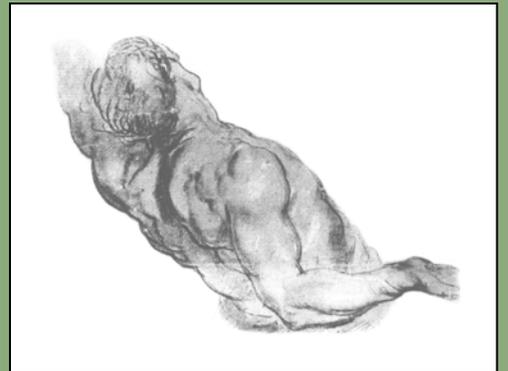


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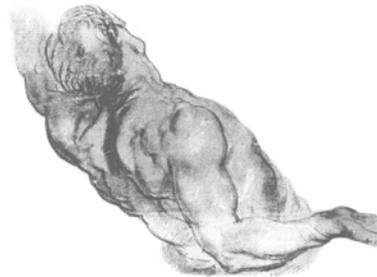


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USABP Mission Statement

The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999).

Preliminary Results Concerning the Effectiveness of Body Psychotherapies in Outpatient Settings: A Multi-Center Study in Germany and Switzerland

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Abstract

Preliminary results of an outcome study on routine applications of body psychotherapy in outpatient settings are reported. Out of 38 member institutions of the European Association for Body psychotherapy (EABP) 8 are participating in this study. At 3 points of measurement (at the beginning, after 6 months and at the end of therapy) established questionnaires (e.g. Beck Anxiety Inventory, Beck Depression Inventory, Symptom Check List-90-R, Inventory of Interpersonal Problems-D) were answered by patients. Patients in body-psychotherapeutic treatment (n= 157) are compared to other outpatient psychotherapeutic patients with regard to socio-demographic data, level of impairment and psychopathology.

After 6 months of therapy patients (N=78) have significantly improved with small to moderate intraclass effect sizes. After two years of treatment, large effect sizes are attained in all scales (N=21), the data base presently available for this latter result still being small.

INTRODUCTION, BACKGROUND, AND TREATMENT

Health professionals have an ethically imposed duty to have their services guided by most recent scientific findings, to take part in educational training programs and to continuously evaluate the effectiveness of their therapeutic work, i.e. to optimize the offered service to their clients' needs. Quality management in the sense of Laireiter and Vogel (1998) means "permanent and self-critical reflection on the structure and process of the offered service, as well as a continuous effort to improve the service in the interest of the patient or client". According to this standard, in Germany, the "Gesundheitsreformgesetz, GRG" (Health Reform Bill, 1988), as well as the "Psychotherapeutengesetz" (Bill for Psychotherapists, 1998) demand an evaluation of the effectiveness of health services. In Switzerland the same is ensured by the "Krankenversicherungsgesetz, KVG" (Health Insurance Bill, 1998).

The standards for assessment and improvement have changed considerably during the last few years. Scarce resources and a critical development in health care also affected psychotherapeutic treatments. The call for more "professionalisation" (as put forward by Grawe et al., 1994) was linked with the assertion of a rather biased understanding of empiricism. Clinical studies that tested hypotheses were preferred over single-case studies, documentation of processes or "discovery-oriented" studies. Task Force, division 12, of the American Psychological Association (APA) further fuelled this development by its demand for "empirically validated treatments - EVT" (Sanderson and Woody 1995; Chambless et al. 1996), despite the fact that professional psychotherapy in Germany developed differently than in the USA (Strauss and Kächele, 1998). Severe imbalances emerged in several countries whose professional services comprised a great variety of treatment approaches: The effectiveness of treatments that could not come up with a sufficient number of hypotheses-testing clinical studies was called in question: These therapeutic schools have already been pushed into the background. However, recent studies (Cierpka et al. 1997, Willutzki et al. 1997, Schweizer and Budowski 2001, Schweizer et al. 2002) show that individual psychotherapists rarely train in only one method, but incorporate several psychotherapeutic techniques into their professional practice.

Political decisions were required before fair research could be done in this professional field. By defining rules of admission for professionals, by implementing certain refunding policies, politicians and health insurance companies influenced the competition among professionals.

¹ The authors would like to thank the Swiss section of the European Association for Body psychotherapy (CH-EABP) and its president Dr.T.Ehrensperger for supporting their work with considerable financial help. The "Deutsche Gesellschaft für Körperpsychotherapie, DGK" (German Association for Body psychotherapy) with its president G.Marlock also promised financial support. Above all, this study is widely based on the honorary engagement of all participating patients, therapists, coordinators and members of the research group. Thanks to all of them.

Cierpka et al. (1997) state that the complexity of the field of application determines the variety of psychotherapeutic methods. The authors of the present article contend that body-psychotherapeutic perspectives - in theory and application - are an integral part of the science of psychotherapy. The origins of body psychotherapy probably go back to the very beginning of medical art. It was self-evident to the philosophers and physicians of occidental antiquity that diseases are comprised of both physical and mental aspects. They also regarded human beings as psychosomatic entities. Only in more recent time, mental and physical medicine developed into separate professional fields. However, there have always been boundary commuters on both sides (von Weizsäcker 1947, von Uexküll 1979, Hahn 1979, Janet 1924, Ferenczi 1984, Groddeck 1988 and many others).

Especially in the 1970's a variety of body-psychotherapeutic schools emerged, most of them remote from academic institutions. Some of them still keep this distance. Body psychotherapists in Switzerland and Germany on the other hand contribute considerably to outpatient and inpatient psychotherapeutic health care (Schweizer and Budowski 2001, Schweizer et al. 2002, Seidler et al. 2002). Although some studies about their effectiveness have been published (i.e. Gudat 1997; Ventling and Gerhard 2000; Müller-Hofer 2002), representatives of this approach are still under pressure to prove the effectiveness of their work. Despite the fact that methods which have not been evaluated do not necessarily have to be ineffective, professional politics seem to be following just this logic. The group of researchers responsible for this study was formed mainly to counteract this development.

By now, many suggestions have been made concerning a systematization and historical classification of body-psychotherapeutic approaches (i.e. Boadella 1990; Müller-Braunschweig 1997; Geuter 1996, 2000; Geissler 1999; Röhrlich 2000; Michel and Koemeda-Lutz 2002; Schatz 2002). The European Association for Body-Psychotherapy published definitions of common basic concepts on their homepage in the World Wide Web, that are continuously refined within a communicative process among representatives of the participating institutions.

Some of the basic body psychotherapeutic concepts are the following (note that this is only a selection):

- 1) The body is an indispensable component of human existence and should therefore be given more attention in (mental) health applications.
- 2) Mental and physical processes evolve parallel in time, interact and can be observed, examined and influenced from separate system levels.
- 3) From a developmental point of view an extended phase of non-verbal communication precedes verbal communication - ontogenetically as well as phylogenetically.
- 4) Also in adult life information processing and communication mediated by cognition or speech only constitute a subset of all processes involved.
- 5) Memory contents as well as unconscious material can to some extent be triggered and moved to consciousness by affective, motor or sensory engrams.
- 6) Vitality and health consist not only of a clear mind, but are also based on well-balanced and well-regulated physiological and emotional functions (this is self-evident in eastern healing techniques)
- 7) Body-psychotherapeutic techniques are characterised by incorporating a) non-verbal interventions, b) behavioural dialogues, c) physical contact, d) diagnostics that also consider non-verbal (i.e. visual) information, e) therapy goals that are defined psychosomatically.

We report here on a study that examines the effectiveness of body-psychotherapeutic treatment in outpatient settings under natural conditions in Germany and Switzerland. According to the rules of research in medical or natural sciences (Linden 1987, 1989), this study can be assigned to phase IV, i.e. an evaluation of "routine applications" in practice. Following Rudolf (1998) it can be associated with the phase of "applied psychotherapy research". We still know little about the effectiveness of psychotherapy other than in inpatient settings or university institutions (Seligman 1995). Essentially the present study evaluates the process and outcome of body psychotherapy. Data about symptoms and well-being of the patients were collected at several points in time throughout the therapeutic process (beginning of therapy, half a year later, end of therapy (at the latest 2 years after the beginning) and a follow-up measurement after one year). Research was initiated in January 1998 by the Hakomi Institute of Europe. First results were presented at the 7th European Congress on Body Psychotherapy at Travemünde, Germany (Soeder et al. 1999). Since then the study has become multi-

centered (Dresden, Heidelberg, Tübingen, Zürich). Only patients who are treated with body-psychotherapy on an outpatient basis are examined.

Therapists from the following schools participate (in order of joining the project; names of foundation presidents (international and national), literature in brackets): Hakomi Experiential Psychology (Ron Kurtz, Halko Weiss; Kurtz 1994); Unitive Psychology (Jacob Stattmann, Gustl Marlock; Stattmann 1987); Biodynamic Psychology (Gerda Boyesen; Boyesen 2001) - in Germany - and Swiss Association for Bioenergetic Analysis and Therapy SGBAT (Alexander Lowen; Thomas Ehrensperger; Koemeda-Lutz et al. 2002); Client-centered Verbal and Body psychotherapy GFK (Christiane Geiser; Ernst Juchli; Geiser-Juchli 2002); Institute for Integrative Body-Psychotherapy IBP (Jack Lee Rosenberg; Markus Fischer; Fischer 2002); Swiss Institute for Body-oriented Psychotherapy SIKOP (George Downing; Meyer et al. 2002); International Institute for Biosynthesis IIBS (David Boadella; Boadella und Boadella 2002) - in Switzerland.

The following questions guided this study:

- 1) What kind of patients ask for outpatient body psychotherapy? They are described by demographic, diagnostic and psychopathological measures (not specific to body psychotherapy)
- 2) How much do patients improve during treatment?
- 3) Can these results be preserved after the termination of treatment (follow-up measurement one year after the end of therapy)?

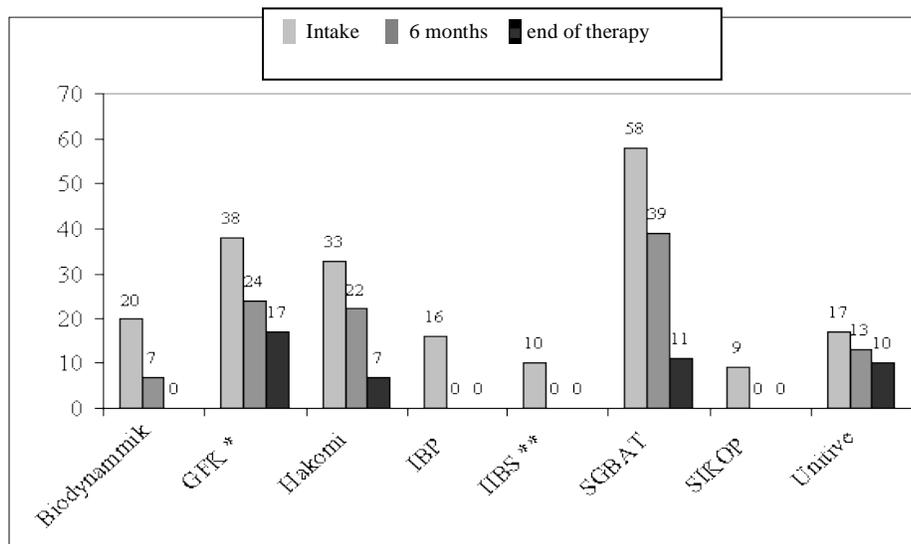


Figure 1: Number of cases at intake, six months later and at termination of therapy - grouped by the participating institutes² Up to now 201 completed questionnaires from intake are available. The following preliminary results are based upon 157 cases (beginning of therapy), 81 cases (after six months) and 28 cases (end of therapy). Cut-off date for data input was the 31st of August 2002).

* Results from 34, 24 and 17 cases (after one year) are reported in Müller-Hofer 2002.

** These questionnaires reached us after the cut-off date.

METHODS

Sample and Procedure

Eight member institutes of the European Association for Body psychotherapy (EABP: <http://www.eabp.org/>) participated. The Swiss institutes among them (N=5) are also members of the "Schweizer Charta für Psychotherapie" (<http://www.psychotherapie-charta.ch/>) (fig. 1). The selection of institutes was not systematic.

² Biodynamic Psychology, Client-centered Verbal and Body psychotherapy (GFK), Hakomi Institute of Europe, Institute for Integrative Body Psychotherapy (IBP), International Institute for Biosynthesis (IIBS), Swiss Association for Bioenergetic Analysis and Therapy (SGBAT), Swiss Institute for Body-Oriented Psychotherapy (SIKOP), Unitive Psychology

The EABP represents 12 professional societies in Switzerland and 16 in Germany ("Deutsche Gesellschaft für Körperpsychotherapie, DGK" (German Society for Body psychotherapy)). Each institute taking part in the study named one research coordinator who was in charge of organizing data collection. All certified members of the participating institutes who had completed a full training and worked in outpatient settings, were invited to take part in the study. The therapists taking part were asked to try to recruit every patient who took up treatment within a previously defined period of time and document demographic data, symptoms and preliminary diagnoses including patients who would not participate. All patients were informed about the study and given the information that participation was voluntary. Participants gave their informed consent to therapists. Data were coded and sent to the coordinators who surveyed the schedule of assessment. Anonymity was ensured by using a self-generated code consisting of 6 letters.

Data collection occurred at the beginning of therapy, after 6 months, and at the end of therapy (at the latest 24 months after intake). There is a follow-up one year after the end of therapy.

The estimation of the sample size necessary for the study followed Bortz (1984). It was guided by the hypothesis that body psychotherapy is as effective as well-established psychotherapy methods with an improvement rate of about 70% (Grawe et al. 1994), supposing a spontaneous remission rate of up to 30% (Bergin, 1971). A test strength of $1-\beta = 80\%$ and a significance level of 5% results in an effect size of $h = 0.82$. This would be considered a strong effect. Consequently a sample size of $n = 18.3$ would be enough to test hypotheses with sufficient statistical security. Taking into account possible dropouts of about 15%, the sample size was set $n = 25$. Since eight institutes participated, an overall sample size of 200 clients was aimed for.

The eight participating institutes joined the study at different points in time. Therefore, in this preliminary report, the numbers of examined cases vary considerably between institutes at the beginning of therapy and at the other points of assessment. Since this is an ongoing study, no information can be given about the proportion of dropouts yet. The composition of the sample on 08/31/02 is shown in Fig. 1.

Questionnaires

For data collection well-established and/or standardised questionnaires were used, in order to make comparison with other studies possible (Fydrich et al. 1996, Schulte 1993). From a body-psychotherapeutic point of view these instruments can be regarded as non-specific.

Demographic information was gathered according to the "Deutsche Standarddemographie" (German standard demography, Ehling et al. 1992).

Psychopathological symptoms were measured using "Beck Angst Inventar, BAI" (Beck Anxiety Inventory, Beck et al. 1988), "Beck Depressions Inventar, BDI" (Beck Depression Inventory, Hautzinger et al. 1994) and the Symptom Check List, SCL-90-R (Franke 1995, 2002). Physical discomfort was measured using the "Beschwerdenliste, BL" (Discomfort List, v. Zerssen, CIPS 1996); social problems were measured using the "Inventar zur Erfassung Interpersonaler Probleme, IIP-D" (Inventory of Interpersonal Problems) (Horowitz et al. 2000). Finally, the general "Selbstwirksamkeitserwartung, SWE" (expected self-effectiveness) (Schwarzer 1994, Schwarzer and Jerusalem 1999) was measured. Patients were also asked to judge changes in important areas of their lives since the beginning of therapy. The overall time to fill in all questionnaires was approximately one hour per examination.

Therapists gave information about the formal state of the therapy and also judged changes in important areas of the patients' lives.

RESULTS

The following section contains the key preliminary results of this study. The characteristics of patients using outpatient body psychotherapeutic services are followed by initial results about the course of therapy.

Clients of outpatient body psychotherapists

At intake, 157 clients with an age range between 22 and 64 years (median 41 years) gave their consent to participate in the study. 62 body psychotherapists were in charge of their treatment. 68% of the patients were female. 41% of all patients were married, 47% were single and 13% were divorced. 56% lived with a partner, 46% had children. 64% of the patients had "Abitur" (graduation from the highest type of school in Germany and Switzerland, required for admission to universities), 28% had completed a University degree. 56% of all clients were already experienced with psychotherapy. Treatment costs were fully refunded by health insurance in 32.5% of all cases; they were partly refunded in 29.3%. 26.8% of the patients had no refund at all. 11.8% did not answer this question.

Demographic data for this group of patients vary within the ranges known from other studies of outpatient psychotherapy (Gudat 1997, Ventling and Gerhard 2000, Scheidt et al. 1998; Schweizer et al. 2002, Müller-Hofer 2002).

Main diagnoses at the beginning of therapy followed the ICD-10 criteria (Dilling et al. 1993), and are summarized in Fig. 2. In 72% of all cases, only one main diagnosis was assigned, in 22% a secondary diagnosis was also made. In 6% of all cases therapists assigned 2 secondary diagnoses. Apart from the high proportion of Z-codes, this study shows the same profile (F4 > F3 > F6) as two other studies on outpatient psychotherapy that involved different psychotherapeutic approaches (Scheidt et al. 1998, Schweizer et al. 2002).

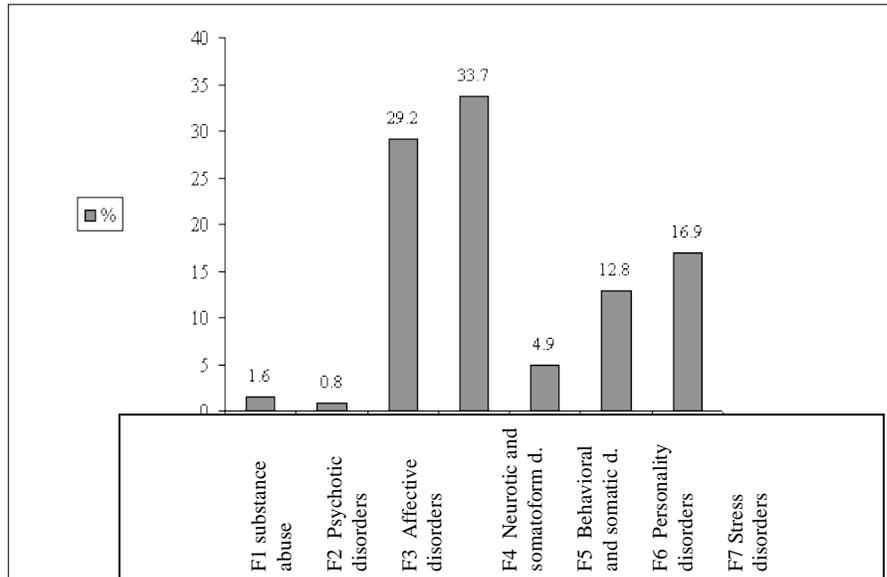
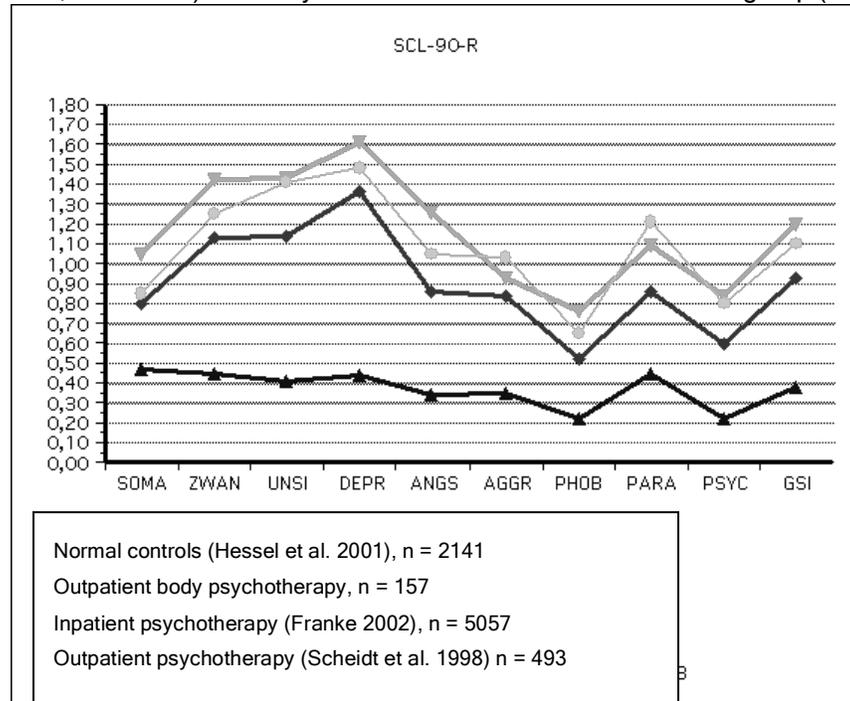


Figure 2: Distribution of main diagnoses in % according to ICD-10. F1 Mental and behavioural disorders due to psychoactive substance abuse, F2 Schizophrenia, schizotypal and delusional disorders, F3 Affective disorders, F4 Neurotic, stress-related and somatoform disorders, F5 Behavioural syndromes associated with somatic disorders, F6 Personality disorders, Z-Code: Factors influencing health status and leading to demands on health services.

According to the questionnaires used patients can be described as follows: In 70.1% anxiety scores were above normal (BAI > 11, complete sample: mean = 17.5, SD = 11.7). Depression scores were normal for 31.2% of the patients (BDI < 10). 35.7% presented raised depression scores (11 < BDI < 17), and 33.1% were clinically affected (BDI > 18, complete sample: mean = 15.1, SD = 9.1). According to data from the SCL-90-R, 62.4% of all patients could be considered to be clinically affected (men: SCL-GSI > 0.57; women: SCL-GSI > 0.77; according to cut-off points c following Jacobson for psychotherapy patients (Franke 2002, p. 32). Complete sample: mean = 0.94, SD = 0.59). Figure 3 displays SCL-90 profiles from different samples. Patients treated by outpatient body psychotherapy are clearly more affected at intake than non-patients, but are less affected than clients in in-patient treatment. A similar profile was obtained by Scheidt et al. (1998).

Physical discomfort with a mean BL score of 28.6 (SD = 12.6) in this sample was comparable to psychiatric patients (mean = 30.0, SD = 15.4) or

anxiety patients (mean = 29.6, SD = 12.2). It clearly exceeded that of a standard control group (mean = 14.3, SD =



10.8, CIPS 1996, p. 38).

Figure 3: SCL-90-R scores of body psychotherapy patients in comparison to normal controls, an out- and an in-patient psychotherapy group at intake (SOMA: somatisation, ZWAN: compulsiveness, UNSI: insecurity in social interactions, DEPR: depression, ANGS: anxiety, AGGR: aggression/hostility, PHOB: phobia, PARA: paranoia, PSYC: psychoticism, GSI: Global Severity Index (total score)).

The score for interpersonal problems (IIP-D) was 11.6 (SD = 4.7). With values converted to age-standardized stanine-scores (Horowitz et al. 2000), 23.7% of the sample presented deviant values between 7 and 9. Compared to other groups of psychotherapy in-patients with different diagnoses, body psychotherapy patients suffer less from interpersonal problems and are comparable to psychosomatic patients (mean = 11.2, SD = 4.1) or patients with addictions (mean = 11.5, SD = 3.8, Wuchner et al. 1993).

The mean for “general expected self-effectiveness” was 24.5 (SD = 5.7) at the beginning of therapy. In comparison with a large sample of adults (mean = 29.3, SD = 5.1, Schwarzer and Jerusalem 1999), the expected self-effectiveness is clearly lower in our sample. 40.4% of all body psychotherapy patients achieved scores more than one standard deviation ($T < 40$) below the mean of a control population.

Treatment Process

Since data collection has not yet been completed, no concluding judgement about the progress of therapy can be made. For 6 months after intake, data from 78 cases could be analysed, while for the end of therapy data for 21 cases were available. Follow-up results cannot be presented yet.

A comparison of intake data from all patients with a subset of intake data from those who had also completed their 6 months assessment and with another subset of those who had completed data sets for the end of therapy yielded no statistically significant differences at intake in any of the variables assessed. Statistical testing was carried out with an α -adjusted two-tailed t-test for all questionnaires.

Group changes

Changes over the course of therapy were tested for significance by means of one-tailed t-tests. Further intra-class effect sizes were computed following Mc Gaw and Glass (1980). Effect sizes were classified small (0.2-0.5), medium (0.5-0.8) and large (>0.8).

Within the first 6 months, on average 23 sessions were held. Data of 78 cases entered the analysis.

Anxiety (BAI), depression (BDI), general symptoms (SCL-90-R), physical discomfort (BL) and interpersonal problems (IIP-D) decreased significantly (see figure 4). In addition, the expected self-effectiveness increased significantly.

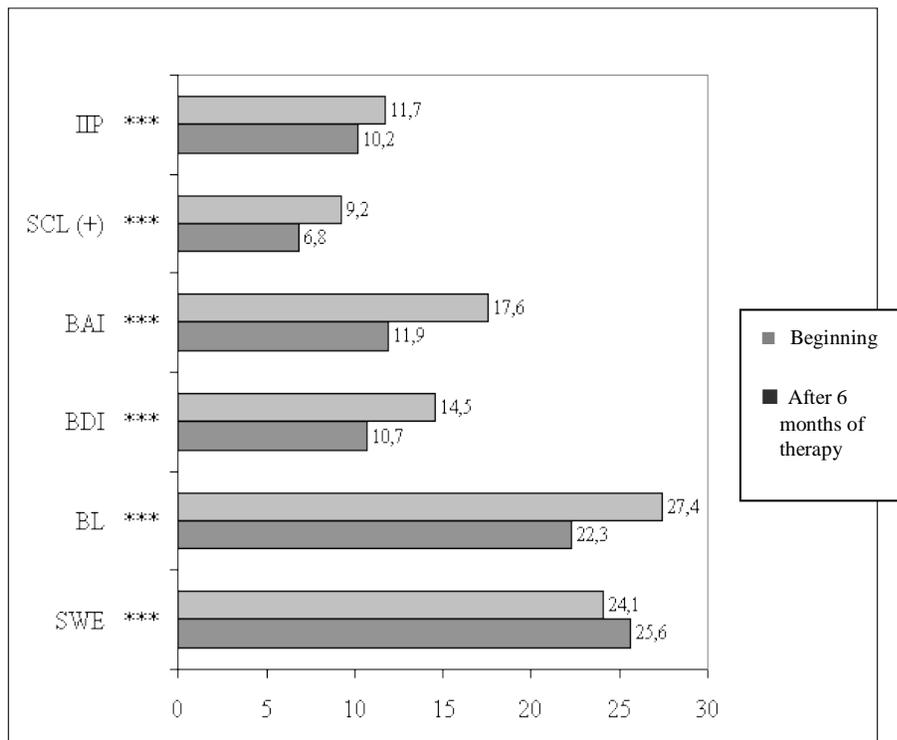


Figure 4: Comparison of means at the beginning of therapy and after six months (n = 78); * p < 0.05, ** p < 0.01, *** p < 0.001; IIP: Inventory of interpersonal problems, SCL: Symptom Check List, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory, BL: Discomfort List and SWE: expected self-effectiveness.

(+) For illustrative reasons SCL-90-R scores were multiplied by 10.

Data from 21 cases could be used for the comparison between intake and termination. An average of 69 sessions was held.

Improvement on all scales was stronger at the end compared to the assessment at intake. Again, anxiety, depression, general symptoms, physical discomfort and interpersonal problems decreased significantly, whereas expected self-effectiveness increased significantly (see fig. 5).

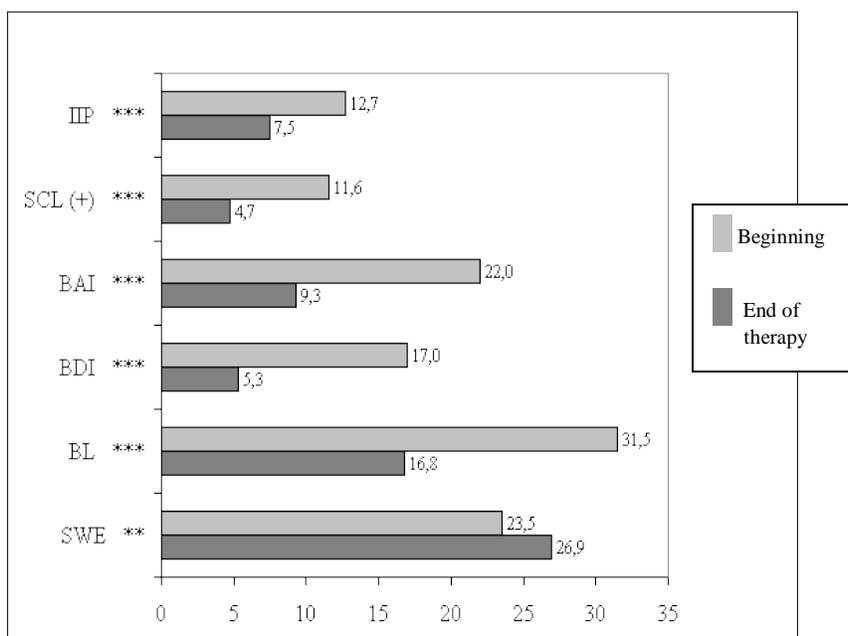


Figure 5: Pre-post Comparison of means (intake vs. termination, $n = 21$); * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$; IIP: Inventory of interpersonal problems, SCL: Symptom Check List, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory, BL: Discomfort List and SWE: expected self-effectiveness.

(+) For illustrative reasons SCL-90-R scores were multiplied by 10.

Effect sizes for the changes between the beginning of therapy and 6 months later, as well as between the beginning and the end of therapy are presented in fig. 6. Within the first 6 months small to medium improvements occurred for all tested criteria. At the end of therapy, large improvements with effects between 0.82 (expected self-effectiveness) and 1.40 (depression) were achieved.

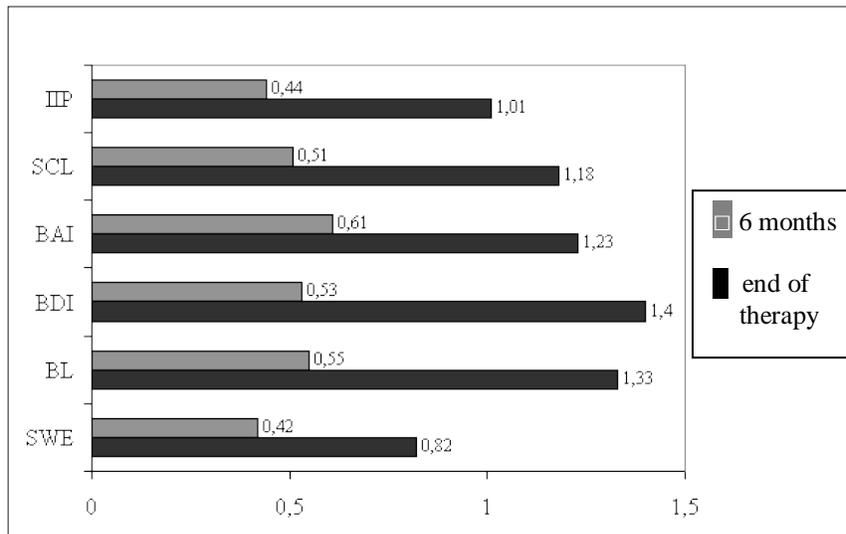


Figure 6: Effect sizes 6 months after intake ($n = 78$) and at termination ($n=21$): small (0.2 - 0.5), medium (0.5 - 0.8) and large (> 0.8).

IIP: Inventory for the inquiry of interpersonal problems, SCL: Symptom Check List, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory, BL: Discomfort List and SWE: expected self-effectiveness.

Individual changes

In addition to group changes, individual changes for the scales BAI, BDI, IIP-D and SCL-90-R are reported. This analysis contains 21 data sets. The occurrence of clinically relevant anxiety symptoms ($BAI > 11$) decreased from 86% in the beginning to 48% after 6 months and dropped to 33% at the end of therapy.

The occurrence of clinically relevant depression scores ($BDI > 18$) dropped from 43% at the beginning to 10% after 6 months and to 0% at the end of therapy. At termination, the depression score of 10% of the patients was still elevated ($11 < BDI < 17$), while 90% of the patients were within the normal range ($BDI < 10$). 33% of the patients ranged within raised scores for interpersonal problems (Stanine > 7) at the beginning of therapy. This was true for 19% after 6 months; at the end of therapy it was only true for 5% of the patients.

Cut-off scores as well as critical differences have been published for the SCL-90-R scale. Therefore, statistically and clinically relevant changes can be differentiated for single cases (Jacobson and Truax 1991, Jacobson et al. 1984). Following Franke (2002), a GSI-raw score of 0.3 for psychotherapy patients was assessed as a critical difference. Gender specific cut-off scores are 0.57 for men and 0.77 for women. Clinically and statistically relevant changes are shown in fig. 7. At the end of therapy, more than half of the patients had improved at a clinically significant rate. About one third did not perceive any improvement in their symptoms.

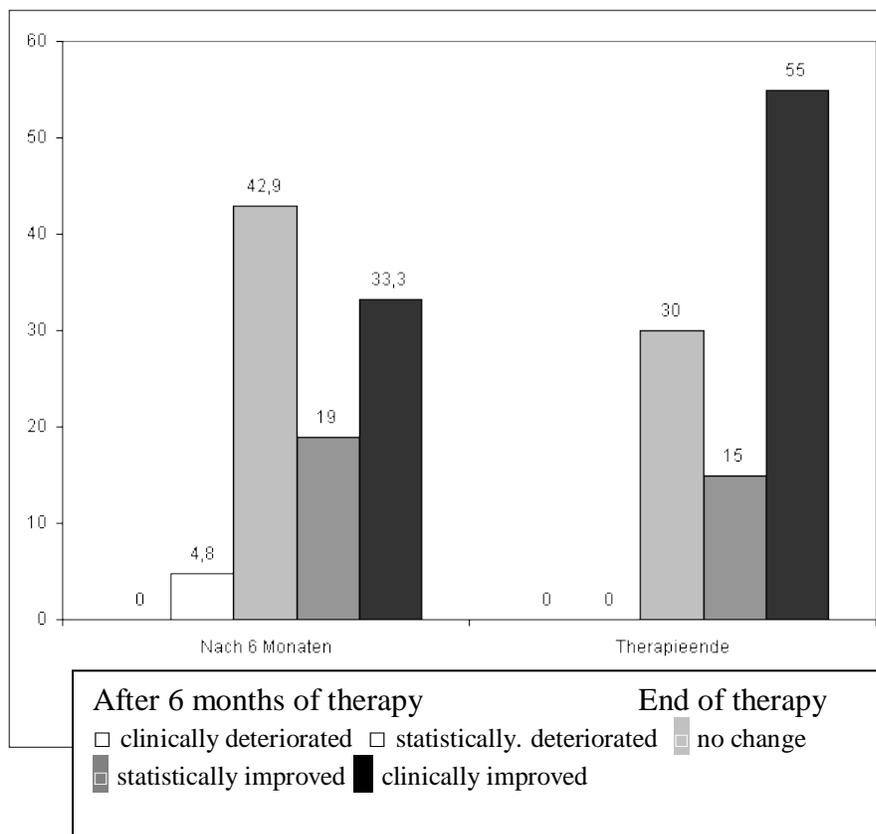


Figure 7: Clinically and statistically relevant changes for the total score of the SCL-90-R (n = 21); Critical difference GSI > 0.30 (psychotherapy patients), cut-off values: 0,57 (Men), 0,77 (Women) according to Franke 2002.

Discussion

The present study documents representative aspects of the factual contribution of body psychotherapists to outpatient psychiatric-psychotherapeutic care in Germany and Switzerland. It also contributes to quality assessment and management in this field. It examines body psychotherapies in the natural environment of outpatient settings.

Many studies of the effectiveness of outpatient psychotherapy have been conducted in university settings. The advantages of high internal validity achieved by manualised versions of therapeutic methods, selected samples and highly elaborated evaluation procedures are opposed by low ecological validity (Seligman 1995). Therefore, comparatively little is known about the effectiveness of psychotherapy outside inpatient or university settings. This study attempts to help fill this gap.

In contrast to other studies evaluating body psychotherapy that only made use of retrospectively collected data (Gudat 1997, Ventling and Gerhard 2000), prospective data are reported here for the first time.

As found for outpatient clients of other therapeutic orientations, the educational level of body psychotherapy patients is higher than that of the average population (Vessey and Howard 1993). Diagnoses and symptom profiles of outpatient body psychotherapy patients at intake are typical of and comparable to outpatient psychotherapy clients in general. The relative frequency of Z-code assignments for the classification of main problems could be related to the requirement that the reported diagnoses were to be made within the first 3 sessions. Patients possibly speak more easily about external factors influencing their lives, at the beginning of therapy. Another reason might be that a significant proportion of the cases does not get refunded by health insurances and therefore a diagnosis "proving illness" is not necessary for formal reasons. Nevertheless, the symptom profiles still exhibited a high proportion of clinically relevant impairment at the beginning of therapy.

Since this is only a preliminary report, the data base is not sufficient yet for a final evaluation of treatment processes. Especially the results from the end of therapy (n = 21) can only be taken as pointing to an increasing effectiveness of outpatient body psychotherapy during the course of the treatment. It seems, however, that statistically significant improvement can be found not only on a group level: treatment also seems to produce clinically relevant symptom reduction for individual cases. Already within the first 6 months significant improvement is achieved that becomes markedly stronger towards the end of therapy. Apart from a reduction of symptoms in mental, somatic, and interpersonal areas, the increase of expected self-effectiveness is remarkable. Self-effectiveness is considered to be an important resource in handling stress and emotional problems. It is also

regarded as a stable personality dimension (Schwarzer 1994). The effect size for the expected self-effectiveness at the end of therapy is lower than the effect size for the total score of the symptom checklist ($d(\text{SWE}) = 0.82$ vs. $d(\text{SCL}) = 1.18$). Nevertheless, it is of high practical value, since it represents a change on a personality dimension. This suggests that body psychotherapy does not merely reduce symptoms but also gives impetus for positive personality development. The results for interpersonal problems demonstrate that positive changes in interpersonal areas occur during the course of therapy.

It remains to be determined if the promising results will be confirmed by the end of the study and if the patients' gains will have been maintained at the one-year follow-up.

So far, body psychotherapy schools have kept their distance from academic research. Only the increasing pressure on all treatment approaches to prove their effectiveness in recent years has made possible an outcome study like the present one.

A multi-centered study of the effectiveness of (body) psychotherapy under natural conditions demands high organisational capability, as well as patience and endurance from all participants. Especially when standardized measurements of effectiveness are not an integral part of therapy, the extra amount of time spent with the evaluation is considerable. Since participation in the study was voluntary, it became obvious that therapists were reluctant to have their practical work scientifically evaluated. Furthermore, motivation was a problem, since for the therapists involved the extra work was honorary. This caused data collection, which started in January 1998, to proceed rather slowly.

The idea to include a "waiting-list" control group (as originally intended) was dropped, partly for practical reasons (psychotherapists are rarely in the position to make waiting lists) and partly for ethical reasons (people seeking therapy should be allocated to treatment as quickly as possible - recommended to colleagues). Also, there exist many evaluation studies of other treatments by now, so that the achieved results can be compared to them.

Prospectively, more collaboration between professional researchers and psychotherapists is desirable, and the dialogue among the different therapeutic schools should be intensified.

For body psychotherapeutic schools this study demonstrates that there is no need to fear comparison using standardised instruments of therapy research. For the future, the task emerges to formulate specific therapeutic goals and to develop suitable measuring instruments. If these were available, the indices for effectiveness discussed here could be augmented by indices that are specific to body psychotherapy. In addition, the disorder-specific effectiveness of body psychotherapy should be investigated.

The preliminary results from this study demonstrate that body psychotherapeutic approaches can claim an adequate position in mental health care.

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