

Evaluation of the Effectiveness of Body Psychotherapy in Outpatient Settings (EEBP): A Multi-Centre Study in Germany & Switzerland

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Editor's note: This study, done by members of the European Association for Body Psychotherapy (EABP), including Hakomi Therapists, is the first major empirical research done that demonstrates the efficacy of body-psychotherapy methods. It was first published in German in the *Psychother Psych Med Psychosom* 2006 (56) 480-487, is translated here into English by the EAPB, and is used with permission. The references remain in European format, as opposed to APA style.

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ABSTRACT: The following are results from a multi-site process and outcome study of body psychotherapies. The design is naturalistic and evaluates the effectiveness of body psychotherapy treatments in outpatient settings. Three German and 5 Swiss member institutes from the European Association for Body Psychotherapy (EABP: 38 members) participated. The Swiss institutes were also members of the Schweizer Charta für Psychotherapie. Well established questionnaires (e.g. BAI, BDI, SCL-90-R, IIP-D) were administered at three points of measurement (at intake, after 6 months and at the end of therapy (after two years

at maximum). Follow-up data were collected at 1 year after termination of therapy (n = 42). Patients who sought body psychotherapeutic treatment (n = 342 participated in the study) did not differ from other outpatient psychotherapeutic patients regarding sociodemographic data, level of impairment and psychopathology. After six months of therapy (n = 253) patients showed significant improvement with small to moderate effect sizes. At the end of therapy or after two years of treatment at maximum (n = 160) a large effect was attained on all scales. These are lasting results according to follow-up data (n = 42). This naturalistic prospective field study provides evidence for the effectiveness of the evaluated body psychotherapy methods and to classify as phase IV- ("routine application") and level I-evidence.

Key words: Psychotherapy research, body psychotherapy, effectiveness, outcome, naturalistic design.

Introduction

Up until recently, there has been little quantitative research on body psychotherapies, although professionals trained in this modality considerably contribute to in- and out-patient psychiatric and psychotherapeutic health care [22, 23, 31].

Meanwhile several models exist for systematizing and historically locating body psychotherapeutic approaches [e.g. 39-46]. A recently published handbook [33] illustrates how body psychotherapies developed in relation to psychodynamic approaches and elaborates several aspects of body psychotherapeutic theory and treatment techniques. The European Association for Body Psychotherapy publishes definitions of shared basic concepts on its Website [47], which continue to be refined via an ongoing process of communication among the proponents of its member institutes.

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

- 1) The body is an indispensable component of human existence and should therefore be explicitly addressed in psychotherapeutic treatments
- 2) Psychic and somatic processes evolve in a parallel manner over time. These processes interact and can be observed, examined and influenced from different 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) In adult life information processing and communication mediated by cognition or speech only constitute a subset of all processes involved.
- 5) Memories as well as unconscious material can to some extent be triggered and moved to consciousness by affective, motor or sensory stimulation.
- 6) Vitality and health consist not only of a clear mind, but are also based on well-balanced and well-regulated physiological and emotional functioning.
- 7) Body psychotherapy techniques are characterized by incorporating a) nonverbal interventions, b) behavioural interactions c) physical contact d) diagnostics that also consider non-verbal (i.e. visual) information and e) psychosomatically defined goals in therapy.

Earlier studies on body psychotherapies were based on retrospectively collected data [32, 34, 38]. This study prospectively examined the effectiveness of body psychotherapeutic treatment in outpatient settings in Germany and Switzerland using a naturalistic design. According to the rules of research in medical or natural sciences [48, 49], this study can be assigned to phase IV, i.e. an evaluation of "routine applications" in practice. Following Rudolf [50] it can be attributed to the phase of "applied psychotherapy research" and claims in this context of naturalistic field studies an evidence rating of level I [51]. Data about symptoms and patients' well-being were collected at several points in time (at intake, after 6 months of therapy, at the end of therapy (after 2 years of therapy at maximum) and at a 1-year follow-up). This research was initiated in January 1998 by the Hakomi Institute of Europe. First results were presented at the 7th European Convention for Body psychotherapy at Travemünde, Germany [33]. Eventually the study expanded to multiple sites (Dresden, Heidelberg, Tübingen, Zürich). Preliminary results were published in 2003 [36, 37]. In 2005 the study was awarded the USABP research prize. Only patients who had body psychotherapeutic treatment in outpatient settings were included in the study.

Therapists from the following schools participated (in order of joining the project; names of foundation presidents (international and national), and references concerning theoretical concepts and treatment techniques in brackets): Hakomi Experiential Psychology (Ron Kurtz, Halko Weiss; [54]); Unitive Psychology (Jacob Stattmann, Gustl Marlock; [55]); Biodynamic Psychology (Gerda Boyesen; [56]) – in Germany – and Bioenergetic Analysis SGBAT (Alexander Lowen; Thomas Ehrensperger; [57, 58]); Client-Centred Verbal and Body Psychotherapy GFK (Christiane Geiser; Ernst Juchli; [59]); Institute for Integrative Body Psychotherapy IBP (Jack Lee Rosenberg; Markus Fischer; [60]); Swiss Institute for Body-Oriented Psychotherapy SIKOP (George Downing; [61]); International Institute for Biosynthesis IIBS (David Boadella; [62]) – in Switzerland.

The following questions guided our study, which completed its data collection by the end of 2005:

- 1) What kind of patients seek and request outpatient body psychotherapy?
- 2) How much do patients improve on the following variables: psychopathological and psychosomatic

- symptoms, interpersonal problems, and expectations of self efficacy during treatment?
- 3) Can these results be maintained for a one-year period following the termination of treatment?
 - 4) To what extent do patients' and their therapists' perspectives on the psychotherapy correspond?

Methods

Sample and Procedure

Eight institutes of the European Association for Body Psychotherapy [47] participated in this study. The Swiss institutes (N = 5) were also members of the Swiss Charter for Psychotherapy [63]. The selection of institutes was not systematic. The EABP represents 12 professional societies in Switzerland [64] and 16 in Germany [65]. Each institute taking part in the study designated 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 participating therapists agreed to apply the method taught in their institutes. They were asked to attempt 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 their participation was voluntary. Participants read, signed and gave their informed consent to therapists. For reasons of anonymity this written consent remained with the therapists. Anonymity was ensured by using a self-generated code consisting of 6 letters.

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

The participating institutes entered the study at different points in time. Therefore data collection was extended over several years (1998-2005).

Questionnaires

For data collection well-established and standardized questionnaires were used, in order to increase comparability with other studies [68, 69]. 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) [70]. Therapists carried out diagnostic assessments according to ICD-10 [71] within the first three sessions. Symptoms of psychopathology were measured

using the "Beck Angst Inventar" (Beck Anxiety Inventory, BAI: [72]), "Beck Depressions Inventar" (Beck Depression Inventory, BDI: [73]) and the "Symptom Check List" (SCL-90-R [74, 75]). Physical discomfort was measured using the "Beschwerdenliste" (List of Psychosomatic Complaints, BL: [76, 77]) and interpersonal problems measured by applying the "Inventar zur Erfassung interpersonaler Probleme" (Inventory of Interpersonal Problems, IIP-D: [78, 79]). In addition, the general "Selbstwirksamkeitserwartung" (expected self-efficacy, SWE: [80, 81]) was measured. Patients were also asked to judge global life changes that occurred since they began therapy in important domains (work, leisure time, family life, domestic duties, somatic well-being). Patients had approximately one hour to fill in all questionnaires. Therapists gave information about the formal state of the therapy and also judged global changes in the above-mentioned areas of their patients' lives.

The average changes over time were analysed using multifactorial analyses of variance (factor „institute“ = membership of therapists; repeated measurement factor „duration of therapy“ = different points of measurement). In addition effect sizes according to McGaw und Glass [82] were computed. According to Cohen [83] they were categorized as small (0.2 – 0.5), medium (0.5 – 0.8) and large (> 0.8).

Results

A description of the characteristics of patients treated with body psychotherapy will be followed by a description of the process and outcome results of their therapies.

Altogether 124 therapists (between 8 and 22 per institute, on average 16) and 342 patients (between 17 und 58 per institute, on average 43) participated. Therapists had 1 – 14 patients, on average 3, included in the study. The participating therapists had the following basic professions: In Switzerland 25% were medical doctors, 54% psychologists and 21% had other basic professions. In Germany 13% were medical doctors, 21% psychologists and 43% had other basic professions; in Germany 23% of the data on therapists' basic professions were missing.

Outpatient Body Psychotherapists' Clients

At intake 342 clients with an age range between 18 and 64 years (median 37 years) were examined. 73% of the clients were female. 36% were married, 52% single and 12% divorced. 60% had a partnership and 43% had children, on average 2. The highest educational level was for 31% graduation from high school („Abitur“). 28% had graduated from a college or university. 41% had no more than ten years of school („mittlere Reife“) or had completed vocational training. 59% of the clients in this study had had previous psychotherapeutic treatment.

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Treatment costs were totally reimbursed by insurance companies for 33% of the clients, partially for 29% of the clients, 28% had no reimbursement at all, 10% did not answer this question. Demographic data of the participating patients tended to vary within the ranges known from other studies of outpatient psychotherapy [23, 32, 34, 84, 85].

Diagnostic assessments were carried out by therapists at intake according to ICD-10 criteria [71]. In 79% of the cases patients were only assigned to one primary diagnostic category, while 21% therapists diagnosed comorbidities. Primary diagnoses were combined into larger categories. These categories were 41.2% neurotic stress and

somatoform disorders (F4), 28.9% affective disorders (F3) and 12.9% personality and behavioural disorders (F6). F5, F1 and F2 ranked only with 8.2%, 1.5% and 0.3% respectively. Z-Codes were assigned in 7.3% of the cases. According to the questionnaires used in this study, patients were described as follows: 40.6% (self efficacy) and 88% (psychosomatic complaints) revealed clinically significant impairments at intake. In all measures taken, the participating patients significantly differed from normal controls ($4.26 < t < 29.55$; $p < 0.0001$). Figure 1 shows the SCL-90-profile at intake and figure 2 shows the IIP-D-profile.

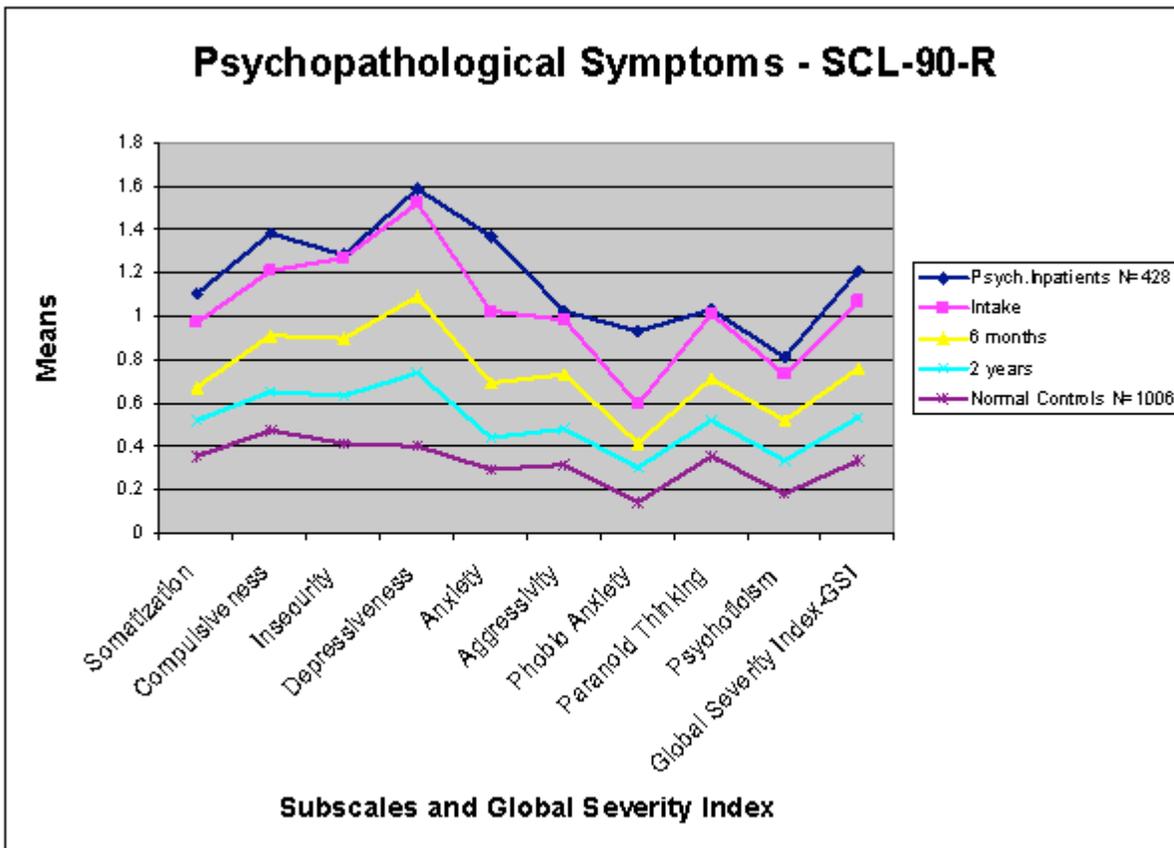


Figure 1: Subscale means and global severity index (SCL-90-R) of body psychotherapy patients at intake, after 6 months and at the end of therapy (after 2 years at maximum) as compared to normal controls and hospitalized psychiatric patients at intake.

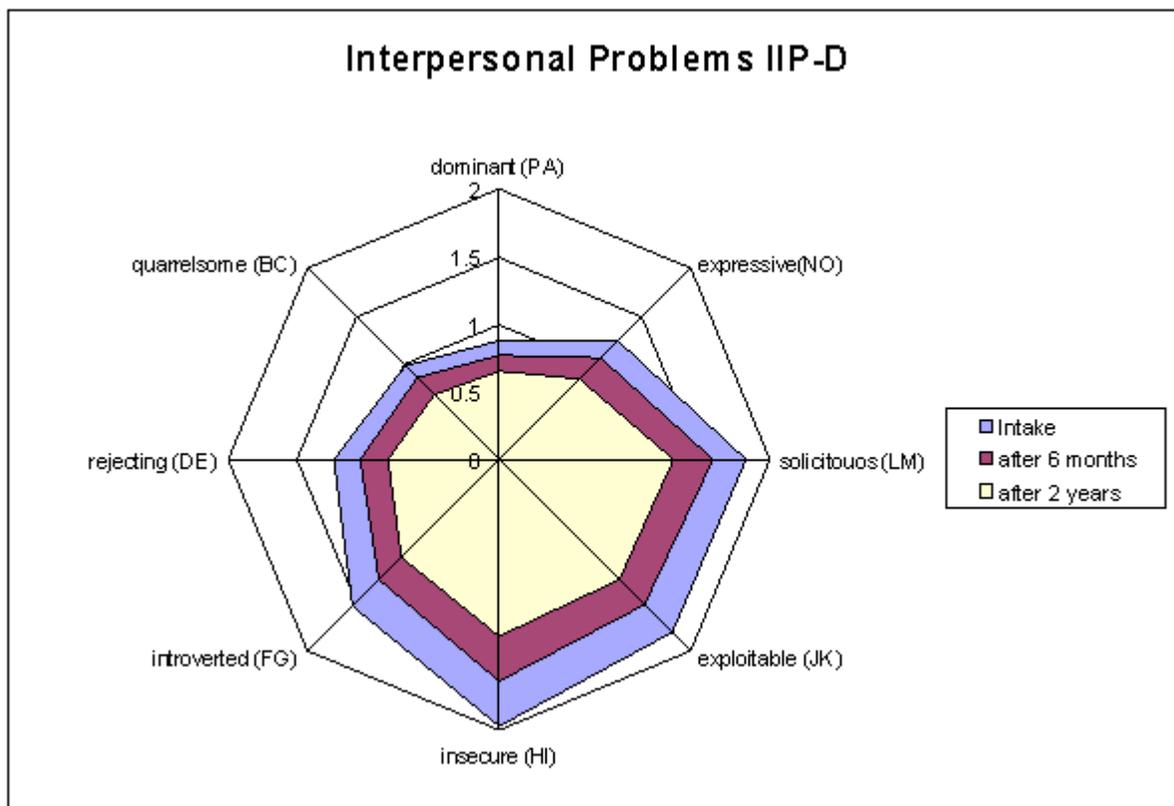


Figure 2: Subscale means IIP-D of body psychotherapy patients at intake, after 6 months and at the end of therapy (after 2 years at maximum).

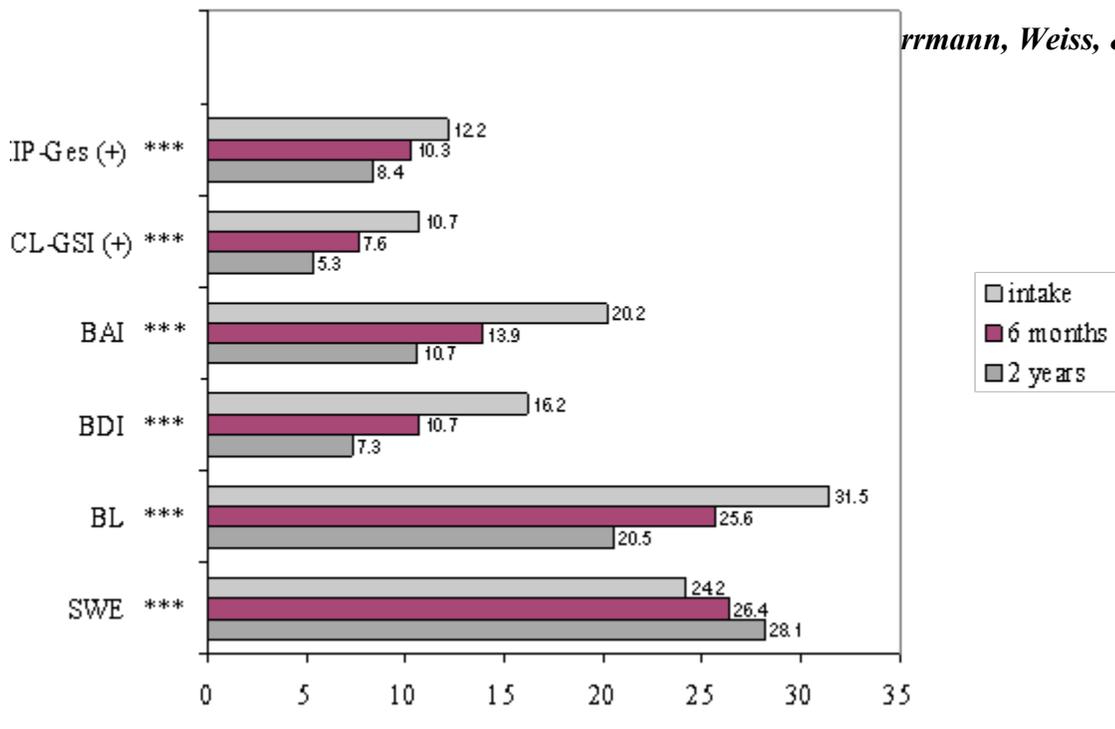
Process description

Although follow-up data is continuing to be collected and analyzed, (s. [89]), the data reported in this article was collected through the end of 2005. Data from 253 cases after 6 months of therapy was analyzed, as was data from 160 cases at termination of treatment (or after 2 years of therapy at maximum). In addition data from 42 cases at a 1 year follow-up was analyzed. During the last quarter of 2005 all participating therapists were once again contacted and asked about the process of all therapies involved in the research. Fifty-eight percent of the participating therapists answered. This covered 199 out of 342 patients. Forty-three percent of these cases had ended their therapy in a way that was mutually agreed upon by both patient and therapist. Twenty-six percent had ended their treatment prematurely from the therapists' point of view (for a variety of external reasons: change of residence, financial shortcomings, death or internal reasons: lack of motivation to continue therapy). In 54.9% of therapies which ended in a mutually agreed upon termination, treatment had lasted less than 2 years. For the remaining cases measurement after two years was intermittent.

Since not all questionnaires were completed, there are varying numbers of cases for varying questionnaires.

Completed therapies (n = 84) lasted 24 months on average (sd=14.8) and took 52.8 sessions (sd= 42.7; median = 42.5). Eleven percent out of these patients received medication in addition to psychotherapeutic treatment. Prematurely terminated therapies (n = 53) lasted 10 months on average (sd=7.7; median = 8) and took 26.3 sessions (sd=21.2; median = 21). Twenty-four percent of these patients had received medication. Therapies not terminated before December 2005 (n = 62) had lasted 6 - 7 years (1.6%), 4 - 5 years (8.2%), 3 - 4 years (14.8%) or 2 - 3 years (75.4%). No intake measurements were carried out later than December 2003. These ongoing treatments had taken 105 sessions on average until December 2005 (SD=59.2; median = 89.5). Twenty-eight percent of these patients received psychotropic medication.

A comparison of intake data from the four subsamples (complete data sets at intake, after 6 months of therapy, at termination (or 2 years of therapy at maximum) and follow-up) resulted in no statistically significant bias by selection (drop-outs). Chi²-tests were carried out for level of education and sex (0.01 ≤ Chi² ≤ 2.28; 0.32 ≤ p ≤ 0.94; exception: complete data sets at follow-up were received from patients with a higher level of education: (Chi² = 15.91; p = 0.0004)). Two-tailed t-tests were carried out for age and all questionnaires (0.29 ≤ t ≤ 1.9; 0.06 ≤ p ≤ 0.78).



Group Changes

Treatment modality had no significant influence on therapy processes ($0.32 \leq F_{Inst}(7; 140) \leq 2.37$; $0.06 \leq p \leq 0.94$; $0.26 \leq F_{Inst*Zeit}(14; 280) \leq 1.89$; $0.14 \leq p \leq 0.95$; exception: IIP-D: $F_{Inst*Zeit}(14; 280) = 1.89$; $p = 0.03$; Unitive Psychology therapists proved to demonstrate a maximum level of change in their patients: mean at intake = 1.83; mean at termination (or after 2 years) = 0.93). However, the influence of therapy duration was highly significant in all cases ($17.07 \leq F_{Zeit} \leq 72.28$; $p < 0.0001$; s. fig. 3).

Analyses of variance were used to analyze the comparison of measures at termination and follow-up (treatments that lasted longer than 6 months were included) and proved that therapy results were stable. The data revealed that even some mild improvements could be observed ($0 \leq F_{Zeit} \leq 2.88$; $0.1 \leq p < 0.97$; BL: $F_{Zeit} = 2.88$; $p < 0.01$).

Changes of Impairment with Increasing Duration of Therapy

Figure 3: Manovas: Comparison of means at intake, after 6 months and at the end of therapy (after 2 years at maximum); $17.07 \leq F_{Therapiedauer}(2; 143) \leq 72.57$; $p < 0.001$; IIP: Inventory for the Inquiry of Interpersonal Problems – Global Score, SCL-GSI: Symptom Check List – Global Severity Index, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory, BL: List of Psychosomatic Complaints and SWE: Selbstwirksamkeitserwartung (Expectation of Self Efficacy). (+) For reasons of perspicuity SCL-90-R-GSI scores were multiplied by 10 and IIP-D-global scores by 8.

Within the first 6 months of therapy an average of 21 sessions (SD = 9.04) were utilized. 253 cases were included in this analysis. Anxiety (BAI), depression (BDI), overall impairment by symptoms (SCL-90), somatic complaints (BL) and interpersonal problems (IIP-D) significantly decreased during this period of time. Concomitantly, the expected self efficacy (SWE) increased significantly (see fig. 3; *** = $p < 0.0001$).

For the comparison of measures at intake and at the termination of treatment (2 years after intake at most) 160 cases were included. An average of 58 sessions was utilized during this period of time.

Improvement in all scales was more pronounced than after 6 months of therapy. Again anxiety, depression, overall symptoms, somatic complaints and interpersonal problems decreased significantly. The expected self efficacy, likewise, increased significantly (see fig. 3; *** = $p < 0.0001$).

Effect sizes for changes between intake and 6 months, as well as between intake and termination (2 years at maximum) are presented in figure 4. Within the first 6 months of therapy small to medium changes occurred in all measures. Before the end of therapy (after 2 years of therapy at maximum) the effect sizes for all scales (except expected self efficacy: $d = 0.41$) were large and ranged between 0.80 und 0.96.

Effect Sizes after 6 Months of Therapy and after 2 Years at Maximum

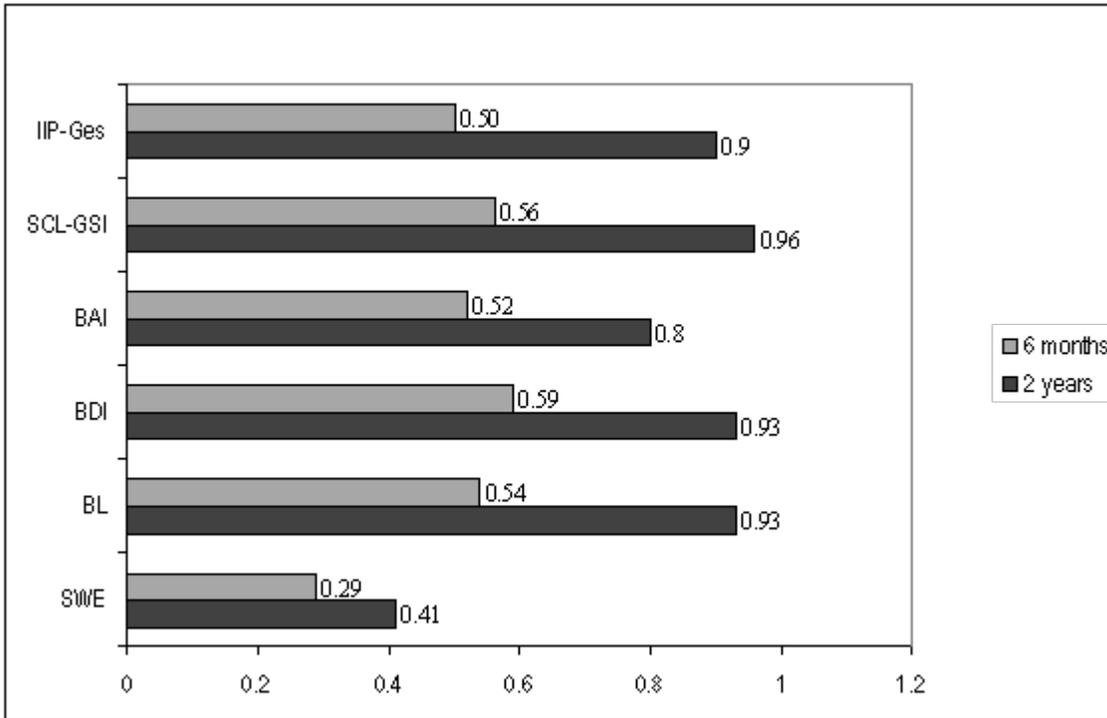


Figure 4: Effect sizes after 6 months and after 2 years of therapy at maximum (as compared to intake): small (0.2 – 0.5), medium (0.5 – 0.8) and large (> 0.8). IIP-Ges: Inventory for the Inquiry of Interpersonal Problems – Global Index, SCL-GSI: Symptom Check List – Global Severity Index, BAI: Beck Anxiety Inventory, BDI: Beck-Depression-Inventory, BL: Beschwerdenliste (List of Psychosomatic Complaints) and SWE: Selbstwirksamkeitserwartung (Expectation of Self Efficacy).

Individual Changes

In addition to group changes, individual changes concerning BAI, BDI, BL, IIP-D and SCL-90 scores will be reported here. These analyses include, according to each point of measurement, data from 253, 160 and. 42 patients respectively.

Frequencies of clinically relevant symptoms of anxiety (BAI ≥ 11) decreased from 70% at intake to 53% after 6 months to 41% at termination (or after 2 years) and 38% at follow-up. Frequencies of clinically relevant symptoms of depression (BDI ≥ 18) decreased from 35% at intake to 17% after 6 months to 5.8% at termination (or after 2 years) and amounted to 19% at follow-up. Mildly increased scores (11 ≤ BDI ≤ 17) at intake decreased from 34% to 17% after 2 years and to 14% at follow-up. Seventy-seven percent of all patients scored within the normal range (BDI ≤ 10) at the end of their therapy (or after 2 years of treatment), 68% at follow-up. At intake 88% had psychosomatic complaints deviating from average scores of healthy subjects (mean=14.3, sd=10.8), 23% after 6 months; 34% at the end of or after 2 years of therapy and 46% at our follow-up survey. Concerning interpersonal problems 29% at intake, 23% after 6 months, 10% at

termination (or after 2 years) and 8% at follow-up had deviant scores (stanines ≥ 7).

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 [90, 91]. Following Franke [75], 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. Within 2 years 41% of the patients improved to the degree that their amount of symptomatic impairment compared to that of normal controls. More than half of all patients (57%) achieved some statistically significant improvement.

Concerning the list of psychosomatic complaints as well as the anxiety inventory, patients who were still in treatment after two years tended to have been more severely impaired at intake (p = 0.06).

Global Measures of Impairment – A Comparison of Perspectives

In four domains (1. profession and education, 2. leisure time and social activities, 3. family life and domestic

duties, and 4. somatic well-being) ratings of therapists and patients were collected at all four points of measurement (scales ranged from 0 = none to 8 = maximum impairment). In addition ratings of perceived changes were collected after 6 months and after 2 years of therapy (1 = much better to 7 = much worse). Both groups consistently stated across all domains a continuous decrease of impairment with increasing duration of treatment (main factor *duration of therapy*: $2.16 \leq F_{\text{time}}(2; 104) \leq 147.65$; $0.0001 < p \leq 0.12$). On average patients and therapists both were in concordance regarding the perceived changes. Interestingly, the therapists' assessment of impairment was significantly more negative than the patients' at intake and still after 6 months of treatment (main factor *perspective*: $0.96 \leq F_{\text{perspective}}(1; 105) \leq 13.98$; $0.0003 \leq p \leq 0.33$). After 2 years this trend was inverted (interaction *duration of therapy * perspective*: $6.52 \leq F(2; 104) \leq 15.93$; $0.0001 < p \leq 0.01$). Pairwise correlations of patients' and therapists' ratings range (at intake, after 6 months and after 2 years) between $r = 0.37$ and $r = 0.45$ ($p < 0.0001$) for *profession and education*, between $r = 0.33$ and $r = 0.54$ ($p < 0.0001$) for *leisure time and social activities*, between $r = 0.13$ ($p = 0.01$ at intake) and $r = 0.46$ ($p < 0.0001$) for *family life and domestic duties* and between $r = 0.32$ and $r = 0.41$ ($p < 0.0001$) for *somatic well-being*. Correlations for perceived changes are $r = 0.50$ after 6 months of treatment and $r = 0.47$ ($p < 0.0001$) at the end of therapy (or after 2 years).

Discussion

The present study documents representative aspects of the 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 efficacy of outpatient psychotherapy have been conducted in university settings. The advantages of high internal validity achieved by previously defined treatment protocols, selected samples and highly elaborated evaluation procedures are opposed by low ecological validity [52, 53]. Therefore, comparatively little is known about the effectiveness of psychotherapy outside inpatient or university settings (phase IV [48, 49], „application-oriented psychotherapy research“ [50], level-I-field-research studies [51]). This study attempts to help fill this gap.

Prospective data are reported here for the first time, as opposed to other studies evaluating body psychotherapy that only used retrospectively collected data [32, 34, 38].

So far, body psychotherapy schools have kept their distance from academic research. However, the increasing pressure on all treatment modalities to prove their

effectiveness in recent years has made possible an outcome study like the present one.

A multi-site focused study of the efficacy of (body) psychotherapy under natural conditions demands high organisational capability, as well as patience and endurance from all participants. When standardized measurements of efficacy are not an integral part of therapy, the extra amount of time spent on 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 the therapists volunteered and their work on this research project was not remunerated. With this in the background, data collection, which started in January 1998, proceeded rather slowly. Considerable decreases in case numbers from intake to termination of therapy presumably are due to this lack of evaluation follow-through not only from patients but also from the participating therapists.

The idea to include a "waiting-list" control group (as originally intended) was dropped, partly for practical reasons (body psychotherapists are rarely in a position to make waiting lists) and partly for ethical reasons (people seeking therapy should be offered treatment as quickly as possible with referrals to colleagues if necessary). Also, several evaluation studies of other modalities currently exist, so that the research results can be compared to them.

Diagnoses and symptom profiles of outpatient body psychotherapy patients at intake are typical of and comparable to outpatient psychotherapy clients in general; their educational level is higher than that of the normal population [92]. A considerable percentage of the patients examined exhibits comorbidities. Apart from a relatively high number of Z-codes (7.3%), a similar profile of diagnoses was found in the present study ($F4 > F3 > F6$) as in two other studies that examined patients in outpatient settings and included different modalities [80, 26]. Furthermore this was true for a recently published meta-analysis carried out at the university of Dresden which included over 150'000 patients [93, 94], according to which F4-diagnoses held by far the highest, F3-diagnoses the second highest rank of psychopathological disorders in Europe. A more detailed analysis of the diagnostic data in relation to outcome measures will be carried out by Kaschke [89].

The relative frequency of Z-code assignments for the classification of problems presented 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 percentage of the cases were not reimbursed by health insurance companies and, therefore, a diagnosis "proving illness" was not necessary. Nevertheless, the

symptom profiles still exhibited a high proportion of clinically relevant impairment at the beginning of therapy.

Statistical analysis demonstrates that with increasing duration of treatment, the effectiveness of outpatient body psychotherapy increases. Statistically significant treatment effects are not only found on a group level, but clinically relevant reduction of impairment and complaints can also be demonstrated on an individual level. Within the first 6 months of treatment, significant improvement was achieved and became markedly stronger toward the end of therapy. Apart from a reduction of symptoms in mental, somatic, and interpersonal areas, the increase of expected self-efficacy was remarkable. Self-efficacy is considered to be an important resource in handling stress and emotional problems. It is also regarded as a stable personality dimension [80]. The within group effect for the expected self-efficacy at the end of therapy was markedly lower than the within group effect for the total score of the symptom checklist ($d(SWE) = 0.41$ vs. $d(SCL) = 0.96$). Nevertheless, it is of high practical value, since it represents a change on a personality dimension. This suggests that body psychotherapy not only reduces symptoms but also gives impetus for positive personality development. The results for interpersonal problems demonstrate that positive changes in interpersonal areas begin to occur during the course of therapy.

Most outcome measures from the end of therapy remained stable until the 1-year-follow-up measurement.

Results from the comparison of perspectives concerning global impairment in several areas of patients' lives demonstrate that patients' and therapists' assessments correspond but are not totally congruent. A comparison of means may reflect a somewhat overprotective attitude on the therapists' side at intake (they tend to overestimate the severity of patients' impairment as compared to patients). Toward the end of therapy the therapists' stance changes and could be interpreted as cajoling patients into autonomy (therapists may underestimate the severity of impairment in contrast to their patients). Correlation coefficients show that individual therapist-patient couples' ratings are far from being totally consistent. This may be one of the sources from which psychotherapies generate their necessary dynamics.

Internally consistent treatment concepts and techniques for the examined treatment modalities do exist [54-62], but they lack carefully detailed disorder-based treatment routines. Therefore, consistent with our naturalistic design, we had to base our assignment of therapists to the different body psychotherapeutic modalities on their membership in the above-mentioned institutes and on their self-declarations as to which modality they applied. There were no significant differences in effectiveness between the eight body psychotherapeutic modalities. This corresponds to the results of meta-analyses comparing different

modalities [3, 4], in which the specific applied methods only explain a very small amount of outcome variance. Only in the domain of interpersonal problems was there a high proportion of patients with higher than average scores at intake requesting therapy from Unitive Psychology-therapists, who in the process of therapy achieved a greater than average decrease in these scores.

Statistical analyses revealed that fully documented cases (4 measurements) did not differ from partially documented cases (3 or less measurements) according to their scores in all questionnaires at intake. Cases in which we have measurements after 6 months of therapy may be considered representative for the total sample of clients examined at intake. Those who stayed in treatment up to 2 years, exhibited slightly higher anxiety scores and psychosomatic complaints at intake. Follow-up data also come from a subsample which may be considered representative for the total sample examined at intake (with the exception that they had a significantly higher education). A higher percentage of patients, whose therapy lasted longer than 2 years (28%), and of those whose treatment prematurely ended (24%), received medication in addition to psychotherapeutic treatment – as compared to patients whose treatment ended in a mutually agreed upon termination, on average after 2 years (11%).

Not all examined patients attained clinically relevant scores on all measured variables at intake. Therefore the category "unchanged" also includes subjects who were not impaired to a clinically relevant degree at intake. Out of the follow-up group of examined patients, 62% did not exhibit raised symptoms of anxiety, 81% had no clinically relevant scores of depression, 54% did not differ from healthy controls concerning psychosomatic complaints, 92% exhibited no interpersonal problems and 41% had no psychopathological symptoms at follow-up, which was 1 year after their therapy had ended.

Prospect

More collaboration between professional researchers and practicing psychotherapists is desirable, and the dialogue among the different therapeutic modalities should be substantially increased. For body psychotherapy schools, this study demonstrates that a comparative evaluation using standardized instruments of therapy research need not be feared. Prospectively, the important task of formulating specific therapeutic goals and developing suitable measuring instruments remains important. If these were developed, the indices for efficacy discussed here could be supplemented by indices that are specific to body psychotherapy. In addition, disorder-specific interventions could be operationally defined and their efficacy could then be investigated. The results from this study demonstrate that body psychotherapeutic approaches can claim an equal stature in mental health care.

Conclusion

Patients who seek body psychotherapy treatment match clients of other outpatient facilities as to demographic variables, symptoms, complaints and severity of impairment.

The efficacy of body psychotherapy treatments could be demonstrated in several domains (anxiety, depression, other psychopathological symptoms, interpersonal problems and psychosomatic complaints). Significant improvement occurred after six months. The longer the treatment, the more the improvement. The effect sizes for treatments that lasted up to 2 years were $\geq .80$.

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