Abstract

This article deals with Concentrative Movement Therapy (CMT; in German: Konzentative Bewegungstherapie, KBT) as a psychotherapy method based on depth psychology. First of all, some of the specifics of its methodology are outlined. Secondly, an overview of psychotherapy using the CMT method offered by the Psychosomatic Ward of the Department of Psychiatry and Psychotherapy at the Medical University of Vienna is provided. Based on a methodological discussion, its application in therapeutic practice is demonstrated. A case study is then used to illustrate some of the aspects of psychotherapy with psychosomatic patients.

Keywords: psychotherapy, Concentrative Movement Therapy (CMT), body perception, objects, externalisation, internalisation, KBT

Concentrative Movement Therapy

Concentrative Movement Therapy (in German: Konzentative Bewegungstherapie, KBT) is viewed as an independent scientific psychotherapy method in Austria. It is based on models from developmental and depth psychology and views humans as a unity of body, cognition and emotions.

Methodological foundations of CMT

Therapeutic work takes place in the concurrence of action regarding physical perception, interaction and conversation, in which experiences are voiced, their meaning is reflected upon and deepened through association (Pokorny, Hochgerner, & Cserny, 1996).

Through the invitation to perceive and to move, patients are prompted to experience themselves in their subjectivity, and they gain access to conscious and subconscious physical and mental contents.

Physical experiences are seen as crucial for the development of self in accordance with psychoanalytic developmental psychology and the findings of infant research.
Perception
Just as modern neurobiology, psychotherapy presupposes that one’s current perception is shaped in essence by experience. We perceive
“at all times through the lens of our memory, for what we perceive is determined for the most part by earlier perceptions” (Roth, 1989), for “every individual sensory perception is influenced by those processes which make up one’s personality structure: fantasies, drives, defence mechanisms, contents and forms of mental representations and instances of the psyche: they determine the meaning and content of individual perception. Any act of perceiving is in accordance with one’s personality and is characteristic” (Adler, 1994).

CMT often works with the patient’s eyes closed, causing a shift in the aspect of perception: the perception of the outer world moves into the background, the perception of what is inside oneself moves to the fore and one’s imagination is activated.

Verbal processing
Verbal processing is an essential methodological element. The experience is made conscious through its verbalisation, meaning it is conceptualised and thus taken to the level of thinking, association, reflection and communication. The experiential level, the level of action and the level of verbal expression form a unity.

Objects
In Concentrative Movement Therapy as well as in psychoanalysis, the therapeutic use of objects has a long-standing tradition. In CMT, objects were originally used to enhance body perception. Along with the development of the method, the use of objects also expanded.

“Objects can have various functions: They are real objects of perception with definable physical characteristics on the first level; they are transitional objects within the meaning of Winnicott’s definition and facilitate the transition from the real, external world to an internal representation; and they are a symbolic expression of what has been repressed, giving it a shape” (Schreiber-Willnow, 2000).

Primarily, the objects used are of little differentiation in order to prompt the patient’s imagination and to allow for individual assignment of meaning: balls, staffs, ropes, but also natural objects such as rocks, pieces of wood, seashells, chestnuts, to mention a few examples. Through my work with patients who mostly suffer from deficits in ego-structure, I came to find that these ‘austere’ objects often actualise deficits in the patients’ imagination. For this reason, I expanded my stock to also include stuffed animals. For obvious reasons, toys and real objects were included in psychoanalysis for children.
Melanie Klein developed a new setting in her ‘game method’. She also noted simplicity as an essential characteristic of the toys and objects she used in order to allow for the expression of fantasies and experiences in individual situations according to the individual content of a game (KLEIN, [1955] 2011).

Externalisation – internalisation
The following section will explain the two terms, and externalisation and internalisation processes will be illustrated by means of a case study.

The transfer of intra-psychical contents to the outside was termed externalisation by Klein. Time and again, she pointed out the importance of externalisation as a symbolisation of the content of anxiety fantasies. Through this ejection, an internal conflict is meant to be mitigated (HINSHELWOOD, 1993).

The second great figure of psychoanalysis with children, Anna Freud, emphasised that it was characteristic of childhood for internal conflicts to be carried out in the form of struggles with the external world (FREUD, [1965] 1988).

The 'acceptance into the subject', the taking in, is summarised under the term internalisation in psychoanalytic tradition.

Otto Kernberg described internalisation in connection with the development of ego identity as a process, with interjection being its most primitive form, and identity formation as the intra-psychical process of integration of libidinous and aggressive self-representations into a cohesive self (KERNBERG, 1997).

Externalisation and Internalisation are to be seen as important processes within the context of normal development.

Stavros Mentzos assigned at least the same amount of importance to the need for externalisation of self and of one’s internal world, to objectify them in real forms, as he did to, conversely, the tendency to internalise objects and to identify with them.

“If internalisation processes are constitutive of the development of self, the same also applies analogously to externalisation processes in relation to the development of the realm of objects.” (MENTZOS, 1991).

“Creative outward expression serves the purpose of improving, differentiating and deepening the perception and view of one’s own person.” (MENTZOS, 2002).

The use of objects becomes very significant in working with internalisation and externalisation (CSENY & TEMFLLI, 2000). For instance, when patients choose an object symbolising their present state, their internalisation and externalisation processes can be promoted in order to express subconscious intra-psychical contents symbolically and to make them more tangible in this representation and form.
Concentrative Movement Therapy within the context of in-patient psychotherapy

In many clinics, Concentrative Movement Therapy belongs to the recognised repertoire in the area of in-patient treatment of patients with psychosomatic and eating disorder. The high level of acceptance towards this type of therapy among patients has been shown in various studies (GATHMANN, 1990, WERNSDORF, 1998).

Setting

The in-patient psychotherapeutic treatment programme of the Psychosomatic Ward of the Department of Psychiatry and Psychotherapy at the Medical University of Vienna is part of an integrative therapy concept with behavioural therapy, depth psychology, systemic therapy being offered and with an emphasis on group therapy. Group size varies from eight to twelve participants, mostly women, about 80%.

Diagnoses for the most part include depressive disorders, neurotic disorders, stress disorders and somatoform disorders, eating disorders, disorders of personality and behaviour.

The group therapies offered include conversational therapy, music therapy, Concentrative Movement Therapy, relaxation therapy, a creativity group, an awareness group, and many more.

In addition, every patient receives weekly individual therapy sessions and regular conversations with an assigned member of the nursing staff.

The treatment period is eight weeks, with an average of 14 CMT sessions.

Treatment concept

The treatment concept for working with Concentrative Movement Therapy within the framework of the in-patient psychotherapy settings is based on the phase model by Almut Mezgolich-Zielke, which includes the therapy phases of building trust, regression, progression and parting (ZIELKE, 1989).

It has been extended and amended by the author to include body therapy and movement therapy aspects (HOFINGER, 2004).

Phase model

During the initial phase, the goal is to create situations which enable the patients to develop trust in the group and in their physical self. This includes finding their place, perceiving their body in various situations; physical boundaries and coherence are addressed as well as the will and ownership. This experiential sense of self is referred to as the core self (STERN, 1992).

One proposal exemplary of this subject area is the perception of one's individual pace and of personal scope of movement. The patients lie down on their backs on the floor with their knees raised, they turn their pelvis and knees to one side, try out various paces and different scopes of movement in order to find their subjective pace and scope of movement.

After this, their experiences and perceptions are processed verbally.
In this context, patients repeatedly say that they no longer know their personal pace and scope of movement. One patient (38 years old and diagnosed with a somatoform pain disorder) gave as a reason for this that he usually took care of others and did not know who he was and what he needed and wanted any more. Many psychosomatic patients, regardless of their specific symptoms, display what is commonly called an instrumentalisation of their body, in the sense of control over their body. It is to be assumed that this also includes controlling repressed parts of their own personality which have been projected into the body.

*Depth psychology uses the term projection into the body to mean a defence mechanism employed by patients to free themselves of incompatible mental contents by treating their body as an external object, as a disposal site for what is mentally unresolved, thus perpetually increasing the pathology of their physical self* (Plassmann, 2002).

Working on repelled affects, including acceptance of one's body, its make-up, its needs is often an essential area of body and movement psychotherapy.

Over the course of in-patient psychotherapy, intra-psychical and ‘intra-physical’ areas are increasingly addressed. On a physical level, patients move from their body surface to the inside of their body; their skeleton, muscles and joints are addressed with regard to their meaning; in the same way, the respiratory and digestive tracts can then be included as the innermost layer of the body.

Towards the end of the patients’ stay, the subjects of parting and separation are addressed. Returning to a standing position from lying down and then walking, for instance, or leaving a designated area. The following proposal is an example of this: "Return to a standing position from lying down. Repeat this several times. While doing this, observe the speed at which you get up, how much power you use for it, the extent of your movements, your breathing, your general state."

When considering how they do this (quickly, reluctantly, laboriously, remaining on their back on the floor, fearfully, briskly...), patients can often see a connection to how they experience and shape farewells in their lives.
Case study

The following section provides a detailed account of the work with a patient, beginning with an excerpt from her anamnesis:

Ms. G., a 22-year-old patient (admission diagnosis: bulimia nervosa); for approx. three years, there has been an increase in mood swings, anxiety, panic and binge eating and vomiting, self-harming in the form of cutting and carving, especially of the lower arms. Her medical history includes cocaine, cannabis, ecstasy and alcohol abuse. As an infant, she suffered from a disorder of the pylorus, which could not be explored further. Her parents’ divorce occurred when she was eight years old. At approx. age ten, the patient developed a case of bulimia nervosa. At the age of twelve, the patient broke off contact with her father. At the age of 14, she had an abortion. At this point, she began consuming increasing amounts of alcohol. The patient had an older sister (four years her senior) who died when still an infant; she has two younger sisters with whom she claims to have a good relationship. The patient attended pre-school, primary school and completed her lower secondary education; she left vocational college prematurely, but completed an apprenticeship successfully. The year before she was admitted, the patient had gained ten kilograms. At the time she was admitted, the patient worked in her profession and had a relationship with a young man.

Aspects of working with Concentrative Movement Therapy

As described above, CMT takes place in a group setting. Ms. G. stated from the first CMT session that she could not feel her body. She described this as though it were an inalterable fact and seemingly without regret, from my point of view.

She was brisk in her overall appearance and also in her verbal expression and kept criticising my approach, saying for instance that I asked too many questions.

At the same time, she reported in various other therapy sessions that she felt no aggression.

In her individual conversational therapy, Ms. G. told her therapist about a dream in which her boyfriend was ‘violent towards her’. Yet she described her boyfriend in reality as affectionate and as a stabilising factor in her life.

When considering her statements that she felt no aggression, yet at the same time did display aggressive behaviour in the CMT group, the treatment team developed the working hypothesis that this dream might constitute a projection of her own aggressive parts onto her boyfriend.

Not feeling her body remained an essential topic in Concentrative Movement Therapy and ran like a red thread through the sessions.

There was presumably a connection between not feeling her body and not perceiving her aggression.

Ms. G. continued to display no distress at all over the fact that she could not feel her body. Her distress could only be assumed since repeated proposals regarding body perception only rein-
forced her resistance and, as described above, she kept on criticising her CMT therapist and this form of therapy.

One aspect of this may also have been the externalisation of an intra-psychical conflict.

On the transference level, the body or movement psychotherapist was confronted with conscious or subconscious feelings towards her own physicalness, in a way representing ‘the body as such’.

It seems logical to assume that, in this case, the body or movement psychotherapist on a projection level also served as a projection surface for repressed attitudes and feelings of the patient towards her own body.

Externalised symbolisation offered a means for addressing her relationship towards her own physicalness in order to then be able to work with supposed repressed parts.

### Procedure of a proposal

I asked the patients to sit around a blanket spread out on the floor and to close their eyes. I placed various different objects on this blanket. I then suggested to the patients to ‘look’ at these objects with their eyes still closed and to examine them. Depending on the working hypothesis, there are different ways to continue this proposal. If perception is the main focus, for instance, the perception of the objects (their shape, size, weight, texture, surface properties etc.) is addressed in greater detail.

In this particular case, I suggested to the patients to take some objects of particular interest to them along to their own blankets; to try out which areas of the body, apart from the hands, the respective object also corresponds to; which characteristics of the object correspond to the body; and which characteristics of the body correspond to the object.

I believe this promotes processes of internalisation and externalisation.

Ms. G. chose a teddy bear and a frog made of fabric. From my point of view, she lovingly held the teddy bear in her arms and on her lap for a long time. During the conversation after the exercise, she stated that she had chosen the teddy bear because of its size, surface and texture, and that she generally liked frogs.

I see this part as a first positive turn towards an object which, a successful internalisation provided, could symbolise the beginning of an accepting turn towards herself.

In one of the next sessions, Ms. G. tearfully admitted after a body perception exercise that she very much regretted being able to concentrate on her body only briefly since this for sure was a nice exercise and since, due to her early ‘exit’, she probably missed out on something very beautiful. With this, she expressed a positive attitude towards her own body and also towards me as a therapist for the first time.

I also see this statement by this patient as questioning her initial conviction that she could not feel her body.
As treatment continued, I went on to address body cavities and the relationship experiences they may be connected with.
One possible proposal to introduce this work with body cavities basically encourages the patients to experience their rib cage with their hands in order to then move on to working with the internal area of the rib cage. While processing this proposal verbally, Ms. G. spoke of her disgust with her ‘fat’ belly. She did not differentiate between her rib cage and her belly. "There is too much of me."

This is a common statement made by patients with an eating disorder. This evaluation can also be looked at from a relational angle.

In order to ‘bring her inner world to the outside’, I suggested a role play to Ms. G. She agreed.
I took on the role of her belly; she took on the role of her mind, which considered this belly too fat.
I then basically told the patient that if I as her body were told time and again that I was too much, I would eventually end up believing it and that it would not make me feel good.
I then asked the patient if she had ever felt like she was too much for someone.
The patient said that since, as a baby, she had suffered from a disease of the pylorus, she had often vomited, cried a lot and had been told by her mother that her father had often picked her up roughly and carried her around.

Since there is no indication of pronounced aggressive behaviour on the part of her parents, this could be interpreted as them feeling overwhelmed and as a so-called mismatch (Stern, 1992). I suppose that through the sequences described above, Ms. G. had tried to question her attitude towards her own body which up until that point had been her natural response.
She could now see her former evaluation of herself as being ‘too much’, which had been unbearable and thus had to be repressed, as being connected to early relationship experiences. She no longer had to repress her ‘being’ to this extent and was therefore able to deal with herself and her body in a less burdensome and different manner.

If repressed contents are made accessible to the conscious mind and a certain degree of distance between the individual and the respective affects is achieved, this process can result in a changed attitude towards one’s own body in the sense of a ‘positive juxtaposition of somatic markers’ (Damasio, 1997).

**Prospects**

After this session, Ms. G. began criticising a different therapist, which in turn was interpreted by the team to mean that her aggressive parts were now aimed less at her own self and that she was increasingly confronting external objects instead.
Final remark
Resistance towards and rejection of a CMT session can be related in particular to rejection of one’s own physicalness and any mental contents relegated to that realm. Moreover, this description is an attempt at illustrating how in transference, the patient’s attitude towards her own body is also represented. Furthermore, some of the aspects of the diverse scope of externalisation and internalisation processes within the framework of Concentrative Movement Therapy have been outlined.

References

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