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Concentrative Movement Therapy (CMT)
in a clinical setting – in-patient group psychotherapy
with burnout patients

**Abstract**

First of all, the clinic for psychosomatics and psychotherapeutic medicine in Nuremberg is introduced, the difficulties in diagnosing burnout are explained and the in-patient treatment concept for patients with this condition is outlined. The approach used in CMT group therapy with burnout patients is then presented in detail. Individual proposals are illustrated step by step and the therapeutic background and experiences expounded. Finally, the attempt is made to work out the unique aspects of CMT (in German: *Konzentративная Воздействия*, KBT) in comparison with other methods.

**Keywords:** in-patient group psychotherapy, KBT, CMT, burnout, body perception

**The clinic for psychosomatics and psychotherapeutic medicine in Nuremberg**

The Nuremberg Hospital is one of the largest municipal hospitals in Europe. It provides approximately 2,180 beds at two locations (Nuremberg Hospital North and Nuremberg Hospital South) and has approximately 6,000 staff members. One of its departments is the clinic for psychosomatics and psychotherapeutic medicine.

On the Hospital's homepage, the department is introduced as follows:

"The clinic for psychosomatics and psychotherapeutic medicine offers comprehensive treatment services with five problem-specific in-patient and day care treatment groups. Moreover, the clinic is integrated into the treatment programme of several day care centres as well as the department for internal medicine. In addition to the in-patient area, the cooperation with and in other departments of the Nuremberg Hospital within the framework of an extensive consultation and liaison service plays an important role and is one of the essential tasks of our clinic's staff members. At the clinic for psychosomatics and psychotherapeutic medicine, we aim at a biopsychosocial understanding of disease. This means that throughout the course of treatment, the biological (physical), emotional (individual stress factors) and social (family and job-related...) conditions of the patient are taken into consideration. Our treatment team is made up of health
care and nursing professionals, therapists specialised in art therapy as well as in Concentrative Movement Therapy, social pedagogues as well as psychologists and physicians."

The five problem-specific treatment groups include:

- the burnout group
- the trauma therapy group for female patients with post-traumatic disorders
- the short-term treatment group: for patients with acute stress responses
- the psychosomatic day care clinic 55+: for the psychotherapeutic treatment of the elderly
- the treatment group for general psychosomatics: for patients with somatoform disorders, anxiety or obsessive-compulsive conditions or mild depressive disorders

The clinic for psychosomatics and psychotherapeutic medicine is an acute clinic, meaning the costs are borne by state or private health insurers. Patients are transferred by their general practitioner or specialist.

**Patients with burnout syndrome**

A brief and a detailed definition of burnout:

"Burnout is a cumulative process which leads to the loss of physical and mental energy, emotional exhaustion and withdrawal." (Maslach, 1981).

"Firstly, burnout is a process or a state of emotional exhaustion, especially on the job. Secondly, it is accompanied by a negative attitude towards the job, namely the contents, methods, partners and customers. Thirdly, it is also characterised by a substantial loss of self-worth in relation to one’s own task-related performance. Burnout is a stress syndrome which develops gradually and has a tendency towards chronification. Eventually, stressors can no longer be processed and dealt with. The root causes of burnout are to be found in the person, the work and living environment as well as the social and cultural environment of an individual." (Rösing, 2003)

Burnout is not clearly defined or delineated as a condition. In the ICD 10, the current international classification of mental disorders published by the WHO, it is mentioned only in Chapter XXI entitled ‘Factors influencing health status and contact with health services’, listed under Z73. The American equivalent, the DSM IV, does not mention burnout at all, either in its old version or in its current version, the DSM V, which was published recently. In part, this may be due to the difficulty of defining burnout symptoms clearly. In literature on the subject, over 100 (!) different symptoms are brought in connection with burnout. For the most part, however, this may be due to the difficulty of distinguishing burnout from other conditions, especially depressive disorders. The key symptoms of depression—despondency, loss of motivation, reduced enjoyment of life and increased exhaustibility—can also usually be found in patients suffering from burnout. As far as the practical work of the clinician is concerned, this means that patients treated always have more than one diagnosis: apart from burnout, they also display mild or
medium episodes of depression bouts of depression, sometimes also anxiety disorders in addition, somatoform disorders, in rarer cases also personality disorders. What is more, without these additional mental disorders accompanying burnout, health insurers would refuse to bear the cost of treatment.

Simply put, one could say that burnout is often (or always?) also a form of depression, but not every case of depression is also a case of burnout.

The treatment concept of the burnout group

In 2008, the head of the clinic, Prof Wolfgang Söllner, introduced the treatment concept of the burnout group in the journal Psychologische Medizin (Psychological Medicine).

"The patients are treated in a special burnout treatment unit, either as in-patients or in day care, over the course of four to six weeks (ideally, an in-patient treatment phase is followed up with a day care phase). The concept integrates elements from both, psychotherapy and body-therapy in an individual and group therapy setting. It is based on principles from depth psychology, but also applies methods from topic-centred interaction, focusing, Concentrative Movement Therapy and art therapy in addition to interactive depth psychology group therapy. Starting from the symptoms and risk factors of the problem of burnout, all treatment measures focus on the early recognition of distress and dysfunctional relationship patterns in the professional and private environment, learning coping strategies and rediscovering and strengthening personal resources. Patients are meant to learn to pay better attention to their needs and boundaries in order to redevelop a sense of satisfaction in their work and to be able to engage on a deeper level in relationships in the workplace, but also with their partners and families.

Apart from individual and group psychotherapy, relaxation training, enjoyment training, a sleep hygiene group and activating movement therapy are offered.” (Eisenberg and Söllner, 2008)

CMT has a fixed and recognised position within this treatment concept, in the same manner as it has enjoyed a long-standing and good tradition at the clinic for psychosomatics and psychotherapeutic medicine as a whole since the 1980s. It stands to reason and is logical to include body psychotherapy in the treatment of psychosomatic illnesses where emotional conflicts are expressed in physical symptoms (Braun, 2006).

Group psychotherapy with CMT

In the following, examples of how the instruments of CMT are used in a group with burnout patients are outlined (Schulteiss, 2009). In order to give the reader a vivid impression of the session, some of the therapist’s instructions are provided in direct speech. They are printed in italics. Extended breaks in the instructions are indicated with (...). Thoughts regarding the therapeutic relevance and efficacy in relation to the problem of burnout are interspersed throughout the text and conclude this section. Of course these CMT proposals can be used in other therapeutic contexts as well.
Exercises while lying down

Find a place in the room to lie down. Feel the floor and how you lie on the floor, which surfaces of your body touch the floor. What does the floor feel like? Is it hard or soft, warm or cold? Do you need something to improve your position? A blanket, a pillow, a change in position? You can lie on your back, on your belly, on your side. You can stretch out your legs or raise your knees. Find out for yourself which position is best for you for the moment. You may change your position at any time. If your body reports tension or pain, a complaint, simply perceive this complaint, feel and breathe into this area. (...) You can try to influence it through small movements, small adjustments in position.

Up until this point, the proposal made is very common in CMT. The important thing is for the participants to take their positions consciously and actively and change them if need be since burnout patients often strongly feel themselves to be victims of their external circumstances. It is just as important for the body to be allowed to complain, to be tense or in pain, and for no one to be ‘forced’ to relax.

We will now go on a perception journey through your body, which you can follow. If other thoughts keep coming into your head, just allow them to come and go. We will start at the feet. Which parts of your feet do you feel at the moment? Where do they touch the floor, where don’t they? (...)

After the feet, the instructions move on to perceiving one's calves, knees, thighs, hip joints, the pelvic area, the back, one's belly and chest, the shoulders, arms and their joints, the wrists and hands. For the sake of brevity, this will not be described in detail.

Where do your hands lie, on the floor, on your body, what are they touching right now and which part of your hands do you feel?

After that, perception is guided towards the throat and neck area and to the head, the back of the head, the skullcap and the face.

How do you sense your breath flowing, in and out? Listen to your own breathing for a few breaths. (...) How do you perceive your own position now, what does it feel like as you lie there; what does the floor feel like? (...) Compared to earlier, has anything changed, and if so, what has changed or is everything the way it was at the beginning of the exercise? (...) Next, you will receive a task from me (...) How does that sound? What does that feel like and what does it trigger when you hear you will receive a task? (...)

Does the way you lie on the floor change because of it and if so, what is changing? (...) Which thoughts are going through your head? (...) And now, of course, I will tell you what your task is, namely to get up within the next few minutes, at your own pace, paying
In closing, the therapist suggests to the participants to take a moment to move around the room, to feel their feet and the floor and to recall the experience they have just made internally. One important point for the group conversation which follows is, of course, what the announcement of a task, especially one that was not clearly defined at first, triggered in each individual participant, physically as well as mentally. Patients often report feeling their body tense up, their breathing change and their position lying down shift. The evolutionary physical alarm response to a stress inducer (= the task) has been examined in stress research in great detail and is described in every self-help guide on dealing with stress. It is vital, however, to sense one’s own individual expression of that stress reaction physically and to perceive it consciously. The body responds early to stressors and signals them even before the information that there is a stressful situation has reached the conscious mind. Especially under stress, body perception is often very low, which is why a mindful attitude towards one’s own body in stressful situations is one of the most important resources.

It is also interesting to note the various fantasies and mental responses the ‘task’ triggers in each participant: "I won’t be able to do it anyway"; "That was almost like being at work"; "I became restless inside"; "It can’t be that bad, coming from you". Time and again, there are patients who did not even hear the task being given because they had dozed off at that point, but who then nonetheless got up with the others.

The physical responses triggered by the task as well as the fantasies it created provide possible connections and starting points for dealing with each individual burnout problem and for gaining a deeper understanding. What seems important for patients in this context is the experience that their body responds uniquely to stress and that their personal mental processing mechanisms for stressors can vary to a large extent.

The break topic

We will begin today with an important and difficult task: we will take a break now. I will give you five minutes you can use in whichever way you want. Every one of you on his or her own, sitting down, standing up or walking around. I will keep the time and let you know when the break is over and when we will continue.

After an estimated time of approximately five minutes has passed: The break is over now. Please pay attention to the transition from the break to a non-break. Can you manage it? How were you able to use the break for yourself? How easy or hard was it for you and how are you coping with the transition right now? We will continue by walking around the room.
Beginning a CMT session with a five-minute break has several effects: it introduces the topic of a ‘break’, which is then looked into more intensively in the following. It provides a tangible experience of what a break feels like and how it can be used. It also takes the patients off guard, which on the one hand causes them to be alert and awake, yet at the same time leads to collective and individual concentration.

After a short period of ‘walking around the room’: we are now going to look at the topic of a break in a symbolic manner using objects; please select an object which symbolises a break for you (…)
What keeps you from taking a break in your everyday life, at work or in your private life?
What disturbs you when taking a break? Please select a few objects to symbolise these disturbances. (…)
What promotes a break and helps you take or receive one? Please also select one or several objects to represent these factors. (…)
Please choose a space for yourself in this room and set up your objects in front of you. (…)
First of all, take a closer look at the object you have chosen to represent a break. What have you selected, what does this object represent, what does it feel like and what does it trigger in you when you examine it?
Now turn to the objects which represent the things that hinder or promote a break. What do they stand for? (…)
What is the overall picture created by your set-up of these objects and what does it look like to you? What does it trigger in you? (…)
Is there anything missing? You may supplement your set-up at any time. (…)

In working with patients suffering from burnout syndrome, the topic of a break is often risky and emotionally charged, a fact that becomes obvious especially in the group conversations after the proposal. Often times, problematic working conditions become apparent, stress-inducing procedures with little room to get some rest in between, insulting behaviour by superiors or permanent stress in a patient’s private and family life. On an emotional level, a combination of anger, exhaustion and powerlessness is expressed, together with unspoken and contradictory appeals to the therapist: Help me! Tell me what to do! You won’t be able to help me anyway! This illustrates with urgency the important and central role the topic of the break plays when dealing with burnout. It is helpful for the therapist to be mentally prepared for intense emotions to be voiced during the conversation after the proposal. What seems significant is the distinction between external circumstances and working conditions on the one hand, and internal images of self and stress management mechanisms on the other. Job requirements and external circumstances which keep someone from getting some rest and taking a break or make it harder cannot be changed in the context of a hospital stay. It is all the more beneficial then to examine one’s internal standards and inner drives. As well as that, the ability to say no and to set bound-
aries with superiors and colleagues becomes an issue in this context. One female patient once described her internal image as follows: "I couldn’t use the five-minute break at the beginning for myself because I thought I had not yet done anything to deserve it."

The conversation is very resource-oriented. The patients’ attention is turned towards the object representing the break and towards what the objects represent which facilitate and promote taking a break. How can these be extended and cultivated? The simple realisation that alternating between activity and rest is absolutely vital and health-promoting for every organism, and that extended neglect of the need for recuperation leads to physical and mental damage, is emphasised. Patients with seemingly low levels of access to their own needs for rest are advised to create a break structure for themselves integrated into their daily routine and to try and adhere to it strictly, and maybe even keep a record of it. At the end of the session, the participants are invited to take the object representing the break with them for the duration of their hospital stay as a reminder (and transitional object).

This topic, which seems easy at first glance, can have a tremendous impact. Some patients state in their feedback towards the end of their hospital stay that it was precisely this attention to taking breaks, pausing, resting and finding time for themselves was among the most important realisations and experiences of their treatment. Even half a year later, when the clinic invites former patients to a so-called ‘refreshment day’ and they report their further development, the break often comes up again as a significant topic.

Place in the group and group dynamics

Today, we will look at the topic ‘My place in the group’. Perceive how you feel at the moment, in the group and on the whole, and then choose an object for yourself to represent that feeling somehow. (...) We will now have a round of talks in which everyone can introduce their object briefly and explain why they have chosen it.

Group participants who have experienced several CMT sessions already and who are familiar with working with objects and symbols usually do not find it difficult to find a suitable object. If the therapist gets the impression that one of the patients is having a hard time finding something, it is pointed out to them that they cannot do anything wrong as long as the object is ‘right’ for them (wanting or having to do everything right is a common issue with burnout), that they will have the opportunity to explain their object in a minute and that, if they cannot find anything suitable at the moment, they can choose an object that appeals to them or that they like. Attempting to create a playful, free atmosphere is important as an anti-pole to the high achievement standards and the perfectionism the patients often bring with them and express. When announcing the round of talks, it is important to emphasise brevity since, at this point, confronting the subject matter on a verbal level is not yet desired. The participants introduce the objects they have selected for themselves more or less briefly. This sometimes takes place
in a somewhat general and seemingly superficial manner, with comments such as "I have chosen a flower because I would like to lie down in the green grass right now". Other times, it can be very personal and deeper: "This rock represents my desire to want to feel more solid and stable again, no longer tossed about and shaky". These statements are usually not commented on. Even if there is no apparent connection to the patients' current position in the group (and thus to the topic) and they describe themselves only very generally, even 'banally', the therapist strictly refrains from any critical, evaluative comments and tries instead to connote the patients' descriptions positively.

Let's now turn to the second part of this proposal: You may now set up your group in the centre of the room. You will do this by setting up your object, your place holder so to speak, and observing where and how your fellow patients set up theirs. You may then change the position of your object until it feels right, until you have found the right place for yourself. What you may not do is to move the position of other objects, that's not possible. I will pay close attention to your adherence to this rule. You may move yourself with your object and change your place, but not that of other group participants. This also applies to real life: you cannot change anyone's position; you can only change your own position. Please don't talk while you're doing this. When every participant has found his or her place and nobody wants to change their position any more, we can talk about it together. (...) (...) (...) (…)

It is extremely interesting and revealing to observe how and in which way each participant now positions himself/herself symbolically, forming a picture of the group made up of objects. This also becomes apparent to the patients fairly quickly, which can lead to the development of a concentrated and suspenseful atmosphere that also takes hold of patients who initially thought this was 'child's play' not to be taken quite so seriously. There are those participants who position their symbol and then do not move any more and simply observe passively how the group is forming around them. Others try to find the right place by regulating their distance to the position of others millimetre by millimetre. This sometimes leads to an extended shifting of objects and responses to the shifts reminiscent of a strategic board game. This not only leads to the development of a symbolic picture of the group and the place of each participant in it, it also makes the dynamics of this development visible and tangible.

Afterwards, in the conversation, the patients are asked to describe their place which they have found within the group picture, what is important to them about it and how they have perceived the process of the development of the group picture. This often leads to a very animated conversation, with the patients participating in it to varying degrees, but with hardly anyone ever remaining silent since everyone feels addressed. Subjects which are often raised are those of proximity and distance: the desire of some for everyone to be closer together—but also the higher degree of distance of those participants who came into treatment only a short while ago or who feel less of a part of the group or value distance. If there is a problem in the group with ostracism or a tendency towards the formation of cliques, this is also very likely to
become more or less apparent. These group dynamics can now be perceived and made tangible and are thus easier to verbalise and open to change if represented by objects. Sometimes, fantasies of omnipotence and rescuing also become apparent, along with their futility: "I want to be equally close to everyone else, but that's impossible". "My most important goal is to keep the group together, but I couldn't do it".

The therapist's own remarks and comments regarding what the patients are saying are restrained; they only emphasise and affirm statements which seem significant. The group's own conclusions as to what is positive, encouraging and supportive or recognised and verbalised as being problematic are far more effective than any interpretations from the outside. The therapist tries to affirm statements in both directions, resources which have become clear and conflicts which have become apparent. The attempt to point out problems seen more clearly by the therapist than perceived and verbalised by the group will only lead to unproductive resistance. Only in those cases where a highly visible conflict is unduly suppressed does the therapist try to confront this issue: "How do you feel when Mr X pursues you like that?" It could be observed beforehand that one patient kept moving his object closer to another patient's, ignoring the second patient's obvious need for distance, until the person who was being followed finally gave up and left his object in place, yet without mentioning this development in the ensuing conversation.

After having gone through this exercise with many groups, it seems significant that each group develops its unique picture in very different ways. The period of time needed for this can be short or long. It is important to point out to the group that there is no such thing as a preferred or less favourable 'result,' no rules regarding what a group should or must look like, no right or wrong. What matters is to see the status quo for the moment. The outside observer always recognises a plethora of topics, processes and dynamics, only a small part of which is then verbalised and worked on. It is not necessary to voice them since the symbolic picture of the group continues to take effect subconsciously. However, what stands out most to the participants and leaves the most lasting impression is the insight already included as a rule in the instructions: you cannot change anyone else; you can only change your own position. Individual patients have often stated this as an important insight and experience in their feedback later on.

Symbolic representation of one's current living situation

Today I would like to suggest to you to take a closer look at your current living situation, first of all on your own. It is up to you which part of this you would like to share with the group afterwards. First, think about who and what is important to you in your life at the moment, people, issues, maybe also specific situations. Then choose an object each as a symbol for the things that come to mind. Don't try to achieve completeness, but keep in mind who or what is most important to you at the moment, who or what you think about most. When you have found your objects, find a place to set up your situation. (...) (...) (...)
This proposal requires that the patients be somewhat familiar with the symbolic work with objects, meaning it is suitable for patient groups in the middle or towards the end of their treatment period. Even then, the suggestion is worked out very differently: some participants consider two to three objects sufficient and their set-up turns out rather simple. Others set up a very complex picture with a vast number of symbols and delve into it for quite a while. When everyone is finished with their set-up, paper and pens are made available.

We will continue by me giving you some food for thought regarding your set-up, your living situation. I will ask you questions, and you will answer them for yourself and quietly in your mind, you do not have to say anything in response. If you would like, you can write something down, I have brought along some paper and pens for this purpose. These notes are for you alone, you will keep them at the end of this session. I will only need my pens back.

1. **Question:** When you look at your set-up, your current living situation, what is your first impression, what stands out to you at first glance? In other words: if this were a scene from a film, what would the title of the film be? (…)

2. **Question:** Where are you located within your set-up, where is your place in it and what does it look like? (…)

3. **Question:** Have you left anything out? Is anything important missing in your set-up and you are only noticing it now? If you have forgotten anything, you may go ahead and add it. You may expand your set-up at any time; realise what you have left out and take note of how the picture changes when you add what you had forgotten. (…)

4. **Question:** Where do the problems, the burdens, the stressors appear in your set-up and what do they look like? Where do they become obvious and what do they consist of? (…)

5. **Question:** Where do the things which are supportive, strengthening and positive for you appear in your set-up? Where does it become obvious and what does it consist of? (…)

6. **Question:** So far, you have looked at the status quo through these questions, a description of what your situation currently looks like. Now, you may take a look into the future: would you like to change anything, do you have any desires and ideas as to what should change? Start with your set-up and try this out practically. How should your set-up change? Does anything need to be added or taken away? Do individual objects need to change their position? You may now try changing your set-up, your situation. If this has resulted in a new picture, find out in what ways this is better for you. If it isn’t any better, keep trying. If there is no desire for a change in you, just leave your set-up the way it is. (…)

7. **Question:** This is my last suggestion: if you have realised your desire for change in your set-up and a better picture has emerged, what would be the first small practical step in your real life towards realising the desired change? I’m emphasising ‘the first small step’, changes can often only be realised in small steps. (…)
The participants are given enough time to take notes between questions. Even if not all participants usually make use of this option, the note-taking makes for a concentrated atmosphere. After this extended period of reflection while sitting on the floor has ended, the therapist suggests that everyone get up to take a look at their set-up from various perspectives or to risk a peek at what other group participants have created.

You now have the opportunity to introduce your situation to the group if you want. You may do this in a more general and abstract manner, or very personal and concrete, it’s up to you. If you don’t want to say anything, that’s OK, too.

The conversation which now follows takes time since experience has shown that most participants want to say something about their set-up after an extended period of quiet reflection and now that everything is right in front of them, concrete and tangible. It is impressive time and again to observe that even patients who have found only few objects and whose set-up looks simple and straightforward have arrived at deeper experiences and insights prompted by the questions. The therapist often focusses on the desired changes and the first concrete and practical steps towards realising them. It is often all about affirming and reinforcing the patients’ perceptions and ideas. It can be important to help specify ideas which are put in general terms, such as "my work shouldn’t take up so much space in my set-up (my life), I need to distance myself more from it; my family, friends and hobbies should receive more space", by using further questions: “How can you distance yourself more from your work? How can you give greater importance to your family and your leisure time? What can you do to facilitate that?” The same also applies if burdensome conflicts have been represented in the set-up, i.e. conflicts with superiors, colleagues or family members. In these cases, the symbol for the other party to the conflict is often placed further away or boundaries are set up around it. The conversation is then used to find out together how this can be realised in real life. The group is involved in this and can provide helpful hints and feedback.

The question regarding visible resources, supporters and sources of strength is also important and can be reintroduced and examined in greater detail. “Were you aware of them before? What does it trigger in you to see them in front of you and what effect does that have on you?” This can lead to very touching emotions of thankfulness being expressed or the decision may be made to perceive and appreciate this area more in the future.

One very interesting question is the question regarding the patient’s own place within the set-up: there are usually always a few patients who ‘have forgotten’ themselves and who do not get an object to represent themselves and make a place for it until they have been given the incentive to include things they have left out in their set-up. The conversation can be used to take up and deepen this issue of what it means to forget about oneself and to see what changes when patients take themselves more seriously, thus becoming more visible and more defined in their position.
In general, the great benefit of this proposal is that through symbolisation and objectification of issues, problems and stressors, but also of resources and supportive elements, they become visible, tangible and handleable in the truest sense of those words. Through the set-up, personal issues are expressed with objects, are thus externalised, become moveable and accessible for a playful and creative approach. This is the significant subconscious message: “I can deal creatively with my problems and my entire life; things can move and change if I want them to.” After the conversation, the participants are given the opportunity to take photos of their set-up, which is often made use of and constitutes no problem at all in this age of mobile phones. What is important is the final, changed picture, of course: “Where do I want to go? What do I want to achieve?”

How CMT differs from other methods

There is no right or wrong

This is one important difference compared to relaxation methods such as autogenous training or progressive muscle relaxation also offered at the clinic, but also compared to other body-related methods such as Qi Gong. In CMT, there are no fixed exercise sequences which can be followed in a more or less right or wrong manner. CMT proposals are usually worded in an open manner: it is not about carrying out movements in a detailed, predetermined way and making a certain experience in the process (such as relaxation). On the contrary, the participants are invited to perceive themselves physically in different postures and movements in whatever way they are capable of doing, the way things are at any given moment. This sounds simple, but is not. Our perception is constantly under the influence of our expectations, evaluations and fears. I do not perceive how erect or bent over I am standing, rather, when asked to perceive this, thoughts may interrupt my perception immediately, such as: "Don't stand there all crooked, straighten up!" A statement typical for CMT in this context would be: "Don't perceive what it (your body) should be like or the way you would like it to be, but the way it really is at the moment." In the ensuing conversation about body perceptions, they are verbalised, which is equally difficult and valuable. By verbalising body perception, it becomes more conscious, concentrated and sensitive. In this context, the therapist tries to reaffirm perception, but strictly avoids valuing comments of any kind. The way patients perceive themselves is suitable and right for them. Even if they can hardly perceive themselves or not at all, that is the way it is and that is what is affirmed: "You perceive that you can hardly feel yourself or can't feel yourself at all. Then that's the way it is.”

This attitude towards body perception can be relieving and freeing for patients suffering from burnout since they are often very performance-oriented, ambitious and dominated by merciless inner drives. This leads to seemingly paradoxical statements, such as a patient being able to relax very well during a perception exercise when lying down, more than he/she could with
a designated relaxation technique. In the CMT exercise, relaxation was not even mentioned. The instruction was merely to try to consciously perceive the tension in individual limbs and joints. If no goal per se is given, it is easier to achieve.

**Body perception as a resource**

Concentrating on the perception of one’s own body during everyday processes and movement sequences while walking, standing, sitting and lying down can be experienced as strengthening, supportive and centring. This is true in particular if this happens without valuing and pressure. Through conscious perception, the patients manage to stay in the present and with themselves. Burdensome thinking cycles can be interrupted; memories of the past of fantasies about the future are rendered ineffective for a moment. Patients who have trouble perceiving themselves can ‘practice’ this easily: feeling various materials with their feet (ropes, pillows, glass marbles, tennis balls) or simply walking barefoot, patting down various body parts (feet, legs, arms or head), massaging the back with the help of a ball and the wall. When talking about these experiences, feelings in connection with the patient’s own body become apparent its emotional cathexis. In the case of very negative attitudes, the therapist can try to ‘correct’ them:

*Do your feet some good, praise them for carrying you through the entire day.*

A new quality is added when perception offers include touching each other, such as patting down each other’s back. Relationship issues will surface, such as the desire for or fear of being touched or the question of trust. Patients are asked to decide whether they want to be touched or not. They can regulate proximity or distance autonomously and are expressly encouraged to say if it does not feel right for them any more and to end the exercise if needed. The therapist’s clear instruction to consciously decide for or against a body perception offer frees up space and mitigates fears.

It is possible for unpleasant phenomena, tension, pain, exhaustion to become apparent for the first time through concentrated perception, things the patient could not feel and was not aware of before. Patients very quickly realise that it is not useful to overlook or ignore those signals of the body. Even with patients suffering from chronic pain, more conscious sensing can be helpful, for instance in perceiving areas of the body which are not affected by the limitations and pains in order to make positive experiences and replace a negative attitude.

**Issues are visualised, made tangible and handleable through objects**

Working with objects as such and with their symbolic function can help visualise an issue or problem in a concrete manner and make it accessible. Strain and stress at the workplace, for example, are not only verbalised and described in a narrative, but can also be symbolised using an object. This opens up many creative and playful possibilities. Their ‘stress’ is placed tangibly in front of the patient, in the form of a stone, for example, to symbolise its heaviness and burden, or in the form of a dinosaur figure representing an unpleasant superior. The patient
can now vary his/her distance to it, move the ‘stress’ further away, completely lose sight of it (some patients come up with the fantasy of throwing it out the window, which the therapist cannot allow though for various reasons), or allow it to come closer.

How do you feel when the strain is further away? How does that feel? What does it feel like when it moves closer? What would be your ideal distance to it? What helps you keep the strain at a distance, to protect yourself from it? Or what helps you manage it better? Go ahead and find yourself an object to symbolise what is supportive, helpful.

Through the expansion with symbols representing resources and helpful options, the set-up becomes more complex, including objects which can be used in further work and experiments. Patients thus experience their problems as moveable and changeable in principle. They can experience themselves as active rather than just as afflicted. At the same time, the symbolic function of objects facilitates talking about and verbalising a problem. For the therapist and for the other patients, complex constellations may become visible and thus become accessible for feedback and new ideas.

CMT from the patients' point of view

"I didn’t know what to make of it at first, but then I felt it to be very helpful." This is a statement often made by patients in the context of feedback towards the end of their treatment. The body perception exercises, which seem so simple and mundane, and working with symbols can trigger astonishment, amazement and even irritation at first. Normally burnout patients are too polite and conformist to say this immediately, even if the therapist urges them to ask questions, for instance regarding the purpose of it all, or to voice their criticism. This often changes over the course of the therapy sessions and it is precisely the alternation of body perception, symbolic objectification and conversations which is experienced to be very revitalising and profound.

CMT is a therapeutic method which accommodates the patient, which provides instruction and offers. It allows individuals to get in touch with their own body, with themselves and with others to the extent possible for them. One patient put it like this: "I can no longer leave the house in the morning without paying attention to how I feel my feet touch the ground."

References


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