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Treatment modalities and self-expectancy of therapists: Modes, self-efficacy and imagination of clients in dance movement therapy

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Abstract
Dance movement therapists' active or observant treatment modalities and their self-expectancies are investigated in this article, additionally to ambulant clients' ($N = 162$) active or receptive modes, their self-efficacy (Bandura, 1994), and imagination. These moderating variables have been checked as part of a major multicentric study in 11 different cities in Germany that included quantitative and qualitative methods (Bräuninger, 2007). Outcomes presented in this paper are gained from the randomized control trial (RCT). The RCT compared treatment groups ($N = 97$) who participated in 10 sessions of short-term group DMT to wait-listed control groups ($N = 65$). The moderating variables were tested in a pre, post, and 6-months follow-up test by means of standardized questionnaires and some items of the Intervention-Checklist ICL2. Results indicate that neither active versus observant treatment modality of therapists nor active versus receptive mode of clients had a major influence on the efficacy of therapy. Clients showed high self-efficacy and imagination already at baseline and hence no significant changes appeared in post and follow-up tests.

Keywords: *Dance movement therapy (DMT), treatment modality, active or receptive mode, self-efficacy, imagination, randomized control trial (RCT)*

Introduction

Dance movement therapy (DMT) has been described as an approach that can be conducted in an intuitively (Whitehouse, 1979) and inner-directed way

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(Chodorow, 1991). Hervey (2000) portrayed intuition as one of several features of aesthetic consciousness that can be included in the artistic inquiry as a creative approach to DMT research. Dance movement therapists lead DMT sessions in different modalities appropriate for the treatment process in response to the interaction with and the needs and reactions of their clients. They actively move with their clients (Chaiklin & Schmais, 1986; Payne, 1992; Stanton-Jones, 1992) and receptively observe and witness their clients' process, as practiced in Authentic Movement (Lewis, 1993). So far, no references and recommendations exist on how dance movement therapists should ''act'' with regard to treating ambulant clients who aim to improve their quality of life and reduce their stress level. Is there such a thing as a ''better'' treatment modality that therapists should choose? Should dance movement therapists guide their clients more into an active mode or receptive mode during DMT sessions? This article presents empirical findings on these topics. It further illustrates what dance movement therapists feel and expect from themselves during DMT sessions, how clients perceive their self-efficacy, and how imaginative clients are prior to and after a 10 session DMT intervention.

Background and objectives

Due to the lack of empirical literature, we do not know how dance movement therapists' active or observant treatment modality affects treatment outcome in the short-term and long-term. Therapists' active treatment modality describes the physical active involvement of the therapist during the DMT session, for example when the dance movement therapist joins the clients' dance. Therapists' observant treatment modality expresses the perceptive and aware mode, for example when the therapist sits at the edge of the room and observes the process of the group while the clients are moving. By evaluating dance movement therapists' treatment modalities it could become clearer if one may be superior to the other.

Clients that are actively moving, dancing, and expressing themselves, who can be observed by others, are in the active mode. Dosamantes-Alperson (1979) described movements in the action mode as more consciously aware by the mover with an external-interactional character that enables people to cope with the external world. In this article, the term active mode is used interchangeably with Dosamantes-Alperson's description of action mode. Internal-intrapsychic movements in the receptive mode, according to Dosamantes-Alperson, connect the inner world with the outer conscious world. Following Dosamantes-Alperson's explanation, receptive mode illustrates inwardly directed movements and body awareness in stillness that might not be visible to external observers. To assess if treatment outcome improves when clients are mainly in the active or receptive mode might clarify if one of the two modes might be better than the other.

Perceived Self-Efficacy, as defined by Bandura (1994), describes people's beliefs in their ability to produce effects. According to Schwarzer (2004), the Generalized Self-Efficacy (GSE) as a personal resource plays a significant

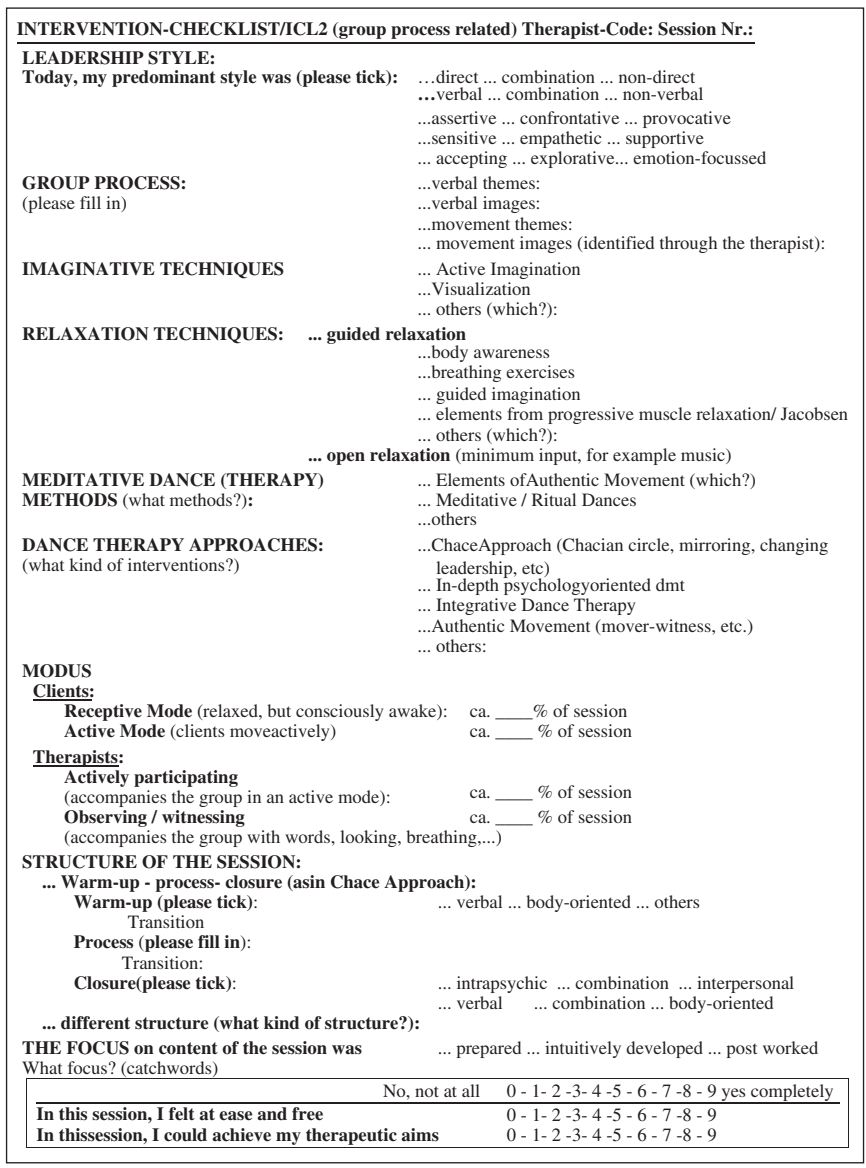
role in stress management, especially when dealing with deep life crisis and major life changes. Schwarzer (1996) further emphasizes the importance of GSE for social support in stress management. Self-efficacy is included in five core foci for medical DMT described by Goodill (2005a). The other four are Vitality, Relationship-Focused Coping, Body Image of Illness, and Mood. Her randomized, controlled pilot study of mood and adherence in adults with cystic fibrosis revealed, participants ($N = 24$) of the treatment group ($n = 14$) showed an improvement in nutritional self-care regimens in comparison to the control group ($n = 10$) a month after the DMT intervention was completed (Goodill, 2005b). According to Goodill (2006), adherence and the capacity for self-care may be learnt through body awareness and self-efficacy. This study evaluates whether clients' self-efficacy improves significantly due to DMT treatment.

Being imaginative indicates that clients are suggestible which seems to be a good base for hypnosis and self-hypnosis (Revenstorf & Zeyer, 2001). Using imagination in DMT is an important tool well documented in DMT literature (Bräuninger 2000a, 2000b; Bräuninger & Blumer, 2004; Chodorow, 1991; Ellis, 2001; Meekums, 2002; Rose, 1995; Schmais, 1985; Stanton-Jones, 1992). In a pilot study with DMT students and a control group with students of social welfare or psychology trainees, Goodman and Holroyd (1993) tested hypnotizability, absorption, and imagery at the beginning and the end of their first year. They found that DMT students ($N = 14$) started with higher levels of absorption and imagery thinking styles compared to the control group ($N = 10$). Absorption increased over time in the DMT group, while the control group scores decreased. Hypnotizability did not increase in the control group, but tended to increase for the DMT group ($p < 0.09$, 1-tailed test). This study further evaluates if DMT clients are imaginative at baseline and improve their imagination due to DMT treatment, like the DMT students described by Goodman and Holroyd. Results of this study may help dance movement therapists to gain more self-confidence, self-consciousness, and positive reinforcement in choosing their personal way of conducting the DMT process.

Method: Research design

In this study, dance movement therapists' active or observant treatment modalities and their self-expectancies are investigated, additionally to ambulant clients' active or receptive modes, their self-efficacy (Bandura, 1994), and imagination. These moderating variables have been checked as part of a major research project, a multi-centred randomized control trial conducted in 11 different cities in Germany, that included quantitative and qualitative methods (Bräuninger, 2007): 162 participants were randomly assigned to 12 DMT treatment groups (TG) ($n = 97$) and nine wait-listed control groups (CG) ($n = 65$). Participants who suffered under stress and wanted to improve their quality of life were recruited through newspaper announcements (exclusion criteria: being in psychiatric or [body] psychotherapeutic treatment within the last 12 months). TG participated in 10 sessions

of short-term group DMT conducted by 11 dance movement therapists with DMT training acknowledged by the German Dance Therapy Association/BTD or comparable to BTD standards. Variables were tested in a pre, post, and 6-months follow-up test by means of standardized questionnaires and some items of the Intervention-Checklist ICL2 (see Figure 1). The overall project and results are described in greater depth in Bräuninger, 2006. Table I gives an overview of the randomized control trial (RCT).



INTERVENTION-CHECKLIST/ICL2 (group process related) Therapist-Code: Session Nr.:

LEADERSHIP STYLE:
Today, my predominant style was (please tick): …direct ... combination ... non-direct
…verbal ... combination ... non-verbal
...assertive ... confrontative ... provocative
...sensitive ... empathetic ... supportive
... accepting ... explorative... emotion-focussed

GROUP PROCESS: ...verbal themes:
(please fill in) ...verbal images:
...movement themes:
... movement images (identified through the therapist):

IMAGINATIVE TECHNIQUES ... Active Imagination
...Visualization
... others (which?):

RELAXATION TECHNIQUES: **... guided relaxation**
...body awareness
...breathing exercises
... guided imagination
... elements from progressive muscle relaxation/ Jacobsen
... others (which?):
... open relaxation (minimum input, for example music)

MEDITATIVE DANCE (THERAPY) ... Elements ofAuthentic Movement (which?)
METHODS (what methods?)**:** ... Meditative / Ritual Dances
...others

DANCE THERAPY APPROACHES: ...ChaceApproach (Chacian circle, mirroring, changing
(what kind of interventions?) leadership, etc)
... In-depth psychologyoriented dmt
... Integrative Dance Therapy
...Authentic Movement (mover-witness, etc.)
... others:

MODUS
Clients:
Receptive Mode (relaxed, but consciously awake): ca. ____% of session
Active Mode (clients moveactively) ca. ____ % of session

Therapists:
Actively participating
(accompanies the group in an active mode): ca. ____ % of session
Observing / witnessing ca. ____ % of session
(accompanies the group with words, looking, breathing,...)

STRUCTURE OF THE SESSION:
... Warm-up - process- closure (asin Chace Approach):
Warm-up (please tick): ... verbal ... body-oriented ... others
Transition
Process (**please fill in**):
Transition:
Closure(please tick): ... intrapsychic ... combination ... interpersonal
... verbal ... combination ... body-oriented
... different structure (what kind of structure?):

THE FOCUS on content of the session was ... prepared ... intuitively developed ... post worked
What focus? (catchwords)

	No, not at all	0 - 1- 2 -3- 4 -5 - 6 - 7 -8 - 9 yes completely
In this session, I felt at ease and free		0 - 1- 2 -3- 4 -5 - 6 - 7 -8 - 9
In thissession, I could achieve my therapeutic aims		0 - 1- 2 -3- 4 -5 - 6 - 7 -8 - 9

Figure 1. ICL2 (Translation of ICL2 by the author, Bräuninger, 2007, p. 103).

Table I. Randomized control trial (RCT) (Questionnaires presented to the participants) (Bräuninger, 2007, p. 88).

	Test phases		
Groups	t1: Pre-test	t2: Post-test	t3: 6-months follow-up test
	(1–2 weeks prior to onset of short term treatment programs)	(ca. 10–12 weeks after t1)	(ca. 9 months after t1)
Treatment group	Standardized questionnaires Written consent form	Standardized questionnaires	Standardized questionnaires
Wait-listed control group	Standardized questionnaires Written consent form	Standardized questionnaires	Standardized questionnaires

Each therapist filled out two kinds of Intervention Checklists (developed by the writer as a "personal memorandum" for the therapists) after each DMT session: ICL1[1] includes one table column per participant and collects interventions per individual in each DMT session. ICL2 combines quantitative and qualitative data regarding the group process and collects all group interventions per session. A total of 103 ICL1's and 128 ICL2's were received and analysed. The CG had the possibility of participating in DMT groups after completion of the study (about 9 months after baseline t1).

Data collection through study participants

The following standardized measurements were presented to all clients (TG and CG) at t1, t2, and t3 for evaluating the moderating and effect variables.

Questionnaires for moderating variables

- Generalized Self-Efficacy [Generalisierte Selbstwirksamkeit] (GSE; Schwarzer, 1994, German Version). The GSE consists of 10 items and measures the general sense of perceived individual self-efficacy on a 4-point scale from 0 = "not at all true," 1 = "barely true," 2 = "moderately true," 3 = "exactly true." It aims to predict:

"(. . .) coping with daily hassles as well as adaptation after experiencing all kinds of stressful life events.

Reliability

In samples from 23 nations, Cronbach's alphas ranged from.76 to.90, with the majority in the high.80s. The scale is one-dimensional.

Validity

Criterion-related validity is documented in numerous correlation studies where positive coefficients were found with favourable emotions, dispositional optimism, and work satisfaction. Negative coefficients were found with depression, anxiety, stress, burnout, and health complaints. In studies with cardiac patients, their recovery over a half-year time period could be predicted by pre-surgery self-efficacy" (Schwarzer, 2005).

- Imagination Test [Imaginationstest] (Revenstorf & Zeyer, 2001). This includes 14 items on a 7-point Likert scale from 1 = "not at all true" to 7 = "exactly true." The total sum measures the imagination ability.

Questionnaires for effect variables (for results see Bräuninger, 2006, 2007)

- World Health Organization Quality of Life Questionnaire 100 (WHOQOL-100; Angermeyer, Kilian, & Matschinger, 2000). This collects the subjective quality of life and health status with 100 items in six domains on a 5-point Likert scale.
- Munich Life Dimensional List [Münchner Lebensdimensionsliste] (MLDL; Heinisch, Ludwig, & Bullinger, 1991). This collects the personal life satisfaction with 19 items in four subscales on an 11-point Likert scale.
- Brief Symptom Inventory (BSI; Franke, 2000, German short version of the Symptom-Checklist SCL-90-R of Derogatis; Franke, 1995). Screens psychological problems and symptoms of psychopathology during the past 7 days, it consists of nine scales including 53 items, and three global indices on a 5-point scale: 1. Somatization (7 items), 2. Obsessiveness (6 items), 3. Insecurity in social interaction (4 items), 4. Depressiveness (6 items), 5. Anxiety (6 Items), 6. Aggressiveness/ hostility (5 Items), 7. Phobic anxiety (5 items), 8. Paranoid thinking (5 items), 9. Psychoticism (5 items). Additionally, there are four subtests that are not included in any scales: bad appetite (item 11), difficulties falling asleep (item 25), thoughts about death and dying (item 39), bad consciousness (item 52).
- Stress Management Questionnaire 120 [Stressverarbeitungsfragebogen] (SVF 120; Janke et al., 1997). Measures individual tendencies of how individuals apply different stress management styles under strain; it consists of three Positive Strategies and one Negative Strategy with a total of 20 subtests and 120 items, answers are on a 5-point scale. Positive Strategy 1 Defence consists of three subtests ("bagatellization," playing down, rejection of guilt), Positive Strategy 2 Distraction consists of four subtests (distraction, compensation, self-insurance, relaxation), Positive Strategy 3 Control consists of three subtests (control of situation, control of reaction, positive self instruction). The Negative Strategy consists of 4 subtests (social isolation, continued thinking, resignation, self accusation). The 4 subtests are not integrated in any subtests: 11 Social need for support, 12 Avoidance, 19 Aggression, and 20 Consumption of pharmaceuticals.

Data analysis of participants' questionnaires (for moderating and effect variables)

All questionnaires were calculated with analysis of variance with repeated measures (measuring point t1 × measuring point t2 vs. measuring point

t1 × measuring point t3). Calculations included the mean of TG, the mean of CG, the total mean, as well as:

- the interaction between
  - TG and CG
  - measuring point t1 and t2 (pre-test and post-test)
  - measuring point t1 and t3 (pre-test and 6-months follow-up)
- the interaction between
  - TG and CG and measuring point t1 and t2
  - TG and CG and measuring point t1 and t3.

Measuring points t1 and t2 vs. t1 and t3 were compared in the Greenhouse-Geisserscher Test. All statistical tests measured the efficacy of DMT with a level of significance at $p < 0.10$ = significant (*) and $p < 0.05$ = highly significant (**).

Data collection through dance movement therapists

All 11 dance movement therapists filled out ICL1 and ICL2 after each of the 10 DMT sessions. Results presented here will focus on those ICL2 items that are relevant to this article (results of ICL1 are presented in Bräuninger, 2006). For results regarding the qualitative items of ICL2, see Bräuninger (2006) (for ICL2, see Figure 1). Dance movement therapists were asked about their clients' and their own mode in the treatment groups. As presented in Figure 2, therapists should estimate:

(1) the mode of their clients during the session, how much (in percentage) the clients would have been receptive or active (the sum should add up to 100%); and
(2) their modality during the session, in other words how long they would have been actively participating or observing/witnessing in percentage (the sum should add up to 100%).

Additionally, dance movement therapists were asked to score if they felt at ease and free, and if they managed to successfully fulfil their therapeutic aims in the sessions? Answers could be put on a 10-point scale from 0 = "not at all true" to 9 = "yes, completely" (see Figure 3).

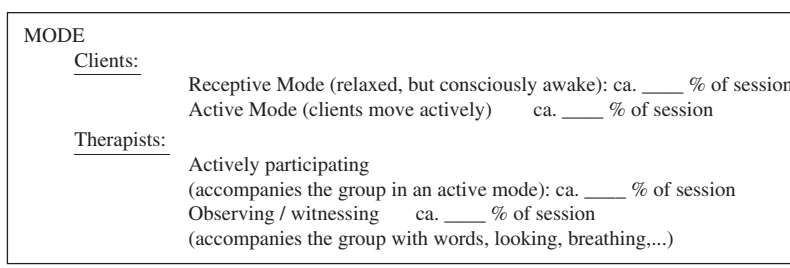


Figure 2. Mode of clients and dance movement therapists.

	No, not at all	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 yes completely
In this session, I felt at ease and free	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9	
In this session, I could achieve my	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9	

Figure 3. Feeling states and self-expectancy of dance movement therapists during DMT sessions.

Table II. Age and gender of participants.

Participants	$N = 162$	Treatment group $n = 97$	Waitlisted-control group $N = 65$
Means (*M*)	$M = 44$ years	$M = 44$ years	$M = 44$ years
Standard Deviation (*SD*)	$SD = 9$ years	$SD = 9$ years	$SD = 8$ years
Gender (%)	147 (90.7)	88 (90.7)	59 (90.8)
Female			
Male	15 (9.3)	9 (9.3)	6 (9.2)

Data analysis of dance movement therapists' items

An explorative data analysis was applied with the dependant variables and the factor list dance movement therapists. Subsequently, these data were correlated with those scales, subscales, and domains of the WHOQOL-100, MLDL, BSI, and SVF120 that showed significant results.

Pearson's correlation analysis (bivariate, one-tailed) was chosen in order to evaluate if (a) WHOQOL-100, MLDL, BSI, and SVF120 correlates with clients' receptive mode vs. clients' active mode, (b) WHOQOL-100, MLDL, BSI, and SVF120 correlates with therapists' active mode vs. therapists' observant mode, and (c) WHOQOL-100, MLDL, BSI, and SVF120 correlates with ICL2 items Self-Expectancy and Successful Achievements of Therapeutic Aims during the session.

Results: Participants

Participants in TG and CG did not vary with regard to age or sex: The mean age of people was 44 years (*SD* 9 years), mean age in both TG and CG was 44 years (*SD* in TG was 9 years, *SD* in CG was 8 years). Of all 162 participants, 147 were female (90.7%) and 15 were male (9.3%). Table II gives an overview of the average age and gender of participants in general, in TG and CG.

Moderating variables of participants

Short-term and long-term effects of DMT on Generalized Self-Efficacy (GSE)

For the evaluation of the GSE (Schwarzer, 1994), the arithmetical mean of the total sum of all 10 items were calculated (with the 4-point scale from 0 = "not at all true," 1 = "barely true," 2 = "moderately true," 3 = "exactly true"). The short-term and long-term results regarding the

GSE (main effect measuring point and interaction between group membership and measuring point) are presented in Table III. Although the values improved more in the TG than in the CG from t1 to t2 and from t1 to t3, the interaction between TG and CG and measuring point t1 and t2 vs. t1 and t3 are not significant. The hypotheses that a positive relation between improvement of self-efficacy and DMT treatment exist could not be confirmed by analysing the moderating variable GSE.

Short-term and long-term effects of DMT on imagination ability

For the evaluation of the Imagination Test (Revenstorf & Zeyer, 2001), the arithmetical mean of the total sum of all 14 items of the 7-point-scale (1 = "not at all true" to 7 = "exactly true") were calculated. Short-term and long-term effects of DMT on imagination ability (main effect measuring points and interaction between group membership and measuring points) are presented in Table IV. The hypothesis that imagination ability would improve significantly in the TG in comparison to the CG could not be confirmed. An interesting result was the high score of imagination ability in both the TG and CG at baseline (85 vs. 86 out of 98 points possible). This result suggests high imagination abilities in the participants who signed up for the DMT study.

ICL2 results of dance movement therapists

Dance movement therapists were asked to measure their clients' receptive (Figure 4) or active mode (Figure 5). The letters (a, b, c1, c2, d, e, k, l, n, r, u, l) relate to the 12 DMT groups led by 11 dance movement therapists (therapist "c" led two groups c1 and c2).

Clients were in the receptive mode in a third of all therapy sessions (33.36%) (Figure 4). The explorative data analysis shows a broad variance regarding the application of the receptive mode. Depending on the dance movement therapist, the emphasis varied extensively. For example, dance movement therapist "l" never led the DMT group into the receptive mode, whereas dance movement therapist "c" worked with the groups c1 and c2 about 50% of the time in that mode. Contrariwise, the explorative data analysis demonstrates that clients were in active mode for 61% of the time. Again, depending on the dance movement therapist, all clients were active, but the variance laid between 10 and 100% of the time. The most active group was that of dance movement therapist "l" (100%), the least active groups were "c1" and "c2" (see Figure 5).

Dance movement therapists were also asked to measure how much of the session they participated in the active mode (Figure 6) or observant mode (Figure 7). Additionally, they had to rate their feelings about the session (Figure 8) and their successful self-expectancy during DMT sessions (Figure 9).

On average, dance movement therapists chose an active mode for about 54% of the sessions. The individual differences between therapists become

Table III. Mean (*M*) and Standard Deviation (*SD*) of GSE at t1 (before the intervention), t2 (after the intervention: short-term result) and t3 (6-months follow-up: long-term result). Main effect of time factor, and interaction between group membership and measuring point; TG = treatment groups, CG = wait-listed control groups, GSE = Generalized Self-Efficacy.

GSE t1-t2 (Pre–post comparison)	Group	*N*	Pre-test t1 *M* (*SD*)	Post-test t2 *M* (*SD*)	Measuring point t1-t2	time × group
Mean of total sum of all 10 items	TG	84	1.61 (.56)	1.74 (.53)	$F(1,136) = 6.45^{**}$	n.s.
	CG	54	1.63 (.45)	1.67 (.51		
GSE t1-t3 (Pre – 6-months follow-up)	Group	*N*	Pre-test t1 *M* (*SD*)	6-monthsfollow-up t3 *M* (*SD*)	Measuring point t1-t3	time × group
Mean of total sum of all 10 items	TG	76	1.63 (.49)	1.79 (.54)	$F(1,123) = 10.18^{***}$	n.s.
	CG	49	1.63 (.49)	1.73 (.59)		

$^{**}p < 0.05$.
$^{***}p < 0.005$.

Table IV. Mean (*M*) and Standard Deviation (*SD*) of imagination ability at t1 (before the intervention), at t2 (after the intervention: short-term result) and at t3 (6-months follow-up: long-term result). Main effect of time factor and interaction between group membership and measuring point; TG = treatment groups, CG = wait-listed control groups.

Imagination ability t1-t2 (pre– post comparison)	group	*N*	Pre-test t1 *M* (*SD*)	Post-test t2 *M* (*SD*)	Measuring point t1-t2	time × group
Mean of total sum of all 10 items	TG	83	6.13 (13.76)	6.09 (11.78)	n.s.	n.s.
	CG	54	5.92 (14.00)	5.97 (9.62)		
Imagination ability t1-t3 (pre – 6-months follow-up)	group	*N*	Pre-test t1 *M* (*SD*)	6- months follow-up t3 *M* (*SD*)	Measuring point t1-t3	time × group
Mean of total sum of all 10 items	TG	75	6.13 (13.83)	6.24 (11.65)	$F(1,123) = 10.18^{***}$	n.s.
	CG	49	5.93 (14.41)	5.99 (12.53)		

$^{***}p < 0.005$.

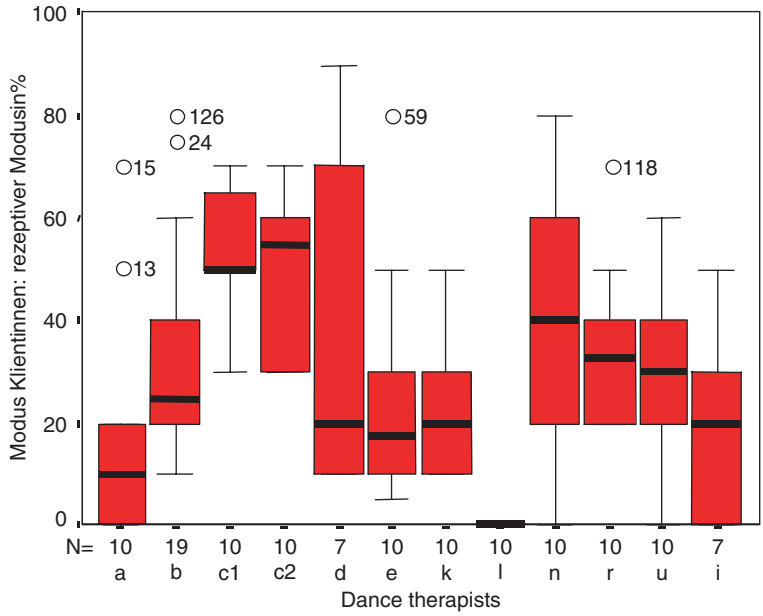


Figure 4. Clients mode: Receptive mode (relaxed, but consciously aware): ca. __% of the session (adapted from Bräuninger, 2006).

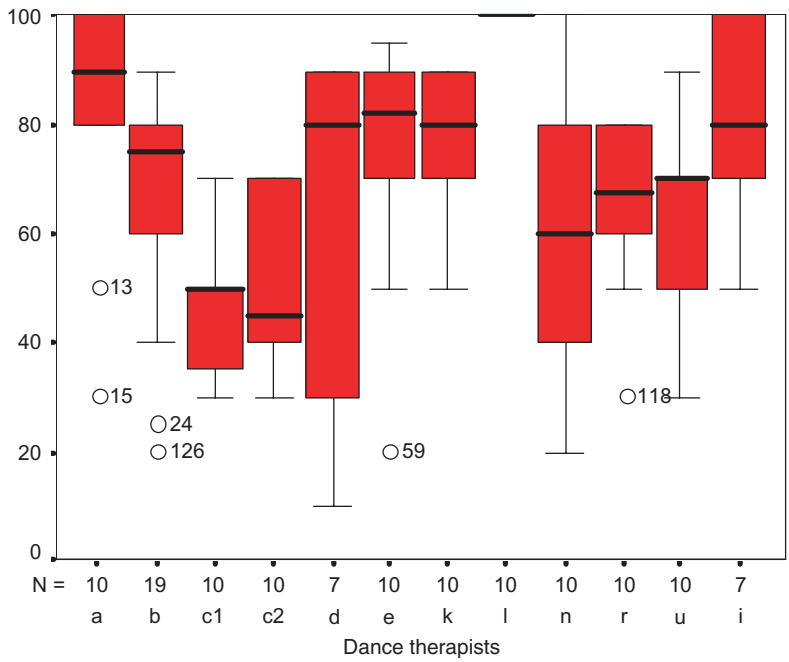


Figure 5. Clients mode: Active mode (clients move actively: ca. __% of the session (adapted from Bräuninger, 2006).

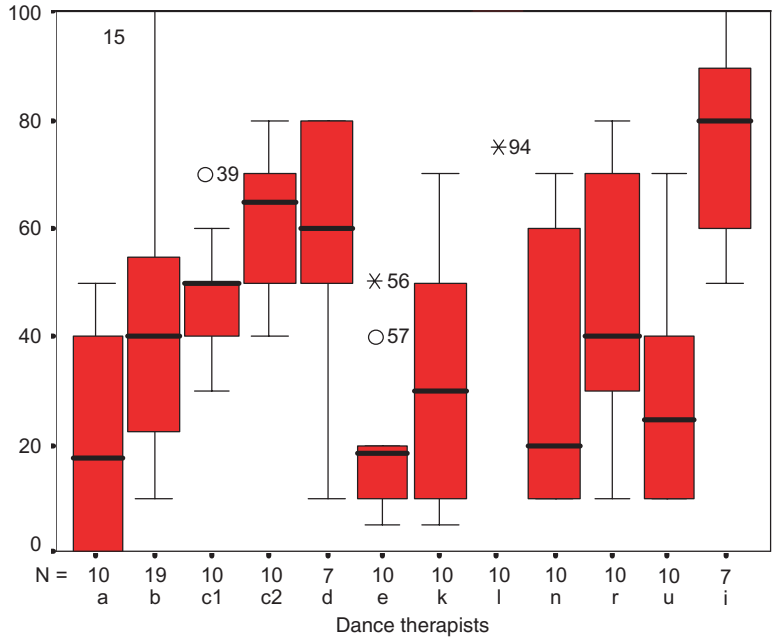


Figure 6. Therapist mode: Therapist participates in an active way: ca. _% of the session (adapted from Bräuninger, 2006).

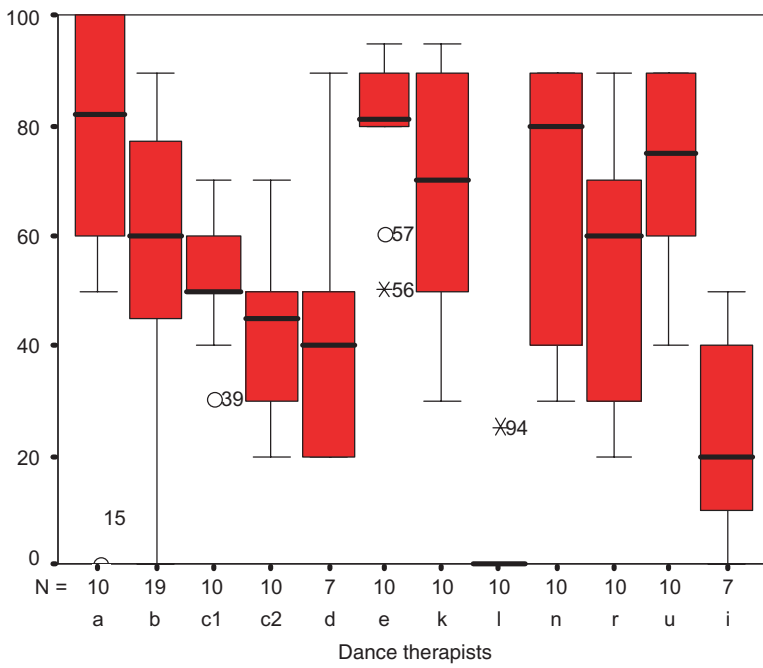


Figure 7. Therapist mode: Therapist observes (accompanies with words, looking, breathing. . .): ca. _% of the session (adapted from Bräuninger, 2006).

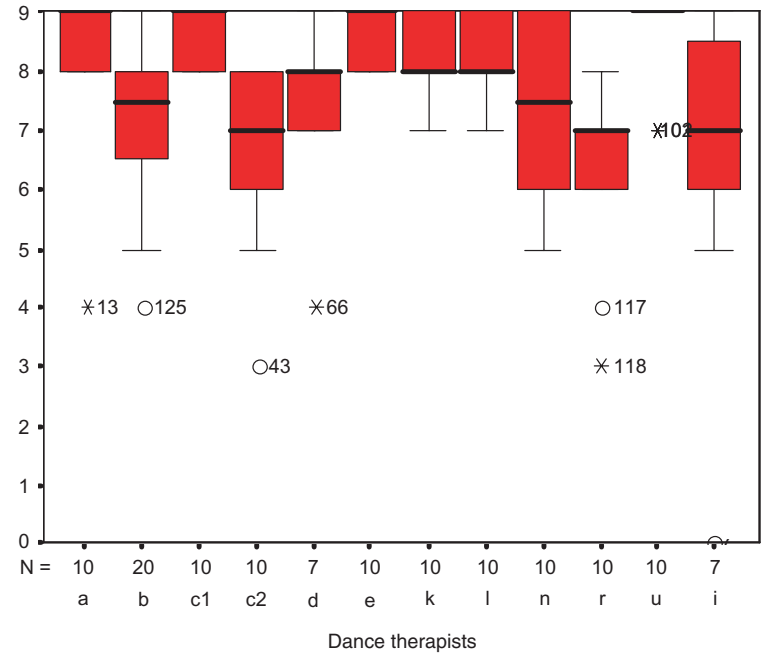


Figure 8. In this session, I felt at ease and free: 0 = no, not at all; 9 = yes, completely (adapted from Bräuninger, 2006).

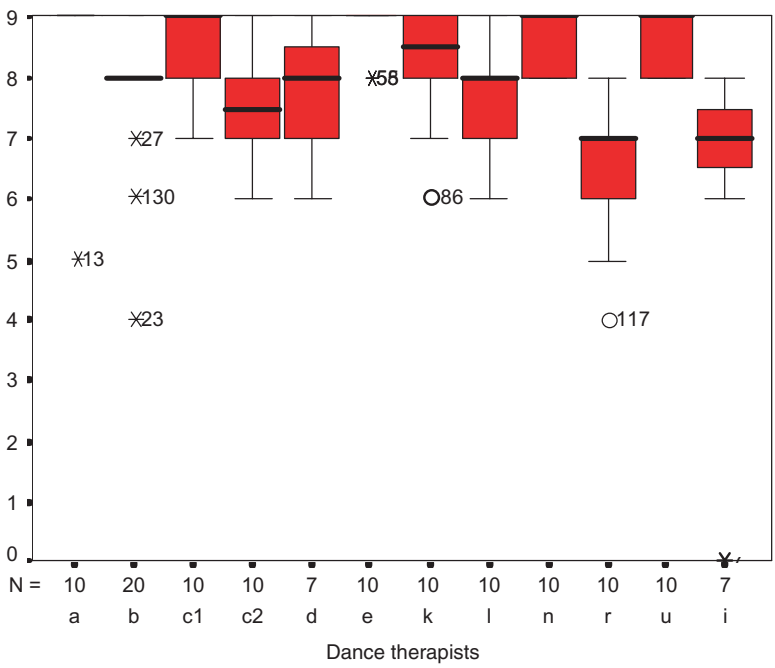


Figure 9. In this session, I could achieve my therapeutic aims: 0 = no, not at all; 9 = yes, completely (adapted from Bräuninger, 2006).

even more articulated: the variance of active participation was between 97% (therapist l) and 20% (therapist e) (see Figure 6). Therapists were in the observant mode for 57.76% on average, with great individual differences (see Figure 7).

The explorative data analysis of the therapists' feeling states during the session shows a mean of 7.6 points regarding the therapists' self-expectancy in the session (see Figure 8). The mean for therapists' successful achievements of their therapeutic aims is 7.9 (Figure 9).

Correlation of WHOQOL-100, MLDL, BSI, and SVF120 with clients' receptive mode vs. clients' active mode

The Pearson's correlation analysis reveals the following tendency: the more clients are in receptive mode, the more their somatic symptoms reduce (BSI scale). Therefore, the more clients are in active mode, the more their somatic symptoms increase. Also, the more clients are in active mode, the more they significantly look for social support and help (SVF Subtest); thus, the more clients are in receptive mode, the less they are likely seek social support and help.[2]

Correlation of WHOQOL-100, MLDL, BSI, and SVF120 with therapists' active mode vs. therapists' observant mode

The more the therapist took on an observant role, the more the client group became independent (WHO domain), their social relations (WHO domain), social life (MLDL subscale), and daily life (MLDL subscale) improved and they sought social support and help (SVF Subtest). However, the more the dance movement therapists were in active mode during the session, the more clients seemed to try to avoid strains.

Correlation WHOQOL-100, MLDL, BSI, and SVF120 with ICL2 items self-expectancy and successful achievements of therapeutic aims during the session

In the Pearson's correlation analysis, the therapists' self-expectancy in the session and successful achievements of therapeutic aims tend to result or significantly results in negative correlations with all questionnaires. This result is inconsistent with the hypothesis of the short-term and long-term healing effect of DMT (Bräuninger, 2006).

Discussion and conclusion

The aim of this article was to illustrate the short-term and long-term effects of moderating variables with regard to how often DMT clients were in active and receptive modes during a 10 session DMT program, how their self-efficacy and imagination changed due to DMT treatment, and how dance movement therapists used active and observant modes while leading DMT groups.

As these topics have not been evaluated before, the author was interested in examining whether dance movement therapists (1) would choose different treatment modalities (active versus observant) for themselves, and (2) would direct clients into different modi (more active or more receptive). (3) Assuming that differences in (1) and (2) would occur, the question would then be whether these differences could affect treatment outcomes. Additional questions were how therapists' self-expectancy would present itself and how they would score successful achievements of their therapeutic aims.

Results showed that dance movement therapists used a broad variety of treatment modalities from very active to observant in order to support their clients' improvement in quality of life and stress management. Dance movement therapists varied extensively in the way they led client groups into active or receptive mode. Despite these differences and individual leading styles, correlations with the clients' questionnaires WHOQOL-100, MLDL, BSI, SVF 120, GSE, and Imagination Test did not reveal a significant dominance of one treatment modality over another. The outcome of this is that treatment modalities of dance movement therapists (active or observant) and clients' modes (active or receptive) do not significantly influence the improvement of quality of life or stress management.

Personal preferences of dance movement therapists seemed to influence which treatment modalities they choose. Additionally, dance movement therapists seemed to orientate themselves in an individual, intuitive, and creative way according to the mode of their clients and, equally, their orientation appeared to influence the mode of their clients. Consequently, different dance movement therapists who provided DMT to the same group of clients did not develop or produce a normative DMT approach. The correlation between treatment modalities and clients' questionnaires underline that:

(1) Choosing an individual, non-conformist way of applying DMT treatment modalities by therapists (from active to observant) does not influence treatment outcomes.
(2) Independent from therapists' treatment modalities, treatment effects of TG are significant when compared to the CG.
(3) Leading DMT groups in an active or a receptive mode does not influence treatment outcomes (Bräuninger, 2006).

Therefore, dance movement therapists should feel free to choose their individual treatment modality for DMT sessions and direct their clients into a more active or receptive mode thereby trusting their intuitive choice. One detailed result seems to be particularly interesting. In the Pearson's correlation analysis the ICL2 item clients' mode receptive correlates in a significantly negative way with the SVF subtest social need for support at measuring point t2 (post-test). And the contrary is also true, the ICL2 item clients' mode active correlates in a significantly positive way with the SVF subtest social need for support at measuring point t2. The ICL2 item

observant therapist mode correlates in a significantly positive way with the WHOQOL domain Social Relations, the MLDL subscale social life, and the SVF subtest social need for support at measuring point t3 (6-months follow-up test). Thus, the more the TG was in active mode and the dance movement therapists were in observant mode, the better clients managed to build social relations in their daily lives, ask for social support and help, and became independent in the short and long term. In order to foster autonomy and independence, the modes observant therapist and active clients seem to serve this treatment goal best.

Under certain circumstances, the treatment goal might be to strengthen clients' defence mechanisms and avoiding behaviours. The ICL2 mode active therapist correlates in a significantly positive way in the short-term and shows a tendency in the long-term with the SVF subtest avoidance. This means that the more a therapist is in active mode, the more clients show behaviour of avoidance. In acute stress or crisis situations, it could be therapeutically indicative as an avoidant behaviour in clients who need help in experiencing ad hoc relief.

Another result showed the marginal influence of the moderating variable self-efficacy on improvement of quality of life and stress management. Although the values improved more in the TG compared to the CG in the short-term and long-term, the results were not significant. Future research with RCTs could evaluate clients' self-efficacy if DMT groups last longer than 10 sessions and if the clients' groups differ, for example in age, diagnosis, or gender.

A further outcome illustrated that the influence of the moderating variable imagination ability on the improvement of quality of life and stress management seems to be irrelevant. Taking into account that participants signed up voluntarily, and that no additional group (for example a relaxation group) was offered as controls, suggests that DMT seems especially attractive to people with a high imagination ability at baseline who further improved their skills over time compared to the control group. This result suggests that both DMT clients and dance movement therapists have well developed resources in imagery thinking. The result additionally confirms the outcome of the Goodman and Holroyd (1993) study on the high level of hypnotizability of DMT students at baseline and their further improvement of this skill during training. This finding is worth integrating into DMT practice when choosing successful DMT interventions. Working with imagination puts a high amount of responsibility and knowledge onto the therapist's shoulders: guide, educate, encourage, and support people who are open to suggestibility. Clients might be flooded with images or in danger of loosing control when not accompanied carefully and professionally. Working consciously with imagination provides a unique opportunity for clients to heal and have enriching experiences. Integrating imagination into DMT practice appears to be one of the unique characteristics of DMT. It is a creative way to incorporate one of our important heritages and make use of our strength.

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Notes

1 Readers interested in ICL1 can contact the author for a copy at tanztherapie@swissonline.ch

2 Detailed results can be downloaded at http://homepage.mac.com/dancetherapy/beltz/ (see pages 29–30)

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References

Angermeyer, M. C., Kilian, R., & Matschinger, H. (2000). *WHOQOL-100 und WHO-BREF. Handbuch für die deutschsprachige Version der WHO Instrumente zur Erfassung von Lebensqualität*. Göttingen: Hogrefe Testzentrale.

Bandura, A. (1994). Self-efficacy. In V. S. Ramachaudran (Ed.), *Encyclopedia of human behavior* (Vol. 4, pp. 71–81). New York: Academic Press (Reprinted in *Encyclopedia of mental health*, by H. Friedman, Ed., 1998, San Diego: Academic Press).

Bräuninger, I. (2000a). Tanztherapie mit Menschen in der zweiten Lebenshälfte: Möglichkeiten der Angst- und Suchtbewältigung [Dance movement therapy with people in their second half of life. Possibilities in the treatment of anxiety and substance abuse disorders]. In P. Bäuerle, H. Radebold, R. D. Hirsch, K. Studer, U. Schmid-Furstoss, & B. Struwe (Eds), *Klinische Psychotherapie mit älteren Menschen. Grundlagen und Praxis* (pp. 136–141). Bern: Verlag Hans Huber.

Bräuninger, I. (2000b). Tanztherapie in der Gerontopsychiatrischen Tagesklinik bei Patienten mit Angststörungen [Dance movement therapy in the geronto-psychiatric day clinic with patients with anxiety disorders]. In C. Kretschmar, R. D. Hirsch, M. Haupt, R. Ihl, R. Kortus, G. Stoppe, & C. Wächter (Eds), *Angst-Sucht-Anpassungsstörungen im Alter.*

Schriftenreihe der Deutschen Gesellschaft für Gerontopsychiatrie und –psychotherapie, DGGPP, Band 1 (pp. 202–206). Düsseldorf: Die Deutsche Bibliothek–CIP Einheitsaufnahme.

Bräuninger, I. (2006). *Tanztherapie [Dance Movement Therapy]*. Weinheim: Beltz PVU.

Bräuninger, I. (2007). Dance movement therapy group process: Investigating short-term DMT programs. In S. Koch & I. Bräuninger (Eds), *Advances in dance movement therapy: Theoretical perspectives and empirical research*. Berlin: Logos Verlag.

Bräuninger, I., & Blumer, E. (2004). Tanz- und Bewegungstherapie [Dance movement therapy]. In W. Rössler (Ed.), *Lehrbuch Psychiatrische Rehabilitation* (pp. 380–387). Heidelberg: Springer Verlag, Fachbuch Medizin/Psychologie.

Chaiklin, S., & Schmais, C. (1986). The Chace approach to dance therapy. In P. Lewis (Ed.), *Theoretical approaches in dance-movement therapy* (Vol. I, pp. 17–36). Dubuque, IA: Kendall/Hunt.

Chodorow, J. (1991). *Dance therapy and depth psychology. The moving imagination*. London: Routledge.

Dosamantes-Alperson, E. (1979). The intrapsychic and interpersonal in movement psychotherapy. *American Journal of Dance Therapy*, *1*, 20–31.

Ellis, R. (2001). Movement metaphors as mediator. A model for the dance/movement therapy process. *The Arts in Psychotherapy*, *28*, 181–190.

Franke, G. H. (1995). *SCL-90-R. The Symptom Checklist of Derogatis–German Version [Die Symptom-Checkliste von Derogatis–Deutsche Version]*. Göttingen: Beltz.

Franke, G. H. (2000). *BSI. Brief Symptom Inventory–German Version of Derogatis [Deutsche Version]*. Göttingen: Beltz.

Goodill, S. (2005a). *An introduction to medical dance/movement therapy: Health care in motion*. London: Jessica Kingsley Publishers.

Goodill, S. (2005b). Research letter: Dance/movement therapy for adults with cystic fibrosis: Pilot data on mood and adherence. *Alternative Therapies in Health and Medicine*, *11*, 76–77.

Goodill, S. (2006). Dance/movement therapy for people living with medical illness. In S. Koch & I. Bräuninger (Eds), *Advances in dance movement therapy: Theoretical perspectives and empirical research*. Berlin: Logos Verlag.

Goodman, L. S., & Holroyd, J. (1993). Are dance/movement therapy trainees a distinctive group? Initial differences and effects of trainings. *American Journal of Dance Therapy*, *15*, 35–45.

Heinisch, M., Ludwig, M., & Bullinger, M. (1991). Psychometrische Testung der Münchner Lebensqualitäts Dimensionenliste (MLDL) [Psychometric test of the Munich Quality of Life Dimensional List (MLDL)]. In M. Bullinger, M. Ludwig, & N. von Steinbüchel (Eds), *Lebensqualität bei vaskulären Erkrankungen. Grundlagen und Methoden der Erfassung* (pp. 73–90). Stuttgart: Hogrefe.

Hervey, L. W. (2000). *Artistic inquiry dance movement therapy: Creative alternatives for research*). Springfield, IL: Charles C. Thomas.

Janke, W., Erdmann, G., Kallus, K. W., & Boucsein, W. (1997). *Stressverarbeitungfragebogen (SVF 120) [Stress-management questionnaire (120)]*. Göttingen: Hogrefe Verlag für Psychologie.

Lewis, P. (1993). *Creative transformation. The healing power of the arts*. Wilmette, Illinois: Chiron Publications.

Meekums, B. (2002). *Dance movement therapy: A creative psychotherapeutic approach*. London: Sage.

Payne, H. (1992). Introduction. In H. Payne (Ed.), *Dance movement therapy: Theory and practice* (pp. 1–17). London: Routledge.

Revenstorf, D., & Zeyer, R. (2001). *Hypnose Lernen. Leistungssteigerung mit Stressbewältigung durch Selbsthypnose (4. Auflage) [How to learn hypnosis. Performance increase through stress-management via self-hypnosis* (pp. 61–63). Heidelberg: Carl-Auer-Systeme Verlag.

Rose, S. (1995). Movement as metaphor: Treating clinical addiction. In F. J. Levy (Ed.), *Dance and other expressive art therapies. When words are not enough* (pp. 101–108). New York: Routledge.

Schmais, C. (1985). Healing process in group and dance therapy. *American Journal of Dance Therapy*, *8*, 17–36.

Schwarzer, R. (1994). Optimistische Kompetenzerwartung: Zur Erfassung einer personellen Bewältigungsressource. [Generalized self-efficacy: Assessment of a personal coping resource]. *Diagnostica*, *40*, 105–123.

Schwarzer, R. (1996). *Psychologie des Gesundheitsverhaltens (2. Auflage)*. Göttingen: Hogrefe.

Schwarzer, R. (2004). *Gesundheitspsychologie*. Retrieved March 23, 2004, from http://www.wissenschaft-online.de/abo/lexikon/psycho/5910

Schwarzer, R. (2005). *General perceived self-efficacy scale (GSE)*. Retrieved July 7, 2005, from http://userpage.fu-berlin.de/~health/engscal.htm

Stanton-Jones, K. (1992). *Dance movement therapy in psychiatry*. London: Routledge.

Whitehouse, M. S. (1979). C. G. Jung and dance therapy: Two major principles. In P. L. Bernstein (Ed.), *Eight approaches in dance-movement therapy* (pp. 51–70). Dubuqua, IA: Kendall/Hunt.