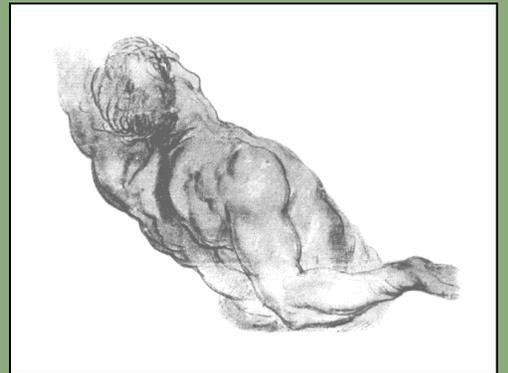


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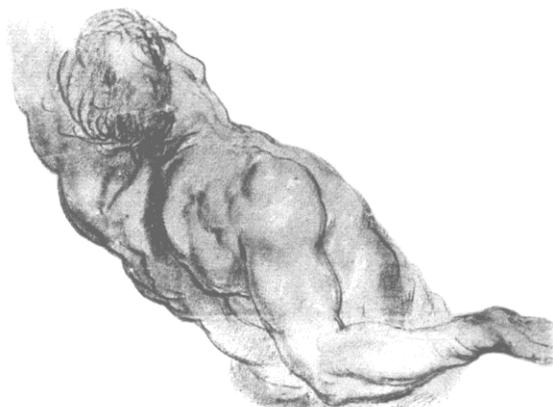


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USABP Mission Statement

The USABP believes that integration of the body and the 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.

Efficacy of Bioenergetic Psychotherapy with Patients of known ICD-10 Diagnosis: A Retrospective Evaluation

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Abstract

In this study, the efficacy of Bioenergetic Analysis and Therapy (BAT) was evaluated retrospectively by means of two questionnaires sent from private practices to former patients with known ICD-10 F group diagnoses. The first questionnaire, the SCL-90-R, was modified to allow assessment of the symptoms at the beginning as well as at the end of therapy. The second questionnaire was self-constructed and contained questions about the quality of the therapeutic work, the body work in general, the relationship with the therapist, and the therapist's techniques. Both questionnaires were answered anonymously. Eight psychotherapists (medical doctors and psychologists) participated, contacting 103 former patients. Forty-eight patients (46.6%) returned the questionnaires. Of these, 10 patients belonged to the F3 group, 26 to the F4 group, and 12 to the F6 group. All data could therefore be interpreted for each of the F groups as well as for all the patients together.

According to the SCL-90-R, BAT reduced symptoms considerably in all three F groups. Analysis of the SCL-90-R individual symptom scales showed high to very high symptom reduction. These were not related to the F group diagnoses. Insight gained as a result of body work produced an even greater symptom reduction independent of the ICD-10 F group diagnosis. Patients receiving BAT rated their therapy favorably and judged their relationship with the therapist as very good. The efficacy of and the satisfaction with the therapy were rated high. The formulation of a therapeutic goal at the beginning of the therapy was most likely not a prerequisite for a positive outcome of the therapy. The present study confirms and complements previous efficacy studies of BAT.

Key words

Bioenergetic Analysis - Psychotherapy Research - Efficacy Study - Private Practice Setting - Retrospective Evaluation.

In Bioenergetic Analysis and Therapy (BAT), we use body work primarily to solve chronic psychological and/or muscular somatic defensive patterns. We aim to modify these patterns in such a way that emotionally effective insights can be verbalized. We also aim to make use of new knowledge arising from infant research or from neurobiology and, whenever possible, incorporate this into our treatment. BAT is used mostly in private practices with ambulant patients.

A number of published case studies of patients suffering from various serious disturbances and receiving BAT treatment show that BAT is an effective method for these particular disturbances, which include severe war traumas, social or emotional stress adjustment problems, chronic severe depressions, somatic disturbances, preverbal or very early childhood traumas, incurable somatic diseases, and eating disorders (Eckberg, 1999; Mahr, 2001; Ventling, 2002; Ventling, 2004, etc.) The studies show that BAT is a suitable treatment modality for a great variety of disturbances. However, they do not enable us to make a general statement about the quality of the therapy, the effectiveness of the treatment, or the stability of the achieved result. Quantitative data are needed to answer these questions.

The very first large-scale investigation into the efficacy of BAT was done by Gudat (1997), who had 309 patients, diagnosed by their respective bioenergetic therapists according to the Diagnostic and Statistical Manual of Mental Disorders (1987) 3rd edition, revised fill out the "Questionnaire on Changes in Experience and Behaviour" (VEV; Zielke & Kopf-Mehnert, 1978) following termination of their therapies. He found altogether high rates of positive changes as a result of the therapies; the results were above average with patients who had neurotic or psychosomatic problems, and somewhat less pronounced with patients who had personality, obsessive-compulsive or borderline disorders. There were no negative effects. Neither the influence nor the mode of working with the body was examined by the questionnaire, due to the fact that the VEV is applicable to psychotherapy in general and not to body psychotherapy. Ventling & Gerhard (2000) filled in the missing link by constructing a special questionnaire that assessed the influence of body work on changes in experience, behavior and insights. They confirmed the data on the positive effects of BAT published by Gudat (1997) with a statistical analysis of the answers from patients who had terminated their therapies as far back as six years prior to the study. While this information allowed for conclusions to be made about the stability of the therapeutic result, because of the anonymity of the returned questionnaires, the data could not be related to the ICD-10 diagnosis previously established by the therapists. While the stability of the result was found to be excellent and body work could be shown to be significantly effective, the question of whether the efficacy of the BAT is ICD-10 diagnosis-dependent could not be answered. In the present study, these questions are revisited.

Two aspects of BAT are reinvestigated using new and different questionnaires:

1. The effectiveness of BAT on patients with a known ICD-10 diagnosis will be investigated retrospectively. More specifically, emphasis is placed on the question of whether BAT is equally suitable for all ICD-10 F diagnosis groups. For this purpose, the standardized "Symptom-Checklist" (SCL-90-R) is used.
2. The question of the effectiveness of body work will be asked again. For this purpose, a special questionnaire is constructed.

Two Hypotheses:

1. BAT is an effective method for patients belonging to the three most common ICD-10 diagnosis groups: F3, F4 and F6.
2. Body work is a prerequisite for successful therapy.

Methodology Data Collection

All licensed psychotherapists of the Swiss Society for Bioenergetic Analysis and Therapy (SGBAT) who worked in private practices with adults were contacted and asked to provide information on their last 10 to 15 clients who had terminated their therapies after a minimum of 20 sessions. The following data was requested: gender, age, number of therapy sessions, and ICD-10-F diagnosis. Eight therapists (4 medical doctors and 4 psychologists) sent in the data of a total of 106 former patients. With the exception of three F5 patients – too few for a statistical study and therefore excluded – all clients' data were used. The remaining 103 subjects consisted of 28 F3 patients, 55 F4 patients, and 20 F6 patients. In order to preserve the anonymity of the patients while making use of the data, we printed the questionnaires in three colors, one color per F group, and asked the therapists to mail questionnaires of the appropriate color to the corresponding patient. Questionnaires were returned anonymously. Thus, we were able to evaluate them in relation to the F categories of the patients.

Questionnaires

The SCL-90-R, developed by Derogatis (as cited in Franke, 2002), is a simple questionnaire designed to reflect the psychological symptom pattern of the respondents and is often used in efficacy studies. This self-report checklist covers nine dimensions and measures the subjectively felt impairment by means of 90 items related to these dimensions. Each of the items is rated on a five-point scale of distress ranging from “not at all” to “extremely.” The nine primary symptom dimensions are labeled as: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

The SCL-90-R is suitable for investigating the psychological changes of the past few days, but not for those of a longer time period. Since we needed to examine changes that occurred between the beginning and the end of the therapy, the time window had to be modified accordingly.

The second questionnaire is a reworked and extended version of one used in a previous study (Ventling & Gerhard, 2000). The updated version contains more specific questions pertaining to the effect of body work on mental insights, the relationship between therapist and patient, and the general satisfaction with the therapy. It is called the “Questionnaire about General Therapeutic Satisfaction“ (FATZ) and consists of 13 questions, 4 of which concern the experience of body work, 3 that relate to general satisfaction with the therapy, 3 that enlighten the relationship between therapist and client, 2 that refer to a possible therapeutic goal, and 1 that asks the gender of the client. For 9 of the 13 questions, there exist 4 possible answers according to the Likert scale: “Definitely not,” “Somewhat yes,” “Partially yes,” and “Definitely yes.” The question that asks about a therapeutic goal can be answered with, “Yes,” “Partially yes,” or “No,” and the remaining 2 questions can be answered with a simple “Yes” or “No.”

Statistical Analysis

Statistical analyses were done with the SPSS 10 program for Windows. The T-test for paired and unpaired variables and the One-way ANOVA were used. Results were significant at $p < 0.05$, highly significant at $p < 0.01$, and most significant at $p < 0.001$.

Results Sociodemographic Data

Table 1: Number of questionnaires sent to and returned from each F-diagnosis group.

F Diagnosis	Sent (%)	Returned (%)
F3	28 (27.2%)	10 (20.8%)
F4	55 (53.4%)	26 (54.2%)
F6	20 (19.4%)	12 (25.0%)
Total	103 (100%)	48 (100%)

Of the 103 contacted patients (76 women, 27 men), 48 persons (36 women, 12 men) returned the questionnaires (return rate 46.6%, proportion women to men unchanged 3:1). The average age of the women was 39 years (varying from 19 – 61 years), and the average age of the men was 41 years (varying from 26 – 64 years). The average number of therapeutic sessions was 106 hours (varying from 20 – 334 hours) for women and 148 hours (varying from 22 – 748 hours)

for men.

Short Description of the ICD-10 Diagnosis Groups F3, F4 and F6

F3: This category consists of affective disorders. Typical symptoms are mood or affect changes, usually in the direction of depressiveness, but also towards elevated mania.

F4: This group is characterized by various somatoform disorders, incapability of tolerating pressure, phobic disturbances (F40), general anxiety and forms of anxiety disorders not initiated by defined stimuli (F41), panic disorders (F41.0), obsessive-compulsive disorders (F42), maladaptive disorders (F43), and disorders due to coping problems and long-lasting depressiveness.

F6: This group of personality and behavior disturbances contains those with long-lasting, steady and characteristic behavior patterns that express an individual lifestyle, with a specific reflection about and comprehension of oneself and others. The diagnosis F4 fit more than half of all the patients in the study. This group also contained three times as many women as men.

Improvement of Symptoms

Table 2: Comparison (T-test) of distress symptoms of all patients before and after psychotherapy. Data gathered using the SCL-90-R.

	M pre	M post	M diff	T	df	p<
All patients	1.1601	0.5273	0.6328	8.191	47	0.0001
Women	1.2209	0.5462	0.6747	7.213	35	0.0001
Men	0.9780	0.4707	0.5073	3.937	11	0.002

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 3: Ratings of SCL-90-R symptom items before and after psychotherapy (T-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.5069	0.4837	0.0231	3.193	47	0.003
Obsessive-compulsive	1.1648	0.5822	0.5826	6.852	47	0.0001
Interpersonal Sensitivity	1.5668	0.6921	0.8747	8.187	47	0.0001
Depression	1.6286	0.7718	0.8568	8.825	47	0.0001
Anxiety	1.0287	0.4495	0.5792	6.176	47	0.0001
Hostility	1.1882	0.5035	0.6847	6.527	47	0.0001
Phobic Anxiety	0.6895	0.3304	0.3591	5.089	47	0.0001
Paranoid Ideation	1.2194	0.5493	0.6701	6.085	47	0.0001
Psychoticism	0.8549	0.3563	0.4986	5.936	47	0.0001

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 4: Ratings of SCL-90-R symptoms by the F-diagnosis groups F3, F4 and F6 (T-test).

F-Diagnosis Group	M pre	M post	M diff	T	df	p<
F3	1.0663	0.2967	0.7696	3.339	9	0.009

F4	1.0809	0.5431	0.5378	6.731	25	0.0001
F6	1.4101	0.6853	0.7247	4.157	11	0.002

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (*t*-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 5: Ratings of SCL-90-R symptom items for the F3 diagnosis group (T-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.3308	0.3167	0.0141	1.157	9	0.277
Obsessive-compulsive	0.9600	0.3700	0.5900	2.579	9	0.030
Interpersonal Sensitivity	1.4208	0.3944	1.0264	3.700	9	0.005
Depression	1.4885	0.4622	1.0263	3.860	9	0.004
Anxiety	0.9200	0.2200	0.7000	2.743	9	0.023
Hostility	1.1133	0.3633	0.7500	3.528	9	0.006
Phobic Anxiety	0.6429	0.1000	0.5429	2.478	9	0.035
Paranoid Ideation	1.1500	0.3000	0.8500	2.918	9	0.017
Psychoticism	0.8400	0.1600	0.6800	2.531	9	0.032

M pre = mean before therapy; M post = mean after therapy; M diff = mean of the differences before and after therapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 6: Ratings of SCL-90-R symptom items for the F4 diagnosis group (T-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.5321	0.5157	0.0163	1.545	25	0.135
Obsessive-compulsive	1.1427	0.6363	0.5064	5.080	25	0.0001
Interpersonal Sensitivity	1.4583	0.7174	0.7409	5.917	25	0.0001
Depression	1.5713	0.8241	0.7472	6.562	25	0.0001
Anxiety	0.8252	0.4026	0.4226	4.944	25	0.0001
Hostility	1.0346	0.4949	0.5397	5.058	25	0.0001
Phobic Anxiety	0.5696	0.3297	0.2399	3.370	25	0.002
Paranoid Ideation	1.1359	0.5141	0.6218	4.635	25	0.0001
Psychoticism	0.7551	0.3564	0.3987	4.323	25	0.0001

M pre = mean before therapy; M post = mean after therapy; M diff = mean of the differences before and after therapy; T = distribution of values (*t*-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 7: Ratings of SCL-90-R symptom items for the **F6** diagnosis group (*t*-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.5991	0.5537	0.0454	3.331	11	0.007
Obsessive- compulsive	1.3833	0.6417	0.7417	3.935	11	0.002
Interpersonal Sensitivity	1.9236	0.8854	1.0382	4.321	11	0.001
Depression	1.8697	0.9167	0.9530	4.561	11	0.001
Anxiety	1.5602	0.7426	0.8176	3.371	11	0.006
Hostility	1.5833	0.6389	0.9444	3.137	11	0.009
Phobic Anxiety	0.9881	0.5238	0.4643	3.199	11	0.008
Paranoid Ideation	1.4583	0.8333	0.6250	2.602	11	0.025
Psychoticism	1.0833	0.5194	0.5639	3.592	11	0.004

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

From the beginning to the end of the therapy, all symptoms decreased remarkably (Tab. 2). Among the 36 women in the study, the result was most significant; among the 12 men, it was highly significant. We can see maximum reduction in all categories (Tab. 3), with somatization symptoms reduction slightly less pronounced than the others, except for somatization, which is still highly significant. BAT shows a high to maximum effectiveness, i.e., significance for the diagnosis groups F3, F4 and F6 (Tab. 4). There were no statistically significant differences between the F groups.

Comparing the degree of the various SCL-90-R symptoms within the three F groups allowed for no distinction at the beginning of the therapy ($F = 0.91$, $df = 2$, $p < 0.41$); at the end of therapy, these symptoms were significantly decreased in all three F groups. In the F6 group, there was a significant improvement with regard to somatization. (see Tab. 5, 6 & 7).

Satisfaction with The Therapy

The answers to the questions of the FATZ showed a high to very high satisfaction with the therapy obtained for all F groups. The quality of the therapy was judged as satisfactory throughout: 90% of all patients evaluated it as good or very good, and nearly all of those who did (97.5%) would recommend their therapist to others. More than 85% of the patients stated that they could speak openly about their problems with their therapist, and 92% stated that their therapist understood their problems.

Satisfaction with the experienced body work is also evident. While there was little agreement regarding the question that asked if body work was a prerequisite for the improvement of the quality of life, those who felt they gained new insights by means of body work profited from an increased reduction in burdening symptoms that was twice as high as in those patients who had not had this experience (Tab. 8, $T = -2.470$, $df = 42$, $p < 0.018$).

Of the 48 patients, 32 (66.6%) started therapy with a goal in mind. Of these, 14 (43.75%) claim to have reached it completely, 16 (50%) speak about having partially reached it, and only 2 patients (6.25%) claim to have not attained it at all. However, the 32 patients with a set goal did not profit more from BAT than the remaining 16 patients without a goal ($T = -0.644$, $df = 46$, $p < 0.523$).

Discussion

Retrospective investigations are economical because they use just one time point (the present) to judge events that

took place months or even years before. While this is advantageous, there are two disadvantages that should be noted: First, the remembered facts might be distorted, and second, the selected cases might be one-sided. We simply do not know the accuracy of the memory of a health state or symptoms that existed before the therapy. What we do know from research about memory is that as time passes, certain events fade while others are distorted by other memories or blended with more recent memories of similar events. However, we know of no research that proves that a certain health state is systematically remembered as better or worse than as it would have been judged while experiencing it. We also know that certain negative events from the past can be forgotten or embellished – most likely for psycho hygienic reasons. The retrospective judgment of a past therapeutic experience by a patient could be an exaggeration as a means of justifying the enormous effort he put into it (see theory of dissonance). While patients at the beginning of a therapy sometimes tend to dramatize their symptoms in order to get attention, they may play them down at the end of therapy, in order to terminate faster. This last argument is not an issue in this study because all questions were answered anonymously and patients did not have to answer to their therapists for the therapy.

A condition to participate in this study was a minimum of 20 hours of BAT therapy experience; participants who terminated before 20 hours were excluded. Even though we asked psychotherapists to provide the information of their last 10 to 15 cases, we do not know if our colleagues selected patients. Problematic cases were possibly purposely excluded; while this certainly is a problem, it is not a phenomenon restricted to retrospective studies. In prospective studies, there exist other ways to exclude patients who seem unfit for the study.

In reviewing our return yield of questionnaires, we refer to the large-scale inquiry of Seligman (1995), who stated conditions for best results was an expected 25% returned answers. In our previous study (Ventling & Gerhard, 2000), our return yield was 49%, and in our current study, it was 46.6%, both very satisfactory results. One could, however, argue that only patients who were satisfied with their therapy took the trouble to return our questionnaires, an effect that would have distorted the results. However, as we found out, not everybody was indeed satisfied: while 87.5% of all the patients would recommend their therapist, 12.5% would not. In our previous study (Ventling & Gerhard, 2000), 13% would not recommend their therapist. In addition, the question that asked if body work is a prerequisite for later mental insights was not judged unanimously: only 40% (previously 44%) of all patients answered in the affirmative.

This study confirmed results obtained in previous investigations on the efficacy of BAT (Gudat, 1997; Ventling & Gerhard, 2000). While three times more women than men were patients in a BAT and their average age was around 40 years, these data are not unique for BAT; similar data were found for patients from psychoanalytical (Frossard, Kaiser, Mullejans & Richterish, 1993) and behavioral psychotherapies (Hutzli & Schneeberger, 1995). The average duration of therapy in the present study was 116 hours, which compares favorably with the findings of Gudat (75 hours) or Ventling & Gerhard (91 hours). At the usual frequency of weekly sessions, these figures suggest a total therapy length of about 2 years. BAT is thus a long-term therapeutic modality.

By far, the largest number of patients (> 50%) was given the diagnosis F4, which, in general, is the most common diagnosis among adults in ambulant psychotherapies (Frossard et al., 1993; Gudat, 1997; Ventling & Gerhard, 2000; Schweizer et al., 2002), followed by F3, F6 and F9. Our hypothesis, that BAT is equally effective for all three ICD-10 categories F3, F4 und F6, is confirmed by the reduction of negative symptoms in each category. The effectiveness of BAT is confirmed by the reduction of distressing symptoms in each ICD-10 category as well as the overall reduction of symptoms in all patients. The group of personality disorders (F6) had the highest level of negative symptoms before therapy and the highest rate of symptom reduction after therapy. Since personality disorders have historically been considered therapeutically resistant because they were defined as incorrigible disorders, the results look promising for these types of disorders. In the subcategories “uncertainty” and “depressiveness” of the SCL-90-R, we found highest symptom reductions.

In the previous study, we showed that most of the patients acknowledge their problems and accordingly set goals to overcome them (Ventling & Gerhard, 2000). In the present study, the T-test does not give a significant result ($T=0.644$, $df = 46$, $p<0.5$), proving that a therapeutic goal has no influence on the effectiveness of the BAT. Thus, successful therapy does not necessarily require the complete fulfillment of a goal. (see Lairaiter, 1995).

Table 8: Difference in ratings of SCL-90-R symptoms of patients who gained new insights after body work.

Body Work led to	M diff	n
None or partial new insights	0.3875	12
Often or very often new insights	0.7936	32

No mention		4
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M diff = mean of the difference before and after psychotherapy; n = number of patients; SCL = symptom check list.

Curiously enough, the body work aspect does not provide uniform results. About 80% of all patients are satisfied with the body work they did, with neither the desire to do more nor the wish they had done less. Only a small percentage of these patients (8%) feel that body work was the cause for their new and improved quality of life, while 44% agree that it contributed to it. Body work can lead to mental insights, and those who profited from these insights showed twice as strong a symptom reduction than patients without such insights (see Tab. 8). No relationship was found between a specific F diagnosis and corresponding answers to questions about body work.

Conclusions for Practice

We conclude from this investigation (and from data of previous studies) that the efficacy of BAT most likely depends on the empathic qualities of the therapist and the way he or she integrates body work into the therapeutic process. It is also based on how these techniques are interpreted by the client. Furthermore, it is of prime importance that patients can make new insights independent of the therapeutic goal and the ICD-10 F diagnosis the therapist ascribes to them. The duration of therapy will most likely be long and depend on the weightiness of the diagnosis. Lastly, the extent to which a symptom reduction occurs depends on the quality of the given psychotherapy and not on the F diagnosis of the patient.

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- The investigation described above was part of the requirements for the Masters Degree (lic.phil) of Herbert Bertschi at the University of Basel, Switzerland. The original, more elaborate article was published in German as follows:
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Biographies

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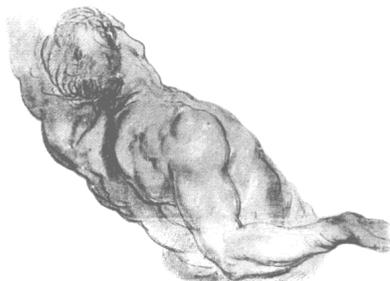
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