The KMP: A Tool for Dance/Movement Therapy

Susan Loman
Hillary Merman

Introduction

The Kestenberg Movement Profile (KMP) is a complex instrument for observing, notating and interpreting nonverbal behavior. It is a Laban-influenced system that expands on Laban Movement Analysis (LMA) (Laban, 1947, 1960; Lamb, 1965) adding refinement, new categories and a framework which is developmental. As such, the KMP lends itself naturally to dance/movement therapy, synthesizing nonverbal behavior with psychological theory and interpretation (Merman, 1990). Dance/movement therapists use the KMP for description, assessment, treatment planning, intervention and interaction with a wide variety of clients. Use of the KMP broadens and enriches the dance/movement therapist’s repertoire of skills for observation and intervention.

Historically, dance/movement therapists have been drawn to the KMP. As early as the 1960’s, several prominent dance/movement therapists studied with Judith Kestenberg, and Penny Lewis (1972) began to publish her theories and to teach them to graduate dance/movement therapy students. Susan Loman, originally a student of Lewis, trained further with Kestenberg and supervised dance/movement therapy interns at the Center for Parents and Children, co-directed by Kestenberg. Currently, Loman teaches the KMP to dance/movement therapy students at Antioch New England Graduate School. The KMP and its
concepts are being taught by Amighi, Goldman, Kestenberg, Lewis, Loman, Merman, Muniz-Lieberman, Sossin and others in dance/movement therapy graduate programs, in movement study centers and treatment settings via workshops and courses offered throughout the country and abroad.

**Overview of the KMP**

The KMP contains nine categories of movement patterns representing two lines of development, a description of the body attitude (the individual's habitual manner of aligning the body and additional descriptive information not notated elsewhere in the KMP) and quantifying numerical data. This information is plotted on a diagram or chart, which gives an overall view of the subject's Profile (see Figure 1).

The KMP can be divided into two major subsystems called the Tension-flow-Effort System or System I and the Shape-flow-Shaping System or System II. System I includes all the diagrams on the left side of the Profile and System II includes all of the diagrams on the right side of the Profile.

System I documents a line of development beginning with movement patterns available to the fetus and newborn and continuing throughout life (tension-flow rhythms and tension-flow attributes) which describe inner needs, feelings and affects. The System evolves to more adult patterns reflecting responses to environmental challenges (pre-effort and effort). System II documents a line of development dealing with relationships to people and things. The top diagrams on the chart, bipolar and unipolar shape-flow, represent movement patterns available to the fetus and newborn which continue throughout life. They describe, respectively, symmetrical and asymmetrical dimensional body expansion and contraction; shape-flow design represents movement pathways towards and away from the body; shaping in directions represents patterns which form linear vectors; and shaping in planes represents elliptical designs within one or more spatial planes.

In psychological terms, System I describes a line for ego development and System II describes a developmental line for object relations. In interpreting a completed KMP one looks for comparable development in both Systems. Movement patterns in System II provide structure for dynamic movement patterns in System I. There are varieties of combinations of movement patterns possible which indicate affinity (a good fit between patterns) or clashing (patterns which do not support each other).
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Figure 1

KMP Diagram Plotting

Body Attitude:

Tension Flow Rhythms

BiPolar Shape-Flow

UniPolar Shape-Flow

Tension-Flow Attributes

Shape-Flow Design

Precursors of Effort

Shaping in Directions

Effort

Shaping in Planes
Tension-Flow

Tension-flow is defined as alternations in the flow of muscle tension. The range of muscle contraction and release is described by free flow (unrestricted predominantly agonist muscle movement) and bound flow (restricted movement with a great deal of antagonist muscle involvement). Free flow corresponds to release and continuity (as seen in a fling of the hand). Bound flow corresponds to inhibition and discontinuity (as in clenching a fist). Bound flow can occur in response to danger and expresses caution. Free flow can occur in response to feeling safe and reflects ease. Neutral tension flow occurs when there is a loss of muscle elasticity resulting in limp, rag-doll type movement (free neutral flow) or doughy, wooden, inert-type movement (bound neutral flow).

According to Kestenberg (1985a), tension-flow is defined as:

a succession of changes in the tension of the body. The basic rhythm of tension flow is an alternation of free and bound flow of tension, which reflects the facilitation and inhibition of nervous impulses... Attunement in tension flow occurs when tension-flow changes in one person lead to similar changes in the other person. Empathy is based on the perception of tension changes (p. 163).

Tension-Flow Rhythms. Tension-flow rhythms are patterns of changes in muscle tension which occur in regular or irregular intervals. They are observable in ten developmentally based patterns: sucking, snapping, twisting, straining, running, stopping/starting, undulating, surging, jumping and spurting. The rhythms are categorized as either indulging or fighting.

All ten rhythms are potentially available to the fetus, later serving age-appropriate functions and remaining as a substrate in the adult's movement repertoire. In interpretation, specific tension-flow rhythms are connected with particular modes of drive discharge and need satisfaction. An individual's preferred manner of dealing with drives and needs is reflected in their predominant tension-flow rhythms. When two or more individuals share similar tension-flow rhythms, the core of empathic communication is present.

Tension-flow rhythms reflect early needs, drives, feelings and specific developmental issues and achievements. Kestenberg (1985b) believes that each of the rhythms is derived from primary biological functioning. The development of the rhythms is associated with both physiological and psychological maturation. The sucking rhythm, for example, is used not only for nutritive sucking, but may be used for self-soothing, affectionate patting, nodding, and rocking. The straining rhythm is the prototypical rhythm for defecation, but it is used for climbing, crawling,
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pushing, and marching activities, too. Because these rhythms derive from basic biological needs, knowledge of an individual’s tension-flow rhythms gives information about needs and drives, developmental stage attained, level of fixation or regression, and the ratio of indulgent to fighting qualities. Comparing two or more tension-flow rhythm diagrams (e.g., those of a mother and child) cues one to the relative attunement and/or clashing likely to appear in interaction on the level of needs.

Rhythms originate in a specific body zone to serve primary biological functions but continue to develop and spread to other parts of the body. They may be visible in movement patterns which cover a wide range of activities.

Tension-Flow Attributes. Tension-flow attributes describe the elasticity of muscle tension (bound and free flow) and the continuity and discontinuity of movement. They regulate the flow of tension and occur in more specific feelings of pleasure and safety (ease) and of displeasure and danger (caution). Preferred patterns of tension-flow are the substrate of a person’s temperament (Kestenberg & Sossin, 1979). Tension-flow attributes serve the expression of feeling tones and needs and reflect an individual’s temperament and characteristics of arousal or quiescence (Sossin & Loman, 1992).

Being aware of the nonverbal aspects of affect can assist the dance/movement therapist in assessing the specifics of a client’s repertoire of feelings and temperament (Lewis and Loman, 1992). The dance/movement therapist’s own tension-flow attribute preferences are brought into the therapeutic process; they may influence which clients the therapist can attune to more easily. A great breach of attunement, especially in the early trust building phase of treatment, interferes with the ability to make contact, foster understanding, and empathize with clients. Ideally, the dance/movement therapist would have awareness of and access to all of the attributes so that she could relate to whatever feeling state the client presents.

Goals for treatment can be based on the assessment of the client’s repertoire of tension-flow attributes. The ratios of free to bound movements people use gives information about how unconstrained or careless or how restrained and anxious they are. Too much restraint inhibits functioning; too much free movement signals a deficiency in control. Healthy functioning strikes a dynamic balance between bound and free flow, so that most movement alternates rhythmically on a continuum between the two polarities. Other relevant diagnostic features include measures of complexity or simplicity of affect expression, the ratio between controlling and spontaneously expressing feelings, and information about animated versus deanimated movement qualities.
Precursors of Effort (Pre-efforts). Whenever one tries very hard to do something new or uncomfortable, the focus is more on one's own body and how it is going to function than on coping with space, weight, or time. As a result, pre-efforts are used and are helpful in the learning stage. Once an activity is learned, however, efforts will emerge and movement will occur more efficiently.

Assessing a patient's defensive make-up and learning style in movement gives invaluable clues to inner dynamics, developmental level, diagnosis, expectable behavior, and potential for improved coping. Knowledge of and use of pre-effort can be especially useful in short-term treatment where, due to the nature of the setting, assessment and intervention must occur quite rapidly. In addition, use of precursors over time enables the therapist to see, monitor, and work with these movement qualities which bridge unconscious and conscious processes.

The use of precursors can also introduce new movements which expand the range of needed defenses available to the individual. An example of this might be working with gentleness to foster reaction formation in overly aggressive individuals. The therapist can also strive to develop available precursors into efforts, such as developing channeling into directness.

Efforts. Defined by Laban (1947; 1960), efforts are movement qualities which express attitudes toward the realities of space, weight and time. They are used to cope with the physical environment. Individuals gradually develop their own characteristic distribution of effort elements. The line of development of an effort element may be traced back to a specific precursor of effort and, even further, to a specific tension-flow attribute pattern. A mature constellation of effort elements shows an individual's preferences in terms of attention, intention, and decision-making (Laban, 1960).

Maturation of movement patterns enables individuals to have an impact on the environment. A value in dance/movement therapy with adults is to achieve dynamic movement as seen in the use of efforts. Providing patients with the opportunity for self-expression while developing immature qualities into more mature patterns can help them reach the goals of improving impulse control, coping, and social skills.

Shape-Flow

Shape-flow refers to the alternations of growing and shrinking in one or more dimensions (width, length, and depth) of the body. Variations in body shape are used to express changes in one's affective relationship to
the environment. People respond to general environmental conditions (air, temperature, light, etc.) with symmetrical (bipolar) changes in shape and respond to discrete stimuli with asymmetrical (unipolar) changes in shape.

In “shrinking” one feels an inner pull which brings the outer part of the body closer to its inside, and lessens the body’s exposure to the environment. In “growing” one feels an external pull which stretches out the body, and increases its exposure to the environment. Kestenberg (1985a) defines shape-flow:

> a succession of changes in the shape of the body. The basic rhythm of shape-flow is an alternation of growing (as in inhalation and smiling) and shrinking (as in exhalation or frowning). The respiratory rhythm is the core mechanism that gives shape to the body... Expressive movements are based on derivatives or direct expressions of changes in breathing. The range of trust and mistrust is based on taking in what is good and ejecting what is bad. The proper balance between the two engenders the feeling of trustworthiness in the self and others (p. 162).

Shape-flow serves early sensations of comfort and discomfort, attraction and repulsion, and creates a structure for feelings of safety and support. Shape-flow patterns provide a means to express and structure internal feelings about relationships. When people feel safe, for example, they tend to “grow,” enlarging their body boundaries. On the other hand, growing while in an unsafe environment may produce a clash between internal feelings and their outward expression. When there is a disturbance in the balance between feeling and expression, individuals may move in conflicting movement patterns and have difficulty communicating their needs and feelings effectively in relationships.

**Bipolar Shape-Flow.** From birth, bipolar shape-flow serves the expression of self-feelings, providing the nonverbal medium for demonstrating feelings and moods related to pleasure and displeasure. The body responds to the global environment through expanding (growing) and contracting (shrinking) movements in horizontal, vertical, and sagittal dimensions. The infant and caregiver, through shared shape-flow patterns, may develop a relationship based on mutual support through interactions such as adjusting to each other’s breathing and holding patterns. Trust develops out of the predictability inherent in compatible breathing rhythms and supportive holding patterns.

**Unipolar Shape-Flow.** Unipolar shape-flow, which exists in utero and throughout the life span, provides the source for approaching people
and withdrawing from unpleasant or noxious contact. It serves as a basis for communication, interactional rhythms, and the core of attraction and repulsion. The body grows toward and shrinks from real or imaginary stimuli that can be attractive or repelling. People grow when they feel comfortable and express satisfaction, increasing contact with others. Shrinking reduces relatedness as the body responds to pain and unpleasant feelings. A rhythm of growing and shrinking helps to form non-verbal interaction styles. Through unipolar shape-flow patterns, the infant can grow and shrink asymmetrically in response to specific stimuli and people in the environment. The infant can now reveal, through expanding and contracting shapes, which interactions are attracting (by growing) and which are repelling (by shrinking). The unipolar shape-flow patterns provide the structure for discriminating between and responding to feelings of safety and danger.

**Shaping in Directions.** Extending body boundaries between oneself and another can be articulated through shaping in directions. These spoke-like and arc-like movements are used to create bridges to people and things in space (such as pointing to someone) and to form protective boundaries used in defending oneself. The ability to erect clear boundaries for self-protection is considered a more developmentally advanced step than unipolar shape-flow. In unipolar shrinking, for example, the individual can only become smaller and shrink away from a dangerous environment or an attacker. When using shaping in directions, however, the individual is able to protect the body by creating linear vectors in space that can shield the body from an attacker (i.e., raising the arm to ward off a blow from above).

**Shaping in Planes.** The most advanced level of interpersonal relationships can occur through shaping in planes. The mover creates concave and convex multidimensional forms that carve space in combinations of horizontal, vertical, and sagittal planes. Unlike spoke-like and arc-like movements, shaping in planes involves elliptical movements which create trace forms, outlining a volume of space. They can represent three dimensional aspects of interaction and are often seen in animated conversation where the participants are fully engaged.

These planes also reflect developmental maturation. In the first year of life, the child is learning to explore large and small spatial areas in the horizontal plane. As the child begins the second year of life, he or she is utilizing the vertical plane to climb, stoop, stand, and confront the world. During the third year of life, toddlers are off and running in the sagittal plane. They have no time to discuss nor will they listen to confrontations; they are gone before the speech is over.
KMP Concepts

Attunement in Tension-Flow and Adjustment in Shape-Flow: The Basis for Empathy and Trust

One of the basic tools for nonverbal intervention utilized by dance/movement therapists is mirroring, a global term referring to the therapeutic movement relationship between therapist and client. The Kestenberg Movement Profile is especially useful to dance/movement therapists by providing guidelines which enable the therapist to refine ways to mirror through kinesthetic attunement in tension-flow and adjustment in shape-flow (Kestenberg, 1985a).

Attunement. Attunement, the process of responsively duplicating changes in muscle tension, is based on mutual empathy. The shape of the body does not need to be matched (Loman, 1991). During attunement, the therapist (attuner) responds to the mover’s physical needs and feelings. “Visual attunement” is accomplished while looking at, but not touching the mover. For example, if an infant kicks his legs vigorously, the therapist can identify how this movement feels by simultaneously moving a body part of her own, such as her hand. The attuner would not have to kick her own legs (Loman, 1990). “Touch attunement” is similar to “visual attunement” but includes the component of touch. In “touch attunement,” the attuner might place her hand on the mover and match the tension changes felt in that hand, while moving with the mover in the same rhythm and degree of tension exerted. There may be little movement at all, apart from small changes in the contraction or stretch in the muscles. While attuning, movement may be felt in the hand alone or throughout the whole body. The numerous variables and sensory combinations inherent in empathic attunement are described by Stern (1985) as “intermodal attunement.” As he states:

There are some qualities or properties that are held in common by most or all of the modalities of perception. These include intensity, shape, time, and number. Such qualities of perception can be abstracted by any sensory mode from the invariant properties of the stimulus world and then translated into other modalities of perception. For example a rhythm such as “long short” (_____), can be delivered in or abstracted from sight, audition, smell, touch, or taste (p. 152).

Responding with visual, touch, or auditory/vocal/verbal attunement can soothe an upset child or adult and lead to mutual understanding.
The degree of tension exhibited by the mover can be matched initially and then developed into less intense, more soothing patterns (Loman, 1980). Crying infants respond well if their rhythm and intensity level is matched, rather than met with the polar opposite quality of gentleness.

Adjustment. Adjustment, the process of responsively duplicating movement patterns regulating the breathing rhythm is based on mutual trust. Here, the tension changes do not need to be matched. Distinguishing which qualities are being responded to (tension-flow or shape-flow), can enhance the therapeutic process. The therapist can attune to the client’s movements, provide empathic support through shared muscle tension, and adjust to the shape of the client’s body (symbolizing the actual physical support of the mother), enhancing a trustworthy and predictable relationship that allows the client to engage more comfortably in the therapeutic process.

When therapists match only the shape of the body but not the dynamics, the structure for feelings is matched but not the feelings themselves (an example of adjustment without attunement). The therapist wishes to communicate not only empathy and understanding, but also support, structure, and confidence (Sossin & Loman, 1992).

Dance/movement therapists can begin to demystify the reason that their interventions are effective or not, both theoretically and practically, by learning such KMP concepts of tension-flow attunement and shape-flow adjustment which help to refine the more general concept of “mirroring.” A dance/movement therapist familiar with her own shape- and tension-flow movement preferences is able to enter into the therapeutic relational process with greater clarity. Therapists have their own movement preferences, however, which may enhance, but also may clash with the movement patterns of those with whom they work. At times it can be especially difficult to attune to certain clients.

Clients who demonstrate an excess of neutral flow characterized by a lack of animation, limpness, woodenness, or blankness may challenge the therapist’s resources because there is such minimal movement expressed (Sossin & Loman, 1992). The KMP framework can make unpleasant affects, passivity, and the seeming absence of movement tolerable and understandable to the therapist (and so, to the patients). As it remains the “therapist’s major responsibility and task to help move the relationship back into connection from periods of disconnection” (Stiver, 1992, p. 6), it is of benefit for the therapist to have an in-depth understanding of his or her personal movement preferences as well as inhibitions. This conscious awareness towards self-empathy and an embodied relationship serves as the vessel for both the creation and expression of often ambiguous and conflictual feeling states (Lewis, 1993). The dance/movement therapist can then make informed choices based on ob-
served and felt clues as to where and how to join, structure, and effect change with patients.

The KMP in Dance/Movement Therapy

Dance/movement therapists have been quite successful in their ability to establish relationships with clients, empathize, and provide a vehicle for transformation and healing through the use of the body. The therapeutic process, however, is difficult to quantify. Clearly describing the nonverbal aspects of the therapeutic process has been challenging. One of the aims of this paper is to show how the KMP can help dance/movement therapists communicate their work to others.

The KMP can be used for pre- and post-testing to determine whether or not treatment has promoted change. The KMP framework can be used to guide therapeutic choices within a session, and to track progress over time. For example, it can be used to analyze the effects of specific movement interventions on subsequent interactions. The KMP supports the therapist’s intuition by providing a rationale and a means of measuring the success or failure of interventions.

Suzanne Hastie Atley (1991), a dance/movement therapist who wrote her master’s thesis on the use of the KMP, states:

Because dance therapy work naturally involves and requires a great deal of intuition, observation and assessment are absolutely necessary in order for there to be balance in the work (pp. 86–87).

Connecting the notation and diagraming processes to the therapeutic realm, Atley states:

After notating and tallying up the data... the dance therapist will get a sense for the ratio or percentage of these qualities in a client’s movement repertoire, which will represent in more concrete terms just how inhibited, cautious, carefree or deanimated one is... it gives dance therapists a clearer and more refined sense for their clients... Secondly, it gives concrete form (a percentage value) to a hard to quantify area (a movement quality), facilitating diagnosis and writing and speaking about clients (pp. 97–98).

The KMP can be used for assessment and as a research tool (using the entire system) or it can be adapted to the clinician’s particular needs. The concepts can be used even if the KMP is not formally constructed. For instance, Hillary Merman created an assessment form and research
tool based on the KMP and drawing on LMA which is in a check-list form (Merman, 1986; 1990).

Atley suggests that:

> It is important to state... that the profile can be used and interpreted in movement terms alone; its use does not require the integration of a psychoanalytic perspective. Learning the profile is a grounding experience, helping one to identify and understand more about... nonverbal communication... (pp. 228-229).

For example, Janet Lemon (1990) wrote her master's thesis on the application of the KMP in professional sports and profiled the American football player, Joe Montana. In order to appeal to an audience interested in sports, she modified the KMP language to fit her specific application of the work. None of the terminology she adopted was linked to any particular theory.

However, many dance therapists, as psychotherapists, do seek a clear theoretical orientation to their work and a bridge between psychodynamic psychotherapy and body movement. Dance/movement therapists have several options to best fit the KMP into their own therapeutic styles and theoretical orientations. They can choose whether or not to use psychoanalytic language and theory. The KMP which traces ego development (System I) and object relationships (System II) through movement, can provide this link. Other theoretical orientations to movement and therapy have and can be applied compatibly with the KMP. These include Laban Movement Analysis, gestalt therapy, self psychology, the relational model and family therapy, to name a few.

As the KMP observes natural movement processes, not requiring the client to follow any specific instructions, it can be used with populations of all ages and levels, verbal or nonverbal. The KMP outlines an individual's level of developmental functioning, movement preferences (including strengths, potentialities, deficits and weaknesses), areas of psychological harmony and conflict, and ways of relating to others (historically and in the present).

Movement patterns evolve and change as the individual matures. The KMP outlines a predictable sequence of movement development which parallels normative psychological development. The following brief description of Chace's work with an autistic child provides us with a glimpse of her use of a developmental orientation:

> ... you go back through the developmental pattern in a rhythmic movement session... you go back completely to the infantile developmental stages, working through them as the child is ready and capable of doing so... (Chace, 1975, p. 221).

A knowledge of normative development provides the dance/movement therapist with a foundation for work with clients of all ages. For exam-
ple, in work with children it is helpful for the clinician to be aware that there is a wide range in normal development, and that a distinction exists between diagnostic symptoms and a breakthrough into normal developmental patterns. In both children and adults, the KMP can show areas of fixation or regression and opportunities for progression.

Dance/movement therapists working with families can use the KMP to compare the profiles of two (or more) family members. Personal preferences in movement and interpersonal harmony and clashing can then be identified and measured. When traumatic events such as abuse, separation and illness impede the normal growth process, reactions get stored in the body and are reflected in body movement (Loman, 1990). Through movement observation the dance/movement therapist can assess developmental-relational issues which may be troubling the family. Based on the KMP assessment, treatment plans can be developed and implemented before individual and family problems become too severe.

Regarding training, specific benefits of learning the KMP include: a fine tuning of observational skills and heightened kinesthetic sensitivity; expanded movement repertoire including access to early developmental rhythms and patterns; increased ability to empathize with others via movement and increased self-knowledge.

In clinical practice, the KMP framework is orienting and focusing for the beginning and advanced practitioner. With all populations, the KMP helps the dance/movement therapist find meaning within a range of behaviors: what is developmental, skill building, relational, or maladaptive? Movement concepts embedded in the KMP offer a range of intervention possibilities which are based on theoretical understanding. Some of these key concepts are: attunement, adjustment, empathy, clashing, holding patterns, body alignment, and the sequence and meaning of movement phases of development.

Both authors are dance/movement therapists who have benefited from the Kestenberg Movement Profile and its concepts in their clinical work. Vignettes from our work with a variety of child and adult clients will be used in the following sections of this paper to help illustrate the value in using this system.

Clinical Case Examples

Attunement with a Child

Loman describes the following case vignette to illustrate attunement concepts with an autistic four-year old boy (Loman, 1995):

I attuned to the child's movements, which provided him empathic support through shared muscle tension. I also adjusted to the shape of
his body, promoting trustworthy and reliable interactions that allowed him to develop a nonverbal relationship at his own pace. He began this particular session by marching around an exercise mat in the middle of the therapy room. His shoulders were tense and raised; his body appeared rigid. He lifted his knees up high, while making thumping sounds with his feet. He vocalized a short “e” sound every time he stepped down. I duplicated his marching rhythm by patting my hands on the mat in time with the rhythm of his feet. I also joined him in the “e” sounds.

He noticed my patting sounds, smiled, and changed his march to quick, short runs. I matched these changes by quickening and slowing down the beat in response to the child. Maintaining eye contact with me while repeatedly switching from running to marching; he watched to make sure that I followed his variations. He looked away, turned away, squinted and laughed playfully. When he looked away, I looked away; when he squinted at me, I squinted back at him.

The child then changed the pattern of circling around me to running away from the circle and returning to a spot behind me. He turned around, squinted, laughed, and ran back to me. As he left the circle, I began to lean my body back to look at him, which made him laugh. This developed further as I lay back every time the child left the circle, and returned to a sitting position when he re-entered the circle. Through my action, I responded to the child’s change in pattern with a similar, although not identical, change. I decided to remain lying down once, in order to see how he would react. He approached, and when I didn’t get up, he put his hand on my knee in a gesture that seemed to indicate that he wanted me to sit up. When I responded by sitting up, he smiled, laughed, and maintained eye contact with me.

A pattern developed between us. When the child ran to the corner, I lay down, and then he ran back, he touched my knee to get me to sit up. Later, he used more strength to push my head up. When it was time for the session to end, I offered him my hand. We marched hand in hand back to the classroom making “e” sounds and smiling.

This was the first time the child showed some continued awareness of me through maintained eye contact, smiling, vocalizing, and touch. A new trust seemed to develop which allowed him to take initiative and exert some control over the environment, exhibited by his touching my knee and head to lift me up. Responding to him by duplicating his rhythm via “intermodal attunement” (Stern, 1985) instead of imitating his march, seemed to enable the child to respond to me more creatively.

The development of a movement ritual helped establish a predictable form for structuring the relationship. A consistent “holding environment” (Winnicott, 1965) and sense of continuity can be created in therapy by providing sameness over time both in the physical layout of the
therapy space and in the consistent presence of the dance/movement therapist. Predictability in a relationship provides the form from which trust can flourish. Creativity, spontaneity, and emotional dynamics can all be contained within a consistent structure.

This child was able to relate with me, within the safety of the ritual, until he was ready to try new and spontaneous patterns. The ritual was created initially when I matched rhythmic sounds (movement empathy) to the beat of his marching movements. It became more elaborate as the sessions progressed, and then began to diminish as he was able to establish the beginning stages of a genuine interaction. It is evident in this interaction that attunement on an embodied level helped lay the foundation for the development of a mutually empathic relationship.

### Developmental Issues

**Developmental Phases**

*With Children.* To demonstrate how developmental phases reveal themselves in creative expression in young children, Loman (1994) describes work with children during the ages when particular rhythms are dominant. The examples come from a group for parents and children offered through Antioch New England Graduate School’s Dance/Movement Therapy Program:

A popular theme for three-year olds is the creation of big and small ocean waves with the parachute. The children can swim in the ocean on top of the waves, or go underneath the parachute and swim underwater. Images of fish swimming, finding their houses, and avoiding monsters help to keep the activity interesting. These suggestions reflect inner-genital themes typical of the three-to-four year old: feeling vague inner bodily sensations, wishing to be soothed by the mother, wanting to know where babies come from and to have a baby, wanting to remember one’s babyhood, and feeling maternal (Kestenberg, 1975). Embodying and exploring creatively on this developmental level contribute to the group’s cohesion and to the children’s growth.

A group of four-year olds enjoys the activity of pretending to be popcorn, choosing to grow small as kernels prior to popping, and becoming big and jumping when ready to be “popped.” Finally, they decide when the popcorn is ready and whether they will have a party. The themes of growing large and more powerful, shooting through space, and enjoyment of strong motor activity all reflect outer-genital phase-specific issues and the age-appropriate movement needs of these children.
With a background of knowing how to help children channel age-appropriate movement into creative outlets, the therapist can help children express intense movement qualities within the safety of the therapeutic container. The dance/movement therapist can adapt to a client's needs, which is especially important when the client is making the transition to a more mature phase of development. The KMP approach can further an understanding of the sequence of movement phases typical in development and enable the therapist to provide a suitable environment in which the developmental process can evolve.

Developmental Sequencing

Adult Case Example. In the following case example Merman begins with tension- and shape-flow, uses indulgent attributes, and moves up the developmental ladder to more mature qualities in pre-effort and directional movement:

In this first group with middle-aged and older adults in short-term inpatient treatment, I noted the dominant group mood of depression and withdrawal expressed in the predominance of neutral tension-flow and channeling, and in the lack of eye contact, speech, and relatedness. Where to start? How to mobilize?

In this group the members sat in chairs in a circle; I put on rhythmic, non-intrusive music. I sat quietly with the patients and then invited them to feel how heavy (neutral bound flow) they felt, to become aware of the support of the chairs behind their backs and under their seats, to feel where their bodies felt comfortable or uncomfortable that day. I asked them to become aware of their breathing, and how their backs grew wider on the inhales, and a bit more narrow on the exhales (this was based on a stance of bipolar widening in shape-flow in body attitude observed in many group members). I then asked the patients to rub their backs gently against the back of the chair, thus introducing some flow adjustment, and to try lifting and dropping an arm to the side (low intensity bound to free flow with graduality). These affined attribute qualities helped them move from neutral flow, reflecting feelings of depression, caution and helplessness, to indulgent attribute qualities expressive of calmness, patience, and adaptability. By using their “heaviness,” they began to move side to side in the horizontal dimension (a developmental prelude to communicating in the horizontal plane).

I noted the clash of bound tension-flow with bipolar widening, which indicates caution while growing into the environment as though comfortable (Kestenberg & Sossin, 1979). Bipolar shape-flow, which occurs very early in life, expresses global feelings of comfort/discomfort. Recognizing the level of regression of these patients, their need to be given to
and to take (Erikson, 1950), I used the space, chairs, my voice, and directions to provide support and structure, to “feed” them, and to go with the resistance at the same time. As they felt supported and accepted, they were able to get in touch with themselves on a body level.

Soothing rocking movements, reflective of the early oral stage of development, ensued followed by rhythmic opening and closing of the hands in the same quality. Active patting and massaging of body parts helped to increase self-awareness and self-nurturance. More energetic tapping of hands and feet followed in a biting type of rhythm, serving heightened alertness, definition of body parts and boundaries, and differentiation (Kestenberg, 1975). The group was able to synchronize while moving in these rhythms. As individual mobility and group energy increased, patients began to become aware of each other, to look, speak, and interact; pre-effort began to appear in their repertoires.

Hesitation and then gentleness (precursors of deceleration and lightness in effort) were used for reaching across to shake hands and for patting a neighbor’s hand, shoulder, knee, or foot. Participants no longer relied solely on my suggestions but spontaneously offered their own. The group mood changed from isolation and depression to one of tentative and then pleasant greeting, discovery, and sharing.

Psychiatric patients often show extreme exaggerations or restrictions in movement (Bartenieff & Davis, 1972). From a KMP perspective, such patients often use a small range in more mature qualities (effort and shaping) and rely on overuse of one or two precursors. There may be a predominance of tension-flow rhythms, and the use of space may be severely restricted. Expanding the range in pre-effort promotes new ways of learning. In the above example, patients made contact slowly and carefully using hesitation and gentleness in pre-effort. They were not ready to delve more deeply but had the positive experience of meeting each other as it felt safe and controlled by them. Learning in this context could mean that total withdrawal from others may not be necessary; the alternatives of protecting oneself and going at one’s own pace exist.

Channeling Aggression with Adults

Merman describes a dance/movement therapy group with developmentally delayed/emotionally disturbed adults in a day treatment setting:

The group members came in upset and agitated, shoving furniture, cursing; some were standing and rocking violently, others kicked a large therapy ball with vehemence, abruptness, or strength. The potential for the acting out of aggression was great. I invited members to use their hands (rather than feet) to hit the ball across the floor to someone in the
room. After modeling this activity to introduce attention in space, I directed group members to smack the ball right in front of themselves before passing it to the person next to them. My modeling that action with affect gave group members permission to express symbolized anger at the ball. As this reflected their moods (anger, frustration and fear) and their preferred movements, I was able to ameliorate their fighting patterns by introducing direct focus, bound flow, and containment in space, creating a safer structure for the emotional expression.

Because the anal straining rhythm is of relatively long duration, it has an organizing influence on other rhythms and can have an organizing influence on fragmented, volatile patients. It also provides a more appropriate way to assert oneself without endangering others. Observing and responding to a group member's pushing action, I asked each person to give the ball a push right in front of themselves, long enough to “really press as hard as you can . . . see how strong you can be”. The directive was suggested to assist the patients in transforming their unrestrained free flow to more self-awareness, containment, and caution in bound flow. The pushing motion was accompanied by grunts, exhalations, and other vocalizations. The activity led to several variations on the pressing theme including: picking up and squeezing the ball, trying to crush it by sitting on it, and pushing a knee into it. The precursor of effort quality of straining was often used. Spontaneous verbalizations proclaimed “bad ball”, “go away”, “I hate you”, etc., and the mood shifted from one of helplessness to enjoyment in shared self-expression and skill development. As the high intensity decreased and self-control increased, group members could throw the ball through space to each other with intentionality and mastery in effort. The less mature temper-tantrum movements reflective of aggression and control issues typical in the second year of life (anal phase) had been transformed to the more mature qualities of the phase: assertiveness, representation, and presentation. Qualities of directness and strength were matched with harmonious directional and shaping movements. Tired, they sat in chairs, able to engage in a “cool down” of recuperative, indulgent movements, and to verbalize briefly about their earlier feelings of anger.

Once boundaries and safety were established in the group, the initial movement qualities of tension-flow and attributes could be developed to more adaptive ones (bound flow, graduality), then to precursors (straining, channeling) serving missing but needed defenses, and finally to effort. This particular population had suffered much abuse in the past. The group members tended to lack indulgent patterns and showed an excess of fighting ones. Prone to identify with their aggressors and to disorganize readily, they could be quite dangerous to themselves and to others. Developmental dance/movement therapy was the treatment of choice for
these patients with poor cognitive skills and language ability. This ses-
sion is an example of providing patients with the opportunity for self-ex-
pression while developing immature qualities into more mature patterns
with the goals of improving impulse control, coping, and social skills.

Relational Development

The developmental progression inherent in the framework of the KMP
can provide the nonverbal foundations of relational development. The
KMP offers movement descriptions beginning with early infant-caregiver
interactions, evolving into more multidimensional and complex interac-
tions. For the purposes of exploring relational development, the right side
of the KMP, which documents a line of development dealing with rela-
tionships to people and things (Loman, 1990) will be focused upon.

Group Dance/Movement Therapy Example. Merman offers a case ex-
ample of a dance/movement therapy group with higher functioning adult
partial hospital patients to illustrate a relational progression leading to
shaping in planes:

The group begins with a movement warm-up in a circle. These clients
have been together for awhile and share leadership. They move in a lin-
ear fashion using directional shaping, reflecting simplicity or defensive-
ness in their object relationships.

In order to work with their preferred patterns and address relational
ability, I structure a section of the session drawing on the defense scales
of Laban (Bartenieff & Lewis, 1980): “Reach up, down, across, to the side,
back, forwards, now add words: I feel up, down, etc.” The patients begin
to verbalize feeling words for the directions on their own. The forward
movement brings them close together, and some begin to move in a more
effortful way, sharing dynamics and emotions.

Moving sideways and across (horizontal dimension) they say playfully,
“get away from me,” “leave me alone” and “get over here,” etc.; in the ver-
tical dimension (up and down) they offer “no,” and “yes” while mock ar-
gruing, asserting, and presenting themselves. As they become more in-
volved, the linear movements become fuller and shaping begins to
emerge. By the end of the session, they are holding hands and performing
in intricate bows while retreating and courtly greetings while advanc-
ing in the sagittal plane, ascending with lightness and descending with
strength in the vertical, and spreading to and enclosing each other for
hugs in the horizontal plane.

Defensiveness has given way to exploration of relationships. The pa-
tients then discuss their preferences for the different directions and
planes, connecting those feelings which stood out for them to people in
their “real” lives. Some state that they have had a new experience: hav- 
ing fun with all their feelings (even the “unacceptable” ones) while oth- 
ers mirrored, echoed, accepted and enjoyed all they offered (Miller, 

**Summary and Discussion**

All of the diagrams of the KMP fit together to create a comprehensive 
tool for movement analysis. The KMP captures the multiplicity of move- 
ments and their diverse forms of interaction in a way that is both com- 
plex and exceedingly organized. The KMP does take time to master. Un- 
like rating scales, the KMP is a complex instrument, requiring skilled 
and experienced notators.

Dance/movement therapists are currently using the KMP for research 
and to enhance their skills at observation, diagnosis, treatment planning 
and intervention (Atley, 1991; Berger, 1994; Binette, 1993; Bridges, 
1995; Loman & Brandt, 1992; Loman, Ender & Burden, 1994; Loman & 
Foley, 1996; Merman, 1990; Ojala, 1995; Stupka-Malloy, 1992; Watkins, 
1995; Williams, 1994).

KMP profilers have applied the KMP in a variety of ways. Some have 
used the profile to obtain diagnostic information and treatment ideas for 
clinical populations (Atley, 1991; Kestenberg, 1985b; Lewis, 1990; 
Loman, 1995; Ojala, 1995; Sossin, 1983). Others have measured the 
client’s progress over time by profiling before and after treatment 
(Bridges, 1989; Daigle, 1993). One innovative project was to profile a 
group of adolescents in a club doing a dance called “moshing” (Binette, 
1993). The profiler was able to gain insights into the social implications 
of this popular dance form. Some graduate students used the medium of 
video to create their master’s theses incorporating the KMP in a multi- 
have profiled Balinese babies, and clinical psychologists (Sossin, 1983) 
have profiled various clinical populations. The Center for Parents and 
Children used the KMP as the basis for understanding family dynamics, 
movement development, and for developing techniques for primary pre- 
vention interventions (Loman, 1994).

Many areas of research and clinical application have yet to be pursued. 
Future studies can produce norms for healthy and clinical populations 
across culture, age and gender, from which a statistical outline of diag- 
nostic indicators can be drawn (Sossin & Loman, 1992). Longitudinal re-
search with the KMP can advance developmental issues from early infancy. Detailed studies of specific diagnostic populations are needed to establish the range of individual variation within groups. Other subjects for study could include premature infants and individuals with physical illnesses. More research can also increase our understanding of risk factors, prevention, and early intervention approaches with vulnerable infants and children (Kestenberg, 1989; Kestenberg & Buelte, 1980; Romer & Sossin, 1990; Sossin, 1993).

Methodological research can examine the reliability of the current notation (Sossin, 1987) and develop amended profiling procedures as needed for specific applications. Computer programs (Lotan, 1994) are being developed to facilitate scoring and correlation of profiles (Sossin, 1994). The validity of the current interpretive schema can be examined, and specific distributions can be related to variables such as I.Q., depression, neurological impairment, defense mechanisms, and various conflicts.

The Kestenberg Movement Profile can provide dance/movement therapists with a tool for enhancing the understanding of the subtle and intricate possibilities for nonverbal relationship. It provides a vocabulary and a well-developed system of notation to clearly describe the nonverbal aspects continually occurring within relationships. An increased knowledge of the complexities involved in non-verbal communication serves to enhance clinical understanding and intervention methods. Movement observation and interaction encourage empathy and relational embodiedness, both of self and other.

The KMP has much to offer as an assessment and clinical tool, and for enhancing skills of observing, describing, and analyzing nonverbal behavior. We encourage its integration within the dance/movement therapy profession.

References


The KMP: A Tool for Dance/Movement Therapy
