

KONZENTRATIVE BEWEGUNGSTHERAPIE – KBT

Concentrative Movement Therapy

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1) The psychotherapeutic modality/method of Concentrative Movement Therapy

„Concentrative movement therapy (KBT) is a psychotherapeutic method for group and individual therapy which is based on thought models stemming from developmental psychology and depth psychology. Taking as its point of departure the theory that perception is comprised of sensation and experience (V. v. Weizsäcker), KBT is interested in the conscious perception of the body in the “here and now“ against the background of the individual life and learning story.“ (Pokorny, Hochgerner; Cserny: Konzentrative Bewegungstherapie, Von der körperorientierten Methode zum psychotherapeutischen Verfahren, 1996, p. 15).

„One of the KBT’s fundamental assumptions is that all of a person’s experiences not only find expression psychically, but also bodily, that is, in terms of gestures, postures or incorrect postures, behavior, stress or tension and result in an „embodied“ life story. According to Freud’s description the “ego is above all a bodily one“. Therefore the body-image builds the basis of the self-image. It contains our first experiences of being-in-the-world and of “I am“. (Bayerl, Konzentrative Bewegungstherapie bei chronisch schizophrenen Patienten-eine Kasuistik, in: Röhrich, Priebe, Körpererleben in der Schizophrenie, 1998, p. 143).

Through the concentrative engagement with early levels of experience, memories are brought to life which appears in bodily expression as posture, movement and behavior. Like the material which appears in dreams, subjective bodily experience also contains information which can extend back to preverbal times. Bodily movements or bodily contact call forth a patient’s basic postures. Through the movement work the biographical material is made topical so that a correlation can be made between what a person has experienced and that person’s life story. “The primary process-like level of experience and the secondary process-like level of spoken expression constitute a unity. Through this, speaking acquires the following meaning: What has been experienced is, in the act of being spoken of, conceptualized, and consequently brought to the levels of thought, association, reflection and communication. This is how the sensory-emotional is linked to the linguistic-cognitive cycle_in the sense of V. v. Weizsäcker’s Gestaltkreis.“ (Pokorny, Hochgerner, Cserny, loc. cit., pp. 15-16).

„When we speak of **movement therapy**, by movement we understand the following:

1. **To-move-oneself**, the experience of movement includes a person's sensor motor functions (...).
2. **To-be-moved**, what internally moves and has been moved (affects and emotions).
3. **To-be-on-the-way**, that means the person's developmental steps and his gradual progress in the overcoming of actual or fantasized external or internal impediments.“
(Pokorny, Hochgerner, Cserny, loc.cit., p. 28).

1.1. Areas of application for KBT

Clinical patients and outpatients in individual or group therapy:

Psychosomatics - Early disturbances: narcissistic and borderline disturbances; in particular, body-schema and body-image disturbances - Neurotic disturbances - Illnesses resulting from addictions - Crisis intervention - Acute reaction to pressure – Traumas – Psychoses - Morbid anxiety - Compulsion disturbance - Eating disorder – Depression - Chronic illnesses with pain - Consciousness raising - Adult education

1.2. The KBT's manner of proceeding

The way we work can be outlined in the following way: „We work at sensitizing a person's senses (seeing, smelling, hearing, taste, touch, sense of movement and depth perception) so that he/she is aware of himself and his environment. Conscious or unconscious habits and progressions are supposed to be brought to consciousness. (Pokorny, loc.cit., p. 28).

„Opening or closing one's eyes changes what one perceives. If one closes one's eyes, the other sense perceptions become clearer (...). Thereby the perception of oneself, of one's proprium, moves into the foreground: The possibility to physically perceive oneself increases; work on the body-ego becomes clearer; the activity of fantasy is stimulated. This means that perception of oneself and of things foreign to oneself is intensified when one's eyes are closed, since seeing also has a controlling function; to have something in one's field of vision provides security, reduces anxiety, but also conveys the experience of distance (...). During the therapeutically work the therapist has to make it clear to the patient that he can open his eyes at any time, should the wish to do so arise, so that resistances but also defense mechanisms, which stand in the service of the ego, do not occur (...). In KBT experiencing often comes about via the path of symbolic action and formation as the expression of one's inner state in thinking and speaking. Symbolic posture has a mediating function between unconscious movements, affects, drives and conflicts and what is consciously lived. The KBT-therapist has the additional possibility, that he can lead experiencing back to bodily experiencing through a so-called „offer“. By „offer“ we mean the therapist's suggestion for focused perception, movement and action, which allows the patient to form an individual way of moving, acting and relating in the sense of free movement association and to put this into

language through a dialogue with the therapist against the background of the bodily and scenically formed experience“ (ibid.).

„In KBT diverse materials are used; typical are sticks, balls, ropes, hand-held sacks, small balls and all objects which come from the sphere of nature, such as, for example, stones, shells, chestnuts. These materials assist, on the one hand, through their real constitution of the sensory-concrete experience of round and angular, light or heavy, rough or smooth etc. and thereby help with the differentiation of bodily sensations. On this level childlike experience-processes are added onto: The way that a child actively deals with „inanimate objects“ plays a central role in how that child learns about the environment. When the child actively does something he learns about “the quality of the objects (...) the space, in which his interaction with objects takes place“. The child acquires structures for dealing with things, which allow him to experience the environment as trusted and manageable. KBT is about reactivating sensory experience, which can be understood in the sense of an addition to creative resources or a “belated-maturation“. Over and above that, through associative combinations, objects can acquire symbolic meaning, which is above all grounded in the individual life story: “That which is not yet comprehensible becomes comprehensible and available for verbalization“ (Pokorny, loc.cit., p. 38).

Different kinds of materials enable many different ways of acting. A word-symbolic can often be attached to them: the terms “flirting“, “to skedaddle“, “to captivate“ someone, “to be in a bad way“, “to condemn someone“, “to put on obstacle on someone’s path“, “to be in cahoots with someone“ etc. convey meanings which can be used for the formation or interpretation of offers. (Chr. Möller, unpublished diploma work: „Körperausdruck und Körpererleben von Patienten in einer Gruppe mit Konzentrativer Bewegungstherapie. Eine Qualitative Untersuchung“ („Bodily Expression and the Bodily Experience of Patients in a Group with Concentrative Movement Therapy“), Berlin 2000).

“The materials also serve as a means for communication. With their help patients can be very consciously led to conflicts. An example of this is as follows: A young hebephrenic patient with hardly any body tension and also with very little “pep“ at his disposal, continuously searched for soft, cuddly materials and totally immersed himself in them. It never came to encounters and discussions in the group. The patient only lived with his over-caring mother; he didn’t have a father. I suggested to him that he turn to solid objects. He walked barefoot across a thick rope, felt pressure under the soles of his feet and was astounded by how awake he all at once felt. Once in another session when I put a stone in his hand, after a brief moment of hesitation, he powerfully threw it across the room. He, who was always only nice, noticed right away that he also had other sides. That the mother’s aggressions were valid – the mother who always made certain that he was not confronted with “hard“ reality – this was first worked through with him at a later time.

It is also important to note that the materials can also present „transitional objects“ in the sense of Winnicott. (Barbara Roßdeutscher: „Konzentrierte Bewegungstherapie. Behandlung einer chronisch schizophrenen Patientin mit schweren Ich-Störungen.“ („Concentrative Movement Therapy. The Treatment of a Chronic Schizophrenic Patient with Strong Ego-Disturbances“) Partially-published diploma work, Berlin 1991, p. 6).

1.3. Nonverbal and verbal

KBT works with a continual alternation between nonverbal and verbal levels. The translation of the nonverbal into the verbal and vice versa is a significant part of the therapeutic work. After linguistically working through what was experienced in the offer, the KBT-therapist is able to, through a new offer; return the experience to the level of what bodily happens.

“The KBT work situation is characterized by the fact that language is taken literally and converted into action. Many words, which are used to describe the psychical, originally stem from the somatic area: “to find oneself in a good or bad position”, “to understand something”, “to have the ground pulled out from beneath you”, “to be steadfast”, “to be (in)dependent”, “to take possession of something”, “to be fed up,” “to tread new ground”. There are an endless number of such examples (...). Regarding the descriptive nature of human language, a relationship can be set up between the concrete and the emotional sides of human doing“ (Möller, loc.cit., p. 24).

1.4. Diagnosis/ assessment and treatment/ intervention

On the one hand we go by the international classifications for psychic and somatic disturbances (ICD 10 and others). For the KBT-specific diagnosis we start with the image (phenomenon). From the anamnestic discussion, personality structures and prevailing defense mechanisms become clear. Deficits such as early disturbances, psychotic and neurotic disturbances are grasped and we receive the first knowledge about the patient's ability to have a relationship. Additional diagnoses for every KBT-therapist include the observance of gestures, facial expressions, movement models, movement coordination, movement expanse in sitting, standing, walking and lying down as well as body-image, body-schema and the ability for symbolization. „The KBT-therapist takes cognizance of the patient in his image on three levels: on the sensor motor - the emotional - and the intellectual/spoken level“ (Cserny and Tempfli, Die Wirkung von Körperinterventionen auf das psychische Geschehen und dessen Veränderung, 1999, p. 6).

Interventions in KBT include the known interventions from psychotherapy and psychoanalysis such as, for example, interpretations. The interventions which appear to be more fundamental for this application are closely connected to the bodily level and are

frequently described as „bodily interventions“. On this occasion, in other therapy forms which involve the body, the body is used as an object, as an instrument, for clarifying something. We, in KBT, see the body as object and subject, which means that for us the body is not the entrance to the psyche but rather the place where the psyche runs its course (cf. Cserny / Tempfli, loc.cit., p. 2).“ The result of this is that in the following we can no longer speak of bodily interventions, since we don't make any bodily interventions. The term particular to us in this place is „offer“– we make offers.

By offer we mean guidelines for the perception of either one's own movement, one's own posture, the expression, the structure, the Gestalt of the body, an object (living and inanimate objects), space and time - with the goal of perceiving the sensory qualities and the emotional meaning (moods, feelings) of this sensory quality; and to also grasp the contents (images, thoughts, ideas) on the intellectual level and to put them into words.

An offer is also an introduction to acting and experimenting in a concrete way, to thereby perceiving through the senses, to feeling, to recognizing and to naming that which is experienced. Our offers are always followed by directed questions

„How is that? “ „What do you feel? “ „What do you think? “

if we address the sensory, emotional and intellectual levels and thereby always the entirety of what happens psychically.

This means that in every offer all three levels are inseparably addressed:

the level of sensations - the emotional level - the intellectual level

(Cserny, Tempfli, loc.cit., pp. 3-4).

“In KBT, complex action interrelations can be simplified so that one can experience them. Fundamental moments, such as, for example, making contact, structuring the contact, parting, and themes, such as, for example, “taking and giving“, “holding onto and letting go of“, “proximity and distance“, “devotion and resistance“, can be detached from their contexts and, through repeatedly trying them out, lead to expanded or new possibilities of behavior (cf. Gräff, 1983 in Möller, loc.cit., p. 27).

The therapist's comportment can mirror, can be confrontational, can be supportive, and can also be indicative in the sense of a first interpretation. The KBT-therapist can, through bodily dialogue, suggest a new way of behaving and therefore intervene in a clarifying manner. Further intervention possibilities include the use of a transitional object, working on resistance in a thoroughly bodily way, working on transference and counter-transference, particularly bodily counter-transference. KBT-therapists request in a very special way that he bring himself into the therapeutic process through his own corporeality, without losing the necessary distance (Ferenczi's active technique)“ (Barbara Bayerl, lecture for the DGK, 1998).

1.5. Our theory of the human being and the therapeutic relationship

“We perceive of the person as an individual who finds himself in constant development (bodily, mentally, intellectually) and as someone who is part of a cultural, social, ecological and spiritual whole. He is marked and determined by these things as much as he marks and determines them. In KBT we call for the development of his ability to perceive himself, to move, to sense, to feel, to think and to want, with the goal that the person comports himself in the world in a way such that he is capable of making decisions, being in a relationship and acting in a responsible manner and that for himself he attains a suitable bodily, mental and intellectual balance“ (Cserny, Tempfli, loc.cit., pp. 1-2).

“According to Budjuhn (1992) both real as well as transference and counter-transference relationships play a role in the therapeutic relationship.

What is meant by real relationship is the level of the “union in the work“ (...). This shows what is needed for the therapeutic happening to take place and lightens the work in terms of aspects of corporeality (...).

In psychoanalysis, transference is defined as an event in which early childhood experiences, in the relationship with the therapist and the group members, are made topical (cf. Laplanche and others, 1991).

Through new experiences and identifications, corrective bodily and emotional manners of experience, can be chanced upon, which allow the patient to free himself from restrictive and illness-favoring models. In contrast to the psychoanalytic situation, the KBT-therapist’s personality is more clearly present; the therapist behaves in a more active, structuring and intervening way and offers himself “as a real and identificatory object“ (Becker 1996, p. 105, in Möller, loc. cit., p. 22).

KBT-therapists can at any time become an object for transference and, in what ensues, have to address and work through these transferences and their counter-transference reactions. The way in which these are worked through is oriented according to our methodology (perception, dissociation, new and desymbolization). This way one becomes conscious of old symbolizations, psychic representations, and the psychic contents which lie behind them with the contents’ accompanying affect and thus they can be integrated“(Cserny, Tempfli, loc. cit., p. 13).

“Transference and counter-transference phenomena show themselves in KBT not only in the verbal-emotional expression of the patient and the therapist, but also in bodily experience and expression and in how one act. The reactivated affects can thus be picked up on the level which is bodily and which acts“(Budjuhn, 1992, p. 146).

“The job of KBT-therapists is not only to actively and supportively offer a positive relationship, but also to enter into conflicts and to criticize, to acquire the participant’s anger and rejection.

This is how to make space for a development, which against the background of a positive transference enables the patient to cope with conflicts as well as to gradually separate from the therapist. On this occasion, the therapist has to decide, to what extent the patients are capable of enduring and working through conflicts and anxieties which appear or to what extent the patients' protective functions have to be strengthened. KBT-therapists take a leading role, which out of pride (...) is described as a "focusing" one" (Möller, loc.cit., pp. 22-23).

We understand ourselves as therapists who work in a holistic way and orient ourselves according to a humanistic concept of illness, in which both the healthy and the sick parts are perceived of as being in a continually-moving process. To work from and to extend the patient's resources is a fundamental characteristic of the KBT's work. We also orient ourselves according to teachings on neurosis and psychosis from depth psychology. Here, particular emphasis is placed on making certain that the KBT's way of working is suitable for, or rather, adapted to the patient.

1.6. Our Understanding of human nature based on

- Gabriel Marcel and Merleau Ponty's existence philosophy,
- Piaget's genetic theory of knowledge,
- Victor v. Weizsäcker's Gestaltkreis teachings,
- A. Freud, Hartmann, and Blanck & Blanck's depth psychology theories about ego development,
- Balint, Mahler, Ericson, Winnicott, Kohut and Kernberg's theories about object relationships,
- Lichtenberg, Stern, and Sanders' more recent infant research.

We extract a deepened understanding of human nature from the existence-philosophical formulation, which Gabriel Marcel articulates in the following way: „I have a body and am my body“. As we already mentioned "for us the body is not the entrance to what psychically happens, but is rather the place **where the entirety of what happens psychically takes place**" (Cserny, Tempfli, loc. cit., p. 2).

"KBT is theoretically based on Gabriel Marcel and Maurice Merleau-Ponty's existence philosophy, Piaget's genetic theory of knowledge, how he presents this in his development of the thought structures, in Viktor von Weizsäcker's medical anthropology (his theory of the Gestaltkreis) and in theories in depth psychology about ego development (A. Freud, Hartmann, Blanck and Blanck) and the object relationship (Balint, Mahler, Ericson, Winnicott, Kohut and Kernberg) and in the newer infant research (Lichtenberg, Stern, Sanders).

KBT's fundamental philosophical principles come from diverse sketches of the body-mind problematic in western philosophy. Up until today Descartes'dualism (body and mind as

separate entities) marks our thinking. The transition from philosophy to psychology through Ehrenfels, Koffka and Köhler, the Gestalt psychologists, brought about the change to a unifying concept. In the field of philosophy, the phenomenologist and existence philosopher Gabriel Marcel made a significant contribution to the overcoming of the body-mind split with his „Etre et avoir“ theory. He arrives at the formulation „I have a body and am my body“ („corp que j` ai et corps que je suis“) as does Maurice Merleau-Ponty in his „Phenomenology of Perception“: „One’s own body is in the world the way that a heart is in an organism: The body is what keeps the entire visible spectacle alive; it innerly nourishes and fills one with life and builds a single system with the spectacle“ (Merleau-Ponty, 1966, p. 239).

In his teachings about psychosomatic illnesses, Victor von Weizsäcker starts with psychophysical parallelisms and interaction theory and moves to his Gestaltkreis teachings; in these teachings he starts with the subjectivity of the perception process and with the notion that perception and movement are linked: „What prevails is a continual and reciprocal, self-illuminating, enclosed in-itself, bodily-mental back and forth, in cycle-like unity“ (Bräutigam, Psychosomatische Medizin, 1981, p. 66).

On the level of developmental psychology the Gestaltkreis teachings correspond to Piaget’s observances on the development of the early childhood structures of perception, attitude and thought. In continual assimilation and accommodation processes, the motor cognitive and the emotional development work together and determine each other. The development of the senses, the continually differentiating thought and comportment structures, and the experience of space and time are, for Piaget, the prerequisites for developing the ability to symbolize.

Compatible with this are the theories of development in depth psychology, where the main emphasis is on early childhood experience with the people with whom one has relationships and where the condition for a healthy development is a happy relationship with the person to whom one relates most closely (Balint, Mahler, Ericson, Winnicott, Kohut, Kernberg, Lichtenberg, Sanders, Stern)“ (Pokorny, among others, loc.cit., pp. 21-22).

“When in therapy it is about gaining more insight and awareness into oneself, language and thinking are needed. But language does not necessarily have to be the verbalization of contents; body language or >the expression of one’s own private language< also helps. It is precisely those patients, who cannot verbally express their feelings and sensations, who more easily find in gesticulation, in symbolic expression about subjects or scenes, a first point of entry into their inner lives“ (Karin Schreiber-Willnow, Körper-,Selbst-,und Gruppenerleben in der stationären Konzentrativen Bewegungstherapie, Gießen, 2000).

1.7. Symbolization

For us symbolization is the mediator between that which is nonverbally experienced and that which is put into language: “The person is capable of symbolization from the beginning on. By symbolization we mean the processing of information in the widest sense, and by this we mean both a process as well as its result. At the beginning, sensor motor sensations (perception and behavioral sensations) and the reaction to them insist on this, the reaction which is processed (=symbolized) into schemata (for perception and behavior this remains the same) and which is thereby psychically represented. This is followed by perception and behavior processes which are always becoming more complex, which are always in an affective and interactional context, and which lead to the linking up of schemata, i.e., the building of more complex structures.

As an illustration:

What we perceive in a patient, his entire appearance, the way that his body expresses itself, his posture, how he moves himself, how he enters into a relationship with objects and the therapist, how he speaks, what he tells the therapist about himself, his problems and his story, is the result of countless symbolizations, his way of processing his experience of himself and of the world. Symbolization understood in this way belongs to the primary and the secondary processes and takes place in the unconscious, the preconscious and the conscious. It really drives forward the secondary process and significantly contributes to ego formation; symbolization (as result) and symbol, consequently, have to be distinguished from one another. Symbol formation is a form of symbolization” (Cserny, Tempfli, loc.cit., p. 15).

1.7.1. New symbolizations

If a patient has symbolized his experiences at a certain time and in a certain context, in a certain way and not differently and again works through his new experiences in the same way, then he can – in a current therapeutically context – undo these symbolizations through perception and dissociation, and, through new experiences, create new representations. At the same time what we always know is that a de- and new symbolization effects the emotional and cognitive level. (...)

1.7.2. Belated-development of the ability to symbolize

In KBT this belated-development takes place through perception work.

Sensory perceptions, one’s own body, as well as what is related to the objects, are in the space of the current therapeutic relationship affectively newly fixed and worked into new schemata, and subsequently into new structures. Analogous to the regularity of psychoanalytical phase teaching, in developing the ability to symbolize, one also only

proceeds to the later level after the previous ones have been sufficiently developed“ (Cserny / Tempfli, loc. cit., pp. 13-19).

1.8. Perception – Association – Dissociation

Our concept of perception is fundamentally oriented according to Maurice Merleau Ponty's „Phenomenology of Perception“ (1965). With Ponty, Sylvia Cserny (...) defines: „Perception is made up of both sensation and experience“. She understands the experience which is intended here as the subjective life and learning story.

The guidelines for perception are directed at

- on the one hand, bringing existent couplings of particular sensory qualities with experiences and their emotional content into consciousness (association),
- on the other hand, extricating sensory qualities from the context in which they are experienced, i.e., uncoupling sensory qualities from their emotional meaning (dissociation)
- and to develop the ability to perceive (differentiation).

2) History of the association/federation

The Munich physician and psychotherapist Helmut Stolze used the method in the university-clinical field and named it “Concentrative movement therapy” in 1958. From this moment on KBT was taught as a special method on congresses and was more and more represented in the psychotherapeutic practice. In Austria the as a “Österreichischer Arbeitskreis für Konzentrative Bewegungstherapie (ÖAKBT)” was founded through the psychologist and psychotherapist Sylvia Cserny in 1980. Here the theoretical basis of this method got further developed in the following years. The KBT got the acknowledgement through the “Bundesministerium für Soziale Sicherheit und Generationen gemäß § 7 Abs. 1 Abs. 1 in connection with § 7 Abs. 4 des BGBl.Nr. 361/1990 as a psychotherapeutic training establishment for the methodspecific orientation “Konzentrative Bewegungstherapie” (concentrative movement therapy) on 3.4.2001, (GZ: 22.500/40-VIII/D14/01).

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