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Therapy goals and treatment results in body psychotherapy: Experience with the concentrative movement therapy evaluation form

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Therapy goals and treatment results in body psychotherapy: Experience with the concentrative movement therapy evaluation form

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In this study, an evaluation form for concentrative movement therapy (CMT; in German: Konzentative Bewegungstherapie, KBT), an approach of psychodynamic body psychotherapy, is presented. This form has two functions: firstly, it is used for the everyday documentation of CMT and secondly, it provides data for quality monitoring. The primary intention is to assess the quality of the treatment course and result for the individual patient, rather than to study the effectiveness of a therapeutic method in general. In this study, it is discussed how this evaluation form meets the requirements of a quality assurance and quality monitoring tool for CMT. The specific therapy goals of CMT are listed because they play an important role in the documentation of CMT. In a pilot study, the treatment goals and results in the CMT group treatment were multcentrically documented with the CMT form and were descriptively analysed. In another application study, the evaluation of the goal attainment in the CMT form was compared with the success evaluation of the entire inpatient treatment.

Keywords: concentrative movement therapy; evaluation form; body-oriented psychotherapy; treatment goals; quality monitoring

Introduction

In Germany, body, dance and movement therapies are primarily used within inpatient psychotherapy. There is an increasing demand for the evaluation and quality monitoring of such psychotherapeutic treatment as well as of psychotherapy in general, particularly within the inpatient context (Levenstein, 1997; Rudolf, Laszig, & Henningsen, 1997). The primary intention is to assess the quality of the treatment course and result for the individual patient, rather than to study the effectiveness of a therapeutic method in general. Such documentation of treatment quality should be objective, clear and economical. As previous evaluation forms for creative therapy (e.g. Fritschi, Schmitz-Buhl, & Kriebel, 2002) were not specifically developed for the requirements of concentrative movement therapy (CMT), the research group of the German association for concentrative movement therapy

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(DAKBT) developed the CMT evaluation form (Konzentративнaя Bewegungstherapie- Dokumentationsbogen (KBT-DoBo); Schreiber-Willnow, Seidler, & Hamacher- Erbguth, 2007). This form has two functions: firstly, it is used for the everyday documentation of CMT and secondly, it provides data for quality monitoring. This form may possibly also serve advanced application studies, which would contribute to the empirical foundation of CMT in the sense of practice-based evidence (Barkham, Hardy, & Mellor-Clark, 2010) beyond randomised controlled trial studies.

Four aspects were considered when the CMT form was developed:

- The form should collect CMT-specific aspects.
- It should be short, so that it does not require a lot of time filling it out.
- It should be possible to fill it in on a computer or on paper.
- It should be applicable for CMT in group and individual therapy settings.

The evaluation form in its current version 1.3 (Schreiber-Willnow et al., 2007) entails the findings on admission, the formulation of specific CMT goals for the respective treatment with the help of a list of target areas, a treatment course description and an evaluation of the results. The feasibility of the form version 1.2 was tested in a pilot study (Schreiber-Willnow, Hamacher-Erbguth, & Seidler, 2006). In another naturalistic clinical application study, within the context of inpatient psychotherapy, it was studied whether the different goals for CMT in group setting are subject to the diagnosis of the patients. CMT treatment results were compared with the overall success of the treatment (Schreiber-Willnow, Kruse, Seidler, & Hamacher-Erbguth, 2006). User responses led to smaller revisions in version 1.3 that is distributed now in different hospitals for quality evaluation and monitoring.

In the following section, the treatment principles of CMT are briefly introduced. Then, the treatment goals of CMT with their theoretical background are described, and the different sections of the CMT form are presented. Finally, the results of both studies are reviewed, and then it is discussed in what way the CMT form is an adequate quality monitoring tool.

**Treatment goals of CMT**

CMT is a psychodynamic body psychotherapeutic method, which is particularly common in psychosomatic hospitals in Germany and Austria. Many CMT therapists are holders of the European Certificate of Psychotherapy. As a typical German method, however, it is not explicitly mentioned in Young’s (2011) overview of body psychotherapy in Europe. CMT has its roots in the body pedagogic work of Elsa Gindler (Ludwig & Haag, 2002; Von Arps-Aubert, 2010), developed during the 1920s, and was applied in England by Heller (2002) in the treatment of psychiatric patients. Stolze (2002) and Gräff (2008) further developed CMT to a body-oriented method of psychotherapy. Compared with other body psychotherapies, CMT can be described as a perception and movement-oriented approach which aims to help patients to symbolise and verbalise implicit body memories and to enhance competency in relationships. CMT may be compared with sensory awareness, which is better known in the USA (Brooks, 1974) and also has roots in the work of Gindler.
Similarities can also be observed with mindfulness-based stress reduction (Kabat-Zinn, 2006) which among others focuses on awareness of sensory perceptions too. CMT is not only widely employed in inpatient psychotherapy but also used in outpatient settings. In psychiatric and psychosomatic clinics, a combination of CMT and verbal psychodynamic group therapy has proven to be successful (Schreiber-Willnow, 2010; Seidler & Schreiber-Willnow, 2004). Patients report that CMT helps increase body perception and a sense of bodily well-being. In addition, new sensory and movement experiences lead to helpful insights (Kordy, Von Rad, & Senf, 1990).

The process orientation of CMT was in the foreground in the 1980s. At this time, the therapist understood herself as the patient’s companion on the therapeutic path (Stolze, 2002). Afterwards, an increasing goal orientation in treatment methodology, particularly in the inpatient context, was developed due to changed external conditions. Psychodynamic therapies and therefore also CMT faced the challenge of developing a brief therapy treatment concept due to the continuously shortened inpatient treatment periods, where standard treatment periods were reduced from between 3 and 6 months to 2 months and less.

The CMT treatment principles may be outlined as follows: the therapy focuses on body perception, body experience and movement expression. A central treatment element is the ‘CMT proposal’, in which the therapist offers the patient to take action and to perceive (Schmidt, 2006a). The therapist develops her offer based on her assessment of the current therapeutic situation and her (also somatic) countertransference. The offer can be understood as her ‘movement interpretation’ of the current therapy event. The patients react to the particular CMT offer in their own personal way. Becker (2001) called this process ‘free movement association’ analogous to psychoanalytic ‘free association’. Consciously and attentively moving and acting alone or with basic objects (such as balls, sticks or stones) or with other group members (or in individual therapy sessions with the therapist), the patient develops something new, a creative product in the interaction of perception and movement. This way self-awareness is initially promoted. Unprocessed or subconscious events, which are saved in the body memory, e.g. motoric affect proportion frozen out of grief, or aggressive impulses, which are held in the muscles, are experienced again in the therapeutic situation through this current ‘embodied experience’. This may lead to cathartic experiences. The symbolisation and integration of bodily experiences are encouraged through verbalisation in the therapeutic dialogue (Schreiber-Willnow, 2006).

Having briefly described the therapy rationale of CMT, we define eight target areas that are listed in the CMT form. These are based on an examination of therapeutic goals for CMT applied by Carl (2001), as well as the CMT process scales, a research tool for the third party assessment of individual CMT sessions (Seidler, Schreiber-Willnow, Hamacher-Erbguth, & Pfäfflin, 2003, 2004a, 2004b), which are described as follows:

1) **Self-awareness**: A central therapeutic goal of CMT is the improvement and promotion of body-related self-awareness, e.g. of physical sensations and physical boundaries. A differentiation of the body scheme due to improved body-related self-awareness is viewed as the foundation of emotional
differentiation. The ‘concentrative perception’ of one’s own body, the differentiated perception of physical sensations and emotions are the method and at the same time the goal of the CMT.

(2) Body concept: Many patients experience extreme difficulties in accepting their body. They dislike certain aspects, e.g. weight or figure, or have a reluctant attitude towards their body on the whole. An important therapeutic goal is the development of a positive emotional attitude or relationship with the body when such negative body concepts exist.

(3) Movement behaviour: CMT does not have a ‘correct’ movement behaviour in mind, but rather a situation-adequate controlled ability to move. Relationship to space, application of strength and time structure is considered an expression of a flexible and mature ego. From that point of view, impairment in movement behaviour may appear as too much or too little movement control and can be seen in specific qualities and configurations of spatial reference, application of strength and time expenditure.

(4) Vitality: CMT is also understood as a resource-oriented treatment which may revitalise the neglected or buried joy of life through conscious perception. Thus, the use of senses, free breathing and joyous aspects in movement are promoted.

(5) Ability to act: Mentally ill people, particularly depressed patients, often have difficulties to become active. CMT offers the patients playful movement sequences and movement with props (such as balls or balloons), which may help them to overcome their lack of motivation, rediscover their ability to act and increase their interest in their environment and a desire to explore it.

(6) Ability to relate: Relationship with co-patients (in group therapy) and relationship with the therapist (in individual therapy) is the central field of experience for encouraging interpersonal relationship skills. Through the support of the CMT therapist, patients are provided with the opportunity to physically test and develop skills related to conflict, the setting of boundaries and trust.

(7) Ability to symbolise: In CMT, symbolisation does not only mean the verbalisation of internal experiences, but also means the expression of experiences in movement or the allocation of symbolic meaning to objects, whereby an externalisation of the experience is achieved (Schmidt, 2006b). A patient can be asked to express the anger felt in a movement or to choose an object (e.g. a stone) which represents his anger best. The intensive exploration of specific sensual emotions in CMT often evokes memories saved in the body memory (Fuchs, 2011), which were not accessible for the patients beforehand. The verbalisation of the previously subconscious memories is also considered a form of symbolisation, which enables the patient in CMT to understand the meaning of their physical symptoms. The goal of CMT is to promote the patients’ ability to symbolise in its different forms.

(8) Self-regulation: A central interest of CMT is the enablement to care for oneself. Within the framework of the therapeutic relationship, patients are motivated to test out how they can use their own feelings and emotions to steer their affective impulses, to take responsibility for their emotions and to develop a frustration tolerance.
The CMT evaluation form

The CMT form begins with patient’s data (age, sex and diagnosis according to ICD-10, International Classification of Diseases (World Health Organization, 1992)) followed by the type of setting (group and individual therapy) and the number of sessions (see Appendix). Notes from preliminary discussions with the patients can be included. Nine therapeutic goal areas, including the eight target areas previously described and an additional ‘other target areas’ option, can be chosen and assessed after the treatment. Willingness to get involved with the CMT therapist’s proposals and to engage in verbal dialogue, as well as overall treatment success, is rated. A general description of the treatment process is the last item.

The evaluations described here were done with the CMT form version 1.2 (Schreiber-Willnow, Seidler, & Hamacher-Erbguth, 2005). The therapist chose a number of therapeutic goals out of a list of nine therapeutic goal areas specified in the CMT form. In most cases, this happened as a result of the preliminary discussion with the patient; sometimes, the goals were formulated by the therapist alone, if preliminary discussion was not scheduled in a hospital. These should be phenomenologically oriented, e.g. ‘better regulation of giving and taking’, or ‘improving body perception’. The above-mentioned CMT target areas are predefined in the form that allows an orientation to different foci in the CMT work. The CMT goals formulated in the phenomenon-oriented description are assigned to a matching target area and are ranked in order of their importance.

At the end of the treatment, an assessment is done by the therapist as to how much the respective goal is achieved. This is based on the goal assessment of the psychotherapeutic basic documentation (Psy-BaDo; Heuft & Senf, 1998) for the assessment of the overall treatment result in psychotherapy. It is assessed whether the goal was ‘not’, ‘moderately’, ‘completely’ or ‘more than completely’ achieved or entirely ‘omitted’.

The assessment of the CMT treatment course is done on two levels – how much the patient engaged with the CMT ‘proposal’ and how much he got involved in the therapeutic verbal dialogue. This differentiation comes from the clinical experience that some patients have difficulties in engaging with the CMT proposals, while others have difficulties in opening up and talking about their experiences. It is assessed whether the patient engaged with it ‘very much’, ‘moderately’, ‘little’ or ‘not at all’. There is also space on the CMT form for a short description of the treatment course. Such a description is particularly important within the inpatient setting, e.g. for the documentation of the patient’s record, to update colleagues about the contextual events in the treatment. It may also serve as a contribution to the discharge report.

Finally, an overall evaluation of the treatment success is done. An assessment is done as to what degree the patient benefited, or did not benefit, from the therapy.

A CMT form filled out in this manner offers the therapist and the treatment team a brief and comprehensible overview of the CMT treatment.

Pilot study about the feasibility of the CMT form

In a pilot study, the feasibility of the CMT form for CMT therapists in the clinic was investigated (Schreiber-Willnow, Hamacher-Erbguth, et al., 2006). The aim was to test
whether the eight mentioned target areas cover the actual phenomenon-oriented treatment goals well. It was expected that all the target areas should be used and that there should be few classifications of ‘other target areas’. Another question was whether the course and success assessment in the given form is feasible for the CMT therapists.

Nine CMT therapists with an average of 10 years CMT experience participated in filling out a total of 87 forms (with a minimum of 4 and a maximum of 23 forms per therapist). Four worked in the psychosomatic clinic, one in the psychiatric clinic, one in the day clinic and one in the addiction clinic. Seven of the nine therapists conducted a preliminary interview with patients prior to starting the CMT treatment. The respective CMT goals were in five cases determined solely by the CMT therapist, in three cases by the treatment team and in six cases together with the patient.

Results

In total, 87 evaluation forms of patients who participated either in group therapy \( n = 74 \), individual therapy \( n = 3 \) or in both \( n = 10 \) were collected. The CMT treatment course was either between 2 and 22 group sessions or between 1 and 15 individual sessions. Because of the pilot character of the study which aimed to examine the feasibility of the CMT form, it was also decided to include forms recording short-term treatment. Sixty-four per cent of the patients had a preliminary interview with the CMT therapist. In 68% of the forms, the treatment course was described in plain text. Sixty-three per cent of the forms include statements about the principal diagnosis according to ICD-10, Chapter F.

The average age of the patients was 42.3 years \( (s = 10.5 \text{ years}) \), of which 80% were women and 20% men. The spectrum of the principal diagnoses according to ICD-10 is wide: 31% depressive disorder \((\text{F}32-33)\), 24% anxiety, obsessive-compulsive and dissociative disorders or neurasthenia \((\text{F}40-42, \text{F}44, \text{F}48)\) and 20% somatoform disorders \((\text{F}45)\), as well as other diagnoses, which were present in less than 10% of the patients.

A total of 266 CMT goals were formulated and analysed for 87 patients. The number of the considered target areas was between 0 and 9 per patient; on average, 3.2 goals were stated. The central target areas were self-awareness and the ability to relate, which were stated in more than 50% of the patients. The other target areas are also included in the formulation of the goals by the therapists and are represented in at least 20% of the patients. Vitality and movement behaviour are with a relative frequency of 24% or 20% the least considered target areas. In contrast, the additional category ‘other target areas’ remains marginal with 9% (see Figure 1).

With respect to the assessment of the goal attainment at the end of the treatment, it appears that the vast majority of the therapy goals are considered achieved (31%) or partially achieved (48%) by the therapists. Nevertheless, 13% of the therapy goals are not achieved. Only a small number of therapy goals are considered more than achieved (3%) or as omitted (2%). It would also seem that some target areas perform better than others (see Figure 2). The target areas of self-awareness and body concept were considered most frequently as at least partially reached (91% or 92%). The respective extent of the attainment of the goal ‘ability to symbolise’ or for ‘other target areas’ was considered to be the lowest mentioned (70% or 63%).
Figure 1. Percentage rate of naming the target area; \(N = 266\) targets in 87 patients (multiple answers possible).

In 76 (88%) of the patients, the level of patient engagement in the therapy and the overall treatment success was evaluated. Seventy-six per cent of the patients engaged in CMT, 16% hardly engaged and 1% did not engage at all. It was significantly more difficult for the patients to cope with the verbal sharing in the group than with the CMT proposals: 64% were able to engage, 30% found it more difficult and for 3% it was not possible at all (comparison possible for 70 patients with both judgements: Wilcoxon test, \(t = -2.8, p = 0.005\)). According to the overall success assessment conducted by the therapists, 49% of patients benefited extremely and 36% benefited slightly from CMT. In 13% of the patients no change was seen, and in only 1% of the patients a worsening was detected.

Figure 2. Extent of goal attainment in the nine target areas (266 assessments by therapists).
Application study for the relation of diagnoses, therapy goals and results in the CMT

In a naturalistic study (Schreiber-Willnow, Kruse, et al., 2006), the CMT form version 1.2 was used for patients of CMT group therapy in a psychosomatic clinic. Psychodynamic group and individual therapy as well as CMT group therapy present the main focus of the integrative inpatient treatment concept in this hospital. It was examined which CMT treatment goals were formulated and whether the goal attainment was different depending on the principal diagnosis of the patients. Furthermore, the relationship between the assessment of CMT success and the overall results of the inpatient psychotherapy was examined.

Forty-five consecutive inpatient CMT group treatments (69% women) were documented by a CMT therapist in one ward using the CMT form. The ICD-10 diagnoses were made by a ward physician or a senior physician. For the measurement of the overall treatment success, the Symptom Checklist-90-Revised (SCL-90-R; Franke, 2002) was used which was filled in by the patient at the beginning and end of the treatment. In addition, a final overall assessment of the treatment success was done by the patient and the ward physician according to the Psy-BaDo (Heuft & Senf, 1998).

Results

Fifty-six per cent of the patients were diagnosed pursuant to ICD-10 with an affective disorder (F31, F32, F33), and 44% were diagnosed with a diagnosis from the neurotic disorder field (anxiety, obsessive-compulsive disorders, dissociative or somatoform disorders [F40–42, F44, F45, F48]). The treatment duration was on average 67.4 days ($s = 15.2$ days). The average global severity index (GSI) in the SCL-90-R was 1.38 ($s = 0.60$) in the beginning of the treatment and 0.76 ($s = 0.50$) at the end of the treatment, which results in a large effect size of $d = 1.12$. Forty per cent of the patients stated that they benefited from the treatment, and an additional 52.5% of the patients stated that they benefited a lot from it. A total of 7.5% of the patients were undecided in their assessment of the therapy success.

There were 114 treatment goals stated in the CMT form for the 45 patients. Similar to the pilot study, ‘self-awareness’ and the ‘ability to relate’, 58% and 49%, respectively, represent the target areas that were considered most in the formulation of the goals, followed by ‘self-regulation’ for 47% of the patients. The comparison of the most common target areas for both diagnosis groups showed a significant difference only with respect to the ‘ability to symbolise’. Treatment goals concerning this ability were far less often mentioned in patients with affective disorders than in patients with neurotic disorders (see Table 1).

Also with respect to the goal attainment, a similar picture to the pilot study was seen: most goals (83%) were achieved at least partially and only a small share of the goals (16%) was not achieved. The comparison of the goal attainment for the most common therapy target areas in the two diagnosis groups did not yield any significant difference (see Table 2).

Forty-two per cent benefited extremely and 42% benefited slightly from CMT according to the overall assessment by the CMT therapist in the CMT form. In 16% of the patients, no change was seen, and no patient suffered a worsening of the
Table 1. Comparison of the percentage of mentioning the most frequent target areas in the two diagnosis groups.

<table>
<thead>
<tr>
<th>Diagnosis group according to ICD-10</th>
<th>Group 1 affective disorders, F31–33</th>
<th>Group 2 neurotic and somatoform disorders, F40–42, F44, F45, F48</th>
<th>Fisher’s exact test: p value, significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>25</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Denomination of target area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-awareness</td>
<td>13 (52%)</td>
<td>13 (65%)</td>
<td>p = 0.55 ns</td>
</tr>
<tr>
<td>Ability to relate</td>
<td>13 (52%)</td>
<td>9 (45%)</td>
<td>p = 0.77 ns</td>
</tr>
<tr>
<td>Ability to symbolise</td>
<td>1 (4%)</td>
<td>9 (45%)</td>
<td>p = 0.001 ns</td>
</tr>
<tr>
<td>Self-regulation</td>
<td>13 (52%)</td>
<td>8 (40%)</td>
<td>p = 0.55 ns</td>
</tr>
</tbody>
</table>

symptoms. There are no significant differences between the two diagnosis groups. The average CMT goal attainment and the overall assessment of the treatment success in CMT highly correlate (Spearman-rank correlation, \( p = 0.75, p < 0.001 \)).

The overall assessment of the treatment success in CMT by the CMT therapist does not correlate significantly with the assessment of the overall treatment success by the patient (\( p = 0.15 \)). Furthermore, there is no significant correlation between the treatment success in CMT and the overall assessment by the physician (\( p = 0.26 \)). Another measure for the overall treatment success in the inpatient psychotherapy was the change in the GSI value in the SCL-90-R. The difference in the GSI from the time of discharge and the time of admission correlates significantly with the patient’s assessment of the overall inpatient treatment success (\( p = 0.51, p = 0.001 \)) but not with the assessment of the treatment success in CMT by the CMT therapist (\( p = 0.21 \)).

Table 2. Comparison of success in the most frequent target areas in the two diagnosis groups.

<table>
<thead>
<tr>
<th>Diagnosis groups</th>
<th>Group 1 affective disorders, F31–33</th>
<th>Group 2 neurotic and somatoform disorders, F40–42, F44, F45, F48</th>
<th>Fisher’s exact test: p value, significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal attainment:</td>
<td>( N ) group 1/group 2</td>
<td>Goal (partially) achieved (%)</td>
<td>Goal not achieved (%)</td>
</tr>
<tr>
<td>Self-awareness</td>
<td>13/12</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Ability to relate</td>
<td>13/9</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>Ability to symbolise</td>
<td>1/8</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Self-regulation</td>
<td>13/8</td>
<td>92</td>
<td>8</td>
</tr>
</tbody>
</table>
Discussion

The results of the pilot study show that the list of the eight predefined target areas in the CMT form covers the spectrum of the therapy goal formulations in the CMT well. Only a very small amount of the goal formulations was classified by the therapists in the category ‘other target areas’. Furthermore, the therapists used the entire range of predetermined target areas. The common consideration of the target areas ‘self-awareness’ and ‘ability to relate’ reflects the central therapeutic objective of CMT as a method of psychodynamic body psychotherapy to promote a better ability to relate on the basis of an improved self-awareness. In comparison, the target areas ‘vitality’ and ‘movement behaviour’ were taken less into consideration. With respect to the target area ‘vitality’, it is possible that it was not as much considered by the therapists because in the inpatient psychotherapy setting this target area is well covered by therapeutic sport, e.g. exercise or running therapy. The small number of goal formulations for the ‘movement behaviour’ may be interpreted as an expression of the specific therapeutic approach in CMT which is different than in the dance therapy approach, for example in CMT, improved movement behaviour is not directly, but indirectly strived for through sensitising self-awareness of movement qualities.

The CMT therapists were able to conduct a process and success assessment in 88% of the patients with the help of the given ratings. The respective items in the CMT form was formulated clearly enough. Based on the feedback from the participating therapists, version 1.2 of the CMT form was revised through differentiating the assessment steps. Based on the results of both studies and of comments from the participating therapists, only up to three therapeutic goals were defined in the CMT form version 1.3, which was more realistic in short-term treatment. The categories of goal attainment were differentiated into five steps (‘not’, ‘slightly’, ‘moderately’, ‘almost’ or ‘complete achieved’) plus ‘entirely omitted’. The assessment of the treatment course was done in two steps: Initially, it was assessed whether the patient changed his behaviour with respect to engaging with the CMT proposal or the therapeutic discussions over the treatment course.

In the case of rather similar behaviour during the treatment course, it was assessed whether the patient engaged very much, moderately, little or not at all. In the case of considerably changing behaviour, it was assessed whether the patient engaged increasingly, decreasingly or alternately. Furthermore, the overall evaluation of the treatment success was done on the basis of a rating scale with five instead of four steps (see Appendix). Version 1.3 is now used for recording the treatment in hospitals and could be used for further statistical evaluations.

The results of the naturalistic application study demonstrate that at least in the context of inpatient psychotherapy, patients with disorders from different diagnostic areas share not only some common therapy goals, but also certain differences. The target areas ‘self-awareness’, ‘ability to relate’ and ‘self-regulation’ were stated the same amount of times; thus, they seem to be independent from the diagnoses. These target areas concern the therapeutic core interest of CMT to achieve an improvement in the relationship with others and oneself with the help of body awareness and emotional perception. The target area ‘ability to symbolise’ was hardly mentioned among patients with affective disorders; however, this target area was relevant for 45% of the patients with neurotic disorders including anxiety, dissociative disorders
as well as somatoform disorders. In patients with such types of diagnoses, the 
disorder-specific focus of CMT emphasises that the patients will be helped to 
understand the symbolic meaning of their body symptoms (Braun, 2006). All in all, 
these results may be used as a proof for the construct validity of the target area list on 
the CMT form, even though further investigations must be done for other disorders 
or diagnosis areas.

The results of the assessments by the CMT therapists in the pilot and application 
study demonstrate that the CMT is a psychotherapeutic method that enables the vast 
majority of patients to get involved in a therapeutic process and to benefit from it. The 
broad range of treatment duration, with very short treatment periods in the pilot study, 
may be criticised as too heterogeneous for the treatment evaluation. It was, however, 
helpful in examining the feasibility of the form which was the main aim of the study. 
Even in very short-term treatments in inpatient therapy, the form seemed to be easy to 
apply.

It has to be mentioned, however, that depending on the target area, approximately 
one-tenth to one-third of the patients did not achieve their therapeutic goals set for 
them in CMT and that one-sixth did not benefit from it based on the overall evaluation 
of the treatment success by the CMT therapist. Therefore, the CMT form does 
meet the requirements of quality monitoring, which allows a documentation of 
whether the patient benefited from the treatment or not and how this was reflected in 
the treatment course.

The overall positive evaluation of the therapeutic success, here from a therapist 
perspective, is also confirmed by studies, in which the effectiveness of CMT is 
investigated from a patient’s perspective (e.g. Gathmann, 1990; Kordy et al., 1990). 
However, there is still a lack of methodologically in good therapy evaluation studies 
regarding CMT (Seidler, 2001). Furthermore, the specific contribution of CMT to 
the efficacy of inpatient psychotherapy has also not been investigated so far. In our 
application study, no significant correlation was found between the physician’s 
overall judgement and the success in CMT assessment by the CMT therapists. The 
same is true for the correlation between the success in CMT and the patient’s overall 
judgement concerning the inpatient therapy. Also, there was no significant 
relationship with the indirect change measure of symptom improvement assessed by 
the SCL-90-R. Whether patients benefit in total from inpatient psychotherapy or not 
does not seem to depend on how much they were able to benefit from the CMT 
group as a specific element of the inpatient treatment plan.

Our study results confirm the ubiquitous result of psychotherapy research that 
there is a low conformity of patient and therapist assessment (Weiss, Rabinowitz, & 
Spiro, 1996) and emphasise the necessity to distinguish between patient and 
physician or therapist assessment perspectives. Whether CMT contributes to the 
overall success of inpatient psychotherapy still needs to be investigated, whereby 
the patient’s perspective in the assessment of success in CMT should also be 
considered. Also, further research in the possibilities of application of the CMT form 
to other body and movement-oriented therapies is necessary. The next step in 
development would be a recording form generally applicable to clinical body and 
movement therapy.

Like in all quantitative research instruments, complexity of the individual case is 
lost by quantification. The CMT form tries to solve this dilemma by offering spaces
for qualitative description of important treatment features, which also serves improved communication within the therapeutic team. In order to establish the therapeutic relationship and formulate therapeutic goals together with the patient, a preliminary talk with the CMT therapist is obligatory. The CMT form serves the therapist as a structure for reflecting the treatment course and results of every single patient.

These first results with the CMT form indicate that it can be used as a practical routine tool in psychiatric and psychosomatic clinics. It allows a structured, time-efficient recording of CMT in the individual and group setting, whereby particularly the individual therapy goals of patients in the CMT are specified and their achievements are documented. At the same time, the CMT form offers relevant data for quality monitoring in the context of inpatient psychotherapy and for further empirical evaluation of body-oriented psychotherapy considering clinical parameters such as diagnosis and symptom severity. Offering the basis for a uniform vocabulary of body psychotherapy (Heller & Westland, 2011), the CMT form may also be applied in similar body-oriented psychotherapy methods for documentation purposes, if required in a modified or supplemented version.

Notes
1. The female form is chosen because most of the therapists in CMT are women.
2. The German version of the CMT form (KBT-DoBo) can be received from the authors.

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Appendix: The evaluation form for concentrative movement therapy
(CMT form; version 1.3)

1. Patient
   1.1 Name
   1.2 Age
   1.3 Sex
   1.4 Up to three diagnoses (ICD-10, chapter F)

2. Therapist
   2.1 Name

3. Treatment setting (group therapy, individual therapy, group and individual therapy)

4. Treatment dose
   4.1 Number of group therapy sessions and duration of therapy session (in minutes)
   4.2 Number of individual therapy sessions and duration of therapy session (in minutes)

5. Preliminary discussions (general commentary)

6. Therapy goals and goal attainment assessment
   6.1 Therapy goals
   6.1.1 Self-awareness (e.g. affect differentiation, body perception, body boundary and body schema)
   6.1.2 Body concept (e.g. emotional attitude and relationship with the body)
   6.1.3 Movement behaviour (e.g. relationship with space, action effort and sequential structure)
   6.1.4 Vitality (e.g. use of the senses, free breathing and pleasure)
   6.1.5 Ability to act (e.g. exploration of new behaviour and discovery and use of resources)
   6.1.6 Ability to relate (e.g. ability to handle conflict, demarcation and authenticity)
   6.1.7 Ability to symbolise (e.g. to understand the meaning of [bodily] symptoms and to develop the ability to symbolise)
   6.1.8 Self-regulation (e.g. self-care, impulse control, self-responsibility and frustration tolerance)
   6.1.9 Other goals
6.2 Assessment at the beginning of the treatment
6.2.1 Outline up to three therapeutic goals and classification according to the given therapy goals 6.1.1–6.1.9
6.2.2 Ranking of the goals due to their importance (1, first rank; 2, second rank; 3, third rank; N, new goal in the treatment course)
6.3 Goal assessment at the end of the treatment (0, goal omitted; 1, not; 2, slightly; 3, moderately; 4, almost; 5, completely)

7. Treatment course
7.1 Engagement with the KBT proposal (1, invariant [if yes: 1.1, very; 1.2, moderately; 1.3, little; 1.4, not at all]; 2, changing [if yes: 2.1, increasing; 2.2, decreasing; 3, varying]; 3, not to judge)
7.2 Engagement with the therapeutic verbal dialogue (1, invariant [if yes: 1.1, very; 1.2, moderately; 1.3, little; 1.4, not at all]; 2, changing [if yes: 2.1, increasing; 2.2, decreasing; 3, varying]; 3, not to judge)

8. Overall evaluation of the treatment success (patient benefits from the treatment: 0, not; 1, slightly; 2, moderately; 3, considerably; 4, extraordinarily)

9. Treatment course and success (general commentary)