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Psychomotor Therapy for Patients with Severe Mental Health Disorders

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Abstract

Psychomotor therapy is defined as a method of treatment based on a holistic view of the human being that is derived from the unity of body and mind. Assessments (observation and/or evaluation) are essential to achieving concrete psychosocial objectives methodically. Psychomotor therapy uses movement, body awareness and a wide range of movement activities to optimize movement behaviour as well as the cognitive, affective and relational aspects of psychomotor functioning (i.e. the relationships between physical movements and cognitive and social-affective aspects). Consequently, the approach to this type of therapy integrates the physical, cognitive and emotional aspects of functioning in relation to the capacity of being and acting in a psychosocial context in order to achieve clearly defined goals in consultation with the patients. Psychomotor therapy framework consists of three different approaches: a health-related approach, a psychosocial approach and a psychotherapeutic approach, which can be embedded in several psychotherapeutic approaches. Through the implementation of both systematically planned evaluations and individually targeted interventions in group, the psychomotor therapist strives to broaden the general action competences and specific skills and to stimulate a positive self-image and personal well-being in balanced social relationships. Today, there is sufficient evidence that psychomotor therapy has a major contribution to both well-being and mental health of patients with severe psychiatric problems. In Flemish psychiatric hospitals, psychomotor therapy is imbedded in different treatment programmes. In this chapter, the theory behind this approach and some practical examples will be provided.

Keywords: body image, physical activity, mental health disorders, psychiatry, psychotherapeutic accent, movement therapy, psychomotor therapy

1. Introduction

In Belgium [1], the Netherlands [2] and Germany [3], psychomotor therapy has been well integrated into psychiatry care since 1965. Psychomotor therapy is defined as a method of treatment that systematically uses a wide variety of physical activities as cornerstones of its approach. It is considered a supplement to and a support for residential psychiatric treatment [4]. Psychomotor therapy attempts to achieve positive therapeutic results regarding the psychiatric problems of the patient (depression, anxiety, schizophrenia, autism, eating disorders, etc.) by systematically using adapted body experiences and physical activities, movement, sensory awareness and sport-derived activities. In this sense, psychomotor therapy is more than just “doing exercise” or “performing recreation activities”. The foundation of psychomotor therapy is based on the well-accepted relationship between mental health and physical activity [5, 6]. It is imbedded in different multidisciplinary psychotherapeutic treatment programmes (behavioural, cognitive, or psychodynamic therapy) for different diagnosis-related patient settings [4]. Psychomotor therapy (see **Figure 1**) stimulates and integrates motor, cognitive and affective competences as inherent aspects of human behaviour, thereby enabling a person to act autonomously within his own psychosocial context [7]. Psychomotor therapy focuses on the somatic effects of physical activity (at the morphological, muscular, cardiorespiratory, metabolic, and motor levels) and on the physio-psychological effects as the core of the treatment. The experiences during PMT and the responses that arise from these experiences function as a dynamic source of change [1, 4]. Psychomotor therapy is mostly a group therapy based on the ideas of Yalom [8]. It has no real side effects, and its safety rules are transparent.

This chapter clarifies the background, history and clinical implementation of psychomotor therapy for patients with severe mental health disorders in psychiatry.

Figure 1. Psychomotor therapy: motor, cognitive and social-affective components.

2. From occupation to psychomotor therapy: a historical perspective

The French Revolution was a milestone in the treatment of patients with psychiatric problems. Pinel (France, 1745–1826) and his contemporaries Esquirol (France, 1772–1840), Tuke

(England, 1745–1813), Greisinger (Germany, 1817–1868), Chiarugi (Italy, 1759–1820), Riedel (Czech Republic, 1803–1870), Rush (USA, 1745–1813) and Guislain (Belgium, 1797–1860) transferred the ideas of the French Revolution to the treatment of patients with psychiatric disorders [9]. A repressive approach (i.e. detention, chaining of patients) was replaced with a more humane and moral treatment that consisted of daily rounds by the medical doctor and different daily activities (housekeeping activities, gardening, working in a vegetable garden, and others). Later, other milestones were important in the development of treatments for patients with severe mental health disorders: The Great World War (1914–1918), the development of neuroleptics (1952), the influence of philosophers and phenomenologists on (mental) health care (Kierkegaard, Husserl, Heidegger, Merleau-Ponty and Sartre) and the development of different types of psychotherapy and adjunctive or complementary therapies.

The book “Aktive Krankenbehandlung in der Irrenanstalt” [10], by Simon (1867–1947), a German psychiatrist, led to new ideas concerning more active treatments for patients with mental illnesses. The approach aimed to address and stimulate the healthy part of the personality of each patient.

Albert Day (1812–1894) developed an institution in New York to treat alcohol addiction. This gymnasium featured appropriate fitness equipment for its time [11, 12]. Shepherd Ivory Franz (1874–1933) [13] studied the effects upon the retardation in conditions of depression. In the United States, Meyer (1866–1950) [14] reported the positive effects of daily activities on mental health. He underlined the unity between body and mind and the effect of exercise on the balance between thinking, doing and being. He was convinced of the effects of activity as a type of therapy and of the advantages in social life for patients with mental illness. Movement activities for psychiatric patients were derived from the so-called active therapies (called “occupational therapy” in some countries) that were organized in psychiatric hospitals [1].

Until 1960, occupational therapy and psychomotor therapy were based on the same ideas [15]. In Belgium, psychomotor therapy and occupational therapy developed as two different tracks. Psychomotor therapy was focused on physical activity [1]. In the Flemish part of Belgium, Simon’s and Meyer’s ideas were adopted by several psychiatrists after the Second World War. Movement therapy became an essential part of mental healthcare treatment services and was initially provided by teachers in physical education settings. The philosophy of this approach was “mens sana in corpore sano” [“a healthy mind in a healthy body”]. Gradually, the attention broadened from movement activities themselves to how people move in relation to their environment. In 1962, Professor De Nayer, dean of the Faculty of Kinesiology and Rehabilitation Sciences at the University of Leuven, introduced courses on movement therapy in mental health within a physical therapy curriculum. At that time, this idea was very innovative. Professors Pierloot [16] and Van Coppenolle [17] developed the theoretical and practical content. Both were influenced by Simon and Meyer who, together with Van Roozendaal (1922–1996) [18], were the trendsetters in the use of movement activities in psychiatry. At the end of the 1960s, the term “movement therapy” was replaced by “psychomotor therapy”. Psychomotor therapy focused on the interactions between the body in motion and the mind, especially from a behavioural perspective. Methods derived from more physical therapy- and body-oriented approaches, such as relaxation and sensory- and body awareness, became an integral part of therapy [1, 4].

3. Definition of psychomotor therapy

Psychomotor therapy was defined as a method or treatment that uses corporality and movement as a driver of its approach and in which the clinician tries—after having performed a methodical psychomotor examination and in consultation with the patient—to realize clearly formulated goals that are relevant to the patient's problems [19]. This definition refers more to the structure than the content of the psychomotor therapy. Psychomotor therapy in mental health is person-centred and aimed at children, adolescents, adults and elderly individuals with common and severe, acute and chronic mental health problems. Psychomotor therapists provide health promotion, preventive health care, treatment and rehabilitation for individuals and groups, mostly in inpatient treatment. They create a therapeutic relationship to provide assessment and services specifically to the complexity of mental health within a supportive environment, applying a biopsychosocial model. The core of psychomotor therapy is to optimize well-being and empower the individual by promoting physical activity, exercise, movement awareness and functional movement, bringing together physical and mental aspects. Psychomotor therapists play a key role in an integrated multidisciplinary team and in an interprofessional care. Psychomotor therapy in psychiatry is based on the available scientific and best clinical evidence [20].

The main purpose of psychomotor therapy is to demonstrate how goal-directed movement situations can have a positive psychological effect, not only physical skills but also cognitive, perceptual, affective and behaviour. The moving body in all its aspects is the cornerstone of the psychomotor approach. This characteristic distinguishes psychomotor therapy from other approaches in psychiatry. Movements that represent real-life situations provide the patient good structure and the opportunity to create a realistic image of his/her own capabilities and boundaries. The commitment requires discipline, responsibility and perseverance. In the first stage of therapy, mostly individualized treatment is offered depending on the problems the patient presents. At a later stage, more group and interactive activities are proposed [1]. Through the implementation of both systematically planned evaluations and individually targeted interventions, psychomotor therapy stimulates and integrates motor, cognitive and affective competences as inherent aspects of human behaviour, thereby enabling a person to act autonomously within his/her own psychosocial context. The goal is to stimulate a positive self-image and personal well-being in balanced social relationships. Psychomotor therapy is used in individual and in group sessions, mostly in inpatient settings. The theoretical foundation of psychomotor therapy came from various disciplines, such as medicine (neurology, psychiatry), psychology (clinical and exercise), pedagogy, sociology, kinesiology and exercise physiology.

4. Some clinical guidelines for optimizing psychomotor therapy

On the one hand, physical activity is currently well accepted in the treatment of patients with mental health problems. On the other hand, data indicate that patients with mental illness have higher levels of social anxiety in physical activity situations compared with healthy control subjects [21]. Consequently, psychomotor therapists should consider social anxiety when trying to improve the outcomes of patients with mental illness and their adherence to

physical activity interventions. Prescribing “sport” activities for patients with severe mental illness without any clarification is therefore counterproductive for the majority of these patients. Most of these patients think they are not skilful enough to fulfil expectations or are afraid of criticism from peers; therefore, they will find many excuses for not attending these activities. Most people are convinced that physical activity is healthy for people with mental illness. This is not always the case, however, as illustrated in the following example of Ellen. This story is an eye-opener.

4.1. Example: Ellen, a 31-year-old patient with borderline personality

Swimming can be an aspect of psychomotor therapy. Swimming is a basic activity, but on an individual level, swimming can have other meanings. The therapist must keep in mind that what obvious is to them is not so obvious to the patient.

A 31-year-old female with borderline personality with eating disorder features was invited to attend a weekly swimming session at the hospital’s swimming hall. The treatment was a group approach based on Linehan [22]. The patient had a negative attitude towards the swimming sessions. She discussed the problem with her therapist. She had difficulties sharing and expressing her feelings. The psychomotor therapist encouraged her to try to attend the session and to write about her experience.

“The whole day, I felt anxious about the fact that I have to go to the swimming session and that I wouldn’t fit in my swimsuit anymore. It would definitely be too small, and I too fat. I imagined a fat, bulging body. The warm weather made me uncomfortable. Sweating gave me the feeling of being too fat and too indolent, which made the thought of putting on my swimsuit quite hard. The other group members were really enthusiastic. This was unimaginable for me. I could not, and still cannot, comprehend that they like to put on their bikini and have fun in the swimming pool. When I put on my swimsuit, it was larger than the last time. I saw that my belly wasn’t sticking out. I felt quite good about my body. The water was less cold than I remembered from the last time. My skin felt soft in the water. I felt a very big contrast between the other group members and me as they moved freely through the water. Some even dared to sit on the edge of the swimming pool. I would have wanted to swim a lap, but I literally felt restricted. It was as if I wasn’t able to swim. I didn’t even know how to start, although I know that I’m a good swimmer. I had the tendency to constantly contract my muscles. When my muscles were tensed, my body felt so much better, less mushy. After a while, I asked to take a shower. The therapist gave me permission. It was very difficult for me to get out of the swimming pool. Everyone would now be able to see me. I didn’t even dare to take a shower. In my fitting room, I really felt...anxious, close to despair. Drying myself and putting on my clothes was very hard for me. I cried, I felt the urge to harm myself, to cut and to ruin myself. I wanted to feel sick and weak by drinking something. However, I didn’t do it. Mostly, I felt very and extremely tired”.

5. The different dimensions in psychomotor therapy

As indicated in Section 1, psychomotor therapy is more than just physical activity. In psychomotor therapy, physical activities are used in relation to psychological dimensions. **Table 1** provides an overview of the different dimensions and the more concrete action points and

clarifications used during the sessions. It is clear that the classification presented in **Table 1** is artificial. There is indeed a connection among thoughts, mood, behaviour, physical reactions and the environment (life experiences = outside the person). The advantage of such a table is that it clarifies what is meant by the situation and the psychomotor, cognitive, affective, behaviour and symbolic dimension. Different situations can lead to different thoughts, moods, behaviours, and physical reactions.

*A seesaw was built with benches and mattresses, as presented in **Figure 2**. The exercise was successful if the group could keep the seesaw in balance with all participants for at least 5 min. Even a small movement could dramatically affect the balance.*

Psychomotor dimension: In addition to the essential skills (balance and the perception of body tonus by the patients), the patient realizes that the physical skills are not the only ones necessary to achieve a

Dimension	Feature
Psychomotor dimension	Physical sensations (heart rate, sweating, dizziness, shortness of breath, blushing, stomach distress, muscle tension, trembling, headaches, restlessness, fatigue irritability, pain, energy and fatigue). Body, movement and sensory awareness; physical fitness; psychomotor skills (manual skills, eye hand coordination, balance, posture, lateralization, time place orientation...).
Cognitive dimension	Including communication aspects. Issues: What are the person's thoughts and beliefs before, during and after the activity? Are the thoughts accurate? Is the person worried about what might occur? Does the person ruminate about the past? Does the person show thoughts of being in danger, narrow attention, and impulsivity? How are the person's planning and organizational skills? How does the person communicate verbally and non-verbally?
Affective dimension	Including the relational dimension and the emotional distress. What are the person's feelings before, during and after the situation? How are the person's relationships with peers and the therapist? How does the person cope with feelings such as sadness, anger, surprise, disgust, shame, hopelessness, being overwhelmed, numbness ...? How is the person's self-esteem, self-image, and attitude? How is his/her level of tolerance or frustration? Who takes the lead? Who follows? Who dares to voice his own opinions?
Behavioural dimension	What is the behaviour of the subject in the given situation? What does the person choose to do or not to do? How does the person overcome the problem; what are his/her problem-solving skills? What type of strategy is used in the given situation? Does the patient use avoidance or checking behaviours, rituals, repetitive behaviour or specific habits (for instance tapping feet, biting fingernails)? Does the patient want to escape the exercise? What is his/her social behaviour like? How does the person function in team efforts? Is he able to achieve the task?
Symbolic dimension	There is a link between the proposed exercise within the therapy and with the outside world (outside the therapy, within society). The proposed exercise contains a life message. The exercise evokes conscious or unconscious events from the past.

Table 1. The different dimensions in psychomotor therapy.

8.4. Psychomotor therapy in a cognitive behavioural setting for patients with eating disorders

The cornerstones of psychomotor therapy for patients with eating disorders are the patient's specific relationship with his/her body (unfamiliarity with their own body, body dissatisfaction and social anxiety) and the drive for exercise, expressed as restlessness or hyperactivity in anorexia and bulimia nervosa or passivity (physical inactivity and a sedentary life style) in binge eating disorder [35]. The therapy focuses on the patient's impression (physical self-concept), expression (the emotional self-concept) and communication (social self-concept) using postural awareness exercises; breathing exercises; relaxation exercises; sensory, body and movement awareness; massage; mirror exercises; physical activity; yoga; tai chi; self-confrontation techniques; psychoeducation; guided imagery exercises; dance and expression; and problem-solving exercises in a group [17, 35, 60–62, 72] (see **Table 4**).

9. Conclusion

Psychomotor therapy in the field of psychiatry is a relatively recent and evolving domain. Depending on the patient's request for assistance, competence or therapeutic possibilities and his/her goals and psychological frame of reference, the psychomotor therapist can choose either a more health-related, a more psychosocial or a more psychotherapeutic approach. The therapist has access to a wide variety of activities. The emphasis is to activate patients, to offer them new experiences, and to stimulate them to express their feelings. The psychomotor therapist needs to have good motivation skills as well as creativity and adaptation skills. Because psychomotor therapy encompasses more than just movement, good communication skills are also important. The focus lays on improving the patient's actions and interaction with peers, learning new skills, behavioural change, new experiences and expression of emotions.

After a phase of clinical observations and explanations, the use of psychomotor therapy in psychiatry is now in a phase of testing the effectiveness of psychomotor interventions in different populations and settings. Many factors will influence clinical practice: the evidence, the skills of the patient and the therapist, the enthusiasm of the therapist's message the marketing, the referral systems, the health service systems and of course the economic situation. Compared with the health-related approach, the efficacy of the psychosocial and psychotherapeutic approaches of psychomotor therapy is hard to prove due to the scientific need to control for large numbers of variables. However, qualitative studies concerning patient satisfaction showed that the adjunctive approach is very helpful for many patients [73]. Future research must analyze which patients benefit the most from this approach.

The psychomotor therapist will face various challenges. Interdisciplinary and transdisciplinary are the future of mental health care. Under these approaches, professionals will reach out to other mental health caregivers who use the same methods as the core of their approach. Hopefully, this will open doors for a more intensive interchange of ideas, and the gap between the different adjunctive therapies that developed in the 1960s will begin to close.

In the future, therapists will need to obtain informed consent for each treatment. Each therapist will need to prove that his/her methods have value for the patient and provide information about what, why, where, when and how he/she will proceed and what the possible outcomes are. The move from inpatient treatment (residential therapy) to community treatment is another important challenge.

In Anglo-Saxon countries, psychomotor therapy as such is not well known as in Flanders, The Netherlands, and Germany. This approach is an evolving domain within psychiatry and can be seen as an adjunct bio-psychosocial treatment, in accordance with internationally accepted models. In Flanders, psychomotor therapy is taught at the university level and integrated in the dominant health care system [4].

Inviting people with mental health problems to participate in psychomotor therapy is not about finding a direct solution; rather, it is about starting a dialogue with the person with mental health problems.

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