# Towards a Differentiated Understanding of Treatment Outcome in Psychotherapy: A Qualitative-Quantitative Multiple Single-Case Study

VOLKER TSCHUSCHKE, AGNES VON WYL, AURELIANO CRAMERI, MARGIT KOEMEDA-LUTZ & PETER SCHULTHESS

**Abstract**
This paper discusses the question of what should be considered treatment success based on detailed investigation of 14 single cases of long-term therapies in a hypothesis-generating study using objective, subjective, quantitative, and qualitative data from clients', therapists', and researchers' perspectives. Treatment outcome in psychotherapy cannot be judged from objective data derived from outcome measures alone. Qualitative and quantitative information from clients' histories, personal backgrounds, detailed analyses of process-outcome relationships of relevant therapeutic factors, and therapists' perspectives on the treatment processes all contribute to a more differentiated picture. Chronification of psychological problems and severity of clients' structural psychological deficits significantly moderated a classification of outcome groups based on clients' test results. Treatment outcome in psychotherapy should be classified using integrated knowledge that is based on major relevant client personality variables, subjective perspectives of the therapists and the clients, and objective treatment data on process-outcome relationships.
**Keywords:** Outcome – success – psychotherapy – process-outcome research – quantitative research – qualitative research.

## 1. Introduction

What are the goals of psychotherapy? What are desired results in psychotherapeutic treatments (Ogles, 2013)? When is psychotherapy successful and when not? And if it is not, what is the reason? What is 'change' in psychotherapy (Hill & Lambert, 2004)? Can there be a coherent standard for the evaluation of outcome in psychotherapy? Researchers discuss a wide range of treatment outcomes, ranging from symptom reductions to resolution of intrapsychic or interpersonal conflicts to changes in personality structure (Luborsky, 1984; Hill & Lambert, 2004; Ogles, 2013).

Everyday clinical practice in psychotherapy is so strongly influenced by integrative therapeutic work that researching any pure or single theoretical approach covers only a very small portion of what is actually practiced by clinicians. However, systematic case studies cover important areas that may be overlooked in large-scale randomized-controlled studies (Iwakabe & Gazzola, 2009). Systematic single-case studies that use a qualitative-quantitative approach may fill the 'research-practice gap' and can add substantially to the theoretical foundations of psychotherapy.

International Journal of Psychotherapy: Nov. 2018, Vol. 22, No. 3, pp. xx-xx: ISSN 1356-9082
© Author and European Association of Psychotherapy (IJP): Reprints and permissions: www.ijp.org.uk
Submitted Feb. 2018; peer-reviewed twice (May & Aug, 2018), reformatted Aug. 2018; revised Sept. 2018.

This contribution tries to overcome most of the common obstacles of single-case research studies by using more recently developed innovative methodological objectives (Iwakabe & Gazzola, 2009). These 'systematic case studies' go beyond 'clinical case studies' or 'single-case experiments' and "... correct some of the methodological limitations inherent in earlier types of clinical case studies …" (p. 602), according to Iwakabe and Gazzola (Table 1).

This study fulfils all requirements for such 'systematic case studies' except the point "transferability of findings" (Iwakabe & Gazzola, 2009). The transferability of findings in this study does not refer to the clinical applicability of the findings, but rather to a new and more differentiated view of treatment outcomes in psychotherapy. By using: different standpoints (clients, therapists, researchers); different methodological views (quantitative and qualitative); objective as well as subjective perspectives; and process and outcome measurements; the construct of 'success' in psychotherapy can be highlighted from different vantage points.

| *Characteristics* | *Clinical case studies* | *Single-case experiment* | *Systematic case studies* | *Criteria of 'systematic case studies' met by this study* |
|---|---|---|---|---|
| Problem best suited | Detailed description and theory building; developing understanding in new or unusual cases over time | Experimental design testing the effects of specific interventions on the target behaviour and symptoms; expected change and patterns | A variety of questions from theory building and elaboration to hypothesis-testing and establishing treatment efficacy | yes |
| Discipline background | Psychoanalysis | Behaviour therapy | Various theoretical orientations including integrative / eclectic | yes |
| Unit of analysis | Unspecified | Quantifiable | Multiple units for a thick description and triangulation | yes |
| Data collection | Unsystematic observation from the therapist perspective. Traditionally single perspective of the therapist | Quantitative measures (physiological measures, process scales, outcome measures) | Combination of quantitative measures and qualitative interviewing and observations; multiple perspectives and | yes |
| Data analysis strategies | Variable: includes intuitive and clinical observations | Statistical analysis (such as repeated measures and time-series analysis); graphic presentations | Combination of quantitative and qualitative strategies | yes |
| Degree of structure in methods | Variable: defined by researcher / clinician | Highly structured and controlled | Variable: depends on "issue" of interest | yes |
| Examples of studies in psychotherapy research | Freud's Little Hans (1933 / 1965) | Mora, Teifer, & Barlow (1993) | Assimilation case studies (Stiles, 1999) | yes |
| Data sources | Multiple: quantitative and qualitative | Multiple: mostly quantitative | Multiple: quantitative and qualitative | yes |
| Transferability of findings | Intuitive and vicarious learning | Generalizability based on client characteristics and treatment manual | Transferability based on the matching of client and therapist characteristics, clinical setting, and treatment | no |

**Table 1**

Characteristics of three single-case study designs in psychotherapy (according to Iwakabe & Gazzola, 2009)

The goal of this approach is to route the discussion of the construct of 'success in psychotherapy' into a more differentiated discussion and consideration, as – it is the case in the evidence-based research designs implemented nowadays most of which are extremely limited in their evaluation of psychotherapy treatment outcomes by restricting themselves to symptom reductions only.

*What is treatment success in psychotherapy?*

The field of medicine distinguishes between *'restitutio ad integrum'*[1] (a complete remission of the disease) and persistent *'defect after healing'*, which may be an organic or functional remaining health problem that endures. But what would *'restitutio ad integrum'* or a *'persistent defect after healing'* be in the field of psychotherapy?

Complete freedom of symptoms does not exist in the psychology of the human personality. It is part of everyday life that people experience bad or depressive moods from time to time, without them being considered 'psychologically disturbed'. *'Restitutio ad integrum'* – in medical treatments, means a return to a starting point, or to a zero value after a complete remission, such as after an appendectomy, or after bone fracture treatment – is not really possible in psychology. For human beings, there will never be 'restoration to original condition' once a person has had life experiences and gains knowledge through life events. And, besides that, some psychological symptoms belong to the 'normal' person, and the transition to illness is fluent. In psychotherapy, *restitutio ad integrum* (or complete remission) is therefore hardly possible.

But even in somatic medicine, *restitutio ad integrum* is often an exception. Much more frequent, and rather normal, are chronic somatic diseases that cannot be cured, or may lead to death in the long term (such as advanced oncological diseases, multiple sclerosis, HIV infections, Parkinson's disease, amyotrophic lateral sclerosis, or dementia). No one would consider an 'ending' necessary, so that sustaining medical treatment because of a possible cure – in a narrow sense – is impossible. Why then should there not be chronic psychological diseases, where the treatment value would consist in restoring or maintaining the ability to go on living, even though the diseases are not curable? Could it be that 'success' in psychotherapy may also be temporal symptom relief, without having to guarantee sustainability of positive effects?

Research in psychotherapy is not alone in its struggle to define treatment outcome (Ogles, 2013). According to Hill and Lambert (2004):

> Currently, the most important practices in assessing outcome involve: (1) clearly specifying what is being measured, so that replication is possible; (2) measuring change from multiple perspectives, with several types of rating scales and methods; (3) employing symptom-based, atheoretical measures; and (4) examining, to some extent, patterns of change over time. (p. 107)

Already in the 1970s, Strupp and Hadley (1977) referred to external impacts on treatment outcomes by interest groups: such as the clients themselves, the therapists, and – last but not least – society.

Today third-party payers (insurances, managed care organizations) are another external influence on definitions of 'treatment outcome' in the medical system (Henry, 1998; Wampold, 2001; Orlinsky, Rønnestad, & Willutzki, 2004; Kihlstrom, 2006; Lambert, 2013; Tschuschke & Freyberger, 2015). Treatment outcomes in psychotherapy can therefore never be viewed when uncoupled from superordinate interests.

In research in psychoanalysis, there is a tradition of empirical single-case studies in psychotherapy (Wallerstein & Sampson, 1971; Weiss, Sampson, & Mount Zion Psychotherapy Research Group, 1986; Dahl, Kächele, & Thomä, 1988; Leuzinger-Bohleber, 1989). These studies tried to surmount the early (more narrative) case study approach, used first by Breuer and Freud (Kächele, Albani, & Pokorny, 2015); these studies are based on systematic single-case research by using techniques for detailed analysis of speech activities in the psychoanalytic dialogue between client and therapist. However, these approaches focused solely on psychoanalytic concepts and often neglected other relevant variables in the psychotherapeutic process. In addition, they neglected process-outcome relationships, and they did not consider anything like the current standards of qualitative research (Iwakabe & Gazzola, 2009; Thompson & Russo, 2012; Kratochwill & Levin, 2014).

More recent process-outcome research in psychotherapy uses a number of highly elaborated methodologies that allow investigation of many more of the therapeutic interactions between client and therapist; and are able to dissect verbal or nonverbal micro-processes of clients' or therapists' behaviour, with the aim to explain therapeutic change – including better or worse outcomes (Hill & Lambert, 2004; Orlinsky *et al.*, 2004; Crits-Christoph, Connolly Gibbons & Mukherjee, 2013). But empirical studies that try to take an integrated look at both detailed process-outcome data (derived from objective, quantitative research) and detailed subjective, qualitative data (derived from participants in the therapeutic process) are still extremely rare.

The central aim of this study was to approach outcome in an integrated way using qualitative and quantitative data from 14 single cases. The aim was to examine client and therapist characteristics, and treatment process variables obtaining the information from objective (independent assessors, objective measures, objective process ratings) and subjective sources (process ratings by clients and therapists, interviews with therapists) to come closer to finding answers to the following complex questions: 'What affects treatment outcomes in psychotherapies?', and 'What treatment can be considered favourable and what not?' Addressing the question of treatment outcome means raising the question as to what 'success' and 'favourable', and thus what 'failure' and 'unfavourable' mean in psychotherapy. Asking what constitutes 'success' and 'outcome' in psychotherapy means also attempting to reach a more differentiated

understanding of what is meant by ‘change in psychotherapy’ and – behind that – the possibilities of psychotherapy.

## 2. Method

This article aims at a deeper understanding of treatment success and treatment failure by using different established outcome measures, process measures such as an objective measure for tracking the therapeutic alliance across sessions and an objective rating system for the investigation of therapists’ real intervention behaviour during sessions, demographic information on clients’ history of psychological treatments and chronicity of psychological problems, and a structured retrospective interview with the therapists 1 to 3 years after treatments had ended.

The research design considered recommendations for facilitating ethical research practice while conducting qualitative research (Table 2) as well as dimensions that improve case-study investigations (Table 3). All ethical recommendations were met, as was approved by seven ethical committees in each Swiss canton involved, and they were checked constantly throughout the study (Table 2).

***Research planning phase – and throughout the project***

- appropriate supervision to ensure discussion of ethical practice, moral dilemmas, and to clarify dual relationships in the context of immediate clinical roles, organisational roles, and clinical skills
- use a reflective diary to ensure adequate consideration of clinical concerns and dilemmas
- ensure ethics committees are informed of any potential challenges to confidentiality and anonymity when doing research in a clinical setting

***Recruitment phase***

- voluntariness of participants
- participants are aware of the noninterventionist role of researcher versus the active role of the practitioner
- facilitate informed consent by providing multiple opportunities for participants to gain information about the study

***Data collection phase***

- facilitate understanding of confidentiality and privacy
- ensure there is a shared understanding of the boundaries of researcher-participant relationship
- facilitate processual consent (the opportunity for participants to provide consent in an ongoing fashion)
- empower the participant to have control in relation to terminating data collection without having to provide reason

***Analysis phase***

- ensure interpretations are grounded in the participant’s accounts from the research interview
- consider what it will be like for participants to read or see the work in its completed form

***Dissemination phase***

- provide feedback and disseminate in an accessible fashion
- enhance anonymity

**Table 2**
Recommendations for facilitating ethical research practice while conducting qualitative research met by this study (according to Thompson & Russo, 2012)

Two of Kratochwill and Levin's (2014) quality criteria for case-study investigations (see Table 3), 'Treatment operationally specified / standardized' and 'integrity of treatment', were not fulfilled because it was the explicit goal of this study to investigate 'real' psychotherapeutic treatments under 'natural' conditions where therapists are free to intervene as they are used to. The therapists' real technical interventions of the therapists were controlled by investigating objectively complete sessions of their treatments. Therapists' technical interventions in treatment sessions were not manualized, and thus reflected everyday psychotherapeutic practice. The study met all of the other 'high inference criteria' of the Kratochwill and Levin dimensions.

| *Characteristics* | *Low Inference* | *High Inference* | *High Inference Criterion Met by This Study* |
|---|---|---|---|
| Type of data | subjective data | objective data | yes |
| Assessment occasions | Single point or pre-test post-test measurement | Repeated measurement across all phases | yes |
| Planned versus ex post facto | Ex post facto treatment | Planned treatment | yes |
| Projections of performance | Acute problem | Chronic problem | yes |
| Effect size | Small | Large | yes |
| Effect impact | Delayed | Immediate | yes |
| Number of participants | N = 1 | N > 1 | yes |
| Heterogeneity of participants | Homogeneous | Heterogeneous | yes |
| Treatment operationally specified / standardized | Non-standardized treatment | Standardized treatment | no |
| Integrity of treatment | No monitoring | Repeated monitoring | no |
| Impact of treatment | Impact on single measure | Impact on multiple measures | yes |
| Generalization and follow-up assessment | No formal assessment | Formal assessment | yes |

***Table 3: Dimensions of case study investigations (according to Kratochwill and Levin, 2014), and criteria met by this study.***

## 2.1 Participants

This study reports data from a naturalistic out-patient psychotherapy study. The study has been described in detail elsewhere (von Wyl et al., 2013; Tschuschke et al., 2015). Here, we focus on an intensive qualitative-quantitative process-outcome analysis of 14 single cases.

At pre- and post- an outcome battery was administered (see below). All sessions with all clients enrolled in the study were audio-recorded, and therapists' technical interventions were rated objectively by independent assessors, in order to investigate the therapists' degree of treatment adherence; the results of the ratings have been reported elsewhere (Tschuschke et al., 2015; Tschuschke et al., 2016). To track the quality of the therapeutic alliance, clients and therapists filled out a session questionnaire after each fifth session (see below).

All data were coded (ID number) by the therapists, so that the researchers worked with anonymous data and had no access to client identification. Therapists had no access to clients' session ratings (clients' ratings were sealed in an envelope by the clients) or outcome battery test

results (because the clients were tested by independent testers and assessors outside of the therapists' practices).

Therapists practicing 10 different forms of psychotherapy were included in the study (see Results). Therapists who were practicing behaviour therapy, client-centred therapy, and systemic therapy, were invited to take part in the study … but declined. From March 2007 to June 2011, co-operating therapists (from all of the participating institutes or schools of psychotherapy) asked all new clients entering psychotherapeutic treatment if they would participate in the study on a voluntary basis. There were no restrictions on client inclusion regarding diagnosis, age, and so on.

Participants were all out-patients, ranging in age from 17 to 72 years. They were recruited through the private practices of the co-operating therapists'. Each participating client signed a written consent form that included the warranty that all participants were free to withdraw from the 'study' NB: not the 'therapy') at any time, and without any justification. Also, each client was assured of having the right not to participate in the study and still to receive therapeutic treatment from the same therapist. Prior to the start of the project, a research application for the study was submitted to the local ethical committees of each of the Swiss states involved; all of the applications were approved by the committees.

We were interested in the typical client / clientele that therapists work with in their daily practice. This resulted in a sample of clients with a broad range of psychological problems and diagnoses. There were also no restrictions regarding length of treatment or psychotherapeutic interventions.

The co-operating therapists work in private practices throughout major cities in Switzerland. The therapists were well-trained, licensed, and affiliated with the training institutes for their respective form of psychotherapy. They could freely use any psychotherapeutic interventions (techniques) during sessions: as this was an effectiveness/naturalistic study of psychotherapies without controlling for therapists' psychotherapeutic interventions (i.e. no manualisation). The study aimed at answering questions about whether there are any indicators for successful and unsuccessful treatment courses; and whether treatments should be considered 'successful' or 'unsuccessful'; and (perhaps) why.

Fourteen cases from the PAP-S study were chosen randomly. The only selection criterion was that the chosen cases were long-term psychotherapies, in order to be able to analyse therapists' degree of treatment adherence and the development of the therapeutic alliance over time.

On average, 14 sessions out of each of the 14 cases were chosen randomly from all the recorded sessions of each treatment case, and these were rated by completely independent and trained assessors, who were blind towards the therapists' form of psychotherapy, diagnoses, and all other information regarding the client, number of the session rated, etc. The independent assessors

of therapists' treatment adherence were extensively trained using a newly developed rating manual (Tschuschke et al., 2014).

Information regarding the clients' history of prior psychiatric or psychotherapeutic treatments, as well as demographic information, was also reported by the therapists in an extensive interview that comprised 11 standard questions. The interview was conducted 1 to 3 years after the end of treatments. The interview elicited information: on the course of treatment; the quality of the therapeutic alliance from the therapists' perspective; therapists' evaluation of the treatment outcome; the therapists' estimation regarding possible technical adaptations or changes in their treatment concept; duration and ending of treatment; therapists' assessment of clients' severity of psychological problems; and the degree of the clients' 'chronification'[2] of their psychological problems from the therapists' perspective – in addition to information gathered by independent assessors who tested clients and asked for demographic information.

## 2.2 Measures

Clients took three established psychological tests at treatment entry (pre-), immediately after the end of treatment (post-), and at follow-up one year after the end of treatment. The three tests in the outcome battery were administered by independent and trained therapists (independent assessors, not identical with the clients' therapists and not involved in the study as therapists). The Global Severity Index (GSI) of the Brief Symptom Inventory (BSI) (Franke, 2000), completed by clients, comprises 53 items and nine subscales covering a broad range of psychological symptoms; the scales of this short version of the Symptom Check-List (SCL-90-R) have satisfactory high internal consistencies, ranging from .70 to .89, and .96 for the GSI (Cronbach's alpha). Concurrent or convergent validity was estimated by high positive correlations with a number of clinical self-rating scales (Geisheim *et al.*, 2002). It is an overall measure of general symptom load.

The Outcome Questionnaire (OQ-45.2) (Lambert *et al.*, 2002), also completed by clients, is a measure for capturing symptom load, interpersonal relationship functioning, and quality of social integration. The internal consistency of the German version ranges from .59 to .93 for the different scales (Cronbach's alpha), and the convergent or concurrent validity was estimated by positive correlations between .45 (German version of the SCL-90-R) and .76 (German version of the Inventory of Interpersonal Problems – IIP).

Finally, we used Beck's Depression Inventory (BDI-II) (Hautzinger, Keller, & Kühner, 2006). The internal consistencies of the BDI-II scales in several studies vary from .84 to .94; the retest reliability for a time range of one week was .93. Correlations with other tests measuring anxiety or similar cognitive constructs ranged from .68 to .89, thus proving the validity of the measure (Kühner, Bürger, Keller, & Hautzinger, 2007).

The three tests were administered within the first probationary sessions before the start of treatment (t.1) and again immediately after the last therapy session (t.2). Approximately two to three trial sessions are normal in psychotherapy and serve as the basis for both client and psychotherapist for the decision on whether to start psychotherapeutic treatment together or not.

Clients rated the therapeutic relationship (therapeutic alliance) after each fifth session using Luborsky's Helping Alliance Questionnaire (HAQ) (De Weert-Van Oene *et al.*, 1999). Internal consistencies (Cronbach's alpha) of the two subscales (Scale 1 ("Cooperation Scale") with six items, and Scale 2 ("Helpfulness Scale") with five items) range from .79 to .90, which provides evidence for a sufficient reliability of the measure. Satisfying positive correlations with several outcome measures indicate the validity of the measure. We used the Cooperation Scale as a measure for clients' experience of the quality of the therapeutic relationship and also therapists' Relationship ratings.

Using a newly developed rating manual (Tschuschke et al., 2014), independent, trained assessors with a satisfactory interrater reliability rated completely ten to twenty sessions of each of the 14 single cases with regard to therapists' technical interventions. Results of the PAP-S study are outlined in detail elsewhere (Tschuschke et al., 2015; 2016; Crameri et al., 2015; 2016; Berglar et al., 2016; Staczan et al., 2017).

### 2.3 Statistical Analysis

A popular critique of outcome research in psychotherapy pertains to the testing of statistical significance that is usually employed, because the impact of the treatment on a given individual as well as the clinical significance of the results do not become clear (Hill & Lambert, 2004). *Statistically significant* differences between start and end of treatment are not necessarily *clinically relevant*. For this reason, Jacobsen *et al.* (1984) invented the concept of *clinical significance*, which means that a client's test score moves from an initially dysfunctional value towards a range of functional values *and* "... a magnitude of change has been reached, which cannot be explained by chance or by insufficient reliability of the measure" (Hiller & Schindler, 2011, p. 171; freely translated here). For this reason, some studies, including this study, used Jacobsen and Truax's (1991) *Reliable Change Index* (RCI).

The specification of which test scores belong to a functional and which test scores belong to a dysfunctional range of a given measure is carried out by defining a *cut-off score*. This cut-off distinguishes scores in the 'normal' (functional) range and scores in the dysfunctional range. In this study we used the cut-off scores that are provided by the authors of the tests in the test manuals. The cut-off score for the OQ-45.2 is 64 and the RCI is 15.5 (Lambert et al., 2002). The cut-off score for the SCL 90-R is .56 and the RCI is .42 (Franke, 2000). Finally, the cut-off score for the BDI-II

is 18 and the RCI is 8.5 (Hautzinger *et al.,* 2006). Using these cut-offs and RCIs led to the following classification of outcome groups:

- *Complete remission (CR):* The test score at start of treatment is reduced reliably (RCI) at end of treatment and moves from a dysfunctional into a functional range (< cut-off score).
- *Responder (R):* The test score at start of treatment is reduced reliably (RCI) at end of treatment but remains in a dysfunctional range (> cut-off score).
- *Non-Responder (NR):* There is no reliable change.
- *Deterioration (D):* There is reliable deterioration (RCI) from start of treatment to end of treatment in a given measure.
- *No dysfunctional score at start of treatment (FR)* (< cut-off score = functional range).

In this study, we used client- and therapist-related data as well as several quantitative and qualitative process variables. For this purpose, we used psychometric measures (outcome measures, process measures such as the therapeutic alliance measure, and objective ratings of therapists' psychotherapeutic interventions, see above), interviews by independent assessors at treatment entrance, and intensive interviews with therapists one to three years after treatments had ended.

The following aspects and variables served as a basis for our integrated approach using both quantitative and qualitative information:

- DSM-IV-**diagnoses**, **chronicity** and **severity** of the disorder, **prior psychiatric or psychotherapeutic treatments** (independent assessors and therapists' assessments)
- **therapeutic alliance** (clients' and therapists' assessments after sessions, independently from each other)
- information on the **specific form of psychotherapy** used, the **therapists' professional experience**, a **global assessment of treatment outcome** (all therapists)
- **objective ratings of therapists' psychotherapeutic interventions** by independent assessors (degree of treatment adherence)
- administration of tests (clients' functioning in **functional versus dysfunctional range**) by independent assessors
- **qualitative information** reported by therapists in post-hoc interviews

## 2.4 Client variables

Age, sex, other demographic data, assessment of the client's level of structural integration (see chronicity), possible early traumatization (such as separations from or loss of parents), and other psychological burden via therapists' assessments reported in interviews or via objective testing (assessors). Information on possible chronicity of the psychological problems was reported by therapists and the independent assessors. Diagnostic information (DSM-IV) was derived from German-language versions of the Structured Clinical Interview for DSM-IV Axis I Disorders and Structured Clinical Interview for DSM-IV Axis II Disorders (SKID-I and SKID-II) (Wittchen, Zaudig, & Fydrich, 1997) used at pre-, post- and follow-up.

### 2.5 Therapist variables

These included demographic information, form of psychotherapy, therapists' professional experience, and objective ratings of therapists' activity during sessions (see in the following).

### 2.6 Ratings of therapists' interventions

Independent, trained assessors who were blind towards therapists' specific form of psychotherapy, client diagnosis, and session number rated randomly selected sessions on therapists' psychotherapeutic interventions (techniques) in order to assess therapists' degree of treatment adherence (using interventions specific to their form of psychotherapy), and their use of nonspecific interventions from other forms of psychotherapy. A newly developed rating manual, the PAP-S-RM (Tschuschke et al., 2014), made it possible for independent trained assessors to identify objectively psychotherapeutic interventions used by the therapists.

### 2.7 Therapeutic Alliance

Clients and therapists assessed the therapeutic alliance every fifth session using the HAQ.

### 2.8 Interviews with Therapists

Eleven therapists treated the 14 clients. For each client case, a one-hour interview with the therapist was conducted two to three years after the end of treatment. Each interview was based on the same structure; it comprised 11 questions on the severity and chronicity of the client's psychological problems, the client's suitability for treatment, possible necessary modifications of the form of psychotherapy used, therapeutic alliance during the treatment, whether the tempo of the treatment had to be adapted to client's needs or abilities, who took the initiative for terminating the treatment, whether the duration of the treatment had to be modified, and a global rating of treatment outcome.

## 3. Results

### 3.1 Socio-demographic information

The 14 cases of this study stem from seven out of the ten forms of psychotherapy that participated in the PAP-S study (see von Wyl et al., 2013). Treatments from the following theoretical conceptual approaches participated in the study.

- Analytical Psychology (psychodynamic)
- Art and Expression Oriented Psychotherapy (EGIS) (integrative)
- Bioenergetic Analysis (Swiss and Austrian Societies for Bioenergetic Analysis, SGBAT/DÖK) (body oriented, psychodynamic)
- Existential Analysis and Logotherapy (EGIS)
- Gestalt Therapy (Swiss Association for Gestalt Therapy) (humanistic)
- Integrative Body Psychotherapy (IBP) (body oriented)
- Logotherapy and Existential Analysis (GLE)
- Process Analytic Psychotherapy (Institute for Process Analysis) (psychodynamic)
- Psychoanalysis (psychodynamic)

- Transactional Analysis (Swiss Society for Transactional Analysis, SGTA/ASAT) (humanistic)

Table 4 (below) shows the 14 cases with their basic demographic and clinical characteristics (the main therapy orientation is shown in parenthesis). The therapists were very experienced, on average they had worked with clients for 18.7 years. Thirteen of the 14 cases can be considered long-term treatments, with treatment duration of one to four years. Nine of the 14 clients had chronic problems with severe early and partially persisting traumatizations, and all nine showed a low level of structural integration. Only two of the 14 clients were rated by the assessors and by the therapists as having a higher level of structural integration. Three clients were found to have acute disorders (not chronic) (see Table 4).

| **Conceptual Approach** | **Therapist** | | **Patient** | | | **Chronicity** | **N of sessions** | **N of rated sessions** | **Prior treatments** |
|---|---|---|---|---|---|---|---|---|---|
| | Professional Experience | Sex | Age | Sex | DSM-IV-Diagnosis | | | | |
| Bioenergetic Analysis (SGBAT) | 20 | female | 40 | female | 301.83 | chronic, structural deficits | 165 | 13 | several |
| Gestalt Therapy (SVG) | 34 | male | 54 | male | 301.13 / 301.81 | chronic | 125 | 14 | several |
| Gestalt Therapy (SVG) | 34 | male | 28 | male | 296.80 | higher structural level | 85 | 12 | none |
| Integrative Body Psychotherapy (IBP) | 10 | female | 24 | female | 300.02 / 307.51 / 301.6 | chronic | 267 | 16 | several |
| Gestalt Therapy (SVG) | 13 | female | 43 | male | 296.80 | not chronic | 115 | 15 | none |
| Integrative Body Psychotherapy (IBP) | 9 | male | 45 | male | 309.81 | chronic | 85 | 16 | none |
| Integrative Body Psychotherapy (IBP) | 9 | female | 39 | male | 301.83 | not chronic | 59 | 10 | none |
| Art and Expression Orien-ted Psychotherapy (EGIS) | 15 | female | 29 | female | 296.2 / 301.83 | chronic, several attempted suicides | 60 | 15 | several |
| Transaction Analysis (SGTA) | 26 | male | 35 | female | 309.81 | not chronic | 93 | 13 | none |
| Transaction Analysis (SGTA) | 26 | male | 29 | female | 296.3 / 301.6 | chronic | 108 | 15 | several |
| Process Analytic Psychotherapy (IPA) | 17 | female | 55 | female | 309.81 / 300.81 | chronic, structural deficits, suicidal | 35 | 11 | several |
| Process Analytic Psychotherapy (IPA) | 17 | female | 41 | female | 296.2 / 301.6 | chronic, early traumatized | 62 | 20 | none |
| Process Analytic Psychotherapy (IPA) | 7 | female | 54 | female | 300.23 / 296.32 | chronic, structural deficits | 59 | 16 | several |
| Psychoanalysis | 25 | male | 49 | male | 309.81 | higher structural level | 53 | 10 | none |
| **Mean** | **18.7** | | **40.4** | | | | **97.9** | **14.0** | |

**Table 4:** Basic sociodemographic, clinical informations, numbers of treatment sessions and rated numbers of rated sessions

| ID | BSI pre | BSI post / FU | BSI-Outcome[1] | OQ-45 pre | OQ-45 post / FU | OQ45-Outcome[1] | BDI pre | BDI post / FU | BDI-Outcome[1]* | Initial strain[2] | Chronicity[3] | Prior treatment(s)[4] | Functional Range[5] | Therapist rating[6] | Treatment adherence[7] | Therapeutic alliance session 5[8] | Therapeutic alliance mean[9] | Therapeutic alliance mean[10] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **17-2** | 1.89 | .17 | CR | 93.00 | 38.00 | CR | 14.00 | 2.00 | CR | +++ | + | +++ | + | 7 | 77.6 (11.7) | 4.7 | 4.0 | 4.7 |
| **1A-1** | .56 | .48 | NR | | 66.50 | | 16.00 | 15.00 | NR | + | + | +++ | + | 2 | 80.0 (5.0) | 5.3 | 5.4 | 4.8 |
| **1A-3** | 1.55 | 1.04 | R | 84.40 | 61.00 | R | 26.00 | 16.00 | R | + | 0 | 0 | + | 9 | 79.8 (3.8) | 5.3 | 4.9 | 4.9 |
| **1F-2** | .79 | .87 | NR | 84.13 | 67.40 | R | 25.00 | 13.00 | NR | ++ | + | ++ | + | 7 | 55.8 (22.3) | 5.5 | 5.1 | 4.6 |
| **26-5** | .45 | .38 | FR | 49.25 | 45.00 | FR | 6.00 | 4.00 | FR | 0 | 0 | 0 | 0 | 9 | 62.1 (12.8) | 4.8 | 5.3 | 4.9 |
| **33-13** | 1.47 | .60 | R | 99.00 | 66.00 | R | 27.00 | 10.00 | CR | +++ | 0 | ++ | + | 4 | 49.7 (34.1) | 3.7 | 3.3 | 4.2 |
| **37-6** | .47 | .00 | FR | 55.00 | 14.00 | FR | 12.00 | 1.00 | FR | 0 | 0 | 0 | 0 | 8 | 59.9 (24.3) | 6.0 | 5.8 | 5.2 |
| **3A-23** | 1.02 | .21 | CR | 74.00 | 32.00 | CR | 11.00 | 1.00 | FR | + | + | +++ | + | 9 | 77.0 (2.3) | 5.7 | 5.8 | 5.2 |
| **4E-13** | .45 | .40 | FR | 44.00 | 40.50 | FR | 11.00 | 3.00 | FR | 0 | 0 | 0 | 0 | 10 | 69.5 (10.8) | 5.2 | 5.3 | 4.6 |
| **4E-14** | .64 | .83 | NR | 72.00 | 64.00 | NR | 19.00 | 17.00 | NR | + | + | ++ | + | 9 | 60.4 (16.5) | 4.2 | 5.2 | 4.6 |
| **4F-1** | .30 | .06 | FR | 42.00 | 25.00 | FR | 7.00 | 0.00 | FR | 0 | + | 0 | 0 | 10 | 72.0 (4.3) | 6.0 | 6.0 | 5.5 |
| **4F-2** | .92 | 1.15 | NR | 78.00 | 82.00 | NR | 24.00 | 21.00 | NR | ++ | + | ++ | + | 5 | 69.8 (6.6) | 5.8 | 5.6 | 5.1 |
| **55-13** | .11 | .04 | FR | 22.33 | 8.00 | FR | 5.00 | 2.00 | FR | 0 | + | +++ | 0 | 4 | 77.4 (1.2) | 6.0 | 5.9 | 5.6 |
| **86-44** | .42 | .26 | FR | 52.00 | 50.00 | FR | 13.00 | 4.00 | FR | 0 | 0 | 0 | 0 | 8 | 46.0 (44.1) | 5.5 | 5.6 | 4.8 |

**Table 5:** Quantitative and qualitative outcome and process data of 14 single cases

1 Test outcomes - CR: complete remission; R: responder; NR: non-responder; FR: functional range; * BDI: reliable score index (RCI) > 50% reduction of initial score
2 level of psychological burden at treatment entry: +++ extremely high ++ very high + high 0 not high / no illness
3 chronicity of the illness: + high, since early childhood/early traumatized or chronic since years 0 no chronicity
4 prior psychiatric or psychotherapeutic treatment(s): +++ many ++ one or several + within the preceeding two years 0 no prior treatment
5 psychometric test scores at treatment entry in the non-functional range (+) versus in the functional range (0)
6 therapists' outcome rating: 1 – 10 (1 worst and 10 best rank)
7 therapists' nonspecific interventions (in parenthesis: therapists' specific/concept-true interventions) (in percent of all interventions)
8 patients' rating after session 5 (1 not true – 6 very much)
9 patients' averaged ratings across treatment (1 not true – 6 very much)
10 therapists' rating (1 not true – 6 very much)

Eight of the 14 clients already had several psychiatric and/or psychotherapeutic treatments, six of them had had none. Seven of the eight clients with chronic problems had been in psychiatric and/or psychotherapeutic treatment several times, one of them was in treatment for the first time (Table 5).

Table 5 (above) also provides information on the status of the clients at the start of treatment (objective assessments by means of tests and subjective assessments via therapists):

- psychological symptom load as measured by BSI-GSI, OQ-45.2, BDI-II at pre, post, and follow-up (if available)
- outcome classification (CR, R, NR, FR)
- assessment of the degree of the total psychological burden at treatment entrance (assessed by researchers)
- number of prior psychological treatments
- classification as functional vs. dysfunctional range at start of treatment (assessed by researchers)
- global assessment of treatment outcome (therapists)
- therapists' degree of treatment adherence (as a percentage) and extent of nonspecific interventions (independent researchers)
- quality of the therapeutic alliance during treatment from two perspectives (clients and therapists)

As Table 5 shows, some clients scored high (were dysfunctional) on all outcome measures at the start of treatment. Six clients were found to score in the functional range; the majority of them (five clients) were clients without chronic problems seeking psychological help for the first time (see also Table 6). The remaining eight clients entered treatment with scores in the dysfunctional range. Seven of these eight clients had chronic psychological problems (clients with chronic problems had significantly higher scores on all three outcome measures than the five clients with no chronic problems; t-tests $p < .01$; $df = 10$).

### 3.2 Treatment Adherence of Therapists' Interventions

On average each seventh session of all treatment sessions was randomly chosen for independent raters to check the degree of therapists' treatment adherence. The sessions chosen ranged from each third to each 17th session (for the two very long lasting treatments, each 17th session from one treatment with 267 sessions was chosen and each 13th session from one therapy with 165 sessions). On average, 14 therapy sessions in each treatment were rated completely regarding therapists' technical interventions.

Table 5 also shows that the therapists' degree of treatment adherence was independent of the clients' initial psychological level of psychological problems, the client diagnosis and the quality of the therapeutic alliance. It seems that the degree of therapists' treatment adherence depended more on the characteristics or personality of the therapist (see also Tschuschke et al., 2015). However, the degree of therapists' treatment adherence was negatively correlated in tendency with the degree of the clients' chronicity (this included the number of prior treatments).

| Patients in the functional range | | | | | | | | Patients not in the functional range | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ID** | **BSI-GSI pre** | **BSI-GSI Gain** | **OQ-45 pre** | **OQ-45 Gain** | **BDI-II pre** | **BDI-II Gain** | **HAQ Patient** | **ID** | **BSI-GSI pre** | **BSI-GSI Gain** | **OQ-45 pre** | **OQ-45 Gain** | **BDI-II pre** | **BDI-II Gain** | **HAQ Patient** |
| **E** | .45 | 15.6 | 49.25 | 8.6 | 6.00 | 33.3 | 5.3 | **17-2** | 1.89 | 91.0 | 93.00 | 59.1 | 14.00** | 85.7 | 4.0 |
| **G** | .47 | 100 | 55.00 | 74.5 | 12.00 | 91.7 | 5.8 | **1A-1** | .56 | 14.3 | | | 16.00** | 6.3 | 4.8 |
| **I** | .45 | 11.1 | 44.00 | 8.0 | 11.00 | 72.7 | 5.2 | **1A-3** | 1.55 | 56.8 | 84.40 | 27.7 | 26.00 | 38.5 | 4.9 |
| **L** | .30 | 80.0 | 42.00 | 40.5 | 25.00* | 100 | 6.0 | **1F-2** | .79 | - 10.1 | 84.13 | 19.9 | 25.00 | 48.0 | 5.1 |
| **N** | .11 | 63.6 | 22.33 | 64.2 | 5.00 | 60.0 | 5.9 | **33-13** | 1.47 | 59.2 | 99.33 | 33.6 | 27.00 | 63.0 | 3.3 |
| **O** | .42 | 40.0 | 52.00 | 4.0 | 13.00 | 69.2 | 5.6 | **3A-23** | 1.02 | 79.4 | 74.00 | 56.8 | 11.00** | 90.9 | 5.8 |
| | | | | | | | | **4E-14** | .64 | - 29.7 | 72.00 | 11.1 | 19.00 | 10.5 | 5.2 |
| | | | | | | | | **4F-2** | .92 | - 25.0 | 78.00 | - 5.1 | 24.00 | 12.5 | 5.6 |
| **Mean** | **.37** | **51.7** | **44.10** | **33.3** | **12.00** | **72.5** | **5.6** | **Mean** | **1.11** | **29.5** | **83.55** | **29.0** | **20.25** | **44.4** | **4.8** |

**Table 6:** Psychological burden at treatment entry, treatment gains (in percent), and therapeutic alliance (mean)

* Illness

** No illness

## 3.3 Severity of Clients' Psychological Problems at Treatment Beginning

The degree of clients' severity of psychological problems when they started treatment was highly significantly negatively correlated with the quality of the therapeutic alliance as experienced by the clients ($BSI_{pre}$ / $HAQ_{Pat}$ $p < .006$; $OQ\text{-}45.2_{pre}$ / $HAQ_{Pat}$ $p < .001$; $BDI\text{-}II_{pre}$ / $HAQ_{Pat}$ $p < .005$). This was true in tendency for the therapists' rating of the therapeutic alliance (OQ-45.2 $p < .06$) and significantly for clients' depressive symptoms (BDI-II $p < .02$). According to these results, the severity of psychological problems at the start of treatment hampered the therapeutic alliance.

Table 6 (see above) compares clients in the functional range with clients in the dysfunctional range at the start of treatment. All six clients in the functional range improved more or less substantially. Because of the marginal level of psychological severity at the start of treatment, a complete remission cannot be calculated. As expected, these six clients started with highly significantly lower scores on all three outcome measures than the clients in the dysfunctional range ($p < .003$) did. Nevertheless, they improved on average more (clients in the functional range: change differences in BSI-GSI: 51.7%; t-test: 2.693; $p < .043$; $df = 5$; in the OQ-45.2: 33.3%; t-test: 2.273; $p < .072$; $df = 5$ and in the BDI-II: 71.2%; t-test: 4.663; $p < .006$; $df = 5$) than the clients in the dysfunctional range did (clients in the dysfunctional range: change differences in the BSI-GSI: 29.5%; t-test: 1.822; $p < .111$; $df = 7$; in the OQ-45.2: 29.0%; t-test: 3.254; $p < .017$; $df = 6$ and in the BDI-II: 44.4%; t-test: 4.134; $p < .004$; $df = 7$). The change differences between both groups were not significant (due to the small sample sizes).

There was a slightly positive correlation between the degree of severity of the psychological problems (functional versus dysfunctional range) and the chronicity of the psychological problems ($chi^2 = 2.431$; $p < .119$; $df = 1$), and there was a highly significantly positive correlation between having had one or more prior psychiatric/psychotherapeutic treatments and a belonging to the group with psychological problems in the dysfunctional range ($chi^2 = 7.024$; $p < .008$; $df = 1$).

Right from the start of treatment, clients in the functional range experienced on average a slightly better therapeutic alliance (mean = 5.6) than clients in the dysfunctional range (mean = 5.0); this remained true throughout the entire therapy (5.7 vs. 4.9). Therapists with clients in the functional range reported a slightly better therapeutic alliance (mean = 5.1) than the therapists with clients in the dysfunctional range did (mean = 4.8).

## 3.4 Chronicity and severity of psychological problems

Table 6 shows that the chronicity of the psychological problems – as assessed by independent assessors and by therapists – had a significant impact on the scores of the outcome measures at each measurement point. The chronicity of four of the six clients in the functional range was not high, and four of these six clients had had no prior psychiatric or psychotherapeutic treatments, whereas

seven out of eight clients in the dysfunctional range had chronic problems, and five of these eight clients had had prior psychiatric or psychotherapeutic treatments (Table 7).

| Patients in the functional range | | Patients **not** in the functional range | |
|---|---|---|---|
| E | No chronicity, structural deficits, but no prior treatment | A | Chronically impaired, structural deficits, and several prior treatments |
| G | No chronicity and no prior treatment | B | Chronically impaired and several prior treatments |
| I | No chronicity and no prior treatment | C | No structural deficits, no chronicity and no prior treatment |
| L | Chronically impaired, structural deficits, and several prior treatments | D | Chronically impaired, structural deficits, and several prior treatments |
| N | Chronically impaired and several prior treatments | F | Chronically impaired, structural deficits, but no prior treatment |
| O | No chronicity and no prior treatment | H | Chronically impaired, structural deficits, and several prior treatments |
| | | K | Chronically impaired, structural deficits, and prior treatment |
| | | M | Chronically impaired, but no prior treatment |

***Table 7: Chronicity and Functional Range***

Severity and chronicity of the psychological problems correlated highly significantly with the number of prior psychiatric or psychotherapeutic treatments ($chi^2 = 7.024$; $p < .008$; $df = 1$). Clients with chronic problems – 'chronification' is not totally identical with belonging to the dysfunctional range – had higher severity of psychological problems at the start of treatment than clients who did not have chronic problems. Notwithstanding this fact, clients without chronic problems showed relatively greater improvements in symptom reductions (BSI-GSI and BDI-II; with the only exception in OQ-45.2).

Therapists working with clients with chronic problems tended to adhere less to their form of psychotherapy and felt the need to modify their treatment concept to adapt better to the clients' abilities and needs. The majority of the clients with chronic problems and prior treatments were found in the group of clients in the dysfunctional range (see Tables 5 and 6).

### 3.5 Therapist interviews: clients' suitability for psychotherapy

The therapists assessed their clients as fairly suited or even as highly suited for psychotherapeutic treatment in retrospect. On a 10-point scale, therapists rated their clients on average as 8.4 (clients in the dysfunctional range) or 7.8 (clients in the functional range). There was no statistically significant difference.

### 3.6 Therapist interviews: adaptation to clients' tempo?

Psychotherapists felt a clearly greater need to adapt to clients' tempo when working with clients in the dysfunctional range (mean = 5.9 on a 10-point scale) than with clients in the functional range (mean = 3.8), although the difference was not statistically significant.

### 3.7 Therapist interviews: clients' motivation

All therapists judged their clients as having had very high motivation on average at the start of treatment. Here, therapists treating clients in the dysfunctional range (mean = 8.5 on a 10-point scale) did not differ from therapists treating clients in the functional range (mean = 8.7).

### 3.8 Therapist interviews: ending the therapy

Surprisingly, all six clients in the functional range took the initiative to end treatment. This was true for only three out of eight clients in the dysfunctional range: Twice the initiative came from the therapist and three times from both sides in this group.

### 3.9 Therapist interviews: global outcome ratings

Therapists' global outcome ratings were not meaningfully correlated with the objective test scores on the outcome measures, neither in the percentages of the change scores (gains) nor in the classification of the change scores. Therapists' ratings were also not correlated with the degree of their treatment adherence, the degree of nonspecific psychotherapeutic interventions, and the quality of the therapeutic alliance. The average outcome rating (on a 10-point scale) was 8.5 for clients in the dysfunctional range and 8.7 for clients in the functional range.

However, there was a significantly negative correlation between therapists' global outcome rating and whether the clients had had one or more prior psychiatric or psychotherapeutic treatments ($R = -.66$; $p < .011$; $N = 14$): The more prior treatments clients had, the lower were therapists' outcome ratings.

In two cases, the objective test scores on the outcome measures diverged remarkably from the therapists' global outcome ratings (for example, this was true for client K). All three outcome measures did not show changes (non-responder), whereas the therapist saw great treatment success (9 out of 10 points). Client K had very chronic problems and had had prior treatments. The therapist doubted the test scores and attributed this discrepancy to the client's inability to see any positive aspects in her life, thus leading to a negative evaluation of her treatment gains.

This was just the other way around in the case of client F. The therapist remained very sceptical (4 out of 10 possible points), even though the objective test scores showed statistically significant improvements (BSI-GSI and OQ-45.2 = responder) and clinically significant improvements on the BDI-II (complete remission). The therapist saw client F as having chronic problems (although the assessors did not) and found confirmation in the fact that the client had had several psychiatric or psychotherapeutic treatments prior to this therapy.

## 4. Discussion

The issue of generalizability from single-case research remains one of the major obstacles in qualitative and single-case research (Iwakabe & Gazzola, 2009). Iwakabe and Gazzola stress further

that “it is not easy to picture how we can build a coherent body of clinical knowledge through the accumulation of single-case studies” (p. 601). This study tries to aggregate and integrate relevant qualitative, quantitative, process and outcome variables, objective and subjective in their nature, from different perspectives (clients, therapists, researchers), prospective and retrospective. Thus, this study evaluates treatment outcome in psychotherapy from far more vantage points as compared to common evidence-based research practice and may serve as a model *‘en miniature’* for a possible approach to aggregate research results from single-case studies.

McLeod and Elliott (2011) see a “growing awareness of the difficulties of basing evidence-based practice solely on evidence from randomized controlled trials” (p. 1). RCT-studies do not address the very processes of treatment and changes during treatment, thus leaving the recipients of such research helpless.

14 single cases were investigated in detail to answer the question as to what factors facilitate a favourable treatment process, with a beneficial treatment effect, and for whom. Qualitative and quantitative information from the perspectives of the client, therapist, and treatment process was considered. The complexity inherent in each case became obvious when different perspectives have had their say: ‘What can be considered treatment success or treatment failure, and who makes the final judgement, because of which criteria: the client, the therapist, both of them, the outcome measures, or an independent expert?’ ‘Can treatment success in psychotherapy only be measured in symptom reduction?’ ‘Is freedom of symptoms possible?’ ‘Or should treatment success in psychotherapy put into perspective: Is there eventually no norm for ‘success’?’ ‘Why do many clients ask repeatedly for psychiatric or psychotherapeutic help over the years?’ ‘Were their previous treatments failures?’ ‘Will they perhaps never be successfully treated – if only the currently practiced ‘evidence-based research’ with its principles is taken into account?’ ‘Or were their treatments successful because such clients with early traumatization, severe abuse, and chronic problems will never be cured, and success for them would mean to go on living and gaining a level of quality of life that can be maintained for a while?’

It became obvious that each of the 14 single cases in this study cannot be judged as ‘successful’ or ‘unsuccessful’ in general. For one reason, the sample size is too small. For another, it became apparent that the information from all contributing sources demands a much more differentiated evaluation of the complex process-outcome relationships. The vast majority of evidence-based medicine (EBM) studies in psychotherapy only attempt to compare one specific form of psychotherapy with another, and they mostly do so without ensuring that the intended treatment under study was realized by the therapist (Perepletchikova *et al.*, 2009; Perepletchikova, 2011; Tschuschke et al., 2015).

However, only very few studies adequately considered the complexity of the psychotherapeutic process by investigating certain process-outcome relationships. There are literally no empirical studies that look at sustainability of the treatment effects by also integrating information on the clients' psychiatric history, the chronicity of their psychological problems, data from the treatment process comprising specific and nonspecific therapeutic factors, or information from the therapist such as therapists' degree of treatment adherence. Most of this important qualitative and quantitative information was examined in this study, and it is very rare that studies try to integrate such information from these multiple perspectives.

All information used in this study – qualitative, quantitative, prospective, retrospective, objective, and subjective data – was brought together from different sources of the psychotherapeutic endeavour. The result is that each single case provides a unique view of the preliminary evaluation of its treatment outcome. The intriguing question can be raised as to whether there are nevertheless – across all 14 single cases – certain commonalities that would allow us to discriminate between more favourable and less favourable treatment processes.

DSM-IV diagnoses did not discriminate between more successful and less successful therapies, nor did they distinguish clients with chronic and not-chronic problems or clients in the dysfunctional range and clients in the functional range. Personality disorders and bipolar diseases were found to be similarly distributed in the categories mentioned.

Eight of the 14 clients were characterized by independent assessors and by therapists as having chronic problems, all of them with more or less structural psychological deficits and with prior psychiatric or psychotherapeutic treatments. Eight of these 14 clients were in the dysfunctional range at the start of treatment.

Five of the six clients with not-chronic problems had had no psychiatric or psychotherapeutic pre-treatments. The assessed chronicity of the disease was highly positively correlated with the fact that these clients had had a prior treatment. Clients with chronic problems – mostly with severe early traumatisations and negative impacts on their structural development, with several pre-treatments – had, compared to clients without chronic problems, relatively less therapeutic benefits in terms of symptom reduction (BSI-GSI and BDI-II), although the not-chronically ill clients started on a clearly lower level loading of symptoms.

Clients with chronic problems can therefore be seen as individuals with massive early traumatization and/or distress, who have been in inpatient or outpatient psychiatric or psychotherapeutic treatment settings, several times. They have a much higher psychological burden at the start of treatment than non-chronic clients and are – in major ways – identical with clients in the dysfunctional range. Their therapists had to adapt to their abilities and needs by concentrating on stabilizing, or repairing, a fragile therapeutic alliance (five of eight clients in the dysfunctional

range show a complicated therapeutic alliance at Session 5 – the therapeutic alliance was more hampered than was the case for the six clients in the functional range). This can be seen in therapists' reduced treatment adherence in favour of more non-specific, supportive, structuring psychotherapeutic interventions (in five of the eight cases). In fact, these therapists – not knowing the results of the objective ratings – reported later on in their interviews that they had seen the necessity to adapt their usual therapeutic technique to their clients' abilities, which was not reported by therapists of clients in the functional range.

Clients with scores in the functional range at the start of treatment had a tendency to be rated as not chronically disturbed ($p < .12$), and they had had significantly fewer psychiatric or psychotherapeutic pre-treatments ($p < .02$). On average, they were psychologically significantly less burdened than clients in the dysfunctional range.

Clients in the dysfunctional range had a tendency towards more chronic problems, and they had been more often in pre-treatment. The fact that they were again experiencing high psychological distress – even if they had had several prior treatments or even had been in treatment within the last two years before this therapy – raises the question as to how effective the preceding treatments had been. Were they all simply ineffective, or do these clients have chronic illness and will relapse soon? Do these clients need psychiatric or psychotherapeutic support repeatedly or continuously?

The sub-group of clients in the initially dysfunctional range shows reduced interpersonal problems and social difficulties (OQ-45.2: from 83.5 to 58.6; t-test: 3.254; $p < .017$), reduced depressive symptoms (clinically significantly) (BDI-II: from 20.3 to 11.9; t-test: 4.134; $p < .004$; complete remissions), and at least a tendency towards reduced other symptoms (t-test: 1.822; $p < .111$). By a majority, most EBM studies would consider this successful. But looking at the clients' chronicity and their repeated health care utilization within shorter periods, then the question of the sustainability of psychotherapeutic treatment effects arises.

Clients *without* chronification of their psychological problems, seeking psychological help for the first time – although they started treatment with a psychological strain in a functional range – nevertheless impressively reduced their psychological problems and had even done so relatively more than clients in the dysfunctional range, who started with a much higher symptom load.

So, it might be that 'success' is a different thing for different groups of clients. Both of our subgroups – the chronic clients, most of them having scores in the dysfunctional range, and the non-chronic clients, most having scores in the functional range at the start of treatment – on average benefit substantially from their therapeutic treatments. But whereas the one group has chronic illness and asks for psychological support repeatedly, the majority of clients in the other – non-chronic – group requests treatment for the first time without being in a dysfunctional range and

benefits measurably more than the chronic group does. We can therefore speculate that they were sustainably 'cured', although they had not been literally ill when they entered treatment. If this were true, it would be an argument for psychotherapeutic treatment at the earliest possible date, when problems are still acute.

At this point, the question of treatment success in psychotherapy may be viewed from a different perspective. If clients with acute (and not chronic) problems request professional psychological help for the first time, they may be helped sustainably, even if they show psychological problems within the functional range of the normal population. They seem to benefit substantially from treatment, for the therapy had measurably reduced their psychological burden to a clearly higher degree than was seen in clients who had started with an objectively higher burden in the dysfunctional range. It can be speculated that if these clients will not show up again because they were able to master an acute life crisis sufficiently.

Clients with chronic mental illness seem to benefit from long-term psychotherapeutic treatments clinically and statistically significantly. This 'treatment success' will presumably be used up within a shorter or longer period, and almost certainly further professional psychological support will be sought. Why should this be labelled as 'unsuccessful'? If clients with chronic mental illness have a relapse and seek help from the health care system from time to time and can then go on with their lives with sufficient quality of life for a time – who would call this 'unsuccessful'? What then is 'successful' or 'unsuccessful'? What would be the difference between clients with chronic somatic illness and chronic mental illness? No one would come up with the idea of stopping medical treatment of clients with chronic somatic illness or expect a *restitutio ad integrum*, complete remission. Why then should it be different for clients with chronic mental illness? Would it not be a success if these clients experienced a drastic reduction in their psychological distress and moved into a functional range that obviously raised their quality of life and allowed them to reinvent themselves and continue their lives in self-responsibility – at least for a while?

A problem with the 'clinical significance' methodology is the fact that a considerable minority of clients asks for psychological help without having a level of distress in the dysfunctional range (Hill & Lambert, 2004). Are these persons who have acute problems? If so, then their treatment results would be proof of the effectiveness of early psychological treatment. Clients with a level of functioning that is not dysfunctional may benefit from treatment at an early stage; this may potentially lead to enduring treatment benefits that would make future treatments redundant.

Clients with chronic mental illness and more severe disorders had a more complicated therapeutic alliance than clients without chronification. This was the case early in treatment (within the first five sessions) as well as on average throughout treatment. Therapists also rated the quality

of the therapeutic alliance higher with clients from the functional range. A heavily loaded therapeutic alliance seems to prompt therapists to adapt their form of psychotherapy to their clients' abilities and needs. Thus, therapists lower their level of treatment adherence even if they work on a rather low level. It seems that this modification of the form of psychotherapy in which the therapist was trained is made in favor of sensitive work on the alliance climate, which in turn lays the foundation for continued work.

Therapists' global outcome assessment stands in no meaningful relationship with any other variable: The degree of clients' psychological distress at the start of treatment, the improvements in the outcome measures, the quality of the therapeutic alliance, clients' chronicity are all not correlated with therapists' global outcome ratings. The only meaningful relationship that could be found was with whether there had been prior psychiatric or psychotherapeutic treatments. In general, therapists rated global outcome worse if clients had prior treatment.

There was in tendency a negative correlation between degree of therapists' treatment adherence and clients' chronicity ($R = -.47$; $p < .09$; $N = 14$), which means that the more that clients' problems were chronic, the less that therapists adhered to their specific form of psychotherapy, as already mentioned above under therapeutic alliance. The degree of nonspecific psychotherapeutic interventions had no meaningful relationship with clients' chronicity. The form of psychotherapy did not play an important role in treatment outcomes.

The clients in our study with chronic mental illness sought psychological help repeatedly. The data suggest that these clients benefited substantially from their treatments, having a reduction in psychological distress clinically or statistically significantly or being able to continue their lives without substantial psychological distress and gained sufficient quality of life. It may be that these clients – as our single cases suggest – will seek help again from the health care system later on. In the interim they seem to build up psychological strain again. In any case they show a statistically significantly higher level of psychological distress than those clients who seem to have fallen ill for the first time.

Compared to the clients with seemingly acute problems, the chronicity of these clients can also be seen in their lower benefit from their treatments, even though they start with a much higher distress, which often is a predictor of treatment outcome (Tschuschke et al., 2015). Although the treatments in this study were long-term treatments that provided enough time for anchoring the achievements of the therapy, it is our hypothesis that these clients with chronic illness will eventually seek professional help again in the future.

Thus, 'success' in psychotherapy should be viewed from a much more differentiated perspective. Clients with chronic mental illness build up a greater level of psychological distress between professional psychological treatments, and most of them seem unable to reach complete

remission (*restitutio ad integrum*) probably by any therapeutic treatment. 'Success' for them would be sustainment of the status quo. Similar to clients with chronic somatic illness, they would need a dose of 'treatment' from time to time in order to be able to continue their lives or to establish equilibrium, respectively. On the other hand, 'success' for clients with problems that are not chronic would mean receiving professional psychological help at an early stage, even if their psychological burden is still in a functional range and reducing the level of their psychological problems substantially; this would thus flow into a probably sustainable effect.

This study is based on 14 single cases only. Therefore, it is not warranted that the 14 cases are representative of the majority of clients who ask for professional psychological support. The results may be biased by a selection of clients who were motivated to undergo long-term treatments and are therefore possibly not representative of the average client in psychotherapy. On the other hand, the conclusions drawn from this study may be of some value for many clients undergoing professional psychological support because of the multiple vantage points that were considered in this study.

The selection of therapists with their different forms of psychotherapy is certainly not representative of the usual spectrum, although therapists in this study were very experienced in humanistic, psychodynamic, and body-oriented treatment approaches. Nevertheless, behaviour therapy, cognitive-behavioural, person-centred therapy, and systemic approaches were not investigated. The restriction in the selection of treatment concepts and the conclusions drawn from the results may therefore not be representative, and generalizations may not be warranted.

The statistical differences reported in this study were sometimes very weak due to insufficient sample sizes. However, statistical tests should be taken only as an additional argument within the frame of the hypothesis-generating nature of the study.

A strength of this study is its complex look at several of the relevant variables in the psychotherapeutic process and the attempt to integrate them, taking into account qualitative and quantitative data. All outcome perspectives that should be used in psychotherapy research as demanded by Hill & Lambert (2004), were taken into consideration, thus providing a more multifaceted look at treatment outcome.

This study meets the strengths of case-studies following McLeod and Elliott (2011):

- *the complexity* (large numbers of observations from each single case under study from different vantage points) (clients' history of psychological problems and prior treatments, therapists' retrospective view of both the treatment process and outcome as well as the therapeutic alliance, researchers' estimations of therapists' treatment adherence, the longitudinal observations of the quality of the therapeutic alliance on both sides, subjective outcome estimations (therapists) and objective outcome estimations (tests, researchers)

- *longitudinal sensitivity* (case-studies look at how change unfolds over time based on series of multiple observations) (treatment adherence of therapists, repeated estimations of therapeutic alliances on both sides: clients and therapists)
- *appreciation of context* (influences of contextual factors) (chronicity of clients' psychological problems, prior treatments, functional versus non-functional range of problems, quality of therapeutic alliance)
- *narrative knowing* (qualitative interviews with therapists at follow-up, retrospective subjective experience of therapists)

Possible limitations of case-study methods do not apply to this study:

- case-studies can never claim the intuitive *general applicability* that is present when a conclusion is derived from analysis of hundreds of diverse cases
- case-studies are *highly ethically sensitive*

Since this multiple case-study tries to serve as a hypothesis-generating and not as a hypothesis-testing study a general applicability was never intended. The highly ethically sensitive nature of complex and detailed case-studies was also not affected in this study since information from each of the 14 cases cannot be compounded, thus making it impossible to identify any of the 14 individuals retrospectively.

## 5. Conclusions

Clients benefited from their psychotherapeutic treatment whether they had chronification of psychological problems or not. For clients with chronic problems, 'successful treatment' led to a drastic and, clinically and statistically significant reduction of psychological distress, which enabled the clients to take courage again und to – at least temporarily – gain a higher level of quality of life or to restore it. For clients without any chronification of problems, psychotherapeutic support at an early stage seems to lead to a healing – to so-called 'complete remission'– which would make future treatments unnecessary and would help to avoid suffering, trouble, and costs.

Treatment effects in psychotherapy should not be judged on the basis of objective outcome measurements alone. Thus, a multiple single-case approach taking into account qualitative as well as quantitative perspectives may lead to a more differentiated view. Although clinically significant changes are an advantage compared to statistically significant changes in objective measures, they do not tell us enough. A statistically or even clinically statistically significant improvement in clients with chronic illness may be seen as a 'success' in psychological treatments – *for the moment.* But these are clients who tend to relapse within shorter or longer periods. Would this then still be a 'treatment success'? From a statistical or a methodological point of view – certainly not. But from a human point of view – definitely.

With clients with chronic illness, the repeated high levels of psychological distress after some time look like relapses over the long run and look like a treatment failure, since the clients do not really recover. On a pre-post basis they are treated in EBM studies as 'successful' but would be

judged as 'unsuccessful' in follow-up studies. But EBM studies do not consider major relevant variables of the psychotherapeutic process (Orlinsky et al., 2004). Therefore, psychometrically derived test scores may provide an insufficient basis for a valid final evaluation; they do not reflect client-relevant variables and clients' and therapists' perspectives of the treatment process. 'Success' in psychotherapy is a double-edged sword. Especially over long-term treatments, therapists perceive a lot more of variables that exert influence on an individual's personality. They come to understand what factors are responsible for sustaining the problems and what resources in the client could be fostered. They thus come to a much more differentiated picture than outcome measures do.

Sceptical therapists may see reasons for their hesitation to judge a given treatment as 'successful' even when the objective tests indicate meaningful positive changes, and seemingly optimistic therapists see sustainable 'success' despite the fact that the objective tests do not show meaningful effects. Given the results of this study, questions regarding the validity of therapists' judgements of treatment outcomes should be raised and discussed from quite another vantage point (Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa, & Sutton, 2005).

All aspects considered, reflection on 'success' in psychotherapy seems to be insufficiently sophisticated in the research literature to date. As in somatic medicine, 'treatment success' has to be put into perspective. EBM studies, based solely on symptomatic reduction or based on significant changes in outcome measures, and mostly using pre-post designs, do not provide valid information on what psychotherapeutic treatments can achieve, for whom, under which treatment conditions, with what forms of psychotherapy, executed by what therapists, in what amount of time, with what duration, and with what sustainability. Psychotherapy research needs to invest much more effort in time, money, and manpower to investigate process-outcome relationships in detail and to integrate qualitative and quantitative information from different vantage points. Qualitative-quantitative single-case research in psychotherapy can thus add substantially to the body of knowledge and may lead to hypotheses to be tested in future studies.

**Authors**

**Volker Tschuschke** is Professor emeritus in the Dept. of Medical Psychology at the University of Cologne, Germany. He is psychoanalyst and psychotherapy researcher for more than 35 years.
**E-mail:** volker.tschuschke@icloud.com

**Agnes von Wyl** is Professor in the Dept. of Applied Psychology, in the University of Applied Sciences (ZHAW), Zurich, Switzerland. She is psychoanalyst and and a lecturer at the ZHAW.

**Aureliano Crameri** is a scientific assistant and also in the Dept. of Applied Psychology, in the University of Applied Sciences (ZHAW), Zurich, Switzerland teaches students at the ZHAW. He is specialized in statistical analyses.

**Margit Koemeda-Lutz, Ph.D.,** is a bioenergetic psychotherapist and works in her own private practice. She is a member of the Swiss Charta for psychotherapy and member of the scientific committee of the Swiss Charta for Psychotherapy.

**Peter Schulthess** is a Gestalt psychotherapist, member of the Swiss Charta for Psychotherapy, and is the Chairperson of the European Association of Psychotherapy (EAP)'s Science & Research Committee.

**Acknowledgement**
This research was supported by a grant from an anonymous donor arranged by the Department of Health of the Canton of Zurich, Switzerland.

**References**

BERGLAR, J., CRAMERI, A., VON WYL, A., KOEMEDA-LUTZ, M., KÖHLER, M., STACZAN, P., SCHULTHESS, P., & TSCHUSCHKE, V. (2016). Therapist effects on treatment outcome in psychotherapy: A multilevel modelling analysis. *International Journal of Psychotherapy,* Vol. 20 (2), pp. 61-80.

CRAMERI, A., VON WYL, A., KOEMEDA, M., SCHULTHESS, & TSCHUSCHKE, V. (2015). Sensitivity analysis in effectiveness studies of psychotherapy. *Frontiers in Psychology 6,* 1042.

CRAMERI, A., SCHUETZ, C, ANDREAE, A., KOEMEDA, M., SCHULTHESS, P., TSCHUSCHKE, V., & VON WYL, A. (2016). The Brief Symptom Inventory and the Outcome Questionnaire-45 in the assessment of the outcome quality of mental health interventions. *Psychiatry Journal,* Article 7830785. https://www.ncbi.nlm.nih.gov/pubmed/27699166.

CRITS-CHRISTOPH, P., CONNOLLY GIBBONS, M.B. & MUKHERJEE, D. (2013). 'Process-outcome research.' In: M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change, (6th Ed.),* (pp. 298-340). New York, Wiley.

DAHL, H., KÄCHELE, H. & THOMÄ, H. (Eds.) (1988). *Psychoanalytic Process Research Strategies.* Springer, Berlin.

DE WEERT-VAN OENE, G.H., DE JONG, C.A. & JORG, F. (1999). The Helping Alliance Questionnaire: Psychometric properties in clients with substance dependence. *Substance Use & Misuse, Vol. 34, pp. 1549-1569.*

FRANKE, G.H. (2000). *Brief Symptom Inventory von L. R. Derogatis (Kurzform der SCL 90-R).* Göttingen: Beltz-Test.

GEISHEIM, C., HAHLWEG, K., FIEGENBAUM, W., FRANK, M., SCHRÖDER, B. & VON WITZLEBEN, I. (2002). Das Brief Symptom Inventory (BSI) als Instrument zur Qualitätssicherung in der Psychotherapie'. *Diagnostica, Vol. 48, pp. 28-36.*

HANNAN, C., LAMBERT, M.J., HARMON, C., NIELSEN, S.L., SMART, D.W., SHIMOKAWA, K. & SUTTON, S.W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, Vol. 61, pp. 155-163.*

HAUTZINGER, M., KELLER, F. & KÜHNER, C. (2006). *Das Beck-Depressionsinventar-II. Deutsche Bearbeitung und Handbuch zum BDI-II.* Frankfurt: Harcourt Test Services.

HENRY, W.P. (1998). Science, politics, and the politics of science: The use and misuse of empirically validated treatment research. *Psychotherapy Research, Vol. 8, pp. 126-140.*

HILL, C.E. & LAMBERT, M.J. (2004). Methodological issues in studying psychotherapy process and outcome. In: M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (5th ed.),* (pp. 84-135). New York: Wiley.

HILLER, W. & SCHINDLER, A. (2011). 'Response und Remission in der Psychotherapieforschung', *Psychotherapie, Psychosomatik, Medizinische Psychologie, Vol. 61, pp. 170-176.*

IWAKABE, S. & GAZZOLA, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research,* Vol. 19, pp. 601-611.

JACOBSEN, N.S. & TRUAX, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, Vol. 59, pp. 12-19.*

JACOBSEN, N.S., FOLLETTE, W.C. & REVENSTORF, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. *Behavior Therapy, Vol. 15, pp. 336-352.*

KÄCHELE, H., ALBANI, C. & POKORNY, D. (2015). From a psychoanalytic narrative case study to quantitative single-case research. In: O.C.G. Gelo, A. Pritz & B. Rieken (Eds.), *Psychotherapy research. foundations, process, and outcome*, (pp. 367-379). Wien, Springer.

KIHLSTROM, J.F. (2006). Scientific research. In: J.C. Norcross, Beutler, L.E. & Levant, R.F. (Eds.), *Evidence-based practices in mental health. debate and dialogue on the fundamental questions,* (pp. 23-31). Washington, DC: American Psychological Association.

KRATOCHWILL, T.R. & LEVIN, J.R. (2014). Introduction: An overview of single-case intervention research. In: T.R. Kratochwill & J.R. Levin (Eds.), *Single-case intervention research. methodological and statistical advances,* (pp. 3-23). Washington, DC: American Psychological Association.

KÜHNER, C., BÜRGER, C., KELLER, F. & HAUTZINGER, M. (2007). Reliabilität und Validität des revidierten Beck-Depressions-Inventars (BDI-II)'. *Nervenarzt, Vol. 78, pp. 651-656.*

LAMBERT, M.J., HANNÖVER, W., NISSLMÜLLER, K., RICHARD, M. & KORDY, H. (2002). 'Fragebogen zum Ergebnis von Psychotherapie. Zur Reliabilität und Validität der deutschen Übersetzung des Outcome Questionnaire 45.2 (OQ-45.2)'. *Zeitschrift für Klinische Psychologie und Psychotherapie, Vol. 31, pp. 40-46.*

LAMBERT, M.J. (2013). The efficacy and effectiveness of psychotherapy. In: M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change,* (6th ed.), (pp. 169-218). New York: Wiley.

LAMBERT, M.J. (2015). Outcome research: Methods for Improving outcome in routine care. In: O.C.G. Gelo, A. Pritz & B. Rieken (Eds.), *Psychotherapy research. foundations, process, and outcome*, (pp. 593-610). Wien: Springer.

LEUZINGER-BOHLEBER, M. (1989). *Veränderung kognitiver Prozesse in Psychoanalysen. Bd. 2: Eine gruppenstatistische Untersuchung [Change of cognitive processes in psychoanalyses]. Vol 2: A group-statistical study].* Berlin: PSZ-Springer.

LUBORSKY, L. (1984). *Principles of psychoanalytic psychotherapy: a manual for supportive-expressive treatment.* New York: Basic Books.

MCLEOD, J. & ELLIOTT, R. (2011). Systematic case study research: a practice-oriented introduction to building an evidence base for counselling and psychotherapy', *Counselling and Psychotherapy Research, Vol. 11, pp. 1-10.*

OGLES, B.M. (2013). 'Measuring change in psychotherapy research', in M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change (6th Ed.),* (pp. 134-166). New York: Wiley.

ORLINSKY, D.E., RØNNESTAD, M.H. & WILLUTZKI, U. (2004). 'Fifty years of psychotherapy process-outcome research: continuity and change. In: M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (5th Ed.),* (pp. 307-389). New York: Wiley.

PEREPLETCHIKOVA, F., HILT, L.M., CHEREJI, E. & KAZDIN, A.E. (2009). Barriers to implementation of treatment integrity procedures: survey of psychotherapy outcome researchers, *Journal of Consulting and Clinical Psychology, Vol. 77, pp. 212-218.*

PEREPLETCHIKOVA, F. (2011). On the topic of treatment integrity, *Clinical Psychology, Sciences and Practices, Vol. 18, pp. 148-153.*

STACZAN, P., SCHMUECKER, R., KOEHLER, M., BERGLAR, J., CRAMERI, A., VON WYL, A., KOEMEDA-LUTZ, M., SCHULTHESS, P., & TSCHUSCHKE, V. (2017). Effects of sex and gender in ten types of psychotherapy. *Psychotherapy Research,* Vol. 27 (1), pp. 74-88.

STRUPP, H.H. & HADLEY, S.W. (1977). A tripartite model of mental health and therapeutic outcome: with special reference to negative effects in psychotherapy, *American Psychologist, Vol. 32, pp. 187-196.*

THOMPSON, A.R. & RUSSO, K. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research, *Qualitative Research in Psychology,* Vol. 9, pp. 32-46.

TSCHUSCHKE, V., KOEMEDA-LUTZ, & SCHLEGEL, M. (2014). PAP-S-Rating-Manual (PAP-S-RM). Rating-Manual zur objektiven Einschätzung therapeutischer Interventionen von Psychotherapeuten unterschiedlicher schultheoretischer Konzepte. *Schriftenreihe der Schweizer Charta für Psychotherapie*, Band 2, Zürich.

TSCHUSCHKE, V. & FREYBERGER, H. J. (2015). Zur aktuellen Situation der Psychotherapiewissenschaft und ihrer Auswirkungen - eine kritische Analyse der Lage. *Zeitschrift für Psychosomatische Medizin und Psychotherapie,* Vol. 61, pp. 122-138.

TSCHUSCHKE, V., CRAMERI, A., KOEHLER, M., BERGLAR, J., MUTH, K., STACZAN, P., VON WYL, A., SCHULTHESS, P., & KOEMEDA-LUTZ, M. (2015). The role of therapists' treatment adherence, professional experience, therapeutic alliance, and clients' severity of psychological problems: Prediction of treatment outcome in eight different psychotherapy approaches. Preliminary results of a naturalistic study. *Psychotherapy Research,* Vol. 25 (4), pp. 420-434.

TSCHUSCHKE, V., VON WYL, A., KOEMEDA-LUTZ, M., CRAMERI, A., SCHLEGEL, M., & SCHULTHESS, P. (2016). Bedeutung der psychotherapeutischen Schulen heute. Geschichte und Ausblick anhand einer empirischen Untersuchung. *Psychotherapeut,* Vol. 61, pp. 54-64.

VON WYL, A., CRAMERI, A., KOEMEDA, M., TSCHUSCHKE, V., & SCHULTHESS, P. (2013). The PAP-S (Practice of Ambulant Psychotherapy-Study), Switzerland. Study design and feasibility. Zurich University of Applied Sciences. http://www.psychotherapieforschung.ch/downloads/PTW-1-2013-Baseline-vWyl.pdf

WALLERSTEIN, R.S. & SAMPSON, H. (1971). Issues in research in the psychoanalytic process', *International Journal of Psychoanalysis, Vol. 52, pp. 11-50.*

WAMPOLD, B. (2001). *The Great Psychotherapy Debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum.

WEISS, J., SAMPSON, H. & THE MOUNT ZION PSYCHOTHERAPY RESEARCH GROUP (1986). *The Psychoanalytic Process: Theory, clinical observation, & empirical research.* New York: Guilford Press.

WITTCHEN, H-U, ZAUDIG, M. & FYDRICH, T. (1997). *SKID-I und SKID-II. Strukturiertes Klinisches Interview für DSM-IV.* Göttingen: Hogrefe.

**Endnotes:**

[1] *'restitutio ad integrum'* – in law, means a restoration to one's original condition and is the main guiding principle used to assess the award of damages in claims against a third party who may have caused the damage.

[2] Chronification: the increased state of becoming chronic or having a long duration.