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Asking questions and making observations: Research results on Concentrative Movement Therapy

Abstract

This article provides an overview of the empirical research in the field of Concentrative Movement Therapy (CMT). By mid-2013, 48 publications had been presented referring to various studies. After a short outline of the history of CMT research, research results regarding the practice, identity, efficacy and indication as well as the specific therapeutic factors in this body-oriented psychotherapy method are presented.

Keywords: Concentrative Movement Therapy, empirical research, review

In body-oriented psychotherapy methods, empirical research is often put in second place. The reasons as to why body-oriented psychotherapists resist their work being examined on an empirical level can be found in the widespread lack of academic background of these methods and of the therapists who practice them. Moreover these therapists have reservations that an empirical research approach will disturb as well as inadequately capture therapeutic action characterised by immediacy of experience and intuition. Even Stolze, who gave Concentrative Movement Therapy (CMT) its name 55 years ago, struck a sceptical note when it came to the ability of empirical therapy research methods to capture the complexity of therapy. In a letter to the author, he wrote (I. Stolze, personal communication, September 9, 1992).

"I generally have my doubts regarding empirical therapy research since 'the realities... [are] slow and indescribably detailed' (Rilke in 'The Notebooks of Malte Laurids Brigge'), for - as he says in the foreword - ': Everything is made up of so many individual details, they cannot be captured.'... You will have to take into account when considering my objection that I am 75 years old."

Despite the wise scepticism of old age towards empirical research, Stolze nevertheless always supported the research efforts in CMT. He was a faithful participant of the annual CMT-research workshop conducted by the German association for Concentrative Movement Therapy (Deutscher Arbeitskreis für Konzentrativie Bewegungstherapie [DAKBT]). During the discussions that took place there, he kept reemphasizing that research should view the patient in CMT as
someone who is ‘on the move’ – and he meant this in a literal as well as in a figurative sense. It is also worth mentioning in this context that Stolze himself initiated a study on CMT in the late 1970s (BADDURA-MACLEAN and STOLZE, 1981).

In the face of the demand for quality control in out-patient and in-patient psychotherapy as well as of the challenge presented by the growing call for evidence-based therapy practice, even body psychotherapists have come to recognise: Research is needed! (ROHRICH, 2009). However, the focus should not be placed solely on providing the evidence for the efficacy of body-oriented psychotherapy which has been called for. Rather, the question of differential indication has come to the fore in light of the vast variety of body-oriented therapy methods and body-related intervention methods, such as instructions for body perception, massage, free dance improvisation, increased breathing or taking on physical stress postures. Not every approach is useful for every patient. Considering the psychologically ‘invasive’ nature of some of these intervention methods, answering the question of contra-indication has become very important. Any research on the effects of body-oriented psychotherapy should therefore take into consideration not only the successes, but also explicitly the failures of any given method. Moreover, it is necessary to examine whether therapy-induced damage can be evoked (YOUNG, 2006).

The following is an overview of the research results on CMT. After a short outline of the history of CMT research, this article will present the questions examined in empirical studies as well as the results observed. The following research questions will be considered:

1. What does the practice of CMT look like?
2. Is there a therapeutic identity of CMT?
3. What is the efficacy of CMT?
4. For which patients is CMT indicated?
5. Does CMT have any specific therapeutic factors?

Finally, the prospects for the future of CMT research will be presented.

Historical background of CMT research
The roots of CMT are to be found already in the work of its ‘primordial mother’ Elsa Gindler. It was of great concern to her to record the results of her work for outsiders. For this reason, she took photographs to document the changes achieved through her type of ‘physical education’ (cf. LUDEWIG, 2002, p. 126 et seq.). The first actual piece of research work on CMT dates back to the year 1961. At that time, Joachim-Ernst Meyer examined the neurophysiological effects of Elsa Gindler’s concentrative relaxation exercises as a type of foundational research. Using the electromyogram, he discovered a supra-threshold activation of the motoneurons in the spinal cord. He interpreted this effect, which he called ‘toning’, as proof that a ‘concentrative posture’,
Unlike for instance a passive posture as taken in autogenic training, leads to an increased level of readiness for action through the intensification of the body image.

However, research activity on a broader scale did not take place until the 1990s. By the end of 2010, 52 papers had been presented, containing empirical findings on CMT (Seidler et al., 2001; Seidler et al., 2011). Forty-one of these publications refer to different empirical studies. Nevertheless, 16 of these are works of so-called grey literature, i.e. in particular unpublished theses and dissertations. By mid-2013, another seven papers had been added to the pool of grey research literature. These are mainly master theses from the relatively new university course in psychotherapy, specialism in CMT, at the Donau-University Krems in Austria.

A number of the papers published in peer-reviewed journals in recent years resulted from the work of the research group within the German association for Concentrative Movement Therapy (DAKBT), the author being one of its members. This research group was founded in 1999. Its initial task was to determine the status quo of empirical research on CMT. This led to the first overview in 2001 (Seidler, 2001). Since 2000, the research group has been conducting an annual research workshop. This workshop is very well-received by CMT therapists. Around 40 CMT therapists gather in this workshop on a regular basis, together with renowned external lecturers from the research field and also lecturers from within the association, to discuss relevant research topics, such as therapy goals or process diagnosis in CMT, and also current research projects. This has led to wider acceptance and interest in research among CMT therapists, replacing their former wide-spread scepticism or even rejection of research.

The practice of CMT
In Germany, CMT has become established in psychotherapy as a so-called adjuvant group therapy approach. Yet the practice of CMT is by no means limited to this, as a study conducted in 2002 shows (Seidler, Schreiber-Wilnow, Hamacher-Erboldt and Pfäfflin, 2002). Of the 458 members of the DAKBT contacted at the time, a little over two thirds (68%) participated in the survey. 62% of those surveyed reported working in the field of psychotherapy. The following results refer to these 191 individuals.

First of all, what characterises a "typical" CMT therapist? 85% of them are women. Over 50% of these have been working in various professions for more than 10 years. As far as their professional backgrounds are concerned, most of them come from the field of pedagogy (31%) or physiotherapy (23%); physicians and psychologists are far less represented (18%). CMT therapists by no means only work in institutions (37%), especially psychosomatic and psycho-

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1 Other members of the research group of the DAKBT are or were Alexandra Epner, Swetlja Grützmacher, Anke Hamacher-Erboldt, Martin Pfäfflin und Karin Schreiber-Wilnow.
therapy clinics (59%), but often in out-patient settings in private practice (40%; 23% work in both an institution as well as in private practice).

It is hardly surprising that a little over half of CMT therapists in private practice work exclusively in an individual therapy setting (53%). This is rare in in-patient treatment (6%), yet over half of CMT therapists (56%) in clinics use both group and individual therapy. Since CMT practice in clinics is determined mainly by the institutional framework, it is of particular interest to examine what CMT looks like in private practice, which is not subject to institutional guidelines. In order to gather information on this, the CMT therapists in private practice were asked to provide further details about the last patient to regularly conclude group or individual treatment in their practice. The results were as follows: 63% of treatments are paid for by the patients themselves. When CMT is used as an adjuvant psychotherapy method within psycho-therapeutic treatment, this is done more frequently in group therapy rather than in individual therapy: 55% of CMT patients in a group therapy setting received additional psychotherapy parallel to their CMT treatment (at least intermittently). This does not apply, however, to most individual therapy CMT patients (76%). Women also tend to be more likely to be drawn to CMT as patients. The percentage of female patients, namely 80%, is markedly higher than the numbers gathered in other studies on out-patient psychotherapy, where the share of female patients was at approximately 62% to 73% (e.g. Eckert and Wuchter, 1994; Guidi, 1997; Leuzinger-Bohleber et al., 2001).

Disorders treated in private practice are all of those for which psychotherapy is usually indicated, especially depression (individual therapy: 39%, group therapy: 27%), neuroses (anxiety disorders, obsessive-compulsive disorders, conversion disorders; 28% and 27%, respectively) as well as stress and adjustment disorders (25% and 27%, respectively). Thus, the use of CMT is not limited to the treatment of so-called psychosomatic disorders often cited as the main area of application for body-oriented psychotherapy in literature, though patients with such a diagnosis constitute a substantial part of treatments with CMT in private practice. If somatoform disorders, psychosomatic organic diseases and behavioural disorders with somatic secondary diseases (e.g. eating disorders) are subsumed under psychosomatic disorders (Wilke and Hautzinger, 2000), 37% of group therapy patients and 47% of individual therapy patients have been diagnosed with such a disorder.

Many body-oriented psychotherapists are of the opinion that, compared to pure verbal psychotherapy, body-related psychotherapy speeds up the therapeutic process, thus leading to a shorter course of treatment (e.g. Green, 1983). Is there any evidence for this regarding individual CMT therapy in private practice? Half of all patients complete their treatment within 50 sessions. Thus, the duration of CMT treatment is within the limits of the quota set by German health insurers for psychotherapy based on psycho dynamic psychotherapy. It is only margin-
ally shorter than with client-centred therapy. With this purely verbal method, half of all patients complete their treatment successfully within 61 sessions (Eckert and Wuchner, 1994). Similar to client-centred therapy, the treatment of eating and personality disorders takes longer with CMT as well (median 105 and 100, respectively). One interesting spin-off of this survey is that the treatment of women takes longer with CMT than with client-centred therapy. While half of all female patients complete their treatment within 60 sessions, half of all male patients do so within 27 sessions. The question as to whether CMT is more of a 'woman's thing' will be examined more closely in the context of the findings regarding indication.

While the foregoing dealt mainly with the "external" characteristics of CMT practice, a closer look will be taken at what exactly happens in CMT in the following. So far, there have been only few empirical findings on this matter. This is likely related to the fact that to date, no systematic categorisation of intervention methods has been undertaken which would allow for a description of the approach used by CMT therapists. Generally speaking, there are various intervention foci in the therapy of CMT as well as in other body-oriented psychotherapy methods (one of the most essential intervention foci is 'bodywork' with the goal of differentiating body perception and body schema. With the development of CMT into a psycho-therapy method, the patient's active dealings with himself or herself, objects and other people and the emotions experienced in this context have become the focal point of therapeutic interest (Becker, 1997). This sets CMT apart from other more functionally oriented body therapy methods such as Eutony (Alexander, 1977) or the Feldenkrais method (Feldenkrais, 1977). The question therefore arises which level of importance is assigned to the different intervention foci in current CMT practice. The results of a study on CMT group therapy (Seidler, 2002) have provided initial indications regarding his matter.

For the purpose of this study, CMT therapists were asked to rank on a scale towards the end of each group therapy session to which extent they had pursued certain intervention foci. Evaluations for 105 group therapy sessions were submitted by group therapists in both outpatient and in-patient settings. They showed that in their work with groups, CMT therapists focus primarily on the perception of emotions and needs (on a scale from "0 = not at all" to "3 = primarily": M = 2.6), the perception of relationship behaviour and experiences (M = 2.4) as well as the expression of emotions and needs (M = 2.4). Openness in the way the CMT proposal is worded in order to allow the individual or the group the freedom to develop their own application of the proposal is comparatively rare (M = 1.7). In the same manner, the CMT proposals are less often used to achieve a differentiation in body perception and body schema (M = 1.7) or a perception of one's own physical expression or the physical expression of other group participants (M = 1.8), respectively, meaning the body is often not at the centre of the therapists' efforts. These results could be replicated in a more recent study (Seidler, Einer, Grützacher, and Schreiber-Wilnow, 2011) on group therapy and were almost identical with

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regard to individual therapy as well. In the latter, the expression of emotions and needs receives even more attention from the therapists than in group therapy.

In conclusion, the methodology of CMT has developed from its roots in movement pedagogy and movement therapy to an experience-oriented psychotherapy method. The question, however, as to how this carries the inherent risk of losing sight of the specific potential of body-work will be analysed in the following in the context of the presentation of studies regarding the efficacy of CMT.

The identity of CMT
Just as other body psychotherapists, CMT therapists are convinced that their body-oriented method has characteristic features which clearly distinguish it from established verbal psychotherapy methods. Despite this need for distinction, however, CMT therapists also see themselves as part of the tradition of psycho dynamic psychotherapy concepts. It is a matter of controversy whether psycho-dynamic psychotherapy can be a suitable and sufficient conceptual umbrella for diagnostico-therapeutic methodology in CMT. An empirical approach to the identity of CMT can be found by asking CMT therapists to state whether they are committed to one of the various therapeutic paradigms in particular, or by examining how the therapeutic goals pursued by them and their approach to building a therapeutic relationship differ from other therapeutic methods. In a study conducted by the research group of the DAKBT (Seidler, Schreiber-Willnow, Hamacher-Erbguth, and Pfafflin, 2003b), the statements given by 91 CMT therapists who had participated in an international survey by the Collaborative Research Network of the Society for Psychotherapy Research regarding the career paths of psychotherapists were analysed. The results could be compared with those of a sample among 2,376 psychotherapists from various countries (42% from Germany, 13% from the USA, 11% from Switzerland; cf. Ambühl and Orlinsky, 1999; Ambühl, Orlinsky, and SPR Collaborative Research Network, 1997; Orlinsky et al., 1996).

The result was that CMT therapists, more so than other psychotherapists, are guided by two therapeutic paradigms (16% vs. 9%) or have an eclectic therapeutic orientation (28% vs. 12%) not limited to one particular therapeutic paradigm. Nearly half of the CMT therapists surveyed (47%) adhere to a (humanistically) modified analytic orientation. Regarding the therapy goals pursued by CMT therapists, the results are as follows: of a list of 15 goals, though none of them focus on the body as the subject matter, the majority of CMT therapists view the following as important: (a) Developing a strong sense of self-esteem and identity (66% of CMT therapists), (b) integrating aspects of one's experience which had previously been suppressed or split off (52%) and (c) finding the courage to enter into new situations or situations previously avoided. These are therapeutic goals also often cited by therapists with a psychoanalytic
or humanistic orientation, but not by therapists who orient themselves on behaviour therapy or systemic therapy (Ambühl and Orunsky, 1999). What sets them apart from therapists with a psychoanalytic or humanistic orientation is that CMT therapists, surprisingly, do not emphasise ‘experiencing one’s emotions to the full’ as an important therapeutic goal nearly as much (22%) as the aforementioned groups of therapists (40% and 60%, respectively). One explanation for this could be that the focus on experience in therapy is expressed less in the development of emotional experience and more in the development of physical experience as a favoured therapeutic goal of CMT as well as in other body-oriented methods (Carli, 2000). However, this was not taken into consideration in the therapy goal list provided in the survey.

What are the CMT therapists’ ideals when it comes to building a therapeutic relationship? Just as other psychotherapists (cf. Ambühl et al., 1997), most CMT therapists (i.e. over 70%) naturally want to be accepting, tolerant, warm-hearted, friendly, committed, involved, intuitive, efficient and skilful in their work with patients. Yet CMT therapists, more than other therapists, tend to aim for both, a protective as well as a critical attitude towards their patients (59% or 55% respectively, vs. 15-49%). However, less than other therapists, CMT therapists consider a receptive attitude as important (31% vs. 50-69%). The common denominator between psychoanalytic and humanistic therapists on the one hand and CMT therapists on the other is the emphasis on an involved and intuitive style in their work (over 85%). Nevertheless, CMT therapists’ ideal concept of themselves with the following characteristics is more in line with therapists who orient themselves on behaviour therapy or systemic therapy: nearly all of the CMT therapists surveyed want to be friendly towards their patients (89%), but some also want to challenge them (51%) or urge them on (32%).

This seems to constitute a tension for CMT therapists similar to what can be found when comparing these ideal concepts for a therapeutic relationship with their actual relationship style as assessed by them. First of all, it can be said that their ideal and actual relationship styles are largely consistent, as is the case with other psychotherapists (cf. Orunsky et al., 1996). Discrepancies (differences of more than 10%) between ideal and actual relationship style can be noted for the following relationship aspects: in the same manner as other therapists, CMT therapists often feel themselves to be very caring towards their patients, yet without straining for this to such a large extent in their therapeutic ideal self. Unlike other therapists, CMT therapists also describe taking on an actual role which, compared to their ideal self-image, is characterised by being more challenging, pragmatic and receptive in building a relationship as well as a less critical in their attitude. By contrast, among the psychotherapists sampled, the actual role taken on compared to the ideal self-image is marked by less efficiency, skillfulness and sensitivity and more permissiveness and protective behaviour. While doubts regarding their own therapeutic technique (efficiency, skillfulness and sensitivity) can be found among therapists working with other methods when they compare their ideal and real self-image, this does not
come into play for CMT therapists. The latter seem to be more preoccupied with their inner ambivalence concerning a challenging, critical attitude in building a therapeutic relationship. Much like therapists working with action and solution-oriented methods in behaviour therapy and systemic therapy, CMT therapists also strive to challenge their patients to discover and use their ability to act. This, however, seems to contradict the desire to also encounter the patient in a protective, friendly manner in the sense of a ‘primary motherliness’ seen as indispensable in body-oriented psychotherapy with patients with a structural ego disturbance (BUDUHN, 1992).

In conclusion, the following can be said: On the one hand, CMT therapists display vast similarities with therapists with an analytic and humanistic orientation in their self-concept. Yet, on the other hand, since it is also a primary concern of CMT therapists to empower their patients to act, there are similarities between them and therapists who orient themselves on behaviour therapy or systemic therapy as well. It seems to be precisely this configuration which defines the identity of CMT: it is the CMT therapists’ central concern to strengthen patients’ sense of self in such a manner that they will come to understand themselves better, but also see themselves as empowered to act again. However, this broad concern contained in their self-concept as therapists may be accomplished by typical potential pitfalls in experiencing their identity: the experience of the limitations of what can actually be achieved through psychotherapy and, in this sense, of their own efficacy as therapists, may have to be disregarded to a certain extent by CMT therapists. Moreover, the pursuit of these different therapeutic concerns apparently often leads to CMT therapists vacillating between a critical, challenging relationship formation versus a protective, friendly relationship formation, which results in a greater demand for integration in their experience of identity.

The efficacy of CMT

According to the standards of psychotherapy research, the efficacy of a psychotherapy method has to be proven within the framework of an experimental design, i.e. with a study in which patients of a particular therapeutic method are compared with patients of a so-called control group which received a different type of treatment or none at all. The assignment of patients to the control group and to the therapeutic method examined should be randomized. For CMT, there are four different controlled therapy studies to date: KEHDE (1994) examined the efficacy of student personal growth groups using CMT compared with the changes among a wait list control group. Rörer, Schaus and Damhörs (2002) examined the efficacy of groups using CMT with patients suffering from chronic back pains within the context of in-patient orthopaedic rehabilitation. The control group was made up of patients who received the regular orthopaedic treatments prescribed. Weber, Haltenhof, Corbecher and Blankenburg (1994) examined the effects of movement therapy groups using elements of CMT, among others, with
patients of a psychiatric clinic within the framework of a quasi-experimental design. The psychiatric patients could choose whether they wanted to participate in movement therapy as additional therapy offered. Those patients who chose not to participate in movement therapy formed the control group. Wernsdorf (1998) examined the efficacy of groups using CMT as an additional therapeutic offer for patients (most of whom had eating disorders) of a psychosomatic clinic. Patients without CMT served as the control group. There was only one study (Weber et al., 1994) which did not use randomized assignment of patients to CMT and to the control group.

Limitations in their methodical quality as well as problems with executing these studies are most likely the reasons why only one of these studies (Weber et al., 1994) was ever published, while the others are so-called grey literature. Nevertheless, these studies resulted in some interesting details. Compared with the control group, participants of CMT personal growth groups or of treatment groups in the psychiatric and psychosomatic clinic, respectively, displayed significantly higher levels of spontaneous aggression (d = 0.52)² and masculinity (0.58) in the sense of self-assertiveness as well as less fear of failing in their jobs (0.60; Kehde, 1994), lowered impulse control (0.16; Wernsdorf, 1998), an improvement in their general sense of well-being (0.63 and 0.38, respectively; Weber et al., 1994; Wernsdorf, 1998), less symptoms (0.55) and a decrease of physical discomfort (0.39; Weber et al., 1994). The size of these effects of CMT can be considered small to medium. There were no significant differences compared with the control group in the study of orthopaedic patients with chronic pain (Röper et al., 2002).

At a very preliminary level, these results can be taken to indicate an efficacy profile of CMT with patients with mental health issues as well as those seeking personal growth. Apparently, CMT unfolds its efficacy in relation to subjective (physical) well-being on the one hand, and in relation to an increase in self-confidence on the other. These effects reflect some of the main priorities in the therapeutic work with CMT. For instance, CMT time and again tries to help patients work out improved ways of relating to themselves. A growing sense of (physical) well-being seems to be the end result of this work. In reference to Winnicott (1971), it is also seen as essential in CMT to support patients in creating therapeutic 'leeway' for themselves throughout the course of treatment in order to be able to discover and try out new ways of acting. It seems plausible to assume that this is conducive to an increase in self-confidence since through this therapeutic approach, a strict super-ego is mitigated. Whether CMT can be considered a suitable treatment method for orthopaedic patients with chronic pain cannot be answered satisfactorily at this point. The authors of the study in question report that many of the orthopaedic patients

² Effect sizes (Cohen's d) were calculated a posteriori in accordance with the data collected in the aforementioned studies. The effect size provides a standard metric for comparing the results of different studies. In evaluation studies the effect size is used to describe the difference of the post-measurement means of the treatment and control group in the unit of the standard deviation of the control group in the pre-measurement.

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showed strong reservations towards CMT group treatment and the psychometric measurement instruments, which in part targeted psychological symptoms, since they feared their physical symptoms would be ‘psychologised’. Apparently, CMT has yet to develop a treatment model geared towards the expectations of orthopaedic patients. There is a number of further studies which do not measure up to the gold standard of psychotherapy research with regard to efficacy studies, but still supplement the overall picture of the efficacy of CMT with relevant findings. For one, there are those studies which ask patients to state how helpful for themselves they consider various therapeutic methods used in in-patient psychotherapy. At the end of treatment (KORDY, von RAD, and SENF, 1990; WERNSDORF, 1998) as well as three to seven years later (GATHMANN, 1990), the majority (53-70%) of the patients of psychosomatic clinics rank CMT as the most helpful therapeutic (group) method. CMT is thus among the therapeutic elements of in-patient psychotherapy most valued by patients alongside verbal individual and group therapy. Moreover, CMT emerges as the method least often ranked as ‘insufficient’ by patients (3%; GATHMANN, 1990). However, it also became apparent that the patients’ opinion about CMT varies depending on the treatment setting, as well as the gender and age of the patients (BAUMANN, 1994; CRONJAEGER, 1998; WERNSDORF, 1998; ZEECK et al., 2002). For instance, only a little over a quarter of all patients in the second half of life rank body-oriented group psychotherapy with CMT elements as very helpful.

Clinic directors also see CMT as very positive (DIETRICH, 1995). Two-thirds of them are of the opinion that CMT is relevant for psychotherapy. This opinion is voiced far less frequently regarding other body-oriented methods, despite the fact that they are not less well-known.

It is hardly surprising that CMT therapists see the therapy results achieved with CMT within the context of (out-patient or) in-patient treatment mostly as positive (SCHREIBER-WILLNOW and SEIDLER, 2013). According to their evaluation, 79-84% of CMT-specific therapy goals were at least partially achieved. In their estimation, 42% of the patients had profited very much from CMT and another 42% had profited to some extent. The CMT therapists do not see a change for the worse in any patient. Nevertheless, despite these high success rates, it is also clear that CMT constitutes a difficult treatment method for part of the patients in (out-patient or) in-patient psychotherapy (SCHREIBER-WILLNOW, HAMACHER-ERBGUTH, and SEIDLER, 2006): 17% of the patients are seen as having no or little engagement with the CMT proposals, and 33% of the patients showed little or no willingness to engage in a therapeutic dialogue.

The following findings of a two years follow-up study on in-patient group treatment with CMT suggest a specific efficacy of CMT (SCHREIBER-WILLNOW and SEIDLER, 2005): patients who achieved improved access to their physical experience and their own feelings during the treatment were characterised in the follow-up period especially by a stability in the improvement in body experience.
To date, studies concerning individual CMT therapy are rare. In a survey undertaken by the DAKBT research group (Seidler, Schreiber-Willnow, and Hamacher-Erbcuth, 2006), patients displayed rather satisfying results after only three months of out-patient treatment. The symptom levels which had initially been very high and at the level of patients in in-patient treatment had already improved significantly to some degree (f = 0.60). As well as that, the direct measurement of change yielded a highly significant result, with patients stating clearly positive changes in their experience and behaviour.

What can be concluded with regard to the efficacy of CMT? All of the studies undertaken thus far hardly meet the requirements of high-level methodical efficacy research, which means the findings presented herein are to be seen as preliminary. Nevertheless, the results are encouraging; The results can be taken to indicate an efficacy profile of CMT which reflects some of its main priorities in therapeutic work. There are no indicators to suggest that CMT as a body-oriented method poses a high risk for patients or leads to therapeutic failures. On the contrary: CMT is generally seen as very positive by patients.

**Indication for CMT**

Among clinicians and in literature, there are often very clearly defined notions as to which patients should receive body-oriented psychotherapy. Ultimately, this includes all those patients for whom an improved (positive) access to their physical experience is considered potentially beneficial. On the one hand, these are patients who seem too ‘stuck in their heads’ to therapists using verbal psychotherapy methods and who make those therapists’ lives difficult with endless rationalising verbiage. On the other hand, psychotherapists using verbal methods often sense the limitations of their treatment approach with patients whose body experience is strongly impaired and who do not feel as though verbal treatment can truly reach them. Nevertheless, psychotherapy research has made it clear by now that the indication for a particular treatment method should be in accordance with a patient’s resources rather than his or her deficits (Grave and Grave-Gerber, 1999).

We followed up on these questions in two studies (Schreiber-Willnow and Seidler, 2002; Seidler and Schreiber-Willnow, 2004). We examined whether the quality of body experience and the gender of the patient had any influence on treatment progression and results, taking into consideration that, with regard to gender, men are generally said to have a tendency for being ‘stuck in their heads’. In the face of the obvious affinity of women to CMT already reported in the context of the practice of CMT, we asked ourselves whether CMT was primarily a ‘woman’s thing’.

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In examining this question, the Group Experience Questionnaire for CMT (SEIDLER, 1995) was used in order to gather information on how patients in an in-patient psychotherapy pro-gramme experienced each group session. Moreover, using scales, the CMT therapist evaluated the patients' progress or impairment at the end of treatment with regard to CMT-related elements (body perception, body experience, ability to symbolise, ability to verbalise). With the help of questionnaires filled in by the patients at the beginning and at the end of treatment, as well as on the basis of an evaluation of the treatment outcome by the individual therapist, the overall success of in-patient psychotherapy was assessed. A total of 62 patients were assessed; 58% of these were women.

Regarding the overall success of treatment and the success of treatment with CMT, the statistical analysis showed no significant differences between men and women. Yet if there is no difference between females and males with regard to treatment results, the question arises as to whether there are any differences between the sexes with regard to treatment course. In order to examine this question more closely, we evaluated the group experience questionnaire in terms of differences at the beginning, at the end and during the overall course of treatment: for example, do women already arrive at an improvement in body experience at the beginning of treatment while men do not gain improved access to body experience until towards the end of treatment? We found, however, that women and men undergo CMT group therapy in relatively similar ways. For instance, both men and women experience the same level of learning and insight during the course of treatment as well as physical well-being and confidence.

We also examined the question as to whether different therapeutic mechanisms may come into play in CMT, depending on whether the patient is male or female. Are there different 'roads that lead to Rome' for men and women, even if their experience over the course of treatment and the treatment results are comparatively similar? To examine this question, the ways in which men and women experience the group were compared whilst taking the treatment results into account. The results made it clear that the course of treatment can sometimes vary to quite an extent with successful versus less successful patients if not only their gender, but also their age is taken into consideration. For instance, only older men showed any statistically significant connection between the process element of 'access to bodily experience' and treatment success: Older men who were successful reported an overall higher level of improvement in their ability to gain exponential access to their own body than less successful older men. Differential results regarding the connection between group experience and treatment success can also be proven for the other scales used on the group experience questionnaire. For instance, older women who profited from CMT, reported especially of an increase in physical well-being and hopefulness towards the end of treatment. Younger women who benefited from CMT, on the other hand, displayed physical well-being towards the beginning of treatment. Moreover, it was of higher relevance for them to be able to contribute to the group. For younger men, a positive
treatment result in CMT was connected to a positive interpersonal experience over the entire course of treatment.

All of these variations in the connection between group experience and treatment success are owed not only to gender-specific effects alone. Therefore it has to be said that men have no more problems with CMT than women. Surely, the 'typical' man does exist also in CMT, to whom 'feeling' is and remains very unfamiliar, as well as the 'typical' woman, to whom the invitation to reflect on her own body is most welcome. As our results prove though, these are not the 'typical' men and women found in CMT treatment in a sense of men and women 'usually' found there. The results regarding the connections between the experience over the course of treatment and the therapy outcome also illustrate that therapeutic action can and should aim for different therapeutic mechanisms, depending on the individual patient.

Neither does bodily experience constitute an indication criterion for CMT, as we could prove in a study of similar design (Seidler and Schreiber-Willnow, 2004): patients who vary in the quality of their body experience differed neither in treatment success or group experience nor with regard to the connection between treatment success and group experience. The conclusion of psychotherapy research (Garfield, 1994), namely that individual personality traits of patients generally carry only limited predictive relevance concerning the therapy outcome, thus also holds true for CMT. As far as predicting treatment success is concerned, different elements in the course of treatment are often of far greater relevance. This also applies to CMT, as will be shown in the context of the next section dealing with the specific therapeutic factors in CMT.

**Therapeutic factors in CMT**

The therapeutic approach of all body-oriented psychotherapy methods is deduced from the close connection between mental and bodily experience. This implies that turning towards bodily experience will provide access to mental experience, which by this means can be influenced positively through therapy. Is there any empirical evidence to corroborate this notion?

The study by Schreiber-Willnow (2000) provides some: of the 70 patients in in-patient psychotherapy, the patients who showed successful clinical results differed from the less successful patients in CMT group treatment in that they reported an increase in physical well-being and confidence, growing learning experiences and insight as well as better access to physical well-being and their own feelings from about the seventh week of treatment. This means that a positive treatment outcome in CMT depends on common therapeutic factors, such as learning experiences and the development of confidence, as well as on gaining access to bodily experience as a therapeutic factor specific to this method.

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The aforementioned study regarding the intervention foci of CMT therapists (Seidler, 2002) also provides some clues as to which elements of therapeutic methodology are connected to these therapeutic factors in CMT group treatment. For 35 group sessions, the statements provided by the CMT therapists regarding their intervention foci as well as the participants’ statements regarding their group experience had been recorded, using a revised edition of the Group Experience Questionnaire for CMT. Data analysis shows that the type of intervention foci in the group sessions is in no way related to whether the group participants find the session productive, meaning for instance that they gained new insights. Rather, group participants reported more significant body experiences when the group sessions were centred around CMT proposals aiming at a differentiation in body experience and body image (rho = .41) or around the perception of one’s own physical expression or that of other group participants (rho = .35). This supports the hypothesis in CMT that through the enhancement of body perception, meaningful body experiences are made possible. It makes the aforementioned finding that CMT therapists rarely pursue this intervention focus all the more surprising. It may therefore be advisable for CMT therapists to reconsider their roots in movement therapy and movement pedagogy. It is also interesting to note that focussing on body expression also promotes significant body experiences. This therapeutic approach to body experience to be found especially in dance therapy could be elaborated further by CMT therapists in their work. Another finding was that group participants experienced less physical discomfort if, on the one hand, the CMT proposals were worded in a more open manner so that each individual had the freedom to develop their own application (rho = .41), or if, on the other hand, experimenting with new ways of relating to oneself, to other group participants or to objects was encouraged (rho = .38). Encouraging explorative behaviour, which is called ‘concentrative exploration’ in CMT, has thus proven to be a useful therapeutic method in order to counter an adverse fixation on negative body experiences.

In order to gain empirical access to the specific therapeutic factors in a psychomotor therapy method, it is ultimately necessary to describe the elements of the process seen as relevant in detail and to operationalise them as well as possible. With this in mind we have attempted over the past years to define significant elements of process diagnosis in CMT (Seidler et al., 2003a). There are seven elements to be noted: (1) focusing on physical sensation (2) movement behaviour, (3) body boundary with regard to the aspects of social proximity regulation and bodily self-experience, (4) symbolisation experience, (5) body cathexis with regard to the aspects of affiliation and control/dominance, (6) explorative behaviour and (7) situational self-regulation. Based on these process elements, we developed the Session Report for CMT (SB-CMT) in various studies with a total of 1,369 group therapy patients and 733 individual therapy patients. This questionnaire can be used to gather data on how patients in CMT individual or group therapy experienced their session with regard to the process elements listed (Schreiber-Willnow and Seidler, 2012). The questionnaire development resulted in the process elements.
being reflected in the patients' experiences in a way specific to the respective setting: in group therapy as well as in individual therapy, a dimension of experience can be found reflecting the degree of a positive vs. a negative body-related self-experience as made by the patients during the session. Items related to the process elements of movement behaviour, body cathexis and bodily self-experience play into this dimension. Another dimension of experience in group therapy is created by the process elements of symbolisation experience, focussing on physical sensation and situational self-regulation. This dimension reflects whether the patients were able to benefit from the therapy session. Concerning individual therapy, two different dimensions of experience emerge: in this setting, patients differentiate between the extent to which proximity-distance regulation was successful in relating to their therapist during a session on the one hand, and whether they had any significant body experiences on the other. Items related to the process elements of symbolisation experience as well as focussing on physical sensation play into the latter dimension.

The results regarding the reliability and validity of the SR-CMT thus far - the version for CMT group treatment in particular - have designated it as a suitable process-related survey instrument for process research (Seidler, Epner, Grützmacher, and Schreiber-Willnow, 2013). However, studies examining the predicative validity are yet to be undertaken. Regarding possible therapeutic factors, it would be interesting to examine to what extent the patients' experiences of the session as assessed with the SR-CMT and the outcome of their therapy are related and whether a connection between differences in the course of therapy regarding patients' experience of therapy sessions and therapeutic success can be established.

Propects
In summary, a brief résumé and future prospects: despite the fact that the present state of research on CMT compared to established psychotherapy methods is to be characterised as scant, CMT nevertheless can no longer be seen as terra incognita as reflected by the empirical studies conducted. Regardless of the relatively small number of studies, some of which are also limited in their methodical quality, the results allow for the precise formulation of empirically proven statements, preliminary conclusions and requirements for future research. More research will be needed, with higher standards for research, for instance methodically refined efficacy studies. Yet good research calls for the right framework conditions. These are rare when it comes to a body-oriented psychotherapy method in times dominated by the zeitgeist of an evidence-based approach which has narrowed the understanding of psychotherapy (Seidler, 2006). A CMT training facility connected to a university and with research tasks could provide suitable framework conditions in order to realise research on the one hand and also the training of young academics to take on these research tasks on the other. The academisation of CMT training in Austria mentioned in the foregoing has been a first step in this direction.
References


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