CONCENTRATIVE MOVEMENT THERAPY
AS BODY-ORIENTED PSYCHOTHERAPY FOR INPATIENTS WITH DIFFERENT BODY EXPERIENCE

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Restricted body experience is frequently found in psychotherapeutic inpatients. Therefore, body-oriented psychotherapy is often applied as an adjuvant method. The authors investigated whether the quality of body experience influences the therapeutic process in concentrative movement therapy (Konzentrative Bewegungstherapie [KBT]) and treatment outcome. Sixty-two inpatients were assigned to 3 different types of body experience based on cluster analysis of their answers in the Assessment of the Own Body Questionnaire. The therapeutic process in KBT was studied using the Group Experience in KBT Questionnaire. A score for global treatment outcome and KBT treatment outcome was multidimensionally determined. The results show that different qualities of body experience do exist but do not have predictive value for (a) treatment outcome, (b) patient differentiation during the course of treatment, and (c) the connection between group experience and treatment outcome. The results do not confirm the clinical opinion that patients show different courses and results in body-oriented inpatient psychotherapy because of different quality of body experience.
lying, and sitting while being in a concentrative mood. They also become aware of their body in relationship to the surroundings as well as to the other group members or to special objects such as rods, balls, and ropes. By developing a new approach to their body and their sensations and naming them, a process of symbolization is initiated. Patients obtain new ideas as to how to handle their restrictions. They begin to integrate aspects into their body image, which were ignored before, developing positive body experience and understanding biographical reasons for their bodily reactions (Becker, 1977).

It could be shown, that patients' restricted body experience improves under KBT as part of psychotherapeutic inpatient treatment (Schreiber-Willnow, 2000b). The question remains whether extent and type of the restrictions have a modifying influence on the effectiveness of KBT. In psychotherapeutic research, one replicated finding is that patients profited best from a special therapeutic method when it was based on the patient's specific resources (Grawe & Grawe-Gerber, 1999). This would lead to the hypothesis that patients with more severe body experience disorders (such as those with posttraumatic stress or eating disorders) will have difficulties in KBT. On the other hand, KBT is seen to be especially indicated for these disorders (Carl & Herzog, 1996) or especially adapted therapeutic techniques are discussed (Peichl & Schmitz, 2000). Yet convincing empirical results are missing up to now.

In this study several questions are investigated:

1. Can different types of body experience in psychotherapeutically treated inpatients be distinguished?
2. How do patients with different quality of body experience react during the course of KBT?
3. Does treatment outcome differ for these groups of patients?
4. Are there different correlations between treatment process characteristics and outcome?

**Method**

**Sample**

We performed a reanalysis of the study data of Schreiber-Willnow (Schreiber-Willnow, 2000a, 2000b) involving 83 patients treated during 14 months in a psychosomatic hospital. The 62 patients with complete data sets form the study sample. The mean age for the 36 women (58.1%) and 26 men (41.9%) was 44.1 years old (SD=10.0 years). The duration of treatment was between 37 and 129 days (M=92.8 days, SD=25.3). According to the International Classification of Diseases-9, which was used for diagnosis during the time of study, the following main diagnoses were found: neurotic diseases (300; 24.2%), personality disorders (301; 40.3%), functional somatic disorders of psychic origin (306; 19.4%), eating, sleeping, and pain disorders (307; 4.8%), adjustment disorders (309; 6.5%), psychosomatic disorders (316; 3.2%), and psychotic disorders (295; 1.6%).

The treatment is an integrated team-based psychoanalytical oriented group or individual psychotherapy, including group therapy in KBT, not separated for special diagnoses.
Measures

For studying body experience, the Assessment of the Own Body Questionnaire (Fragebogen zur Beurteilung des eigenen Körpers [FBeK]; Strauß & Richter-Appelt, 1996) was used. The four-factor solution of the FBeK was taken, using the four scales Attractiveness and Self-Confidence (FBeK-1), Accentuation of the Bodily Appearance (FBeK-2), Insecurity/Apprehension (FBeK-3), and Negative Bodily-Sexual Sensation (FBeK-4). Data were standardized relating to sex (Brähler, Strauß, Hessel, & Schumacher, 2000).

Success of treatment was multidimensionally calculated by using the Global Severity Index from the Symptom Checklist of Derogatis (Derogatis, 1983; Franke, 1995), the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Bauer, Ureño, & Vilaseñor, 1988; Horowitz, Strauß, & Kordy, 1994), the Gießen Test (Beckmann, Brähler, & Richter, 1990) as a multidimensional personality questionnaire, patients' goal attainment scaling, and a global clinical impression of improvement by the physician. Critical values were defined for each measure (for details, see Schreiber-Willnow, 2000b). The global success score was defined as the proportion of measures having reached the critical value. Success in KBT was assessed by the KBT therapist by a rating on four different scales—Change of Body Perception, Change of Body Experience, Change of Nonverbal Symbolization, and Change of Verbal Symbolization—ranging from 1 (clearly deteriorated) to 5 (clearly improved). Global KBT success score was defined as the mean of the four ratings.

Process of treatment in group therapy with KBT was studied by use of the Group Experience in KBT Questionnaire (GEB-KBT; Seidler, 1995), leading to six scales that are obtained by factor analysis: Bodily Well-Being and Confidence (GEB-KBT-1), Experiences of Learning and Insight (GEB-KBT-2), Approach to Body Experience and Sensations (GEB-KBT-3), Discontentment With Therapist and Uneasiness (GEB-KBT-4), Discontentment With Group (GEB-KBT-5), and Restraint and Feeling of Not Being Understood (GEB-KBT-6). The scales ranged from 0 (absolutely not fitting) to 5 (absolutely fitting). After each KBT session, each patient completed the questionnaire.

Statistical Analysis

To find different types of body experience, predata of FBeK were studied by cluster analysis. First using a single linkage procedure to identify and remove extreme values, a ward cluster analysis followed and was compared with the solution of κ-means cluster analysis. Most selectivity in subsequent discriminant analysis has been used as a criterion to choose the number of clusters and to select between solutions of ward and κ-means cluster analysis.

The types of body experience found by means of that procedure were compared in their specific course during treatment using the GEB-KBT scales. For each scale and patient, the mean over all group sessions was calculated as a characteristic for the average level of a scale for each patient. To measure increasing or decreasing trends during the course of treatment, Spearman correlation between scale values and session numbers was calculated. An increasing course during treatment is shown in positive correlation, and decreasing trends are shown in negative correlation. Constant or fluctuating courses are reflected in low correlations.

After being transformed into an equivalent to product moment correlation (Bortz & Döring, 1995, p. 595) and to Fisher's z values, these correlation coefficients
and the six scale means were then used as dependent variables in ANOVA having the body experience clusters as a grouping factor. Global treatment effects and KBT treatment effects were compared between the clusters by means of Kruskal-Wallis H test.

To identify connections between treatment course and outcome, the transformed correlation coefficients and the means of the GEB-KBT scales both were used as dependent variables in ANOVA having the body experience clusters again as one grouping factor and dichotomized global treatment success or KBT treatment success respectively as the second grouping factor.

Although multiple testing was done in ANOVA, no alpha-adjusting was performed. A two-sided level of significance of 5% was taken because of the explorative data analysis in this study.

**Results**

*Types of Body Experience*

For 2 patients, single linkage cluster analysis identified extreme values. After comparing the results of ward and \( \kappa \)-means cluster analysis, a three-cluster solution of the \( \kappa \)-means procedure was chosen.

The description of the three clusters (Table 1) results from comparing the height of FBeK scales to that of a representative sample of German population (Brähler et al., 2000). Twenty-seven patients of cluster 1 clearly show negative body experience. Compared with the representative sample and patients from the other clusters, they experience less bodily attractiveness and self-confidence (FBeK-1). They are more insecure and apprehensive (FBeK-3) and state more negative bodily-sexual sensations (FBeK-4). Compared with the representative sample, the 19 patients in Cluster 2 experience their body appearance as more accentuated (FBeK-2) and are more worried about their body (FBeK-3). These results indicating narcissistic and hypochondriac traits in body experience lead to the cluster name fragile body experience. Showing mainly inconspicuous values, the 14 patients of Cluster 3 are only

<table>
<thead>
<tr>
<th>TABLE 1. Assessment of the Own Body Questionnaire (FBeK): Mean and Standard Deviations for the Three-Cluster Solution and the German Representative Sample (REP-GERM)</th>
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<tbody>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>FBeK-1</td>
</tr>
<tr>
<td>FBeK-2</td>
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<tr>
<td>FBeK-3</td>
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<td>FBeK-4</td>
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*Note.* FBeK-1 = attractiveness and self-confidence; FBeK-2 = accentuation of the bodily appearance; FBeK-3 = insecurity/apprehension; FBeK-4 = negative bodily-sexual sensation; Cluster 1 = negative body experience; Cluster 2 = fragile body experience; Cluster 3 = unconcerned body experience.

<sup>a</sup>n = 27.
<sup>b</sup>n = 19.
<sup>c</sup>n = 14.
<sup>d</sup>N = 2,047.
characterised by little accentuation of the bodily appearance (FBeK-2). Caring for the body appearance is not seen to be very important. Thus, the cluster is named unconcerned body experience.

The clusters clearly differ in the four FBeK scales but not in patients’ sex, age, and diagnosis. Treatment duration of 106 days for patients with negative body experience is significantly longer than for those with fragile or unconcerned body experience (84 and 85 days, respectively, $F(2, 57) = 7.03, p < .01$).

**Group Experience in KBT**

Treatment duration shows no significant correlation with group experience, neither concerning the average level of GEB-KBT scale values nor concerning the trend coefficients. Therefore, ANOVA instead of ANCOVA was used to compare the three clusters.

Concerning average levels of GEB-KBT scale values and trend coefficients, ANOVA yielded no significant results (Table 2). Independent of the type of body experience, patients’ values in scale GEB-KBT-1 (bodily well-being and confidence) and GEB-KBT-3 (approach to body experience and sensations) are slightly above the scale mean, whereas in scale GEB-KBT-2 (experiences of learning and insight) they are slightly below the mean. Negative experiences are seldom mentioned, values for all three scales (GEB-KBT-4: discontentment with the therapist and uneasiness, GEB-KBT-5: discontentment with the group and GEB-KBT-6: restraint and feeling of not being understood) show low values.

Standard deviations of the trend coefficients are large. Clear trends existing for some patients vanish in the average of the complete sample. Therefore, the average gain for patients in KBT concerning bodily well-being and confidence (GEB-KBT-1), experience of learning and insight (GEB-KBT-2), and approach to body experience and sensations (GEB-KBT-3) is small.

**Treatment Success**

Global treatment success ($M = 0.46, SD = 0.30$) and KBT success ($M = 3.83, SD = 0.59$) are significantly correlated ($\rho = .53, p < .01$). Patients in the three clusters

| Table 2. Group Experience: Means (M) and Standard Deviations (SD) of Trend Related Spearman Rang Correlations, Average Levels, and Results of ANOVA Concerning Body Experience Clusters |
|-------------------------------------------------|-----|-----|-----|-----|-----|
| Scale                                           | Trend | Level | ANOVA |
| GEB-KBT-1                                       | 0.16 | 2.73 | 0.13 | 0.66 |
| GEB-KBT-2                                       | 0.13 | 2.31 | 0.50 | 0.94 |
| GEB-KBT-3                                       | 0.22 | 2.88 | 0.29 | 0.17 |
| GEB-KBT-4                                       | −0.07| 0.82 | 0.29 | 0.31 |
| GEB-KBT-5                                       | 0.02 | 1.30 | 0.77 | 0.01 |
| GEB-KBT-6                                       | 0.04 | 1.56 | 2.36 | 0.18 |

**Note.** ANOVA = analysis of variance; GEB-KBT-1 = bodily well-being and confidence; GEB-KBT-2 = experiences of learning and insight; GEB-KBT-3 = approach to body experience and sensations; GEB-KBT-4 = discontentment with therapist and uneasiness; GEB-KBT-5 = discontentment with group; GEB-KBT-6 = restraint and feeling of not being understood.
Table 3. Spearman Correlation of the FBeK-Scales With the Global Treatment Outcome and the Outcome in KBT (n = 62)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Treatment outcome</th>
<th>KBT outcome</th>
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<tbody>
<tr>
<td>FBeK-1</td>
<td>-.08</td>
<td>-.11</td>
</tr>
<tr>
<td>FBeK-2</td>
<td>-.20</td>
<td>-.15</td>
</tr>
<tr>
<td>FBeK-3</td>
<td>-.01</td>
<td>-.09</td>
</tr>
<tr>
<td>FBeK-4</td>
<td>.24</td>
<td>.12</td>
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Note. FBeK-1 = attractiveness and self-confidence; FBeK-2 = accentuation of the bodily appearance; FBeK-3 = insecurity/apprehension; FBeK-4 = negative bodily-sexual sensation.

differ neither in global treatment outcome, $H$ test: $\chi^2(2, N=60) = 4.09, p > .05$, nor in KBT outcome, $H$ test: $\chi^2(2, N=60) = 0.74, p > .05$. The low and insignificant correlations of the FBeK scales with the global treatment outcome and the outcome in KBT confirm that treatment success is not related to the quality of body experience (Table 3).

Treatment Course Characteristics of Patients With Different Treatment Success

By ANOVA it was found that successful patients had more and increasing bodily well-being and confidence (GEB-KBT-1) than less successful patients, $F(1, 54) = 9.01, p = .01$, and $F(1, 54) = 6.16, p = .02$, respectively. They tend to gain more experiences of learning and insight, GEB-KBT-2: $F(1, 54) = 3.52, p = .07$; developed a better approach to body experience and sensations, GEB-KBT-3: $F(1, 54) = 3.49, p = .07$; and were less discontent with their therapist, GEB-KBT-4L $F(1, 54) = 3.72, p = .06$. However, no significant interactions were found between success and cluster.

Calculating another ANOVA with KBT success and cluster as grouping factors showed no significant results either in each factor or in interactions.

Discussion

Putting the results together, it is found that psychotherapeutic inpatients differ in their way of body experience. Three distinct patient groups could be identified: those who experienced their body as (a) negative or (b) fragile and (c) those who were unconcerned. Some clinical relevance in the clusters can be found. There are some similarities to the three body image types, found by Roth (1999, 2000) in healthy and bodily-diseased adolescents by means of cluster analysis. Roth distinguished body-uninterested, body-unintegrated, and body-active self-confident groups. The group of body-unintegrated adolescents was mostly burdened by psychopathological symptoms. Their features are similar to the group with negative body experience in this study because of a high amount of discontentment with body attractiveness as well as alienation from the body, accompanied by negative body sensations and insecurity. The group of body-uninterested adolescents as well as those with unconcerned body experience do not show much concern for their own body. However, the group of body-active young people and the group of patients with fragile body experience do not show similarities; they might be specific to the
different study populations. As long as prospective long-term studies on stability and changes in body experience from a developmental psychopathology point of view do not exist, the similarities in some aspects cannot be proved as continuity of body experience.

Contrary to the expectations, the distinct body experience qualities have no predictive meaning for global clinical outcome as well as for KBT success measured specifically according to the method. Furthermore, patients with different body experience do not differ in their group experiences during the course of KBT. Their success could not be shown to be a result of different group experience. Therefore, clinical or resource-oriented suggestions of a specific indication for body psychotherapy relating to different restraints in body experience could not be confirmed. The assumption of different therapeutic mechanisms according to the type of body experience (Schreiber-Willnow & Seidler, 2002) could not be supported here; no interactions between treatment results and type of body experience in their effects on group experience scales were found. Altogether, differences in body experience in general could not be found to be of importance to distinguish treatment process and results in body psychotherapy or in the whole inpatient treatment. The psychotherapeutic concept of the hospital is group oriented and focused on interpersonal difficulties and conflicts. Possibly interpersonal features such as interpersonal problems (Horowitz, Rosenberg, & Bartholomew, 1993) are more fundamental for treatment course and results, even in body-oriented group therapy.

The reported results are to be valued as preliminary because of the explorative character of the study using multiple testing and having small sample sizes in subgroups. It could not be considered by this study design that KBT is part of an integrated team-based psychotherapeutic concept, in which synergetic effects with other components of the treatment program are desired (Carl, Fischer-Antze, Gaedike, Hoffmann, & Wendler, 1985). Perhaps patients who do not profit much in KBT as a result of their negative body experience are achieving good global results because they gained a lot from other treatment components. However, it can be mentioned as an important result that different body experience does not lead to different outcome relating to a specific measure of success in KBT. Moreover, it needs further investigation to determine whether there is an individual adaptation of the therapist's intervention for different types of body experience.

In some psychic diseases, such as posttraumatic stress disorders or eating disorders, the strong clinical impression of typical restraints in body experience leads to indications for body-oriented psychotherapy. Studies have to be designed for specific diagnostic groups with specific treatment and specific disorder related body experience questionnaires (e.g., van Coppenolle, Probst, Vandereycken, Goris, & Meermann, 1990; Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1996) to determine whether different diagnostic groups have more or less benefit from body-oriented psychotherapy.

References

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**Zusammenfassung**

**Résumé**
Une expérience corporelle restreinte se trouve souvent chez les patients en psychothérapie hospitalière. Une psychothérapie focalisée sur le corps est donc fréquemment appliquée comme méthode adjuvante. Les auteurs ont investigué si la qualité de l’expérience corporelle influençait le processus thérapeutique et le résultat dans la thérapie par le mouvement concentré (KBT). 62 patients hospitalisés étaient attribués à 3 différents types d’expérience corporelle sur la base d’une analyse cluster de leurs réponses à un questionnaire d’évaluation du propre corps. Le processus thérapeutique en KBT était étudié à l’aide d’un questionnaire sur l’expérience en groupe dans la KBT. Un score de résultat de traitement global et de traitement par KBT était déterminé de façon multidimensionnelle. Les résultats montrent que des qualités différentes de l’expériences de son corps existent, mais qu’elles n’ont pas de valeur prédictive pour (a) le résultat du traitement, (b) les différences entre patients au cours du traitement, et (c) pour le lien entre expérience groupale et résultat du traitement. Les résultats ne confirment pas l’opinion clinique que les patients montrent des évolutions et des résultats différents en fonction de qualités différentes d’expérience de leur corps, en psychothérapie focalisée sur le corps à l’hôpital.

**Resumen**
Es frecuente encontrar una experiencia corporal restringida en pacientes de psicoterapia internados. De ahí que frecuentemente se administre psicoterapia orientada al cuerpo como método coadyuvante. Los autores investigaron si la calidad de la experiencia corporal influye sobre el proceso terapéutico y sobre el resultado final del tratamiento debido al movimiento concentrado (KBT). Teniendo en cuenta sus respuestas en la Evaluación del cuestionario sobre el propio cuerpo, se distribuyeron sesenta y dos pacientes internados en tres diferentes tipos de experiencia corporal. El proceso terapéutico según el KBT se estudió usando la Experiencia Grupal de acuerdo con el Cuestionario KBT. Se estableció un puntaje multidimensional para evaluar el resultado global del tratamiento y del tratamiento KBT. Los resultados muestran que existen diferentes calidades de la experiencia corporal pero sin valor predictivo de a) el resultado del tratamiento; b) la diferencia entre pacientes durante el curso del tratamiento y c) la conexión entre la experiencia grupal y el resultado del tratamiento. Los resultados no confirman la opinión clínica de que, debido a la diferente calidad de su experiencia corporal, los pacientes internados muestran cursos y resultados diferentes en la psicoterapia orientada al cuerpo.
Resumo
Experiências corporais restritas são frequentemente encontradas em pacientes internados que recebem psicoterapia. Por isso, é frequentemente aplicada psicoterapia orientada para o corpo como um método adjuvante. Os autores investigaram se a qualidade de experiências corporais influenciam o processo terapêutico na Terapia do Movimento Concentrativo (KBT) e no resultado terapêutico. Sessenta e dois pacientes internados foram distribuídos por 3 tipos diferentes de experiências corporais baseadas numa análise de cluster das suas respostas no Questionário de Avaliação do próprio Corpo. O processo terapêutico foi estudado com a KBT usando a experiência de grupo no Questionário da KBT. Foi multidimensionalmente determinado um score global para o resultado terapêutico e para o resultado terapêutico da KBT. Os resultados demonstram que existem diferentes qualidades de experiências corporais, mas eles não têm valor predictivo para (a) o resultado terapêutico (b) a diferenciação dos pacientes durante o curso do tratamento e, (c) a relação entre a experiência de grupo e o resultado terapêutico. Os resultados não confirmam a opinião clínica de que os pacientes demonstram diferentes cursos e resultados com a psicoterapia orientada para o corpo em pacientes internados devido a diferentes qualidades de experiência corporal.

Sommario
Una limitata percezione del corpo è stata trovata frequentemente in pazienti ricoverati. Perciò la body-oriented psychotherapy è spesso applicata come un metodo aggiuntivo. Gli autori investigavano se la qualità dell’esperienza corporea influenza il processo terapêutico nella concentrative movement therapy (KBT) e sui risultati del trattamento. Sono stati divisi sessantadue pazienti a 3 differenti tipi di esperienza corporea basati sulla cluster analisi delle loro risposte nel corso della valutazione del Questionario sul proprio corpo (Assessment of the Own Body Questionnaire). Il processo terapêutico nella KBT è stato studiato mescolando il Group Experience nel KBT Questionnaire. Un punteggio del risultato dell’intero trattamento e stato determinato multidimensionalmente. I risultati mostrano che esistono diverse qualità dell’esperienza somatica, ma non hanno: (a) un valore predittivo per risultati del trattamento; (b) un valore per differenziare i pazienti durante il corso del trattamento; (c) legame tra esperienza di gruppo e risultato del trattamento. I risultati non confermano l’opinione clinica che i pazienti che mostrano andamenti e risultati differenti nella psicoterapia orientata all’esperienze somatiche sono causati da una diversa qualità dell’esperienza corporea.

摘要
對接受心理治療的病患而言，我們常發現他們在身體方面的經驗是侷限的。因此，身體取向的心理治療在應用時，經常居於輔助地位。本文作者調查身體經驗的品質是否影響「專注移動治療」 (Concentrative Movement Therapy, KBT) 的治療歷程及治療效果。六十二位病人被分到三個不同身體經驗的組別，分組依據為他們在「個我身體評估問卷」(Own Body Questionnaire) 上作答的群聚分析結果。專注移動治療的歷程，以 KBT 問卷中的團體經驗量表進行調查。整體治療效果以及 KBT 治療效果的分數，則以多向度的方式來決定。研究結果發現不同性質的身體經驗確實存在，但對於治療效果、治療過程中的病患區別，以及團體經驗與治療結果的連結並沒有預測力。本研究結果並沒有驗證臨床上的想法，門診病患並不會因為不同性質的身體經驗而導致身體取向心理治療上的不同歷程及結果。