Experiences in in-patient rehabilitative work with tinnitus patients from the perspective of Concentrative Movement Therapy (CMT)

Abstract
Concentrative Movement Therapy (CMT; in German: Konzentative Bewegungstherapie, KBT) as an approach of psychodynamic body psychotherapy has a fixed place in the treatment of tinnitus patients in specialist clinics for psychosomatic medicine. The goal of treatment is to restore the patients' capability to work or to prevent future chronification of a tinnitus occurrence. Beginning with the symptom, CMT tries to establish a connection between cognition, feeling and living situation and to facilitate the development of a greater awareness of the way the illness is expressed. The body is the starting point, the movement and the encounter with others, also with the assistance of objects. Three case studies are meant to illustrate the practical implementation of CMT with tinnitus as well as the reflective thoughts in this context.
- Movement and affects
- From physical touch to biography
- From symptom to symbolisation

Keywords: rehabilitation, Concentrative Movement Therapy and tinnitus treatment, CMT as psychodynamic body psychotherapy, the 'here and now' as the starting point, body movement and symbolisation, the use of objects, pars pro toto principle, diversion of focus, external and internal movement, CMT as group work, transfer into everyday life, individual and purposeful movement

Preface
The treatment of patients in so-called In-patient Rehabilitation Centres in Germany, in this case a specialist clinic for psychotherapy and psychosomatic medicine, is unique internationally. It is regulated in the SGB IX, the ninth volume of the German Social Security Code, and is generally covered by pension insurance companies or by health insurance companies. Psychiatric institutions and acute care units for patients with psychosomatic disorders are not counted among so-called Medical Rehabilitation Centres. The goal of any in-patient rehabilitation treatment is to restore a working person's ability to work and/or to prevent impending long-term
inability to work or even premature retirement. The simple equation is that every euro spent on rehabilitation service will pay off doubly since the patient will be capable of re-entering into regular work life directly or successively by way of a step-by-step increase from a reduced performance level to the level prior to incapacitation. If possible, this is arranged prior to the patient being released from the clinic in cooperation with the employer. By definition as set forth in the Social Security Code, in-patient rehabilitation treatment is not indicated until all out-patient treatment options have been exhausted. What is also crucial for receiving insurance approval is an expert opinion regarding whether the illness is grave enough to justify in-patient treatment; an application for in-patient treatment can also be turned down for this reason. Quite a few patients in psychosomatic care had to object to their application being turned down before receiving approval for rehabilitation.

Patients' motivations can be quite different: some patients are determined by outside forces in in-patient care and (subconsciously) hope to have their incapacity to work confirmed by a final authority in order to ultimately receive premature retirement; others see the active restoration of their ability to perform as an important goal. Depending on the patients' diagnosis or structure, the overall picture of who is in in-patient care is mixed, from patients with structural disorders to neurotic disorders to anxiety disorders to obsessive-compulsive disorders to pain disorders etc; the group of patients with hearing disorders in the broadest sense of the term includes tinnitus patients, patients with Ménière's disease, patients with tinnitus after sudden hearing loss, patients with unilateral or bilateral hearing loss with or without hearing aid.

Aspects of treatment of tinnitus patients
The group of patients with tinnitus is normally extraordinarily performance-oriented, rather perfectionist in their life attitude, presupposing a strong desire to restore previous levels of capacity, which at the same time makes it more difficult for them to listen to their innermost feelings on a psychosomatic level. The key stressor often listed is the job with growing demands and a simultaneous reduction in personnel, round-the-clock availability, the pressure to compete and difficulties with co-workers and superiors. Personal problems also play a role, however, more or less affecting the ability to perform on the job. The initial phase of in-patient therapy is often characterised by frustration since having one's health restored to the level before tinnitus is prognostically unlikely, meaning tinnitus syndrome will probably remain a part of one's life.

Tinnitus is basically present in each human as a physiological sound and we can hear it when it is quiet enough and when we concentrate on our physical processes. This means that it would not take up our entire attention and result in therapeutic measures being taken if this sound did not sometimes develop into a clinical or decompensated tinnitus through a variety
of sudden or gradual influences and if there were not any (subconscious) links to one's living situation. According to statistics, approximately 10% of the German population suffer more or less from tinnitus (BIESINGER, 2005).

Like burnout, tinnitus has no doubt taken a fixed place in our midst as a phenomenon of the times and of our society. In accordance with common nomenclature, we speak of a tinnitus syndrome nowadays since interactive conditions and influences as factors in the development of tinnitus can be found which can relate to all areas of life (social isolation, feelings of anxiety, depression all the way to suicidal tendencies, incapacity to work). When tinnitus sufferers enter in-patient treatment, they have often already undergone an odyssey of treatments and are considered unresponsive to further organic medical treatment, even if a last vestige of hope remains that new, effective treatment methods will be discovered. The duration of treatment is determined in accordance with the underlying diagnoses as set forth in the ICD 10 (H 93.1 for tinnitus and often F-diagnoses relating to depressive disorders); it varies from three to five weeks. (ICD 10, 2011) Patients take part in a multi-modal therapy programme with a multi-professional team. CMT is an integral part of treatment as the only movement psychotherapy method. Anamnestic history includes unilateral and bilateral tinnitus, unilateral tinnitus after sudden hearing loss, Ménière’s disease in connection with tinnitus, hyperacusis, hearing loss to the point of deafness—unilateral or bilateral, with or without the provision of a hearing aid.

**From objectifiable tinnitus to its subjective occurrence**

My work as a CMT therapist begins at a point where a somatic root cause has been excluded for the most part by way of the thorough prior medical examination and testing required. We can thus speak of a subjective occurrence of tinnitus beyond what is objectifiable, in which the filtering functions of the ear are irritated and the selection processes for real acoustic stimuli are no longer operative. Stress plays an important role in this context (‘manager tinnitus’). Moreover, the ear is linked to other regions of the body by a complex networking system. Tinnitus sufferers often complain of tension in the cervical region and jaw. This, in turn, may affect the sense of balance and position.

Some patients wear a mouth guard against teeth grinding. Spatial orientation furthermore requires the cooperation of both ears. In the worst case, tinnitus has developed as a result of a Ménière’s attack. The list of possible triggers and consequences of disturbances in our hearing shows the complexity of causes and effects.

The close connection to the limbic system further underlines the proximity to the emotional centres of the brain, explaining the extreme and fearful responses to disturbances in this functional circle. Psychogenic consequences are thus understandable.
Pre-existing condition and search for compliance

The difficulties in working with tinnitus patients lie in moving their mechanistic and one-dimensional thinking towards a broader context of experiences and emotions; CMT with its body-related access constitutes one facet within the range of possible treatments for this purpose. Recurring issues tinnitus patients deal with are:

- **Accepting their illness**
The patients are not yet done with their search for a drastically effective method to treat tinnitus. Therefore, they carry a lot of hope, but also reticence and criticism when they meet me as their CMT therapist. Their high expectations become physically tangible for me through counter-transference.

- **Letting go/trust**
  situations, movement proposals and external circumstances are measured exclusively by the degree of their tinnitus and are ranked accordingly.

- **Resilience**
The noise level in a therapy setting is assigned great importance: for some, silence is unbearable; for others, it is sounds and the voices of other people talking; if either becomes unbearable, the patient will sometimes leave the room.

- **Tolerance/social (re)integration**
  hyperacusis patients in particular can have a special influence on group dynamics in a mixed group: fellow patients, particularly those with different prevalent problems, easily come into conflict with the tinnitus sufferer when the group is playfully noisy, louder; there is an implied or even expressed rule to be considerate.

- **Affects and emotions**
  tinnitus patients' mood is matter-of-fact, with their focus being on the symptom; an intellectual orientation is dominant. In more extreme cases, their attitude towards tinnitus is reminiscent of anxiety and compulsive processes.

Treatment examples from CMT work

Several treatment examples in the following are meant to illustrate and explain the therapeutic approach used in CMT.
Case 1: movement and affects

The starting point in the first example is several group participants complaining of pressure in the head area, heavy thoughts, tinnitus noise.

Initial CMT proposal:

"Stand up and then walk around the room. Consciously include your head in the walking movement and try to work on the way you hold your head. Which points of view does the current posture of your head allow? Do you feel the connection between your head and torso to be rigid, moveable, tense? How far can you move your head in various directions without making things worse? Is moving it especially easy/difficult in any particular direction? Now take your head between your hands and feel its diameter, its length,... its entire shape; feel its size, temperature, surface; feel the skin around your head, the muscles, the bones; feel out the transition from your head to your torso. Where do your muscles feel hard, soft, painful? Simply register it without beginning to massage the area. (...) Now try touching as many parts of the room as possible with your head: how does your head feel in contact with the wall, the floor lamp, the carpet etc.? Touch the fixtures and objects in the room with various areas of your head: your forehead, the back of your head etc. (...). Are there any noticeable reactions from your head? What does it like, what does it find off-putting? What does the hardness and coldness of the wall feel like, the metal of the floor lamp, the roughness of the carpet?" (...)

With one patient, a senior manager in charge of 200 employees, who had reported before this exercise that he still had two years to get through until retirement, but had decompensated time and again in the past, the following scenario developed:

he sighed loudly and very audibly the moment he could rest his head sideways against the wall. Feelings of sadness overwhelmed him and I encouraged him, telling him that he did not have to control them. As soon as he moved under the ceiling slope and hit the top of his skull on it, the tears stopped flowing and he stood erect in a position of attention; as soon as he returned to the previous sideways posture, the feelings returned.

What was then confirmed in reflection was the special social role in which he saw himself as a manager: he had tried to establish a personal relationship with his employees, extending into his and their private life. He could not admit to himself that this was too much in the long run. This had led to him decompensating time and again since he kept overextending himself. The lack of a reciprocal relationship where he could lean on someone became apparent very suddenly when leaning against a dead wall and led to a state of longing. The pressure on his skull, in turn, reminded him of the special burden on him of having to carry everything and invariably led to his routine posture of responsibility. In the conversation that followed, we worked out possibilities for time-outs for him to take his own needs into consideration more; conversations and more time with his wife as well as rediscovering a hobby with a good friend moved to the fore in this context.
Commentary

Affects may be triggered far more quickly in CMT than in verbal therapy forms since defences are loosened. Especially for tinnitus patients, who often possess great intellectual capacity, this can also be an opportunity to gain important new impulses regarding how they experience their tinnitus.

This example shows how even the smallest changes in a physical proposal can have very different and sometimes dramatic and diametrical consequences. On the one hand, this requires the therapist to be vigilant, to perceive situations and address them, but it also requires him/her to steer processes and to filter moments which are significant in the current situation from an abundance of scenarios which take place.

One essential characteristic of CMT becomes apparent in this case study: the diversified external movement of the body inspired by CMT leads to someone being moved on the inside; being touched inside, in turn, shows on the outside in the form of an expression or an action. Thus, CMT takes effect in both directions: impression and expression.

Case 2: from physical touch to biography–CMT as a group experience

Traditionally, CMT took place in a group setting. It was not until later that individual therapy was added as a preferably type of treatment in individual cases. Today, training in CMT emphasises both treatment types and their specific potential benefits. The highly experiential character of the variety of playful moments of CMT in a group and the reintegration into a social experience are what makes CMT in a group therapy setting so important for tinnitus sufferers. The group also becomes important with regard to group dynamics as a field of reference for successful and unsuccessful relationships and conflict management. Surely, what makes the CMT group setting special is the movement and the alternation of closeness and distance on a physical movement level; where encounters take place again, the experience of erotic and sexual issues may surface. Especially in a group, the CMT proposals often lead to the re-enactment of family-related or work-related situations and of team dynamics. (Kost, 1988)

At the beginning of a group session, persistent complaints about the high level of tinnitus noise were voiced. I was beginning to feel as though we were going around in circles. Tiredness and impatience began to surface in me and this called for a new impulse. I often experience such paradoxical situations with tinnitus patients: on the one hand, they want any form of help anyone can offer, but on the other, they keep me as a CMT therapist at a distance with their verbal contributions; their talk revolving around the symptom cements the distance between us. This is particularly true for CMT, in which the dialogue with one's own body as well as encountering objects and other people normally constitute the centre of attention.
I suggest moving away from the verbal level to the level of body experience:

"Choose one hand and start patting down your other hand and your other arm with it. Pat them with varying force—first of all strongly, then carefully. What does your skin feel like, your muscles, your bones when you do this? Where do you pat more forcefully, where are you more careful? Pause for a moment and compare the patted arm with the other arm; do you feel any difference? And now do the same thing again with your other arm (...). At the end, compare them again and see if there is any difference between your two arms."

I then suggest extending the exercise to other body parts. "When you pat down cavities such as your stomach, your chest... do you feel it resonating through your body?"

With this patting down exercise, I can reach various levels of perception, from the surface of the skin to deeper impressions.

In a first reflection phase, one patient described the effect of this self-treatment in mechanical terms, in the same manner in which he would have liked to 'repair' his tinnitus. As far as treatment was concerned, I still considered it a step forward since quite apart from words, he was learning to differentiate what different parts of the body sound and feel like and his focus had shifted away from his tinnitus.

In one of the later group sessions, the same patient agreed to repeating this proposal, but only together with another person: in this mixed-gender group, he partnered up with another man for the exercise. The two men initially engaged in some sportsmanlike playfighting; it was more about demonstrating strength and enduring pain levels than allowing closeness. Through the concentrated work of the others, the two men also grew more and more quiet without any intervention on my part. In my observations, I noticed a change in mood in the aforementioned patient.

Later on while reflecting on what happened, the patient reported feeling embarrassed at first about touching and being touched; he hardly dared feel that it was also pleasant, which seemed odd between men. In the following, the patient made an unexpected connection with his biography: he could not remember ever being touched by his parents, with the exception of brief, punishing, directive 'nudges'. So he became a diligent student and always had good marks (note: his tinnitus appeared at a time when he was criticised for his lack of social competence as team leader in a company). During this emotional account, his tinnitus grew stronger again, but this time in a logical context, and he did not despair over it at all any more. An increase in the release of adrenalin can lead to a temporary increase in tinnitus noise, but that does not mean that this should be avoided. In order to better integrate tinnitus in everyday situations, it helps recognise and feel its connection to particular actions.
Commentary
In this case, the purpose of the physical exercise was a shift in focus. It makes sense to try what is still possible and what can still be done instead of continuing to look at one’s limitations. This is a further basic principle of CMT: when one thing has become impossible, what are the things that can still be done? (STOLZE, 2002)

When extending an exercise to working in twos, relationship and group dynamics increasingly come into play. This can help in rediscovering the light-heartedness of playful situations reminiscent of childhood, but it can also lead to emotional wounds and needs associated with shame surfacing, things which took place or were not fulfilled (any more) in a patient’s biography. Many emotionally charged issues have to do with conflicts and the inability to deal with them adequately. In my counter-transference as a CMT therapist, I often feel anger becoming apparent when working with tinnitus patients. The constant preoccupation with the annoying symptom is associated with drastic fantasies, although cutting off one’s auricle as van Gogh supposedly did should probably be relegated to the realm of legends. It is worth considering, however, whether a patient’s attitude towards tinnitus could be an expression of a displaced issue resulting from unresolved emotional stress in a different area; one could then tentatively speak of a conversion disorder in this context.

In summary, the following could be said:
through his experiences in CMT, the patient has learned to no longer view his tinnitus as isolated, but within the context of his life. What was crucial in this context was the physical touch which allowed an old father-son-issue to resurface. Understanding these connections does not mean changing them yet, but it gives the patient the chance to deal with them differently in the future.

I would like to give one last example to describe the use of objects and their function in CMT.

Case 3: From symptom to symbolisation
Working with objects, meaning inanimate things, as the starting point for further psychotherapeutic work on a deeper level is an essential characteristic of CMT. These objects such as balls, staffs, ropes, but also manifold everyday materials are assigned a deeper, individual meaning through concentrated examination and exploration. The effect can start at a physical level and result in a differentiated physical self-perception (example: "The rock is just as hard as the muscles in my neck."). However, the objects can also be used to represent situations or people, they can become the initial spark for new perspectives and new problem-solving approaches (example: if the rock mentioned above is replaced by a softball and discovered as a physical alternative to the hard rock that provides some relief) (GRÄFF, 2008).

Ultimately, we do not know which individual experiences in working with materials are experienced as essential; its individual meaning is attained only through the patient’s spontaneous experience, through observation from the outside, through the therapist’s empathetic reso-
nance and is then summarised and translated in the verbal-cognitive part of a CMT session. Nevertheless, there remains an ‘excess of meaning’ which sometimes cannot be understood properly until the therapeutic process has continued.

In this last example, I would like to focus on a group situation with tinnitus patients, in which problems in the cervical region received a disproportionate amount of attention in the introductory conversation and gave rise to a transition to working with symbols.

"I will use your constraint in the cervical region as a starting point and suggest that you set up an area for yourself in which you can lie down. Your attention is now focussed on the mobility of your head and its constraints. Move your head slowly and consciously in every direction without lifting it; don't strain! If you stop breathing for a moment, it's a sign that you are trying too hard to force movement by willpower—try to avoid that. (…) Take your time in between the individual movements to feel, meaning that you move your head and then you feel the effects of that movement before you make the next movement. (…) When you continue these movements now, try to open and close your eyes alternately." (…) "Do the same thing with your ears: close your ears with your hands while moving your head. What do you hear inside? What has your jaw been doing in the meantime? Have you been clenching your teeth? Have your lips been closed? Try out both options—relax your jaw, open your mouth and part your lips during the movement." (…) "And now try the same with clenched teeth and lips. Does that make a difference? Where do you feel that difference?"

Commentary
At this point, I as the therapist point to the overall physical processes which can be triggered by local movement.

One of the principles of CMT becomes apparent in this context: the patient is supposed to be re-enabled to compare and, in doing so, to extend the latitude within what he thought to be a fateful and inalterable illness. Let us presuppose a pars pro toto principle; thus, any given experience with therapeutic intention aimed at any given region of the body can be seen as exemplary and transferred to the entire organism and thus to life in general. When patients experience, as in this case study, how they tighten their jaw muscles unnecessarily while making small movements and make their tinnitus worse as a result, they can also gain access to this subconscious behaviour in their everyday life and correct it. This shows one further basic paradigm of CMT: the therapist makes proposals to try something out and to compare, but what is aimed for is the patient’s very own power of control over life. The potential for this is found in the body’s capacities and its scope of experience with feedback effects onto the patient’s entire personality. This constitutes a unique continuation of the tradition of CMT as derived from ‘Gindler work’. (For further details regarding Elsa Gindler and her work, please
refer to the article by A. Carl.) With her understanding of movement, Gindler rose above the practice of disciplined and uniform body exercises prevalent in her day and age and even went against considerable political resistance to advance the concept of individual and purposeful movement. (Gindler in: Jacoby, 1994)

Let us now return to the case study:

"The task now in this second step is to place as many objects as possible in and around the head space of your area and then to lie down with your head amidst these objects. Try to find the right place for your head and/or also try to work out which head postures are uncomfortable." (...)"If need be, you can change the objects around until they suit your head."

As an outside observer, I watched a patient trying in vain to find a place to rest his head on a square piece of wood until he finally became annoyed and gave up.

I then moved on to the symbolic level:

When you're up to your ears in things, when there are so many things surrounding your head, how does it make you feel and which conclusions can you draw from that? If needed, make a list of priorities, of what can be moved closer or further away physically."

During this sequence, I observed, among other things, the way in which patients dealt with the objects and which affects this indicated. The patient mentioned above ultimately shoved his object aside helplessly as though he were angry.

In a third step, I ventured into establishing a connection with the patients' biographical situation or future plans:

"If you view these objects as exemplifying your professional and private life, what suits you in your life and what bothers you?" (...) "Can you arrange it (tentatively) so that it suits you? What is impossible to change, what is easier to change? And how do you handle the inalterable facts?" (...) During this processing phase, each participant was allowed to assign their own individual meaning to the objects in accordance with their living situation.

Final commentary
The problems with the head-neck-area originally described on a merely symptomatic level are then lifted to a new reference level in a verbal reflection phase
- by connecting them with an overall physical experience
- by developing associative links with the objects and opening up a space for one's own reality
- through the conclusions the chosen objects and the way they are handled allow with regard to the types of problems at hand and the possibilities to adjust to one's own life circumstances or, if possible, to make a change
The aforementioned patient with his futile attempts to find the right place for his head on a hard wooden block profited from this experience since his unsolvable personal situation became tangible for him, regardless of the attempts he had made over the years. For him, this meant facing the issue of separation he had been putting off for a long time.

Conclusion
Concentrative Movement Therapy plays a fixed and important role in treating tinnitus patients. Through the variety of physical experiences made in CMT – with oneself, with symbolic objects and with other group participants in manifold scenarios – the restrictions imposed by tinnitus and the feeling of being reduced to it are removed and a new space for experience is created. In this context, CMT can shed some light on biographical connections or, through tentative action, point to forward-looking alternatives. Nevertheless, the starting point in any encounter with the patients is always the ‘here and now’. Despite the fact that the theoretical background of CMT is the same for all therapists, the practical implementation of CMT is ‘always different’. This implies that the examples mentioned above cannot be seen as a user’s manual.

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