Quantitative Evidence for the Effectiveness of Bioenergetic Analysis in Outpatient Settings

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ABSTRACT

This paper presents quantitative evidence on the effectiveness of Bioenergetic Analysis in outpatient psychotherapy.

In the first section, we report pre–post data from 39 patients in outpatient settings whose therapists applied Bioenergetic Analysis. Data were drawn from a larger nonrandomized process–outcome field study (PAP-S; von Wyl *et al.*, 2013; Tschuschke *et al.*, 2013; Crameri *et al.*, 2014, 2016). Treatments in this subsample showed significant improvements on four outcome measures: the Outcome Questionnaire-45 (OQ-45), Brief Symptom Inventory (BSI), Beck Depression Inventory (BDI), and Global Assessment of Functioning (GAF). The average effect size across these measures was 0.83.

In the second section, we report pre–post data (BSI) from 90 patients treated by students of Bioenergetic Analysis under supervision. These treatments yielded an effect size of 1.09, compared to 0.93 in the PAP-S BSI subsample. Both effect sizes are high and comparable to those typically reported for other approaches, such as Cognitive Behavior Therapy (CBT). For example, Cuijpers *et al.* (2023) reported an average effect size of 0.54 for psychological interventions in patients with depressive and/or anxiety disorders. In our study, patients with severe symptom distress at intake showed the greatest improvement.

Although the outcome assessment of patients treated by students under supervision did not meet all requirements of a rigorous study design (e.g., absence of matched controls, reliance on a single self-report measure, lack of independent diagnostic assessments), the findings nonetheless provide supportive evidence for the effectiveness of bioenergetic treatments. By inference, they also suggest the potential effectiveness of continuing education and psychotherapy training programs in Bioenergetic Analysis.

Keywords: Bioenergetic Analysis, effectiveness, outpatient settings, effectiveness of psychotherapy training programs

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Across two outpatient samples, Bioenergetic Analysis produced large effect sizes, providing robust quantitative evidence for its effectiveness as a psychotherapeutic method.

Introduction

In economized health care systems, psychotherapeutic methods should be scientifically grounded and demonstrate effectiveness. Many body-oriented psychotherapies, however, lack sufficient quantitative research. In particular, only a few studies have systematically examined the effectiveness of Bioenergetic Analysis.

Bioenergetic Analysis is rarely taught at universities, with some exceptions such as Osnabrück and Toulouse. In Switzerland and Italy, the modality is recognized as a licensed psychotherapy method (Bundesamt für Gesundheit, Consiglio Nazionale). In Brazil, where regulation is less strict, Bioenergetic Analysis is also integrated into health care practice. Its concepts and techniques have been described in books (e.g., Lowen, 1958; Koemeda-Lutz, 2002; Heinrich-Clauer, 2011; Schroeter, 2018; Schroeter & Thompson, 2018) and journals such as *The Clinical Journal of the IIBA*, and others. Internationally, it is taught by faculty members and local societies of the International Institute for Bioenergetic Analysis (IIBA), and is applied in both clinical and outpatient settings.

Koemeda-Lutz (in Cockburn & Filoni, in press) outlined the development of outcome research in Bioenergetic Analysis since the 1990s. Four main types of outcome studies have been conducted: (a) retrospective (Amstutz, 1992; Gudat, 1995, 1997; Ventling & Gerhard, 2000; Ventling 2002; Ventling *et al.*, 2006), (b) prospective process and outcome studies (Koemeda-Lutz *et al.*, 2006; Tschuschke *et al.*, 2013, 2015; Crameri *et al.*, 2014, 2015, 2016), (c) randomized controlled trials (Nickel *et al.*, 2006), and (d) meta-analyses (Rosendahl *et al.*, 2021; CABSIN, 2023). Among these, the PAP-S naturalistic study (*Praxisstudie Ambulante Psychotherapie Schweiz*), organized by the Swiss Charter for Psychotherapy, was particularly extensive. The present paper draws on PAP-S data for Bioenergetic treatments (part one) and, in part two, reports outcomes from trainees of the Swiss Society for Bioenergetic Analysis and Therapy (SGBAT) during their supervised clinical practice.

Since 1992, German-speaking European countries have sought not only to assume but also to empirically evaluate the effectiveness of Bioenergetic Analysis, in line with international psychotherapy research standards and recommendations (Barkham *et al.*, 2021; Lambert, 2004, 2013).

Self-report questionnaires are widely used, cost-efficient tools for assessing psychotherapy outcomes. As part of the larger PAP-S study (Tschuschke *et al.*, 2013, 2015; von Wyl *et al.*, 2013; Crameri *et al.*, 2014, 2015, 2016), the effectiveness of routine outpatient treatments across different approaches was examined. No significant outcome differences were found between methods. Within this project, the Swiss and Austrian Societies for Bioenergetic Analysis (SGBAT and DÖK) contributed 47 cases.

For the Bioenergetic subgroup, pre–post data were available for 39 patients. Reliable change indices and cut-off points distinguishing functional from dysfunctional populations were calculated using Jacobson and Truax's (1991, also Schmitz *et al.*, 2000) method. Data were collected from March 2007 to December 2012.

Meta-analyses indicate that no single psychotherapeutic approach is inherently superior to others in terms of overall efficacy (Wampold & Imel, 2001, 2015). Each method must therefore provide evidence of its comparative effectiveness. The present paper focuses on Bioenergetic Analysis within the PAP-S dataset (39 patients out of 362 treated across nine different approaches).

Method

Evidence for the Effectiveness of Bioenergetic Analysis in Outpatient Settings (Sample 1)

Aim and design

The PAP-S study (*Praxisstudie Ambulante Psychotherapie Schweiz*) was a nonrandomized field study investigating process–outcome aspects of outpatient treatments across nine experiential or psychodynamic methods (von Wyl *et al.*, 2013). The Swiss Society for Bioenergetic Analysis and Therapy (SGBAT) and the Austrian Society for Bioenergetic Analysis (DÖK) contributed 47 cases, representing 13% of all individual treatments in the total sample (N = 362).

Bioenergetic Analysis treatments were defined as those conducted by certified therapists trained according to the International Institute for Bioenergetic Analysis (IIBA) curriculum. Sessions were

audio-recorded, and rated using the PAP-S intervention manual (Tschuschke *et al.*, 2014), which defined essential interventions for each therapeutic approach as well as common psychotherapeutic techniques. Three randomly selected sessions from each treatment were analyzed by trained raters blind to treatment modality. This yielded a measure of treatment adherence (Perepletchikova *et al.*, 2007; Perepletchikova, 2009).

Therapists

Thirteen Bioenergetic therapists (nine female) contributed 47 treatments, of which 39 included complete data for evaluation. The remaining cases lacked test data due to attrition or incomplete questionnaires. Therapists' average age was 48.5 years (range = 38–57). Clinical experience averaged 13.2 years (range = 2–24).

Seven therapists held university degrees in psychology, three were physicians, one held another university degree, and two held applied sciences degrees.

Patients

Inclusion criteria were: (a) at least one DSM-IV Axis I disorder, diagnosed independently by trained assessors (not otherwise involved in the patients' treatment); (b) age ≥ 18 years; and (c) at least 10 therapy sessions completed.

Patients' mean age was 37.3 years, on average 11 years younger than their therapists. The majority were female (71.8%). Most were single, separated/divorced, or widowed (79.5%), while 17.9% reported being in a stable relationship. Socioeconomic status was comparable to other outpatient populations in Central Europe (Crameri *et al.*, 2016).

Diagnoses were based on *Structured Clinical Interview for DSM-IV Disorders* (SCID-I/II; Wittchen *et al.*, 1997; Saß *et al.*, 2003) and OPD-2 interviews (*Operationalized Psychodynamic Diagnosis*; Arbeitskreis OPD, 2006). According to ICD-10 (Dilling *et al.*, 2000), most patients were treated for affective (F3) or neurotic/adjustment disorders (F4) (71.4%). Nine cases involved personality disorders (21.4%). Initial psychological stress levels were approximately normally distributed (von Wyl *et al.*, 2013).

The study was conducted in accordance with the ethical principles of the *Declaration of Helsinki*. Ethics committees in each participating Swiss canton approved the project, and all patients provided written informed consent.

Measures

- **Basic Documentation**: Clinical and sociodemographic data recorded by treating therapists.
- **SCID-I/II (DSM-IV)**: Independent diagnostic interviews for Axis I and II disorders (Wittchen *et al.*, 1997; Saß *et al.*, 2003).
- **Global Assessment of Functioning (GAF)**: Clinician rating of psychological, social, and occupational functioning from 0 (severe illness) to 100 (mental health; Endicott *et al.*, 1976).
- **Outcome Questionnaire-45 (OQ-45)**: 45 items covering Symptom Distress (SD), Interpersonal Relations (IR), and Social Role (SR). Total score provides global outcome (OQ Total Score). The scale structure of the original version is supported by confirmatory factor analysis (Lambert *et al.*, 2004). The single scales in the German version exhibit good internal consistency (Lambert *et al.*, 2002).
- **Brief Symptom Inventory (BSI)**: The BSI is a 53-item short form of the SCL-90-R (Derogatis, 1983, 1997; Franke, 2000, 2010). It assesses nine symptom dimensions: Somatization (SOM), Obsessive–Compulsiveness (OBS), Interpersonal Sensitivity (INS), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic Anxiety (PHOB), Paranoid Ideation (PAR), and Psychoticism (PSY). In addition, global indices of distress can be calculated, most notably the General Symptom Index (GSI), the mean score of all items. The German version demonstrates satisfactory test–retest reliability (Franke, 1997).
- **Beck Depression Inventory (BDI)**: Assesses depressive symptoms (Hautzinger *et al.*, 1994).
- **Helping Alliance Questionnaire (HAQ-P, HAQ-T)**: Assesses therapeutic relationship and treatment satisfaction (Bassler *et al.*, 1995; de Weert-van Oene *et al.*, 1999; Groß & Riedel, 1995).

Patients completed the BSI and OQ-45 at intake and at treatment end; the OQ-45 was also administered after every fifth session. The BDI was administered pre–post. Therapist- and patient-rated HAQ forms were completed after every fifth session.

■ ■ ■

Evidence for the Effectiveness of Therapies Conducted by Students Under Supervision (Sample 2)

Design

The Swiss Society for Bioenergetic Analysis and Therapy (SGBAT) offers a postgraduate training program in psychotherapy. Students with master's degrees in psychology or medicine train toward licensure. As part of the program's quality assurance system, outcomes of student-led therapies were monitored. Ninety patients completed pre–post outcome measures between 2021 and 2025.

Therapists

Eight female trainees (seven psychologists, one physician) provided data on 90 treatments. Their average age was 46.8 years (range = 32.6–62.4).

Patients

Patients' average age was 40.0 years (range = 18–69), with 58.9% female. Diagnoses (ICD-10; Dilling *et al.*, 2000) included affective disorders (F3; 44.8%), neurotic/adjustment disorders (F4; 44.8%), as well as three personality (F6), three psychosomatic (F5), and one addictive (F1) disorder. Comorbidities were diagnosed in 57% of patients, based on consultations between therapists and supervisors.

Measures

- **Basic Documentation**: Clinical and sociodemographic information collected by treating therapists.
- **Brief Symptom Inventory (BSI)**: Administered at intake and treatment completion. Global Symptom Index (GSI) scores were used for pre–post comparisons (Derogatis, 1983, 1997; Franke, 2000, 2010).

Results

Results for Sample 1 (PAP-S, 2007–2012) [1]

Outcome tests and effect sizes

Table 1 presents treatment effects for Bioenergetic Analysis, based on four outcome measures: BSI, OQ-45, BDI and GAF. All effect sizes were statistically significant.

For the OQ-45, remission is defined as a post-treatment score below 59 and a pre–post reduction greater than 18 (Lambert *et al.* 2004). Remission criteria were met on average. For the BSI

Table 1

Pre–post values and effect sizes (Cohen's d) in four outcome measures for 39 Bioenergetic Analysis treatments (PAP-S, SGBAT & DÖK).

Measure	Time	*M*	*N*	*SD*	*t*	*p*	*d*
BSI-GSI	Pre	0.78	39	0.51	4.72	< .001	0.93
	Post	0.37	39	0.34			
OQ-45	Pre	61.60	39	21.25	5.36	< .001	0.93
	Post	42.51	39	19.62			
GAF	Pre	66.51	39	15.84	−4.77	< .001	0.70
	Post	76.82	39	13.47			
BDI	Pre	13.59	39	10.26	4.83	< .001	0.75
	Post	6.85	39	7.79			

1. Data and results in this and the following paragraph are extracted from Tschuschke *et al.*, 2013.

Table 2

Pre–post BSI scores and effect size for 90 Bioenergetic Analysis treatments by students under supervision (SGBAT).

Measure	Time	*M*	*N*	*SD*	*t*	*p*	*d*
BSI-GSI	Pre	68.8	90	77.0	7.25	< .001	1.09
	Post	58.0	90	120.9			

Global Symptom Index (GSI), remission required a post-treatment score below 0.57 and a reduction greater than 0.38 (Schmitz *et al.*, 2000). Patients in this subsample achieved these thresholds.

The mean effect size across measures was 0.83, considered large (Cohen, 1988). Symptom-related measures (BSI, OQ-45) showed the strongest effects. At treatment completion, 71.8% of cases (28 of 39) were classified as "moderate success" (improvement across all tests), 17.9% (7 of 39) as "good or very good success," and 10.3% (4 of 39) showed no change or deterioration.

Process data

Treatment length varied widely, though most were longer than short-term. Nearly two-thirds of cases (62.4%) lasted ≤ 32 sessions; five exceeded 100 sessions, with a maximum of 156 (M = 49.4, SD = 37.0, N = 35). Sessions typically occurred weekly.

Patient-rated therapeutic alliance scores indicated a slight but nonsignificant increase in satisfaction with the therapeutic relationship (M = 0.07, SD = 0.51, N = 36) and a significant increase in satisfaction with treatment (M = 0.43, SD = 0.90, N = 36). Mean scores at both intake and completion were already high (relationship satisfaction: M = 5.45, SD = 0.47, N = 36; treatment satisfaction: M = 4.66, SD = 0.72, N = 36).

■ ■ ■

Results for Sample 2
(SGBAT Students, 2021–2025)

Outcome tests and effect size

Treatments in this sample averaged 12 months in duration (range = 15–879 days) and 25 sessions (range = 5–79).

BSI scores were T-transformed for gender and six age groups. The mean Global Symptom Index (GSI) at intake was 68.8, decreasing to 58.0 post-treatment. Values between 40 and 60 indicate the normal range.

Patients reported significantly fewer symptoms post-treatment (t = 7.25, p < .001), with a large effect size (d = 1.09). The average pre–post reduction was 10.8 points. At intake, patients reported higher symptom levels than typical psychotherapy clients in Franke's (2010) calibration sample (M = 62.40, SD = 8.22). Post-treatment, the mean GSI score fell within the normal range (40–60).

Discussion

This paper reported data from two outcome studies of Bioenergetic Analysis: (a) the process–outcome study PAP-S, and (b) an evaluation of therapies carried out by students under supervision. In both samples, treatments followed the body-psychotherapeutic concepts of Bioenergetic Analysis.

In the PAP-S subsample (39 cases), the average effect size was d = 0.83, indicating high effectiveness, comparable to the outcomes of psychotherapy approaches more frequently studied (e.g., Chambless & Ollendick, 2001; Wampold, 2001, 2015; American Psychological Association, 2002).

Treatment results differed somewhat by diagnostic group. Patients with personality disorders or mixed anxious–depressive presentations improved more than those with depressive or anxiety–adjustment disorders. Since sample sizes of these subgroups were very small, these findings were not reported in detail. They are therefore exploratory and should be interpreted with caution.

In the full PAP-S dataset, neither therapists' professional background (medicine vs. psychology), nor therapist gender, patient gender, nor therapist–patient gender matching had significant ef-

fects on outcomes (Tschuschke *et al.*, 2015). Given the small size of the Bioenergetic subsample (n = 39), such analyses were not pursued here.

Across both samples, higher symptom severity at intake predicted greater improvement, likely due to ceiling effects among patients with mild symptoms. Improvement was positively correlated with patients' satisfaction with their therapy, suggesting that effective working alliances were established even with severely distressed patients, leading to significant outcomes.

Crameri *et al.* (2016) noted that self-report questionnaires may underestimate psychopathology, and recommended complementing them with clinician-rated instruments. This was done with the GAF in Sample 1.

Although the student sample (Sample 2) lacked features of a rigorous design (e.g., matched controls, multiple measures, independent diagnostic assessments), it still contributes to the evidence base for Bioenergetic Analysis. The large effect size (d = 1.09) exceeded that of the PAP-S Bioenergetic subsample. This difference may reflect case selection bias, as PAP-S included all consecutive admissions, whereas student trainees may have excluded less promising cases. This possibility should be examined in future research.

Overall, these results support the effectiveness of Bioenergetic Analysis in outpatient psychotherapy and highlight the potential value of continuing education and training programs in this method.

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