 5 did not indicate the form of therapy they had selected

Discussion

The investigation of the efficacy of BAT with patients from private practices who had actually terminated their psychotherapies at least 6 months, even up to 6 years earlier, shows that it is absolutely possible to collect significant data retrospectively, after the termination of therapies, and that such data not only substantiate the efficacy of the therapy but also testify to the stability of the achieved therapeutic result. In an earlier investigation done by Gudat (1997) immediately at the end of therapy it was already shown that BAT is a highly effective form of psychotherapy. Thus study confirms Gudat's results. With Gudat's and the present study the school of BAT has provided the first two important proofs of efficacy of the method.

Both of these studies are field studies. They were done outside of the usual university setting. At the latter very different strategies and techniques for researching are available, and usually also the financial means which allow extensive studies with appropriate control groups.

All the previously published efficacy studies (cognitive-behavioral interventions, client-centered cognitive therapies and others) were done using a university and not a field setting (Grawe et al. 1990 a-d, Lambert & Bergin 1994). These studies differ from ours as the length of time of therapy was determined from the beginning (usually a set number of sessions, never extending over a year) and that patients were randomly assigned to the experimental and control groups. The rules of a university setting differ from those in private practice settings and it is this discrepancy which often leads to the accusation that private practioners are unscientific in their approaches. This is certainly a first possible criticism of our work. A closer look shows that by "unscientific" most often is meant the lack of controls. To use a waiting group as control, e.g. to let them wait on purpose or in other words, to deny them therapy is considered unethical by private practitioners. A control group consisting of needing yet untreated individuals is therefore unthinkable. One could however, think up a plan whereby a similar group of patients from another therapeutic direction participates in such a study, e.g. would be also sent the questionnaire. This design would suffer from other drawbacks, e.g. that some of the questions would not be relevant for the other group or more seriously to set up a competitive situation.

A second point of criticism could be that for the proper calculation of the degree of effectiveness, a control group is necessary as reference point. However, it can be argued that it is also possible to calculate the effectiveness based on the percentage of the patients who improved corrected by the percentage of the patients who did not, but changed for the worse. On this basis the results we obtained are considered excellent (compared to the aim of an assessment of "good"(see Tables 1a and 1b)): 62% of all patients improved regarding their psychological state, 45% regarding their self-acceptance, 41% regarding their self-esteem and 39% regarding their assertiveness. The improvement was still very good, but somewhat less in the areas of ability to make contact (35%) and ability to maintain a job (25%). However, keep in mind that in these two areas only 19% respectively 15% of the

patients placed "poor" marks before therapy. Thus, while taking into consideration possible distortions of the correct answers due to e.g. the time elapsed since termination of the therapy, overall the improvements are impressively substantiated.

A further issue is the heterogeneity of the patients as seen by the ICD-10 diagnosis and the fact that due to the anonymity of the returned questionnaires no correlation could be calculated between diagnosis and therapeutic effect. This problem did not exist in the study of Gudat (1997) because he questioned the patients himself at the end of the therapy and had a DSM-III diagnosis from their therapists available with which to correlate the data. We assume however, that similar to the equal distribution pattern of the patients' sexes before and after questioning, the distribution of the ICD-10 diagnosis remained equally constant. In any case the patients can essentially be found in only three categories: F4 (58%, neurotic, stress-induced and somatic disorders), F6 (13.5%, personality and behavioral disorders) and F3 (12.3%, affective disorders). All of them show positive improvements after a Bioenergetic Therapy. F40 clients (panic disorders and phobias), a subgroup of F4, are rarely found among our patients. A high percentage of F4 patients seems to be a general phenomenon among the clientele of private practices. Thus, not only Gudat (1997) but also Frossard et al. (1993) noted this, whereby interestingly in the latter the F4 patients were in therapy of psychoanalysts. One can then further conclude that it is not so much the form of psychotherapy being offered which guarantees a good outcome, but more likely the availability of the therapist at the time.

Patients in our study were in therapy on the average for 91 hours, in Gudat's (1997) 75 hours and in Keller et al.'s (1997), who describes efficacy and overlasting effect of Jungian therapies, 193 hours. When a therapy treats not only the symptoms but aims at modifying traits imbedded in the character structure of the personality, a long-term therapy is required. The necessary processing times for analytical work can never be dealt with and integrated in a short-term therapy (Gudat 1997, Keller et al. 1997, Seligman 1995).

A third point of criticism concerns the questionnaire. An officially tested and validated questionnaire measuring 3 time points at one time and including questions about body work does not yet exist. It was therefore necessary to resort to a self-constructed inventory, which had to satisfy the above criteria and yield a high return. Considering the retrospective point of questioning – for many patients up to 6 years after they terminated their therapy – we judge the 49% return as very high indeed. Amstutz (1992) sent her VEV questionnaire out two years after the end of treatment and had a return of 74% with the BAT patients and of 50% with the AT patients. It is well-known that the expected return of a questionnaire decreases proportional to the complexity and differentiation of the questions, especially if these are distributed over several pages. The well-known Bernese comparison-of–therapies-study (Grawe 1990), which was prospective and which by its design should have a very high return expectancy, only yielded answers from 27% of the original 230 patients divided into four groups.

How trustworthy are the anonymous and retrospective answers of our patients?

Would it have been better to design a questionnaire to be answered by a person close to the patient? To find a person close enough to have followed the process and development of the patient during his therapy could be a very difficult and time-consuming endeavor and would decrease most certainly the number of returned questionnaires. In addition the influence of the patient or his well-being on the other person near him cannot be assessed. If the questioning is done while the therapy is going on, let us say before it really begins and at several time points during the therapy, then we have the problem of influencing the therapy, the therapist and the patient. And if we try to find a relative or person close to the patient to assess the patient's well-being, we would be entangled in endless distortions and problems of validity.

The validity of the answers of the patients are indeed worth of a discussion. Questions relating to therapy are so personal that only a subjective questioning can provide reasonably valid answers. If the questioning is done during distinct intervals while the therapy is going on, the answers can first tell us something about the process going on and eventually also about the outcome. But influence on the

therapy could never be disproved.

Every form of data collection has its drawbacks. Retrospec-tive questioning desescribed here, e.g. neither therapist nor patient had any idea that sometime in the future an investigation would take place, has the unique advantage that any influence on the therapeutic process is eliminated.

Retrospective answers, however, place high demands on the memory. We assume that a patient remembers his state of well-being when he first went into therapy, almost as well as he can describe his current state of being. A problem arises only for the "middle section of the memory curve "(Baddeley 1979). Baddeley showed that this part is not remembered as well as either beginning or end. Still we assume that the time point of terminating the therapy was a very memorable one and that a patient is very capable of describing his well-being and how he felt then. Other distortions, like deliberate untruths are of course always possible and beyond any control, yet we believe that a self-judgment, especially when done anonymously, can be trusted.

One could argue of course that only those patients answered the questionnaire that were happy with the result of their therapy. As a counterargument let us consider this: first, some patients noted changes for the worse for some items and surely answered very truthfully and second, not all patients recommended their therapist (13% did not). Therefore, some not-so-happy patients must have also returned the questionnaire. Presumably they are also among those who started a second therapy. And, last but not least, there may be quite a number of former patients who at the time were quite satisfied with their therapy but who show no interest whatsoever today in discussing any aspect of it.

The body work in Bioenergetic Therapy may be a weighty aspect, but it is never considered alone. A major emphasis is placed on integrating the body work (or better the insights made through the physical and also verbal interventions) with the personal history. Therefore, the outcome of a bioenergetic therapy is always the sum of many things. Although we assumed that our patients would be ascribing a high efficacy to body work with regard to gaining new insights, we were disappointed in the answer, as only 56% did so. Even fewer (46%) felt that body work was the cause of their improved quality of life. Clearly the exact variables that are causing the overall very positive changes in BAT cannot be pinpointed at this time. The theory that it is mainly the body work needs further investigation. The Bernese study, (Grawe 1990) with a very similar clientele to ours, also tried to answer the question what exactly led to the positive result, and they did not find an answer either. We assume that the quality of the relationship between patient and therapist plays a major role and plan to study it further.

Setting a therapeutic goal, however, seems to be an important factor affecting the outcome of the therapy. The majority of our patients (86%) had such a goal in the beginning, a third claimed to have reached it and half of them claimed to have reached the goal partially. Even such a partial attainment of the goal is for some patients a major achievement, as it implies an improvement of the psychopathological state. Laireiter (1997) wrote that the mere existence of a goal already has a very positive influence on the outcome of the therapy.

Investigation of the stability of any item always requires a retrospective approach (Hautzinger 1994). In the Bernese study this was done both 6 months and 1 year after termination of the various therapies. They found the achieved results stable after 1 year regardless of the therapeutic form chosen. In our study we could show that all our variables without exception were stable or improved further in 75% of all patients and this over a time period for up to 6 years, far longer than only a few months. Included in the 25% of the patients where this did not apply, are probably also those 5% of the patients who indicated a change for the worse since the termination of the therapy. Still, 3 out of 4 patients needed no further treatment. The results of Jungian long-term psychoanalysis (Keller et al 1997) are very similar: 70% of their patients indicated a further improvement 6 years after having their analyses ended. Here again we see that long-term therapies may provide much more stable results than short-term therapies.

We would like to see the data presented here as a step in the direction of quality control of bioenergetic therapies. Even if we take into consideration that one or the other patient did not remember all that well, and that his answers are not the absolute truth and even though due to the anonymity of the returned questionnaires we had regrettably to omit a more precise analysis of the result in relation to the diagnosis, it can no longer be assumed that BAT is not a serious form of psychotherapy. It takes an equal place among psychoanalysis, Gestalt, and cognitive therapy. The positive results and the long lasting effect speak for themselves. It does not mean, however, that BAT can now take a rest – on the contrary it is hoped that research will be stimulated and that many extended studies, especially those investigating the process, will follow.

The original data were published in an article entitled "Zur Wirksamkeit bioenergetischer Psychotherapien und Stabilität des Therapieresults: eine retrospektive Untersuchung" by Christa D.Ventling and Urs Gerhard in Psychotherapeut 45: 230-236, 2000. Urs Gerhard was responsible for the questionnaire and Barbara Annen for the statistical analysis. I thank both of them for their commitment. The study was financially supported by the Swiss Association of Body-Psychotherapy (CH-EABP).

Appendix 1
Results of Bioenergetic Therapy (BAT)

Sex: female □ male □ Start of BAT: □□ □□
Age (years) now: □□ End of BAT: □□ □□

The following questions refer to the time period immediately **before the therapy**.
Before therapy

My general feeling was :	poor □	satisfactory □	good □
My ability to make contact was:	poor □	satisfactory □	good □
My ability to work was:	poor □	satisfactory □	good □
My self-esteem was:	poor □	satisfactory □	good □
My self-acceptance was:	poor □	satisfactory □	good □
My assertiveness was:	poor □	satisfactory □	good □

I had relationship problems with my	partner	□
	children	□
	parents	□
	colleagues	□
	friends	□
	superiors	□

I suffered physically due to pains/problems of	digestive tract	□
	circulatory system	□
	headaches, neck tension	□
	lower back	□
	sleep disorders	□
	others	□

I needed medication to relieve the pains □

The following questions refer to the time period **at the termination of the therapy**.
At termination of the therapy

My general feeling was:	poor □	satisfactory □	good □
My ability to make contact was:	poor □	satisfactory □	good □

My ability to work: poor □ satisfactory □ good □
My self-esteem was: poor □ satisfactory □ good □
My self-acceptance was: poor □ satisfactory □ good □
My assertiveness was: poor □ satisfactory □ good □

I had relationship problems with my
- partner □
- children □
- parents □
- colleagues □
- friends □
- superiors □

I suffered physically due to pains/problems of
- digestive tract □
- circulatory system □
- headaches, neck tension □
- lower back □
- sleep disorders □
- others □

I needed medication to relieve the pains □

The following questions refer to the time period **between end of therapy and time of questionning**.
(If you experienced neither aggravation nor improvement, you need not mark anything)

Since ending the therapy and today

My general feeling has improved □ changed for the worse □
My ability to make contact has improved □ changed for the worse □
My ability to work has improved □ changed for the worse □
My self-esteem has improved □ changed for the worse □
My self-acceptance has improved □ changed for the worse □
My assertiveness has improved □ changed for the worse □

My relationships problems with
- partner improved □ changed for the worse □
- children improved □ changed for the worse □
- parents improved □ changed for the worse □
- colleagues improved □ changed for the worse □
- friends improved □ changed for the worse □
- superiors improved □ changed for the worse □

My physical pains in the aerea of
- digestive tract improved □ changed for the worse □
- circulation improved □ changed for the worse □
- headaches, neck tension improved □ changed for the worse □
- lower back improved □ changed for the worse
- sleep disorders improved □ changed for the worse□
- others improved □ changed for the worse □

My need to take medication has decreased □ increased □

The following questions refer to changes in the quality of life **during the therapy**.

During the time of therapy

My personal hygiene improved □ changed for the worse □
My creativity has improved □ changed for the worse □
My eating habits improved □ changed for the worse □
My sexuality improved □ changed for the worse □
My vitality has improved □ changed for the worse □
My circle of friends improved □ changed for the worse □
My physical activity increased □ decreased □
My hobbies or time devoted to increased □ decreased □

Did you have a therapeutic goal at the beginning of the therapy ?
yes □ no □
Did you reach this goal ? yes □ in part □ no □
Did your therapist do body work ? yes □ no □
(If your answer is NO, skip the next 4 questions)
Would you have liked more body work? yes □ no □
Did you gain a new body consciousness through body work ?
yes □ in part □ no □
Did you gain new insights through body work ?
yes □ in part □ no □
Are changes in your quality of life mainly due to body work ?
yes □ in part □ no □

Did you enter a new therapy since terminating the BAT ? yes □ no □
If yes, what type of therapy did you chose ? .....
Would you recommend your therapist ? yes □ no □

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