BJPsychoterapy
Brazilian Journal of Psychotherapy
Volume 21, number 1, april 2019
www.rbp.celg.org.br

ORIGINAL ARTICLE

Expressive Therapy – Psychoanalytic Dance Therapy

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DOI 10.5935/2318-0404.20190015

Abstract

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

Keywords: Archaic ego disorders; Dance; Dance therapy; Group; TATs (Thematic Apperception Tests).

Within the past few decades, various forms of body-centered therapies have been developed. This is an indication of the growing attention which is currently being accorded the body. Generally, it was not included in psycho-therapeutic concepts. *Petra Klein* coins the expression of the "forgotten body" [1]. Interestingly enough, Freud takes the bodily expressions of psychic processes seriously "instead of explaining them away as a system of mere conventions akin to semantics, or treating them as a simple mechanic reflex which behaviour psychologists would deduct from some form of conditioning" [2]. He actually developed a therapy involving direct contact to the body, the so-called pressure method, which he later, however, gave up in favour of the technique of free association. *Ferenczi* [3] and *Reich* [4], with their respective techniques of "neocatharsis" and vegetative therapy recognized the intensive correlation between the psyche and the body. However, it was only within the past decades that their work was incorporated into the field of psychotherapy.

Meanwhile, a large number of quite different body-centered therapies has come to exist: the *Pesso* system of psychomotor therapy [5], psychomotor therapy [6], the *Alexander* technique [7], the concentrative kinesiotherapy [8], bioenergetics [9], eutonics [10], integrative kinesio-therapy [11], sensory awareness [12], breathing therapy [13], rhythmic kinesio-therapy as a special form of rhythmics [14], rolfing [15], healing eurhythmics [16], Lomi therapy [17], Expression corporelle [18], and many others (cf. [19]).

Dance therapy is a special kind of body-centered therapy. In it, the objective is to spontaneously translate feelings into movement, to develop a relationship to one's own body, and to discover creative new potentials in oneself. Most other body-centered therapies concern themselves primarily with performing certain exercises which are supposed to improve body awareness, loosen tension and induce cathartic effects.

In dance therapy, the dance itself is regarded as an expression of emotions, conditions and needs as a result of the need common to all of mankind: to communicate.

Dance therapy was developed in the United States in the nineteenforties and was successfully practised in psychiatric institutions, especially in treating schizophrenic patients. All pioneers of dance therapy, such as *Liljan Espenak*, *Marian Chace*, *Mary Whitehouse*, and *Trudi Schoop* were dancers themselves. It was only in the course of their work that they sought to theoretically support their approaches. The point of departure was the new movement Modern Dance, in which the development of the personality of the dancers was possible. In Germany, this new movement was led by *Mary Wigman* and *Rudolf von Laban*. Increasingly, these dancers recognized how therapeutic the effects of their dance were for themselves, and how important it could be to use dance as a means to help others. Dance therapy was successfully applied as a therapy for handicapped children and for the elderly. Since 1970, dance therapy was introduced in Germany. However, it remained largely unnoticed in the treatment program of psychiatric institutions.

In the Dynamisch-Psychiatrische Klinik (Dynamic Psychiatric Hospital) in Menterschwaige, Günter Ammon developed the Expressive Analytic Dance Therapy some thirty-five years ago. It was his aim to create new possibilities of expression for those patients who often could not express themselves verbally: the so called unreached patients. It quickly became apparent that many patients could completely differently experience themselves in the dance therapy group than in other groups, and were also understood in a different way by the other patients.

It is common to all methods of dance therapy that their point of departure is the spontaneous movement in dance: this is referred to as "Basic Dance" in North American literature. "Basic Dance is the externalisation of those inner feelings which cannot be expressed in rational speech, but can only be shared in a rhythmic, symbolic action." [20].

All of them emphasize the close ties between bodily and psychic expression. The following movements in dance therapy can be outlined:

First, the therapeutic dance method according to *Marian Chace* [20] which works with four important

aspects: “body action” prepares the elaboration of psychic conflicts by activating the body and especially its pathologically tensed regions. “Symbolism” means that symbolic movements and positions are included and processed. In “kinaesthetic empathy”, the therapist reacts to the non-verbal communications of the patients, takes them up with his or her body and can thus participate in the feelings of the patient. “Rhythmic group activity” is another very important factor in her method. Rhythm is a basic prerequisite for coordination. The joint rhythmic experience in the group gives the participants the feeling of solidarity and security. *Marian Chace* was not orientated by a psycho-analytic or psychological school, rather, her work was oriented by her clients.

Trudi Schoop attaches great importance to the perception of the healthy means of expression of the patient [21]. The therapist should, according to her, be aware of his or her self-perception. The categories: empathic understanding, positive appreciation and authenticity are important to her method. She as well was not oriented by any psycho-analytic or psychological school.

Liljan Espenak was mainly influenced by *Alfred Adler’*s individual psychology [22]. It is important to her to have the patients develop a positive self-image, a feeling for their own power and vitality. This restores the capability for social integration which initially existed. She works with retarded and mentally handicapped children.

Mary Whitehouse is oriented by the Jungian understanding of the psyche [23]. She is concerned with establishing contact between the ego and the self; symbolic events, images and dreams should be included in this process. Active imagination serves as an important method. In it, unconscious images are to be brought into the conscious, which can then be dealt with on a therapeutic level.

Penny Bernstein has tried to integrate various approaches; her point of departure is the psycho-analytic theory of evolution joined to the stages of a child’s bodily development [24, 25]. Her basic understanding is marked by C. G. Jung; thus, she often uses symbols in communicating with her patients. In the process of dance therapy, she is mainly oriented by the Gestalt therapy. In it, a problem area is worked out and posited in the center of attention. The “unsettled situation”, the conflict not yet worked out, is brought to consciousness by adequate movement experiences.

Elaine Siegel follows the *Freud*ian psycho-sexual phases of development in her work [26]. She enters a psycho-dynamic symbiosis with the patient and allows him to regress to the point of his fixation. Thereupon, the patient-therapist symbiosis is dissolved in phases (cf [19, 24]).

It is the problem to all schools of dance therapy that they incur the danger of being eclectic: they lack a real integration into a theoretic concept. A further problem is the fact that dance therapy often cannot be integrated into the respective institution and into its concept of treatment.

In contrast, the therapy of expressive analytic dance developed by *Günter Ammon* since 1982 is embedded in his theoretic concept of human structurology. Human struturology is based on the concept of social energy, on a positive definition of the unconscious personality and its human functions and structures, on the spectral

theory with its holistic comprehension of personality and its integrated – or, in the case of illness, disintegrated multidimensionality, on the importance of the group and social-energetic, group dynamic fields [27-29].

"Human structurology was developed with an understanding of a constant procedural interplay of human functions influenced and developed in constructive, destructive and deficient ways (of primarily biological, centrally not conscious functions of human expression) with the functions of behaviour, abilities, thought, works, and affection" [29]. The most important central human functions are the body ego, anxiety, aggression, creativity, interior and exterior ego demarcation, narcissism, conceptual thought, sexuality, imaginative abilities and abilities to dream, sociability and ability to participate in groups. The total of all human functions constitutes a person's identity. The entire development of the human functions is based on *Ammon*'s concept of social energy [29, 30].

Expressive analytic dance therapy, via the integrating self-expression of the dancer, renders the growth of identity and a freer flow of the synergism between the experience of one's body, feelings and thought possible – beyond verbal speech. Within the protective space of the group, dancers can express themselves, they are able to experience their body ego and the limits of their body via their movements in this space and can enter into contact with themselves and the group via body language and their personal magnetism. In the dance performed within the context of a dance therapy group, patients can non-verbally express their ideal ego and different possibilities for identification. In addition, they receive social energy after the dance by the feedback from the group which subsequently enables them to change their reality ego.

The holistic experience of the dance takes place in the interplay of the body – via the play of muscles – and the psyche via the transformation of music to movement (cf. [31]).

The expressive analytic dance therapy is an intensive body-centered therapy. The following factors are of fundamental importance:

- the spontaneous and individual dance
- the body language and movements of the individual, performing in clothes chosen by the patients themselves
- the performance with music, without music, or with drums
- the group meditation, with or without an input at its beginning and without an input at its end which is a meditative concluding dance of the group
- the members of the group give the individual dancer feedback after his dance.

The social energetic field is of extreme importance for the possibilities of each dancer to express himself. The spontaneous and surprising dance of the individual also has a healing effect on the other members of the group while encouraging their creativity. This ressembles the healing dances of the Sufi [32] and of the Kung [33] (concerning the expressive dance therapy, cf. [31, 35-38])

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

1. the bodily expression, i. e. bodily self-esteem and possibilities for movement,
2. the access of the patients to their feelings and their ability to utter these feelings before, during and after the dance,
3. the anchoring within the group and the contact to it and
4. the ability to verbally express feelings, also within the context of verbal therapy, i. e. with the formal group therapy.

Method

The studied group undergoing expressive analytic dance therapy encompassed 30 patients, which means that one out of two patients in the clinic participated in it. All diagnostic and age groups were represented in the dance group; the duration of the stay of the patients was also different. Often, an enormous difference could be noted when working with a patient in dance therapy and then experiencing him or her in other groups of the clinic. The group existed since five years and was directed by Dr. *Ammon* and myself. Ten patients from this group were examined twice within three months. The examinees had been participants in the dance therapy group for different spans of time. The first examination took place after the first dance of the patient within this group. The repeat-examination took place three months later.

As the emotional experience undergone during a dance is extremely difficult to apprehend, an open interview with guiding questions defining the thematic blocks important to the examination seemed to be the most useful instrument for this study. In addition, the TAG (Thematic Apperception Test), a projective personality test, was used. Furthermore, for six patients, video recordings of their dances were consulted. As the interviews were concerned with exploring the subjective experience of a clearly defined event, in this case the dance, one terms them focussed interviews with guiding questions corresponding to the event [39].

The duration of the interviews averaged three quarters of an hour; they were structured, as already stated, by the guiding questions compressing the four thematic complexes described.

Results

The qualitative and quantitative results of the interviews, the TATs and the video recordings for all ten patients will be briefly related while concentrating on the most important results and tendencies to change

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

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

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

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

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

For nine patients, the feedback was very important. They were able to remember the glad reactions and comments. Only two remained mistrustful of the feedback comments. All in all, the importance of the contact to individual patients had increased. In dancing, the group was sensed more strongly and perceived more in the second dance. For eight patients, the feedbacks now corresponded more with their individual experience of the (second) dance.

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

Two patients state that they felt sadness and despair that they felt at a loss, small and helpless. One female patient felt a liberating eroticism and longing. After the dance, only two patients felt better and relieved, three patients were disappointed with themselves and did not really fell liberated. They felt that there was more to them. Five patients did not speak of their feelings after the dance. The experience of dances performed by others is seldom described, only by three patients. One is strongly touched and feels strong aggression, and a female patient only sensed something when the dancer entered into contact with her.

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

In concluding, one can say that a decisively larger number of patients spoke of their feelings in a much more differentiated and detailed manner: for example, feelings of love and warmth were uttered. They felt their anxiety more intensively and were able to experience aggressive feelings and sadness.

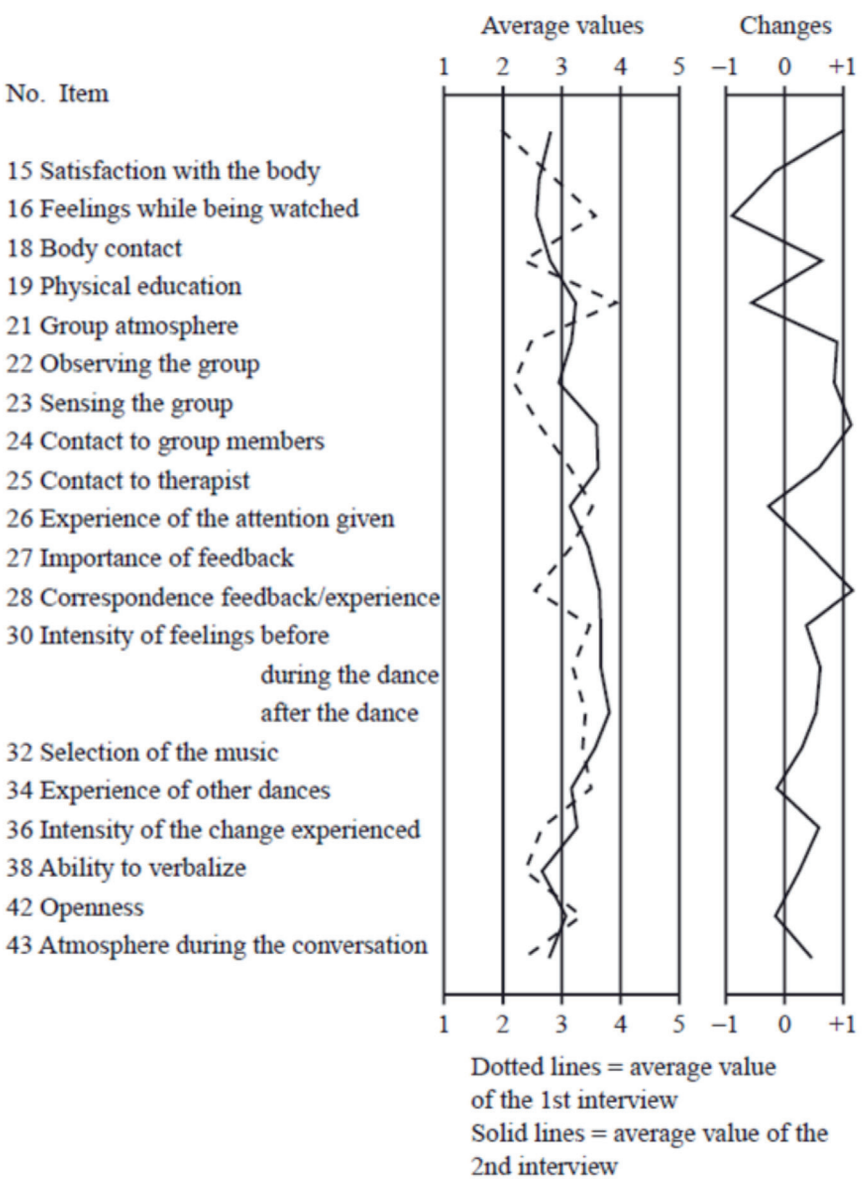
Concerning the area of verbal abilities of expression, it can be noted that eight patients were hardly able to speak about their feelings and about themselves after the first dance, and some of them were not at all able to do so. Two patients mentioned that they were well able to speak of their feelings and points of view – this was, however, not at all corroborated by their interviews. With the exception of one patient, all of the persons questioned stated that they were better able to show their feelings in the dance therapy than in other groups. While they were able to present themselves, they could speak only very little about their feelings.

In the second interview as well, all patients had great difficulties in verbalizing their feelings. However, they were generally better able to differentiate their feelings verbally, which can also be seen from the course of the interview. Only four patients stated that they could verbally express their feelings only with difficulty, one female patient said that she had problems in describing deeper feelings, one patient could verbalize feelings only with difficulty. Two patients were generally very quiet in groups. Especially because they experienced such difficulties in speaking about their feelings, the dance therapy was especially important to most patients as opposed to other groups. Thus, nine patients voiced their feelings that they had better access to their feelings

in the dance therapy group. Feelings could be better and more spontaneously expressed, one could fool the others less easily, one was more protected and could not be hurt as easily. The dance therapy group was more real for them. When questioned directly concerning the change they had experienced during dance therapy, the patients stated an improved relationship to their bodies, an improved access to their feelings and better abilities to establish contact with others.

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

FIGURE 1
Results of the ratings of the interviews



The ratings of the interviews show a good correlation with the qualitative evaluation of the interviews (see figure 1). In the area of somatism, the satisfaction with one's body had definitely risen, a tendency to change can be noted for the other items concerning somatism. Changes become most apparent in the area of the contact to the group. In almost all of the items noted, conspicuous improvements were noted, especially in the perception and sensing of the group, contact to individual members of the group and to the group leader, importance of the feed backs, and especially in the correspondence of the feedback with the own experience. This is an indication of the fact that self-perception and external perception became more closely connected. In the areas of emotional experience and verbal expression, the tendency to positive change can also be noted. However, the item «emotional experience» shows a decreased value after the dance. This can easily be interpreted in the following way when regarding the qualitative evaluation: the patients experience stronger feelings during the dance and thus, the importance of feelings decreases after the dance.

In evaluating the TAT statements, and comparing the first TAT with the second, one can say that a change has taken place where the stories told are concerned. In the stories related by eight patients, the characters can be generally more easily senses emotionally, they enter into clearer relations with another. In this process, four patients change more drastically, the other four rather less. The stories approach reality more, become clearer and let a relationship to the teller of the story become apparent.

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

TABLE 1
TAT-Ratings

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

(continued)

TABLE 1 (continued)
TAT-Ratings

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

TABLE 2
Ratings of the video evaluation

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

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

Discussion of the results: In comparing the two examinations, the interview and the TAT, and including the ratings of the video evaluations, it can be said that a relatively good correlation can be found between the statements made in the interviews by the patients and the assessments made by the raters of the videos. For all patients, tendencies for change can be seen in the different areas which must always be interpreted in connection with the overall therapeutic process. Patients who were very confined in the area of the body were able to develop a stronger relationship to their bodies as well as stronger emotions. This is mirrored by the results of the TATs in which the general mood becomes friendlier. This group of the physically confined patients can be counterposed to those patients who, while possessing a large repertoire of movements, were only able to show their feelings with great difficulty. For this group, it became apparent that in the second examination, they were able to develop stronger access to their feelings, for example to their sadness, but also to their aggression. At the same time, a certain quality of being real and able to be sensed became stronger. Changes in aggression and sadness became apparent for these patients also in the TAT.

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

The statements of the patients in the interviews, which took place directly after the dances, show that the patients were able to speak about their feelings in a more differentiated and detailed manner in the second interview. They showed more contact to the group and more trust in it and had begun to deal with their bodies

and their possibilities of movement. Most patients appreciate dance therapy more than verbal therapy. For many, the dance therapy group is the most important group for their development.

In considering the values discussed, one must keep in mind that the time allotted for the sturdy was relatively short (three months) – which is a very short span of time in the total duration of a therapy for more seriously ill people. However, in the four areas of study, important tendencies for change could be demonstrated.

This study is intended as a contribution towards showing the effectivity and the importance of expressive dance therapy.

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Submitted on: 14/04/2019

Accepted at: 08/02/2019