Psychological Studies on Human Structural Dance

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This article focuses on Human Structural Dance, developed by Günter Ammon in Munich. Following a brief history of the development of dance therapy, the author documents the proven benefits of dance therapy, particularly in enabling patients to verbalize their feelings and supported by research findings relating to a group of 30 patients, all of whom had been diagnosed with 'archaic ego disorders' and with all ages represented.

Key words: archaic ego disorders, dance, dance therapy, group, TATs (Thematic Apperception Tests)

Over the past few decades, various forms of body-centred therapies have been developed. The main focus of dance therapy is to transform emotions directly into movements. Generally, this aspect was not originally included in psychotherapeutic concepts. Petra Klein (1983) criticized the fact that not enough attention is paid to the body in psychotherapeutic settings and called this phenomenon the 'forgotten body'. One exception to this was Freud and Breuer (1895), who took the expression of psychic processes through the body very seriously, rather than dismissing them as a system of mere conventions. He also developed a technique of direct contact, which he subsequently rejected in favour of free association, which he found more useful in a therapeutic setting. Ferenczi (1921) and Reich (1972), with his respective techniques of 'neo-catharsis' and vegetative therapy recognized the intensive correlation between the psyche and the body. However, their work has only been incorporated into the field of psychotherapy for the last few decades.

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In the meantime, a large number of quite different body-centred therapies has been developed: the Pesso system of psychomotor therapy (Pesso, 1973), psychomotor therapy (Kiphard, 1975), the Alexander technique (Alexander, 1971), concentrative kinesiotherapy (Stolze, 1977), bioenergetics (Lowen, 1979), eutonics (Alexander, 1978), integrative kinesiotherapy (Petzold, 1981), sensory awareness (Brooks, 1974), breathing therapy (Middendorf, 1977), rhythmic kinesiotherapy as a special form of rhythmics (Kirchmann, 1979), rolfing (Rolf, 1958), healing eurhythmics (Wilmar, 1977), Lomitherapy (Leeds, 1977), Expression corporelle (Dropsy and Sheleen, 1977), and many others (cf. Klein, 1983).

Dance therapy is a special kind of body-centred therapy. It improves a person's relationship to his or her body and allows the dancers to discover new creative potential in themselves. Most other body-centred therapies are primarily concerned with performing certain exercises that are intended to improve body awareness.

Dance therapy was developed in the United States in the 1940s and was successfully integrated into psychiatric institutions, especially for treating schizophrenic patients. All pioneers of dance therapy, such as Liljan Espenak, Marian Chace, Mary Whitehouse, and Trudi Schoop were dancers themselves. It was only during the course of their work that they began to look for a theoretical substantiation to their approach. In Germany, this new movement was introduced by Mary, Wigman and Rudolf von Laban. As dancers, too, they recognized the therapeutic effect they experienced and began to think that psychiatric patients could gain similar benefits. Dance therapy was introduced in Germany in 1970 but has generally been overlooked in the treatment programmes offered by psychiatric institutions.

In the early 1990s, Günter Ammon began to develop what is known as human structural dance therapy at the Menterschwaige Dynamic Psychiatric Clinic. His patients were mostly people with personality disorders originating in their early childhood. In working with them, he came to realize that conventional therapeutic treatment was often not useful in establishing an emotional relationship between the therapist and the patients. Patients often suffered from disorders first developed when they had yet to develop the verbal competence needed to talk about their feelings. Günter Ammon developed the idea of allowing patients to express their emotions through their bodies, which he felt could be more

useful especially for patients with schizophrenic or borderline disorders.

And indeed, this group of patients responded particularly well to human structural dance therapy, which enabled them to express their emotions and feel better understood by their environment and fellow patients, in a way that had not been seen in other environments.

One of the first to notice the cathartic effect of dance was a North American author, Marian Chace, who noted:

> Basic Dance is the externalisation of those inner feelings which cannot be expressed in rational speech, but can only be shared in a rhythmic, symbolic action. (Chace, quoted after Chaiklin 1975, page 24).

The following movements in dance therapy can be outlined:

The first is the therapeutic dance method according to Marian Chace. It has four principal components: (component 1) 'body action' prepares the elaboration of psychic conflicts by activating the body and its pathologically tensed regions in particular. 'Symbolism' (component 2) means that symbolic movements and positions become involved and are processed. In 'kinaesthetic empathy' (component 3) the therapist responds to messages expressed by the patient non-verbally, thereby sharing the emotions felt by the patient. 'Rhythmic group activity' (component 4) is another very important factor in her method. Rhythm is a prerequisite for coordination. The rhythmic experience in the group gives the participants the feeling of solidarity and security. Marian Chace was not influenced by a psychoanalytical or psychological school. Instead, her procedures were directly focused on her clients.

Trudi Schoop attaches great importance to observing how patients express themselves in healthy ways. According to her, the therapist should be aware of his or her self-perception. The categories: empathic understanding, positive appreciation and authenticity are important in her method. She too was not oriented by any psychoanalytical or psychological school.

Liljan Espenak was mainly influenced by Alfred Adler's individual psychology. To her it is important that patients develop a positive self-image, a feeling for their own power and vitality. This restores the capability for social integration that existed originally. She works with retarded and mentally handicapped children.

Mary Whitehouse adopts the Jungian understanding of the

psychological structure. She is concerned with establishing contact between the ego and the self; symbolic events, images and dreams should be included in this process. Active imagination serves as an important method. In it, unconscious images are to be brought into the conscious, which can then be dealt with on a therapeutic level.

Penny Bernstein has tried to integrate various approaches; her point of departure is the psychoanalytical theory of evolution joined to the stages of a child's bodily development. Her basic understanding is characterized by her readings of Jung; thus, she often uses symbols in communicating with her patients. In the process of dance therapy, she is mainly oriented by Gestalt therapy. In it, a problem area is worked out and positioned in the centre of attention. The 'unsettled situation', the conflict not yet worked out, is brought to consciousness by appropriate movement experiences.

Elaine Siegel follows the Freudian psycho-sexual phases of development in her work. She enters a psycho-dynamic symbiosis with the patient and allows him to regress to the point of his fixation. Thereupon the patient-therapist symbiosis is dissolved in phases (cf. Klein, 1983; Bernstein, 1979).

One problem facing all schools of dance therapy is that they are in danger of becoming eclectic – none of them are properly integrated in a theoretical concept. A further problem is that dance therapy is often not integrated into a clinical institution and its concept of treatment.

In contrast, the therapy of human structural dance developed by Günter Ammon since 1982 is embedded in his theoretical concept of human structurology (that means a holistic personality concept in which the body is integrated). Ammon postulates a group dynamic, energetical comprehension of the personality. Unlike the Freudian school of psychoanalysis, Ammon postulates that the 'personality structure' is a holistic system with different 'ego functions' (Ammon, 1979a: 317). The development of 'ego functions' depends on the interaction with the mother and a surrounding group. They do exist genuinely as 'unconscious cores' which have to be developed (Ammon, 1979b). In his model he differentiates primary, secondary and central 'ego functions'. The primary 'ego functions' represent all the biological and neuro-physiological domains of the human while the secondary 'ego functions' are the functional realms of the personality. All behaviour is determined by secondary

'ego functions' which are centred in the conscious of the human being.

The core of the personality is represented by the central 'ego functions' which are anchored in the unconscious. Creativity, sexuality, narcissism, demarcation and many others are central functions.

The identity, which is the main function in this dimension, has to integrate all the other parts of the human system. Mental illnesses are caused by surrounding groups that prevent the development of 'ego functions' and thus prevent the child from developing an identity of its own. The group dynamic field in these families is pathogenetically determined.

Development is understood as an incorporation of relationships experienced in early childhood. (cf. Ammon, 1986a).

As a result, 'human structural dance therapy' was specially developed for patients who suffer from psychic disorders that are caused in early childhood, such as schizophrenia, borderline disorders and for all patients who cannot express themselves verbally – patients suffering from damage done before verbal development is the reason that they need an opportunity to express themselves through body language. These types of disorders which originate in very early childhood, are known as 'archaic ego diseases' (Ammon, 1979a). In 'human structural dance therapy', the patients are surrounded by a friendly group atmosphere and can express themselves and act within a group dynamic social energetic field with the possibility of experiencing their emotions. Of great importance for creating contact between the group members and the dancer is the feedback and the reaction of the different group members after the dance. Dance therapy is always combined with verbal psychotherapeutic treatment because the experience expressed through the body needs to be integrated into the whole personality.

In conjunction with other, mostly verbal therapy methods, 'human structural dance' is a useful supplementary treatment for these mental disorders. The 'social-energetic' experience within the group helps the patients to develop a better understanding of themselves and to feel sheltered inside a group. They experience a degree of acceptance they never felt in their families in their early childhood.

Social energy is defined as emotional warmth and support of the own development of the identity (cf. Ammon, 1982b).

The spontaneous and surprising dance of the individual also has a healing effect on the other members of the group while encouraging their creativity. This resembles the healing dances of the Sufi (Güvenc, 1986) and of the Kung (Katz, 1985) (concerning human structural dance therapy, cf. Ammon, 1985, 1986a-f).

The holistic experience of the dance takes place in the interplay of the body – via the play of muscles – and the psyche as a result of the transformation of music to movement (cf. Ammon, 1986c).

Human structural dance therapy is an intensive body-centred therapy. The following factors are of fundamental importance:

spontaneous, individual dancing in the middle of the group;
the body language and movements of the individual, performing in clothes chosen by the patients themselves;
performing with or without music, or with drums;
group meditation at the beginning and end, providing a meditative conclusion to the group's dancing;
the members of the group give the individual dancer verbal feedback after his dance.

The aim of my research into human structural dance therapy was to ascertain whether, and if so, to what extent, the access to psychic experiences and the ability to express feelings change as a result of participating in a human structural dance therapy within a certain time of observation. Four areas are of special interest to this study:

bodily expression, i.e. bodily self-esteem and possibilities for movement;
the patients' access to their feelings and their ability to utter these feelings before, during and after the dance;
the relationship to the group; and
the ability to express feelings verbally, in the context of verbal therapy as well, i.e. formal group therapy.

Method

The human structural dance therapy group under observation was made up of 30 patients, which meant that one out of every two patients in the clinic took part. All diagnostic groups, constituting patients diagnosed with 'archaic ego diseases', and all age groups were represented in the dance group; the duration of the

stay of the patients was also different. It was often possible to note an enormous difference between working with a patient in dance therapy and then experiencing him or her in other groups of the clinic. The group has been in existence for five years and was directed by Dr. Ammon and myself. I examined ten patients from this group twice within three months. Those examined had participated in the dance therapy group for different lengths of time. The first examination took place after the patient's first dance in this particular group. The follow-up examination took place three months later.

As it is extremely difficult to define or to put into words the emotional experience undergone during a dance, an open interview with guiding questions defining the thematic blocks important to the examination seemed to be the most useful instrument for me for this study. I also used a projective personality test, the TAT (Thematic Apperception Test), and, for six of the patients, video recordings of dances. As the interviews sought to explore the subjective experience of a clearly defined event, in this case the dance, they are referred to as focused interviews with guiding questions appropriate for the event (Merton and Kendall in Hopf and Weingarten, 1979). The duration of the interviews averaged three quarters of an hour.

Results

The qualitative and quantitative results of the interviews, the TATs and the video recordings for all ten patients will be described briefly while concentrating on the most important results and tendencies to change within the four areas studied.

Let me begin with the qualitative evaluation of the interviews: in the area of 'experience of the body', a preponderant part of the ten patients experienced nothing or almost nothing of their body. Three patients did not experience their body at all. Five patients felt immobile, stiff and confined within their bodies. This is not in any way surprising since eight patients had related that their early education had not integrated the body. Only two patients – who, incidentally, reported a positive approach to their physical education in childhood – had experienced their bodies as more flexible and lighter in the dance.

After the second dance, almost all patients related the experience of their bodies in greater detail and more positively. Two patients

reported no change in their attitude towards their bodies. Two patients felt considerably better, two patients who had not felt themselves at all in the first dance could now experience themselves better – one patient reported a feeling of warmth in his body. Five patients reported that they had experienced their bodies as feeling more free, more flexible, lighter and more powerful during the second dance.

Concerning the anchoring within the group and the contact to it, it was noted that during the first dance, eight patients had not perceived the group, they had generally danced with closed eyes and had not had any contact to any individual patient within the group. With the exception of two patients, the group atmosphere was experienced as friendly.

In the second interview, two patients experienced themselves as more sympathetic and were more interested in other dancers' performance. Two patients had experienced the group as supportive and had contacted individual group members who were important to them. Three patients had said after the first dance that their self-perception had not corresponded to the feedback they had received, and four were not able to recall the feedback. The feedback was, however, important to all patients with the exception of one who did not care about it. Four patients emphasized the contact to the group leader. One female patient said that she only felt protected in the presence of the group leader. Another patient did not dare enter into contact with him even though he was important to her.

After the second dance, the group was described in a much more differentiated way. Four patients voiced their opinion quite clearly, stating that they had experienced the group as warm and had felt well, accepted, comfortable, and sheltered. Two patients regarded the group as important and felt secure because of the contact they had established with individual group members. The group did not play any part in the eyes of only two patients, who had concentrated on the music or on themselves. One of these two was a patient who was in a very poor physical condition at the time, he did not feel the group at all.

For nine patients, the feedback was very important. They were able to remember the happy reactions and comments. Only two remained mistrustful of the feedback comments. All in all, the importance of the contact to individual patients had increased. In dancing, the group was sensed more strongly and perceived more

in the second dance. For eight patients, the feedback now corresponded more with their individual experience of the (second) dance.

With regard to their feelings, six patients spoke of their anxiety before the dance in the first interview. Two patients felt very aggressive, two patients felt nervous and tense and sensed a certain agitation. Seven patients were hardly able to speak about their feelings during the dance, they could only say what they had actually wanted to express and had concentrated entirely on the music. Three patients were able to express and differentiate their feelings and their anxiety during their dance.

Two patients stated that they felt sadness and despair, feeling at a loss, small and helpless. One female patient felt a liberating eroticism and longing. After the dance, only two patients felt better and relieved, three patients were disappointed with themselves and did not really feel liberated. They felt that there was more hidden away in themselves. Five patients did not speak of their feelings after the dance. There are few descriptions of how dances performed by others were experienced: only three patients expressed a view. One was strongly affected and felt strong aggression, and a female patient only sensed something when the dancer entered into contact with her.

In the second interview, five patients were able to relate their feelings in detail. They spoke of their longings and their hope, of belonging and of love towards others, erotic feelings and warmth, one patient felt life awakening in himself. Another patient said that he could not express his feelings during the dance as they were so beautiful. They were feelings of being at home, and of relief. They also spoke of the strong anxiety they felt during the dance; they had never experienced such anxiety. One patient felt real anxiety for the first time in his life. Another female patient felt great anger and scorn, two patients were not at all able to express any feelings. Three patients expressed their opinions about the dances of others in a much more differentiated way than they had after the first dance.

In conclusion, it can be said that considerably more patients spoke of their feelings in a more differentiated and detailed manner: for example, feelings of love and warmth were uttered. They felt their anxiety more intensively and were able to experience aggressive feelings and sadness.

Concerning the area of verbal abilities of expression, it can be

noted that eight patients were hardly able to speak about their feelings and about themselves after the first dance, and some of them were not at all able to do so. Two patients mentioned that they were well able to speak of their feelings and points of view – this was, however, not at all corroborated by their interviews. With the exception of one patient, those questioned stated that they were more capable of showing their feelings in dance therapy than in other groups. The dance therapy gave them an opportunity to present themselves, but they could speak only very little about their feelings.

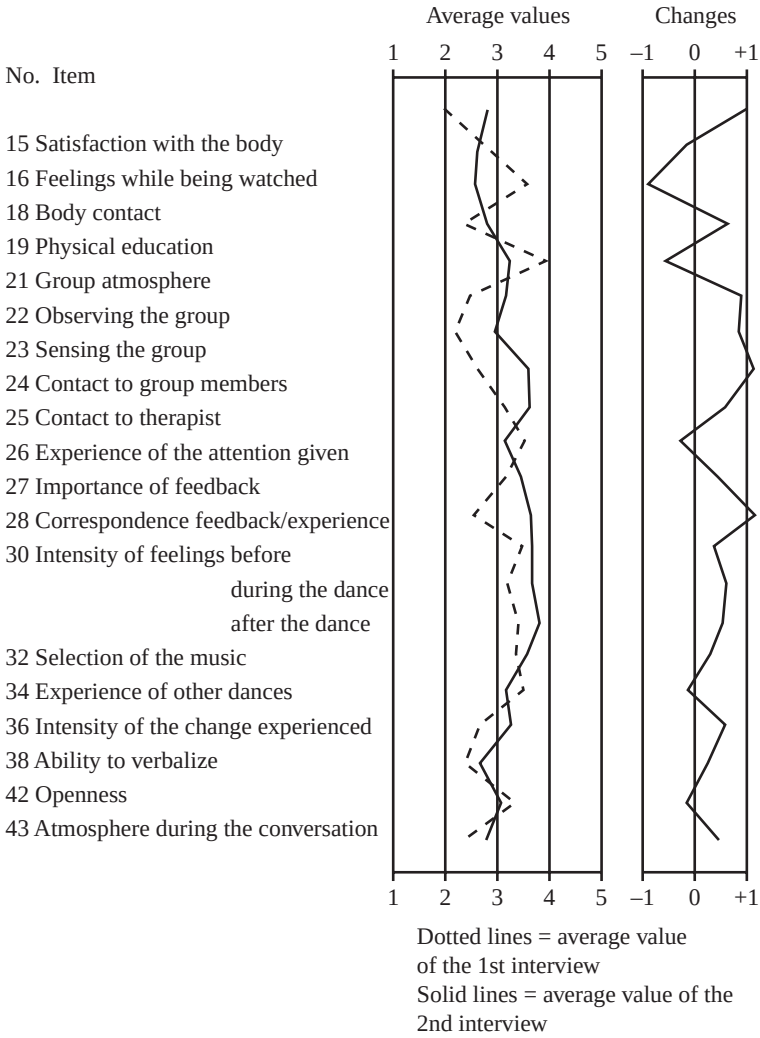
In the second interview, too, all patients had great difficulties in verbalizing their feelings. However, they were generally better able to differentiate their feelings verbally, which can also be seen from the course of the interview. Only four patients said that they still experienced difficulties in expressing their feelings in words, one female patient said that she had problems in describing deeper feelings, one patient could verbalize feelings only with difficulty. Two patients were generally very quiet in groups. It was especially because they experienced such difficulties in speaking about their feelings that dance therapy was so important to most patients, as opposed to other groups. Hence the reason why nine patients explained that they had better access to their feelings in the dance therapy group. Feelings could be expressed more easily and spontaneously, it was less easy to fool the others, they felt more protected and could not be hurt so easily. The dance therapy group was more real for them. When questioned directly about the change they had experienced during dance therapy, the patients cited an improved relationship to their bodies, greater access to their feelings and improved abilities to establish contact with others.

This appears to corroborate the preliminary examination in which it was ascertained that these areas are regarded as important factors in dance therapy. That is the reason I have included them as thematic topics in the study. Eight patients spoke of very obvious improvements in this area, of whom six patients mentioned the area of the body, six the emotional field, and four patients stated that they were now better able to enter into contact with others.

The ratings of the interviews show a good correlation with the qualitative evaluation of the interviews (cf. Figure 1). In the area of somatism, the satisfaction with one's body had definitely risen, and a tendency to change can be noted for the other items concerning somatism. Changes become most apparent in the area of the contact

to the group. In almost all of the items noted, very noticeable improvements were noted, especially in the perception and sensing of the group, contact to individual members of the group and to

FIGURE 1
Results of the ratings of the interviews



Dotted lines = average value of the 1st interview
Solid lines = average value of the 2nd interview

the group leader, importance of feedback, and especially in the correspondence of the feedback with the own experience. This is an indication of the fact that self-perception and external perception became more closely connected. In the areas of emotional experience and verbal expression, the tendency towards positive change can also be noted. However, the item 'emotional experience' shows a decreased value after the dance. This can easily be interpreted in the following way when regarding the qualitative evaluation: the patients experience stronger feelings *during* the dance and thus, the importance of feelings decreases *after* the dance.

In evaluating the TAT statements, and comparing the first TAT with the second, there are definite tendencies towards changes in that the characters in the stories related by eight patients become more perceptible and they have a greater relationship with one another. In this process, four patients change more drastically, the other four rather less. The stories become closer to reality, they become clearer and demonstrate a closer relationship to the narrator.

The ratings of the TATs were irregular (cf. Table 2). On the whole, it can be said, however, that for six out of ten patients, the general emotional mood of those taking part had changed noticeably. For the other four patients, it remained unchanged. The attitude of the protagonist to his surroundings became friendlier for five patients, for one patient, it became less friendly, and for two patients, it remained unchanged. For three patients, an improvement in the bodily life of the characters became apparent (the bodies were described in a friendlier manner). The denial of sexuality decreased for six patients. For six patients, tendencies for change were also apparent in the area of aggression. In two people, auto-aggression was decreased while simultaneously, the destructive aggression towards the exterior increased. For three patients, the denial of anxiety was reduced. Three patients described the ends of their stories in a friendlier manner.

Discussion of the results

In comparing the two tests, the interview and the TAT, and also taking the ratings of the video evaluations into account, it can be said that a relatively good correlation can be found between the statements made in the interviews by the patients and the assessments made by those rating the videos. For all patients, tendencies

TABLE 1
TAT-Ratings

Patient		A		B		C		D		E		F		G		H		I		K	
Rating item		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Basic professions																					
1 Experience of the body	–+	2.1	2.0	1.8	1.8	1.5	2.8	2.4	(2)	2.9	2.4	1.2	1.8	3.1	2.2	2.7	2.3	2.4	2.4	2.6	3.1
2 Contact to surroundings	–+	2.0	2.6	1.6	1.4	2.5	2.3	1.3	(1)	1.8	1.7	1.7	1.7	2.4	2.7	1.8	1.7	2.0	2.0	2.0	2.6
3 Desire for contact	–+	1.9	2.3	1.6	1.3	2.5	2.3	1.8	(1)	2.6	2.0	2.0	1.8	3.2	3.1	1.9	1.9	2.1	1.9	2.3	2.4
4 Drive	–+	1.9	2.9	2.3	1.7	3.5	3.7	2.1	(1)	2.3	2.6	2.0	2.3	3.4	3.4	2.1	1.9	2.0	1.9	3.1	3.1
5 Ambivalence	+–	3.0	2.4	3.0	2.5	2.7	3.5	2.8		2.4	3.1	3.0	3.0	3.5	3.5	2.3	2.9	2.4	2.6	3.2	2.9
6 Attitude towards surroundings	–+	2.3	3.4	2.0	2.5	3.0	2.5	2.5		2.8	2.9	2.8	3.3	3.1	2.5	2.0	2.4	2.9	2.9	2.6	3.1
7 Experience of surroundings	–+	2.4	2.7	1.8	2.3	2.3	2.2	2.4		3.0	2.4	2.6	2.8	2.6	2.6	2.1	2.5	2.3	2.2	3.2	2.8
8 Social adaptivity	–+	2.7	2.4	1.7	2.0	2.8	2.3	2.1		2.1	2.2	2.3	2.6	2.9	2.6	1.9	2.0	2.2	2.0	2.2	2.6
9 Ability to learn	–+	2.9	2.6	2.6	1.4	3.0	3.3	2.0		2.6	2.9	(3.5)	(2)	3.2	3.6	2.3	2.3	2.7	2.0	3.0	2.9
10 Search for sympathy	–+	2.7	2.0	3.0	2.5	3.2	3.2	3.0		2.1	2.9	2.5	2.8	3.0	3.0	2.4	2.3	2.6	2.2	3.6	2.8
11 Desire for autonomy	–+	2.4	2.4	3.2	2.2	3.8	3.6	3.3		2.2	2.9	3.3	2.3	3.3	3.2	2.8	2.4	2.6	2.8	3.2	3.4
12 Capacity for conflicts	–+	2.3	2.0	2.4	2.4	3.2	3.2	3.0		1.9	2.1	3.0	2.0	3.2	3.1	1.9	1.6	2.3	2.4	2.3	2.7
13 General mood	–+	1.7	2.6	1.8	2.6	2.7	2.8	2.4	(2)	2.1	1.8	1.9	2.3	2.1	2.6	1.8	2.6	2.0	1.9	2.1	2.8
14 Initial optimism	–+	3.0	2.6	(1)	(1)	4.0	2.8	2.1	1.9	2.6	2.2	2.4	2.8	3.1	3.0	1.6	2.1	2.4	2.3	3.0	3.0
15 Initial maturity	–+	3.3	3.0	3.8	1.8	3.0	2.8	2.1		3.1	2.9	2.3	3.3	3.3	3.1	2.7	2.4	2.8	2.1	2.8	3.0
16 Emotional maturity	–+	3.0	2.6	3.2	2.5	3.3	3.3	2.8		3.0	2.8	3.0	2.5	2.8	2.8	2.8	2.2	2.8	2.6	2.9	2.9
17 Guilt feelings	–+	2.7	2.9	3.5	4.2	3.8	3.8	3.9		4.0	4.2	(3)	(5)	3.9	4.1	3.3	3.0	3.0	2.9	3.1	3.1

(continued)

TABLE 1 (continued)
TAT-Ratings

Patient		A		B		C		D		E		F		G		H		I		K	
Rating item		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
18 Destructive aggression towards others	–+	2.0	1.6	2.6	2.0	2.3	3.5	2.0		1.9	1.9	(2)	(3)	1.8	2.8	1.7	2.1	1.4	2.2	2.4	1.9
19 Destructive aggression towards self	–+	2.0	2.6	2.9	2.4	3.0	2.3	2.9	(1)	3.0	2.8	/	/	2.7	2.7	2.9	2.4	3.2	3.6	2.2	2.7
20 Loss of aggression	–+	3.0	2.9	3.3	4.3	2.8	2.6	4.0	(5)	3.4	3.3	(3)	(3)	3.4	2.6	3.0	3.2	3.6	3.3	4.1	3.2
21 Experience of anxiety	–+	2.9	2.7	3.2	2.8	2.7	2.8	3.5		3.1	3.4	3.0	2.3	3.5	3.5	3.2	2.8	3.4	3.6	2.2	3.0
22 Loss of anxiety	–+	2.4	3.0	4.0	4.3	3.0	4.0	4.3	(5)	2.9	2.4	(3.5)	(2.5)	2.7	2.5	3.0	2.4	3.1	3.1	3.6	3.1
23 Sexual desires	–+	2.1	2.6	1.3	1.3	1.5	3.0	2.1		1.9	1.9	2.3	2.0	2.8	1.5	1.0	1.1	2.1	2.1	1.1	1.7
24 Loss of sexuality	–+	3.0	2.9	4.0	4.0	3.7	3.0	3.9	(4)	3.3	2.8	4.6	1.7	2.9	4.3	4.6	4.0	3.8	4.0	4.9	3.4
25 Search for an identity	–+	3.0	2.1	2.3	1.6	3.8	3.3	2.5	(1)	2.3	2.3	2.9	1.8	3.6	3.2	2.6	2.4	2.8	2.4	2.7	3.2
26 Indentity	–+	3.1	3.1	2.1	2.2	3.0	3.7	2.1		2.3	2.1	2.7	3.0	3.2	3.1	2.3	2.3	2.4	2.4	3.1	3.1
27 Narrative style	–+	3.0	3.0	1.5	1.4	2.4	3.7	(1)		3.0	2.8	2.0	2.1	3.4	3.0	1.9	1.2	2.6	2.4	4.7	4.0
28 Original creativity	–+	3.0	3.0	1.5	1.3	3.0	3.0	1.9	(1)	2.8	2.0	2.0	2.3	3.5	2.9	1.8	1.9	2.3	2.1	4.4	4.3
29 Holistic experience	–+	3.7	3.6	2.5	1.3	3.8	3.0	2.1	(1)	2.9	2.3	2.6	2.4	9.9	3.3	2.3	2.0	2.9	2.1	4.4	4.2
30 Narrative attitude	–+	3.0	3.0	2.5	1.3	2.8	3.2	2.4	(1)	3.3	3.2	2.0	2.3	3.2	2.6	2.7	2.7	2.6	2.4	4.2	3.6
31 Introduction to the story	–+	3.1	3.6	2.8	1.4	3.2	3.7	3.0	(1)	3.1	2.4	2.1	3.1	3.3	3.3	3.2	2.2	3.1	2.6	3.7	3.4
32 Identification with protagonist	–+	3.0	3.7	2.9	1.6	3.3	4.3	2.9	(1)	3.4	2.9	3.0	3.1	3.3	3.4	3.2	3.2	3.3	2.8	3.2	3.2
33 Sympathy for the protagonist	–+	3.6	3.9	3.3	2.0	4.0	3.0	3.8	(1.5)	3.4	3.2	3.2	3.4	3.3	3.0	3.3	2.5	3.6	3.4	3.9	3.4
34 Expression of feelings	–+	3.6	3.0	2.6	1.4	2.3	3.5	2.0	(1)	2.8	2.7	2.4	2.2	3.3	3.1	2.6	2.2	2.6	2.1	3.6	3.1

TABLE 2
Ratings of the video evaluation

Patient	A		B		C		D		F		G	
Item/Patient	1	2	1	2	1	2	1	2	1	2	1	2
1 Somatism												
3 Posture	2.7	4.5	1.7	3.7	3.7	2.7	3.0	2.0	3.3	3.0	4.3	2.7
5 Facial expression	2.3	3.3	1.3	2.7	3.0	2.3	3.3	2.7	3.3	2.7	3.0	2.0
7 Ability to move	1.3	3.0	1.3	2.3	4.3	1.7	2.3	2.7	2.7	2.3	4.0	2.7
8 Flow of movements	1.3	3.7	1.0	2.3	4.0	3.0	3.3	2.0	3.3	2.3	4.0	3.3
9 Space	1.3	3.7	1.3	2.3	4.0	1.3	2.3	2.3	3.0	3.0	4.0	3.0
10 Time	2.3	3.3	1.3	2.0	3.0	1.7	2.3	3.0	3.3	3.3	3.7	3.0
2 Contact to the group												
12 Contact to the group	1.7	3.0	1.7	2.3	3.7	1.0	3.7	2.3	3.0	2.7	2.7	1.7
13 Contact by the group	1.7	2.7	1.5	3.0	4.0	1.7	4.0	3.3	3.3	2.0	3.0	2.0
3 Expression of feelings												
16 Ability to be sensed	2.0	3.3	4.3	3.3	4.0	4.0	3.7	4.0	4.0	3.7	4.0	2.3
17 Aggression	1.7	1.7	2.0	2.0	4.7	3.0	1.7	2.7	2.7	2.0	3.0	2.0
18 Sadness	1.7	2.7	4.0	2.3	2.3	4.0	2.0	2.7	2.0	3.0	2.7	2.7
19 Anxiety	3.0	2.7	4.3	3.7	3.0	3.3	3.0	3.3	3.7	3.7	3.0	3.0
20 Happiness	1.7	3.0	1.0	2.3	2.3	1.0	3.7	3.0	3.3	2.7	2.7	1.7
22 Consistency	3.0	4.0	3.3	3.3	4.0	3.0	4.0	3.3	3.7	2.7	4.0	2.3
24 Change	1.0	2.3	1.7	3.0	3.0	2.3	3.0	2.3	2.0	2.3	2.3	1.7

The order of the videos of the patients C, D, F and G was changed

towards change can be seen in the different areas which must always be interpreted in connection with the overall therapeutic process. Patients who were very confined somatically were able to develop a stronger relationship to their bodies as well as stronger emotions. This is mirrored by the results of the TATs, in which the general mood becomes friendlier. This group of the physically confined patients can be contrasted to the group of those patients who, while possessing a large repertoire of movements, found it difficult to show their feelings. For this group, it became apparent that in the second examination, they were able to develop stronger access to their feelings, for example to their sadness, but also to their aggression. At the same time, a certain quality of being real and able to be sensed became stronger. Changes in aggression and sadness became apparent for these patients in the TAT as well.

The evaluations of the TATs proved to be relatively problematic when compared to the evaluations of the interviews. This was a result of the fact that the TAT is a verbal projective test which was developed for patients in the neurotic range and which aims to uncover repressed conflicts. The patients participating in dance therapy are people who must be ranked as archaically ego-sick and who have extreme difficulties in verbalizing their feelings. It is especially for this reason that Ammon developed the human structural dance: so that these patients can find an access to themselves on a non-verbal level.

The statements of the patients in the interviews, which took place directly after the dances, show that the patients were able to speak about their feelings in a more differentiated and detailed manner in the second interview. They showed more contact to the group and more trust in it, and that they had begun to deal with their bodies and their possibilities of movement. Most patients appreciate dance therapy more than verbal therapy. For many, the dance therapy group is the most important group in their own development.

In considering the values discussed, one must keep in mind that the time allotted for the study was relatively short (three months) – which is a very short space of time in the overall duration of therapy for more seriously ill people. However, in the four areas being examined, there was evidence of important tendencies towards change.

This study is intended to contribute towards demonstrating the effectiveness and the importance of human structural dance therapy.

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