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Analogic Communication as a Method of Facilitating Change

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ANALOGIC COMMUNICATION AS A METHOD OF FACILITATING CHANGE

(TITLE)

BY

PATRICIA ANN TENNERY-WILLIAMS

THESIS

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Abstract

This thesis focused on nonverbal communication and the ways in which it may be employed to facilitate change in the context of psychotherapy. The anthropological, psychological, and medical literature was reviewed, and an overview presented of the relevant research on nonverbal communication. Nonverbal communication forms a critical dimension in the overall communication in the psychotherapeutic interaction. The importance of the therapist's recognition of nonverbal behaviors characteristic of particular personality structures as well as the functions of nonverbal messages was examined. The utilization of meaningful nonverbal behavior by the therapist can greatly facilitate the client's change into more healthy and constructive modes of affective, behavioral, and cognitive functioning. Additional research on specific psychotherapeutic applications of nonverbal communication is necessary to expand current understanding of more effective modalities of psychotherapeutic treatment in the future.

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INTRODUCTION

Investigators from a number of different fields --- but principally psychology, anthropology and medicine --- have taken numerous approaches to understanding nonverbal communication. By its very nature, analogic communication is elusive and difficult to capture in words. This is not a field that develops and grows primarily through the literature. Existing research, from the facial recognition studies of the 1930's to the more recent kinesics communication research, has depended primarily on photographs, films, videotapes, or direct collaboration in the area.

Today, investigators analyze all manner of movement. This includes visual behavior such as facial expressions, hand gestures, posture, and muscle tension. The existence of expressive movement or nonverbal behavior has been acknowledged for centuries, but the research and therapeutic work involving an understanding of the psychology or anthropology of nonverbal behavior is a phenomenon of the last three decades.

The history of nonverbal behavior largely parallels behavioral research. This is especially clear in the shift from a focus on physiological aspects to an interest in affect, personality, and intrapsychic processes to a concentration on interpersonal and cultural-level phenomena. The increased use of film has allowed researchers interested in what "really" goes on in complex, interpersonal interactions to capture behavior at specific times and in specific verbal

contexts.

The area of nonverbal communication has become extraordinarily interesting and diverse. Members of theoretical disciplines debate innate versus learned (Cushman & Whiting, 1972; Davis, 1971; Katz, 1937), individual versus cultural (Argyle, 1973; Birdwhistell, 1970; Hall, 1959; Hawes, 1975; Morris, 1977), and expression versus communication (Bettinghaus, 1976; Nofsinger, 1976; Rapaport, 1969). The oversimplification in some of these debates is countered by the complexity of the subject. The problem is no longer whether nonverbal communication is the legitimate realm of any one discipline, but how this form of communication can be analyzed and interpreted.

This paper will review the psychological, medical, and anthropological literature and the methods by which nonverbal communication can be used to facilitate change. In a therapeutic relationship, it has been theorized that a person cannot help but communicate. The possibility of nonbehavior does not exist, and the client's attempt to avoid behavior results in incongruent messages that can be recognized and interpreted by the therapist. Watzlawick, Beavin, and Jackson (1967) in addition to developing this theory of communication, have defined analogic communication as "virtually all nonverbal postures, gesture, facial expression, voice inflection, the sequence, rhythm, and cadence of the words themselves." Change, for the purposes of this paper, will be defined as a behavioral, cognitive, or affective difference from one state to another.

LITERATURE REVIEW

This section reviews the anthropological, psychological, and medical literature on nonverbal communication. While there is a substantial degree of overlap between these areas, this section will present the most significant findings in each.

Anthropological Literature

In the anthropological literature, the interest is divided between animal and human comparative issues and culturally developed language systems.

The literature in which body movement has been studied as a language begins with John Casper Lavater, who, in 1789, published his Essays on Physiognomy. He was the first to systematize observation of nonverbal behavior in the name of science. Lavater also originated the analogy of nonverbal communication to verbal language, as follows:

> I do not promise, for it would be the height of folly to make such a promise, to give entire the immense Alphabet necessary to decipher the original language of Nature, written on the face of man and on the whole of his exterior; But I flatter myself that I have been so happy as to trace a few of the characters of that devine Alphabet, and that they will be so legible, that a sound eye will readily distinguish them wherever they occur.

Lavater wished to educate the public in the art of observation,

and there is no doubt that he established the importance of the comparative method, making minute observations of bodily features and of training the "visual imagination" to perceive what is ordinarily passed over or treated as intuition.

In the recent past, strong interest in devising grammatical of rule-system approaches to the study of nonverbal communication has developed. Cushman and Whiting (1972) and Davis (1971) have presented some intriguing arguments about the potential value of viewing symbolic interactions as manifestations of generally understood systems of rules. More recently, Bettinghaus (1976) and Nofsinger (1976) have applied such an approach to specific subsets of interactions with considerable descriptive and explanatory gain. Birdwhistell (1970) developed a model, called Kinesics, of nonverbal behavior. This model views nonverbal behavior as analogous to linguistic behavior. Both are considered to be determined by the culture in which they occur. Each culture selects and uses a minimal number of significant motions. These motions are learned, and children of that culture acquire the capacity to use and interpret them very early. Birdwhistell estimates that fewer than a hundred symbols are needed to record and analyze any specific interpersonal interaction.

Nonverbal communication should not be studied as an isolated unit, but as an inseparable part of the total communication process (Birdwhistell, 1970). Nonverbal communication may serve to repeat, contradict, substitute, compliment, accent, or regulate ordinary ver-

bal communication (Argyle, 1973). Nonverbal communication is important because of its role in the total communication system and the large number of informational cues it provides. Nonverbal actions are often performed unconsciously and are so familiar that people are unaware of them. For example, when people interlock their fingers, one thumb rests on top of the other. Each person has a dominant thumb, and whenever left and right hand interlock, the same thumb tends to rest on top of the other. Yet most people cannot guess which is their dominant thumb without going through the motions of interlocking their hands and looking to see which thumb comes out on top. Over the years, each person has developed a fixed pattern of interlocking without realizing it (Critchly, 1975). If they try to reverse the positions, bringing the dominant thumb beneath the other, the hand posture will feel strange and awkward.

Various expressions and gestures are important in nonverbal communication. Our facial muscles are elaborate and make possible a wide range of subtly variable facial signals. The majority of nonverbal signalling, in fact, is transmitted by the face (Argyle & Cook, 1976). Ekman and Friesen (1969) believe some affect displays may be culture-bound. This raises a long-standing question in nonverbal communication research. Birdwhistell claims, "There are no universal gestures. As far as we know, there is no single facial expression, stance, or body position which conveys the same meaning in all societies." Davitz (1964), however, presents evidence which suggests that some expressive facial patterns are not learned; their

emergence depends primarily on physical maturation. He indicates there may even be a relationship between certain facial muscular patterns and discrete emotions like happiness and anger. As Ekman and Friesen (1969) note:

> ...we believe that, while the facial muscles which move when particular affect is aroused are the same across cultures, the evoking stimuli, the linked effects, the display rules and the behavioral consequences all can vary enormously from one culture to another.

The hands are also important with their manual gesticulations, transmitting many small mood changes by shifts in their postures and movements (Critchly, 1975), and they tend to vary across cultures.

When two friends talk informally they typically adopt similar body postures (Kendon, 1973). If they are particularly friendly and share identical attitudes about the subjects being discussed, they will also tend to adopt similar postures. This is not a deliberate imitative process, but has been called "postural echo" or congruent postures. Research has shown that a therapist can utilize this "posture echo" as a method of building rapport (Knapp, 1972).

If a person is lying, his or her behavior often fragments. Instead of actions and words fitting together harmoniously, they form contradictory assemblages that serve to signal the therapist. As demonstrated in Table 1, the various elements of nonverbal behavior can be interpreted according to greater or lesser believability in the context in which they are being observed. There is a distinction between ambivalent signals and contradictory signals, however, though both are incongruent. Both display conflicting elements, but in the

TABLE 1

CONFLICTING ANALOGIC ELEMENTS

Physiological Signal	Signal Evaluation
Autonomic Signals	Even when a client is aware of these signals, they are rarely controllable. These autonomic signals resulting from physiological changes that are usually considered to be beyond the client's deliberate conscious control are valuable when deciding what elements are true or false in an incongruent message. They are usually limited to strong emotional affect. These elements include signals of blood pressure, respirations, skin color, skin temperature, sweating, and pupil dilation.
Leg and Foot Signals	The lower extremities of the client's body appear to escape deliberate control due in part to a client's inattention to these body parts during a face-to-face interaction. These signals can be utilized as clues to the client's mood.
Trunk Signals	The body posture is a useful accurate guide to evaluating a client's mood. Posture reflects the general muscular tonus of the whole body system. It is difficult, for example, for an excited client to sag or slump artificially.
Hand Signals	The hands are under more control than the feet, legs, and trunk. If a client waves his or her hands while speaking, the movements are not focused upon. Many hand gestures are indefinite wavings and appear to be the least controlled manuel elements. These signals can be evaluated as more relevant than voice tonality in an incongruent message. Many hand movements a precise signals, such as a wave "hello."

Facial Expression Signals	Most clients are so aware of what their faces are doing that it is easy to be deceptive with gross facial musculature. When an incongruent communication occurs, the gross facial expressions are of little evaluative assistance. These signals include the smile, the laugh, the frown, the pout, et. Minute facial muscular changes are more difficult for the client to fake. These are facial changes such as a slight narrowing of the eyes, added tension of the forehead skin, a small turning-in of the lips, or a minute tightening of the jaw muscles. The face is so complex that it can express a change in the client's underlying mood while hardly altering at all in the sense of gross changes.
Voice Signals	These prosodic signals include tonality, inflection, pitch, volume, tempo, pauses, vocal tension, and speech rate. A slow tempo and/or a high pitched voice, for example, has unpleasant connotations and appears to be evaluated more readily as less truthful, less emphatic, and more nervous. A more energetic voice with few hesitations is more often evaluated as more assertive than a monotonous tone and halting speech.

Argyle & Cook, 1976; Critchley, 1975; Ekman & Friesen, 1969; Kendon, 1973; Morris, 1977.

case of ambivalent signals the conflict is the result of the person's mixed mood (Morris, 1977). A contradictory signal is more difficult to assess. A contradictory signal occurs when the person's nonverbal behavior is modified as a result of the person's conjectures as to the therapist's interpretation of the nonverbal behavior presented. Thus, the person may tell a lie, while looking directly into the eyes of the therapist, assuming the therapist will believe that statements made while looking away are not truthful.

Freud one said, "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger tips; betrayal oozes out of him at every pore." (Knapp, 1972). Ekman and Friesen (1969) have tried to explore the specific nature of Freud's hypothesis by asking what particular nonverbal cues give a person away when they are trying to deceive. The findings indicate that the feet and legs are a good source for observing deception; the hands next; and the face last (Knapp, 1972; Morris, 1977). It is reasoned that the person will not expend much effort inhibiting areas of the body largely ignored by others. Deceptive facial cues generally come from minute facial movements and imperfectly performed simulations. For example, that smile that is drawn out too long or the frown that is too severe. Hands are easier to inhibit than the face because they can be hidden from view. The hands, however, may be digging into the person's cheek, tearing at fingernails, or protectively holding the knees while the face is smiling and pleasant. Cues of deception

in the legs or feet might include aggressive footkicks, flirtatious leg displays, autoerotic or soothing leg squeezing, or aborted movements. Other cues might be tense leg positions, frequent shifts of leg posture, or repetitive leg or foot movements.

Anthropologists also consider proximity, or spatial distance, as an important communicative cue in an interpersonal interaction. The systematic investigation of the meaning given to space by social groups was pioneered by Edward Hall (1966) who researched the role space plays in the communication process. The particular position a therapist chooses in relation to the other person can vary with the task at hand. Leaders, for example, are often expected to be seated at the head of a table. Sommer's (1969) observations indicate seating arrangement preferences are dependent on the type of interaction preferred or the purpose of the interaction: intimacy, conversation, cooperation, co-action, or competition. For example, chess players will sit facing each other while two students studying together usually sit side-by-side.

Psychological Literature

The psychological literature emphasizes the role nonverbal behavior has in the transmission of information about emotions and attitudes in interpersonal interactions. Investigators in this discipline continue to wrestle with the difficult matter of distinguishing the degree of conscious intent associated with any given

message. Some have used the communicator's conscious intent as a major criterion for distinguishing between nonverbal behavior and nonverbal communication (Weiner, et al., 1972). The difficulties in making such distinctions become clear when the subtleties of the behaviors being identified are considered. Some messages, for instance, are planned and sent with a high degree of conscious awareness while others appear to be totally derived from an unconscious level of awareness (Goffman, 1971).

A substantial body of the psychological literature has focused on deception, including studies on such problems as the classification of nonverbal deceptive behaviors (Ekman & Friesen, 1969; Knapp, Hart, & Dennis, 1974; Mehrabian, 1981) and possible physiological indicators of deceptive behavior (Bauchner, Kaplan, & Miller, 1980).

Most of this research is based on the assumption that nonverbal behavior provides cues which assist the therapist in judging the truth or falsity of a person's verbal message. All people face situations where they must make decisions about the honesty of what someone else is saying. These situations are common in economic transactions. For example, it is not uncommon to wonder "Is $5000 really the lowest price he'll accept for that car?" It is also common to ask oneself similar questions when making important relational commitments --- "Does she really love me, or does she want to marry me for personal gain?" Since the consequences of these decisions are often serious it is not surprising that the average person manifests an interest in the process of deception and incongruent messages

(Knapp, Hart & Dennis, 1974).

A person is exposed to a considerable amount of data about feelings, thoughts, and actions through conscious hearing, sight, touch, and smell (Reusch, 1957). Further data is acquired by the process known as intuition and through unconscious perceptions (Korzybski, 1950). A person communicates nonverbally throughout any interpersonal interaction. Theodor Reik (1949) noted that, "The most minute movements, accompany every process of thought; muscular twitchings in the face or hands and movements of the eyes speak as well as words. Important communication is contained in a glance, a bodily movement, or a special way of breathing."

A series of neurodynamic stimuli, such as tension, butterflies, are experienced in the context of any interpersonal interaction. These messages play a role in one person's impressions of another. There are certain expressive movements (e.g. smiles, frowns) that may be understood without entering conscious awareness. In addition to bodily movements, certain vocal modulations are experienced consciously or unconsciously by the receiver. Information is signaled in the particular pitch and timbre of the voice, the particular speech rhythm, the variations of tone, pauses, and shifted accentuation (Reik, 1949). There are variations so slight that they may never reach the limits of conscious observation.

Body movements have been researched in the context of liking or disliking for another person. Work by Mehrabian (Efron, 1972) forms a useful baseline in this area. Mehrabian studied the relationship

between body orientation (position) and personal attraction. His work did not show consistent correlation with the degree of liking and was explained by him (1981) in terms of relaxation. He noted:

> ...an open arm position of seated communicators may more appropriately be considered an index of relaxation, with relatively more open positions indicating greater relaxation. In contrast, for standing communicators, a folded arm position may be more relaxed than one with the arms hanging.

In addition to body orientation and attraction, Mehrabian was also interested in the nonverbal transmission of feelings. Rather than focusing on primary emotions (e.g. happiness, anger surprise, fear, disgust, sadness, and interest) Mehrabian developed a three dimensional scheme that subsumes these primary emotions, their combinations, and many other emotions. He believed that all emotional states can be described adequately in terms of the three independent dimensions of pleasure-displeasure, arousal-nonarousal, and dominance-submissiveness. The descriptions most commonly used by his subjects to describe the emotion of pleasure are happy, pleased, and hopeful; for displeasure --- unhappy, annoyed, despairing; for arousal --- stimulated, excited, frenzied; for nonarousal --- relaxed, calm, sluggish; for dominance --- controlling, influential, important; and, for submissiveness --- controlled, influenced, and awed. These dimensions and the nonverbal behavior recognized as observable in these particular emotions are listed in Table 2.

Various eye movements are associated with emotional expression (Argyle & Cook, 1976). While concern with the eye has been varied, the research has focused mainly on two areas. One area is known as

TABLE 2

NONVERBAL REFERENCE FOR EMOTIONS

Pleasure	Displeasure
Smile	Frowning
Laughter	Glaring eyes
Jovial facial features	Sneering
Low pitched voice	Mocking actions
More rapid speech	Mocking voice
	Disgusted voice tone
	Angry voice
	Crying
	Increased speech errors
	Halting speech
	Higher voice pitch
	Slower speech
	Hedging

Arousal	Nonarousal
Increased blood pressure	Decreased blood pressure
Higher skin temperature	Decreased skin temperature
Sweating	Pupil contraction
Pupil dilation	Slower speech
Increased muscle tension	Relaxed posture
Increased physical activity	Decreased voice volume
Animated speech	Increased use of utterences
Increased voice volume	
Increased speech errors	
Halting speech	
Voice tremors	

Dominance	Submissiveness
Relaxed posture	Tense posture
Rocking movements	Forward lean
Backward lean	Head erect
Head lean	Smiling
Increased speech volume	Increased head nodding
Low pitched voice	Lower speech volume
Rapid speech	Higher pitched voice
Decreased hesitations	Slow speech rate
	Increased hesitations

Mehrabian, 1981.

eye contact, while the other area concerns pupil dilation and constriction under various social conditions. Downward glances are associated with modesty; wide eyes may be associated with frankness, wonder, naivete, or terror; raised upper eyelids along with a slight squinting may mean displeasure; immobile facial muscles with a constant stare are frequently associated with coldness; eyes rolled upward may be associated with fatigue or a suggestion that another's behavior is a bit weird. Excessive blinking may be associated with various states of anxiety.

Kendon (1967) has hypothesized four functions of gazing behavior: cognitive, in which a person tends to look away when understanding what has been said or asked is difficult; monitoring, in which a person tends to look at the listener to indicate the conclusion of a thought and to check the listener's attentiveness; regulatory, in which responses may be demanded or suppressed by looking; and, expressive, in which the degree of involvement or arousal may be signaled through looking. When two people meet and make eye contact, they find themselves in an immediate state of conflict (Morris, 1977). They want to look at each other and at the same time they want to look away. The result is a complicated series of eye movements, back and forth, and a careful study of this eye behavior can reveal a great deal about their relationship. In strong emotional situations these eye movements (away and towards) will be undiluted and unmistakable. The vast majority of interpersonal interactions, however, are mild and muted affairs. Even if slight feelings of sexual arousal, hostility, or

anxiety are present, they tend to remain submerged beneath a mask of social politeness (Yarbus, 1967). At a party, a meeting, a dinner, or some other gathering, the man who finds the woman to whom he is talking exceptionally appealing will probably not reveal the fact by adopting an obviously lecherous facial expression. Under these conditions, emotions can be controlled and the outward display is flattened out to one of almost uniform "nodding-and-smiling." Smiles are easier to discipline than glances. Changes in our pattern of eye movements are hardly noticeable during conversations. The man who finds a beautiful colleague unusually arousing may not show feelings in other ways, but his gaze, when their eyes meet, holds hers fractionally longer than usual. Another man, forced to talk to his singularly unappealing hostess, will reveal his inner reactions to her not by his beaming smile, but by the brevity of his glances in her direction. Another variation is the smiling, but actually hostile and domineering guest who tends to fixate his companions with over-long glances. His victims tend to smile in return, but become anxious and divert their eyes much more than in the average encounter.

The obvious problem with these situations is trying to tell whether a person who "super-gazes" fancies the target person, or actively dislikes them (Efran & Broughton, 1966; Exlin & Eldridge, 1967). The most revealing message may only be that the target person is receiving slightly more or slightly less attention than usual. The precise nature of that attention must be sought in other nonverbal cues.

Faces can deceive, and sometimes can do it so well that it becomes difficult to interpret the true emotions of their owners. But there is at least one facial signal that cannot easily be used for deception. It is a small signal, and extremely subtle, but because it is so hard to consciously alter it is of special interest. This signal comes from the pupils and has to do with their size in relation to the amount of light that is falling upon them. It is not only light that affects the pupils. They are affected by emotional changes (Hess, 1975; Woodmansee, 1970). Emotional changes can noticeably alter pupil size when the light remains constant and researchers theorize that pupil size change operates as a mood signal. If a person sees something that is exciting, whether it is accompanied by pleasurable anticipation or by fear, the pupils expand more than usual for the existing light conditions (Stass & Willis, 1967). The research findings suggest that pupil dilation may signal emotional arousal, interest, or attentiveness, but the role that this signal plays in interpersonal interaction is still being investigated (Knapp, 1972). The difficulty lies in the fact that pupil signals are not only unconsciously emitted, they are also unconsciously received. Two companions will feel an added emotional excitement if their pupils are dilating, or an added emotional dampening if their pupils are contracting, but they are unlikely to link these feelings to the pupillary signals they are transmitting and receiving.

Another area of interest was investigated by Scheflen (1965). He discovered behavior similar to patterns of courtship in numerous

therapeutic encounters and conferences. He made sound films of these interactions and after analysis concluded that there were consistent and patterned pseudo-courtship behaviors exhibited in these settings. He then developed classifications for these behaviors. "Courtship readiness" defines a category of behaviors characterized by constant manifestations of high shoulder hunching, and decreasing belly sag. "Preening behavior" is exemplified by such things as stroking the hair, rearrangement of makeup, glancing in the mirror, rearranging clothing, leaving buttons open, tucking in the shirt, tugging at socks, and re-adjusting tie knots. "Positional cues" are reflected in seating arrangements which suggested "we're not open to interactions with anyone else." Arms, legs, and torsos can be arranged so as to inhibit others from entering the conversation. "Actions of invitation" include flirtatious glances, gaze-holding, rolling of the pelvis, crossing of the legs to expose a thigh, or exposing the breasts.

Medical Literature

Nonverbal communication and its relationship to psychopathology and disease has been extensively investigated by medical researchers. This literature emphasizes the relationship between the nervous system and the expression of emotions. Sir Charles Bell, author of Anatomy and Philosophy of Expression (1844), was one of the first medical investigators to study the link between nonverbal communication and illness. He was an anatomist, surgeon, and neurophysiologist, and it was

as an anatomist that he first became interested in the expression of the emotions. Through his investigation of the nervous system he theorized a correlation between the various body movements and particular emotional reactions. Bell, the discoverer of the distinction between the sensory and motor expressions, observed that strong emotions (fear, rage, grief, or sexual excitement) are accompanied by alterations in breathing, and alterations of facial and trunk muscles as they affect and are affected by the changed respiratory patterns. Bell held the conviction that bodily responses were communicated faster than mental responses. He noted:

> Expression is to passion what language is to thought. It may be too much to affirm that without the cooperation of these organs of the frame of mind would remain a blank; but surely the mind must owe something to its connection with an operation of the features which precedes its own conscious activity, and which is unerring in its exercise from the very commencement.

The multitude of bodily expressions and behavioral gestures lends insight and understanding to psychosomatic illness. In the symbolism of symptoms, the individual unable to find an outlet for tension of an emotional origin, either by word or action, discovers a means of expressing these tensions through a kind of "organ language" (Johnson, 1946). Unable to holistically verbalize his feelings, thoughts, or actions, either intrapsychically or interpersonally, the organism as a whole becomes threatened and the struggle toward achieving "wholeness" is revealed in nonverbal behavior.

The body has a language of its own through which it conveys feelings and meanings that a person may have difficulty in verbalizing. Language of the body is astonishingly well described in our

everyday popular phrases. A person will speak, for example, of not being able to "swallow" an unpleasant life situation, an insult, or belittling remark. Frequently a feeling of oppression in the chest accompanied by sighing respirations in the absence of organic findings indicates that a person has a "load on his chest" that he would like to get rid of by talking about the dilemma. Nausea usually expressed symbolically in the words "can't stomach it" represents an attempt on the part of the individual to "vomit away" his difficulties. A common advice to others who "burn up" or "explode with anger" is "don't get your blood pressure up" (Berg, 1958). Bodily expression in the form of fatigue is often due to emotional conflict which used up so much of the person's energy that there is little left for constructive use (Hayakawa, 1939). An ache in the arm may, for instance, symbolize a defensive action against striking at someone else (Ekman & Friesen, 1969). Itching with no organic basis often represents an attempt to "come alive" (Lee, 1941).

Disturbances in nonverbal behavior, language, and communication are associated with more severe, and often longer lasting, mental and nervous conditions, while disturbances in verbal behavior, language, and communication are associated with less severe psychiatric conditions (Aden, 1963). In hysteria, for example, there can be a dramatic form of expression of communication behavior (Johnson, 1946). The hysterical person may, when faced with an unbearable of unacceptable reality, unconsciously avoid experiencing or perceiving the situation by resorting to symptom formation. In the attempt to avoid feeling an-

xious, and in order "to pull one's self together", the hysterical individual externalizes the disturbance associated with the anxiety to the body, and attempts to utilize an imaginative method of creating a body image that is acceptable. Hysterical speechlessness may represent an attempt to satisfy two conflicting drives in a particular speaking situation (Aden, 1963) such as the wish to assert oneself, or express hostility openly, and the conflicting need to be accepted, loved, and thought of as being a "nice" person. This leads to a state of emotional and physical stress, inhibition, paralysis and blocking, resulting in the hysterical speechlessness.

When a person perceives another's nonverbal messages, an individual and personalized interpretation of that behavior results. In other words, the person makes inferences depending on the context in which the behavior occurs on the basis of preceding experiences (Lorenz, 1955). Inferences can be made from such cultural externals as the pretentiousness of a person's home, automobile, or clothes, his or her wealth or social position. Inferences can be made on the nature of a person's work by observing the person's body configuration (Hayakawa, 1939; Lowen, 1967). Although the various forms of nonverbal messages differ somewhat from each other, they can be considered together for comparison with verbal messages. From the evidence presented in Table 3, the experience gained in the construction of computers (Ridenour, 1952), the study of neuroanatomy, neurophysiology, and speech pathology (Goldstein, 1948), and the study of interpersonal communication (Ruesch, 1973), one can

TABLE 3

SIMILARITIES AND DIFFERENCES BETWEEN VERBAL AND NONVERBAL MESSAGES

Nonverbal	Verbal
General Characteristics	
The nonverbal message is a Gestalt, the appreciation of which is based on analogies.	The verbal message, either spoken or written, is based on phonetics.
The nonverbal message can be broken down further; for example, details of a gesture are meaningful in themselves.	The verbal message cannot be broken down further; for example, there does not exist a meaningful fraction of the letter "A".
Nonverbal messages are based on continuous functions; for example, the hand is continuously involved in movement.	Verbal messages are based on discontinuous functions; for example, sounds and letters have a discrete beginning and end.
Nonverbal messages are governed by principles and rules which depend largely upon biological necessities; for example, the signals which indicate alarm.	Verbal messages are governed by arbitrary, man-made principles; for example, grammatical and language rules differ in various cultural groups.
Nonverbal messages are used as a interracial, international, intercultural, and interspecies language; it is adapted to communication with an "out" group.	Verbal messages are used as a culturally specific language; it is adapted to communication with an "in" group.
Spatiotemporal Characteristics	
Nonverbal messages are temporally flexible; for example, a movement can be carried out slowly or quickly.	Verbal messages are temporally inflexible; for example, words when spoken too slowly or too quickly become unintelligible.

Nonverbal messages can indicate successive events simultaneously; for example, "come" and "go" signals can be given at the same time.	Verbal messages must indicate sumultanious events successively; for example, a spoken or written report consists of words which are aligned serially.
The nonverbal message is spatially inflexible; movements and objects reauire a known but inflexible amount of space.	The verbal message is spacially flexible; print may be large or small.

Characteristics Referring to Perception

Nonverbal messages can be perceived by visual, auditory, or kinesthetic receivers alike; for example, action may be not only seen and heard, but also produce physical impact.	Verbal messages can be perceived by visual and auditory receivers only; that is, they can only be heard or read.
The nonverbal message influences perception and integration, and leads to the acquisition of new skills.	The verbal message influences thinking and leads to the acquisition of information.

Characteristics Referring to Evaluation

In a nonverbal message, the evaluation is tied to appreciation of similarities and differences.	In a verbal message, evaluation is governed by principles of logic.
In the nonverbal message, expression may be skilled or unskilled, but regardless of its quality, is usually understandable.	In the verbal message, expression must be skilled; otherwise it is unintelligible.
The understanding of a nonverbal message is based upon the participant's empathic assessment of biological similarity; no explanation is needed for understanding what pain is.	The understanding of a verbal message is based on prior verbal agreement; the word "pain" differs from the German word "Schmerz" and the understanding of the significance of these words is cultural-bound.

Neurophysiological Characteristics

Nonverbal messages	Verbal messages
are tied to phylogenetically old structures of the central and autonomic nervous systems.	are tied to phylogenetically younger structures, particularly the cortex.
In the presence of brain lesions, analogic understanding may be effected while repetition of words or ability to read is retained; for example, disturbances such as aphasic alexia or transcortical sensory aphasia indicate separate neural pathways for nonverbal as opposed to verbal messages.	In the presence of brain lesions, understanding may be retained while verbal ability is impaired; for example, verbal agnosia or alexia indicate again separate neural pathways for verbal as opposed to nonverbal messages.
Nonverbal messages involve complicated networks and includes the effector organs; for example, athletes and musicians go through certain warming-up motions prior to a performance.	Verbal messages involve the central nervous system only; for example, no movements and no external perceptions are necessary in order to recall a name.

Developmental Characteristics

Nonverbal messages	Verbal messages
are learned early in life.	are learned later in life.

Semantic Characteristics

Nonverbal messages	Verbal messages
Actions and objects exist in their own right and usually fulfill not only symbolic but also practical functions.	Words do not exist in their own right; they are only symbols. Words represent abstractions of aspects of events.
Nonverbal messages permit redundancies.	Verbal messages produce fatique when redundant.

Nonverbal messages permit brief and concise statements.	Verbal messages necessitate more elaborate statements.
Nonverbal messages are subject-oriented.	Verbal messages are predicate-oriented.
Nonverbal messages are demonstrative in nature and have emotional appeal.	Verbal messages are descriptive in nature and have an intellectual appeal.
Nonverbal messages are suitable for understanding.	Verbal messages are suitable for reaching agreements.
Nonverbal messages represent an intimate language.	Verbal messages represent a distant language.

Chomsky, 1965; Goldstein, 1948; Ridenour, 1952; Ruesch, 1973; Morris, 1977.

presume the existence of at least two forms of communication. One is the nonverbal message and the other is the verbal message. Since these two types of messages yield different information, a person is faced with the task of utilizing the resulting attenuations, reinforcements, repetitions or contradictions in order to obtain additional knowledge about the events to be understood. The gradual shift from nonverbal to verbal messages in language development occurs in three steps (Brown, 1973). The first step involves action signals, mediated predominantly through contraction of the smooth muscles, which are noted by changes in the color and temperature of the skin (vascular), the consistency of bowel movements (intestinal), the rate of breathing (respiratory), and other movements, such as sucking, which are subordinated to autonomic functions. The second step occurs when such somatic language is supplemented by action signals mediated through contraction of the striped muscles. The external expression of inner events through bodily manifestations of the intestinal, respiratory, and vascular systems recedes and is replaced by movements of the face and the extremities. The third step occurs when social action has been learned. Verbal, gestural, and other symbolic forms of communication suppliment and then replace the primary modalities of communication.

An examination of language development and its relationship to nonverbal and verbal messages sheds some light on the shortcomings of psychotherapeutic methods. For example, when a person talks about his or her experiences, a therapist who attempts to

reconstruct earlier events usually obtains only partial information since there are a number of experiential factors not amenable to verbal expression. Those aspects of the experience that lend themselves most readily to verbal expression tend to make up the bulk of these accounts while the remainder of the experience is deleted from consideration (Giedt, 1955). More specifically, verbal messages cannot adequately represent experiences and skills which are accessible in terms of action only.

According to Johnson (1946), people who cannot communicate nonverbally may experience a psychosis. The need to use nonverbal messages is expressed in the behavior of both manic-depressives and schizophrenics who, during a psychotic episode, may reproduce movements which accompanied earlier emotional experiences (Arieti, 1955; Ruesch, 1957). Thus, clients may suck their thumb or caress the arm of their chair in the process of recalling early memories. They may make shaking, pulling, or poking gestures (Ekman & Friesen, 1969) in the course of a verbal account. The psychotic's uncoordinated movements may be an attempt to re-establish an infantile communication pattern (Ruesch, 1948; Slone, 1955). It is as if these clients were trying to relive the patterns of communication that were not frustrating for them in early childhood. This is supported by observations of the behavior of psychotic children who tend to play with their fingers, make grimaces, or assume bizarre body postures (Brown, 1973). Their movements rarely are directed at other people but rather at themselves, sometimes to the point of

producing serious injuries. As therapy proceeds, interpersonal movements gradually replace the solipsistic movements described above. Through therapy, these children become willing to learn verbal forms of communication and begin to acquire mastery of verbal language (Brown, 1973; Weitz, 1974).

The early lack of appropriate congruent communication is imprinted on the movements of many schizophrenic clients (Watzlawick, Beavin & Jackson, 1967). Such schizophrenics are characterized by angular, jerky, uncoordinated movements, carried out with uneven acceleration and deceleration, and at either too slow or too fast a tempo (Arieti, 1955). This lack of motor agility may well be the result of insufficient practice in personal nonverbal interaction during infancy. There is evidence (Arieti, 1955; Bateson, Haley & Weakland, 1956; Mahl, 1956) for believing the incongruency between verbal and nonverbal messages and the lack of responsiveness by the parents in terms of using congruent messages is later compensated for on the client's part by an increased perceptual sensitivity to the actions of others.

In comparison, the manic-depressive, when not psychotic, makes ample use of nonverbal communication (Slone, 1955). They are warm, interpersonal, and sometimes artistic, and frequently have well-rounded, coordinated movements. During a depression the relationship between cognition and the muscular system appears to be lost (Anderson, 1956; Johnson, 1946). One explanation assumes that during a depression the congruency between the non-

verbal and verbal messages is impaired. This theory seems justified in view of the fact that depressives have been observed to improve in a matter of hours or days as a result of psychotherapy (Kalis & Bennett, 1957). The effect is similar to that observed when a sound track and motion picture are not synchronized; even if the scene is a powerful one, the viewer is not "moved." The defect can be remedied in a short time by proper juxtaposition of picture and sound.

Psychosomatic clients display still another kind of disorder. They have learned nonverbal language, but they lack the mastery of verbal communication (Ruesch, 1957; Thorne, 1946). As a result, they have difficulties in decision-making, extrapolation, interpolation, and the use of discursive language. In these clients one can observe a predominance of autonomic behavior, with body movement secondary, and verbal behavior employed least of all. It has been repeatedly observed that when clients learn to use body movement as a language, some physical symptoms disappear (Scheflen, 1974). Psychosomatic clients frequently complain that they cannot appropriately represent their feelings and thoughts in verbal terms. This inability seems to arise from the fact that their manipulation of verbal language does not involve their emotional participation (Anderson, 1956).

The same appears to be true for psychopaths, who use actions as a way of conveying messages to others. The psychopath believes that when he or she is not active, nothing is conveyed about their feelings and thoughts (Anderson, 1956; Hayakawa, 1939).

Summary

The literature on nonverbal communication is extensive and research covers an exhaustive list of nonverbal phenomena. This section has attempted to present a brief overview of the relevant research in this area, through a consideration of the anthropological, psychological, and medical literature. The next section examines some of the methods by which nonverbal communication can be used in the therapeutic relationship to facilitate change.

FACILITATING CHANGE USING NONVERBAL COMMUNICATION

Nonverbal behavior can be used in several different ways. This form of communication can be used by the client to express emotion; it can communicate interpersonal attitudes; it can communicate information about the client's personality and, combined with verbal messages, communicate a vast array of cues that can be used by the therapist to assess the value and content of the client's "total" communication.

For the purpose of convenience and clarification, this section will discuss the client's communication in behavioral, affective, and cognitive areas. These categories have areas of overlap for any given clinical problem. The effectiveness of therapeutic intervention can be determined by the changes that may occur in any one of these categories, in any combination of two, or in all three categories simultaneously.

Evaluation and Application of Nonverbal Communication

A client's nonverbal messages generally are more useful than verbal messages to the therapist who wishes to understand the client's feelings and attitudes (Mehrabian, 1981). Incongruent messages are interpreted by the therapist as confusing and a source of disturbance for the client. For instance, when a mother tells her son,

"Come and give your mommy a kiss" and then turns away from him as he approaches because his hands are dirty, the child is confused (Bateson, 1972). This is a typical example of a "double-bind" situation that gives the child, as in this example, no clear choice for action and leads him to a point where he himself begins to use incongruent messages. Often a client's interpretation of the social rules and prohibitions about the expression of feelings (particularly negative ones) leads to the frequent use of incongruent messages. A client may also use these incongruencies to achieve efficient communication or even to be funny, as in sarcasm. It is helpful for the therapist to focus on the impact of the client's "total" communication. Thus, the importance in therapy may be whether the messages have a positive or negative quality. Unusually frequent negative messages may be indicative of a frustrating situation for the client. Analogic communication may contradict or reinforce things the client says. In either event, these nonverbal messages should be recognized as a potential tool for the therapist to facilitate change.

Many people experiencing anxiety present a myriad of somatic complaints such as fatigue, anorexia, irritability, headache, and chest tightness. They are quite unaware that the source of their problem is anxiety. Anxiety is also exhibited in a wide variety of other maladaptive patterns such as eating disorders, ritualistic behavior, assaultive behavior, hallucinations, delusions, withdrawal, and suicidal preoccupation. Anxiety often signals a struggle within the personality, indicating that something is amiss

(Sullivan, 1948). The anxiety experienced when an individual is in a high status position or preparing for an exam can mobilize coping behavior. If looked at within this context, anxiety can serve as a motivating force, warning the individual to avoid or correct threatening situations. The therapist can assist the client in alleviating the problem by recognizing the analogic communication accompaning the client's verbal message.

Accompanying the psychological responses to anxiety are various psychophysiological symptoms that are regulated by the autonomic nervous system. These include palpitations, tachycardia, sweating, urinary frequency, vertigo, chest pains, headaches, dryness of the mouth, diarrhea, anorexia or excessive eating, and increased rate and depth of respirations. They may occur alone or with other psychological symptoms.

Clients experiencing intolerable anxiety may display excessive physical activity to relieve tension (Menninger, 1964). These behaviors may include wringing the hands, rubbing the body, wiping the brow, and trying to catch the breath. Such clients engage in repetitive foot swinging, finger tapping, cuticle picking, and nail biting.

Anxious clients often attempt to induce the therapist to take the role of problem solver or healer. Clients who demand that the therapist alleviate their pain, and supply answers to their problems, create an impossible expectation. Therapists who fall victim to this seduction impair the client's ability to assume responsibil-

ity for difficulties and keep them from learning problem-solving behavior. If the therapist assumes the role of problem-solver, the solutions they suggest are often rejected or not implemented by the client. Clients who do attempt to implement suggestions often do not succeed. The ability to integrate learning is missing when the client is experiencing more than mild levels of anxiety. Agitated clients may ignore verbal requests. Using selective inattention, they may continue in an activity they are pursuing. These clients require repeated reinforcement and reminders. Another dynamic is the client's repeated harassment, pleading, or requests for attention.

A client labelled as psychotic is one who experiences difficulty in evaluating reality. This individual often has problems characterized by mood changes, perceptual disturbances, disordered thinking, and a general impoverishment in interpersonal relationships resulting in isolation and withdrawal. High levels of anxiety contribute to this development in that the individual experiences a loss of ability to focus on contents of awareness (selective inattention). The client instead attends to everything yet misses relationships between ideas (Scheflen, 1963). There is continual physical discomfort that can be observed by the therapist.

Schizophrenic psychoses are diagnosed by observing certain types of behaviors. For instance, hebephrenic schizophrenia is characterized by disorganized thinking, superficial and inappropriate affect, unpredictable laughter, silly and regressive behav-

ior and mannerisms, and frequent hypochondriacal complaints. Delusions and hallucinations, if present, are transient and not well organized. Catatonic schizophrenia can be either of two types. One is characterized by excitation and the other by withdrawal. The excited form is marked by excessive, sometimes violent motor activity and agitation, whereas the withdrawn type is characterized by generalized inhibition manifested by stupor, mutism, negativity, and waxy flexibility. In time, some clients may deteriorate to a vegetative state.

Behind all mental disorders rests an affective element of anxiety and loneliness (Peplau, 1955). Loneliness is usually not a chosen condition, and what is experienced by the client is not so much loneliness as estrangement, unexpected dread, desperation, or extreme restlessness. Schizophrenic clients may and often do experience feelings of emotional emptiness --- manifesting flat affect, inappropriate affect, and ambivalence (Arieti, 1955). Flat affect is a form of mood change in which there is a loss of feeling. The client feels inert and incapable of any emotional display. There is also an absence of emotion in the tone of voice and kinesthetic movements. Although most individuals experience dull periods from time to time, these periods are exaggerated in duration and intensity in the psychotic. For example, during the psychiatric interview a client described her three-year-old son's sudden death under the wheels of the family car in the driveway in a monotone voice, and with no facial expression or verbal evidence of distress.

Inappropriate affect is affect which is incongruous to the situation, content of thought, and the ideas expressed. A client, in discussing the recent death of his mother, described her funeral as if it had been a party, laughing and smiling throughout the narrative.

Ambivalence refers to conflicting feelings experienced by the client. These are normally present in all relationships, however, the schizophrenic experiences excessive ambivalence (Bateson, 1972). This ambivalence has an unrealistic quality in terms of objects, people, and situations. For example, a particular client would often make obvious opposing statements about her mother such as "I love you, I hate you!" or "I want to live on my own, I need my parents so much."

A female client who initially gave information about herself and her family in great detail altered her behavior as the therapeutic relationship progressed. As she was encouraged to focus on her feelings (affect), she soon did not respond, lost eye contact, and looked across the room. At such times the therapist can help the client to notice what is happening and identify what it is that is frightening, so that resistance can be overcome.

Frustration is a feeling experienced by the client when important expectations are not met. The frustrated client experiences a generalized uneasiness and irritability which can blossom into anger if unchecked or unresolved. An important criterion for therapy is the client's ability to tolerate reasonable frustration and

traumatic events, and to use more adaptive modes of behavior.

Development of some neurotic patterns in individuals seems to be influenced by the underlying personality structure, and the symptoms seem to fit the person's lifestyle (Shapiro, 1965). For example, the hysterical neurotic who frequently exhibits inauthentic emotional outbursts may earn a living as a performing artist in the theater. The meticulous accountant is more apt, under intolerable stress, to exaggerate already ingrained behavioral patterns and exhibit compulsive behavior rather than hysterical (Nemiah, 1975). The phobic housekeeper may be a woman who tells others that she really wants to get out of the house and do things in the community, but in actuality is unable to do so because of a fear of being outdoors. In attempting to control intolerable anxiety, the neurotic client may exhibit a variety of physical symptoms which have no organic basis, inauthentic emotions, repetitive and ritualistic actions, and excessive fears.

Hysteria is a term applied to various sensory, motor, or psychic disturbances (Abse, 1974). The behavior of clients with such symptoms may be bizarre. Manifestations of hysteria include somnambulism (sleepwalking), amnesia (fugue states), multiple personalities, dissociative experiences, apparent paralysis of a limb, deafness, and mutism. These manifestations are grouped under the general label of conversion reactions.

The primary mode of coping with anxiety laden cognitions in hysteria is repression (Abse, 1974). This coping process results

in a tendency toward forgetfulness. The client exhibits a noticeable lack of affect, in proportion to the apparent severity of the symptoms. For example, a middle-aged woman experienced total blindness and all organic causes were ruled out. When the doctor spoke with the client, she did not deny the blindness, but rather seemed calm and unconcerned about her loss of vision. She asked no questions and expressed no anxiety about her condition, nor did she ask about the medical prognosis. This is typical behavior of someone experiencing a hysterical conversion reaction.

Hysteria occurs in many forms. The example given, of hysterical blindness, falls into the category of conversion reactions. This means that the underlying psychological conflict is literally converted into a physical manifestation. The secondary gains a person derives from the surrounding environment during illness is a significant factor to be taken into account when planning therapy.

Clinically, therapists often identify an overlapping of substance-abusive and psychopathic traits (Bersten, 1973). There are common dynamic elements: mistrust, excessive dependency, faulty learning, and low tolerance for the tensions of anxiety, guilt, and anger, These elements give rise to several behavioral problems with which therapists must be concerned in both substance abusers and psychopaths. These include manipulation, impulsiveness, withdrawal, and grandiosity. These behaviors are not in and of themselves pathological or maladaptive: in fact, circumstances may give rise to such behaviors in almost anyone at one time or another. What must con-

cern the therapist, however, are repetitive patterns which emerge as obstacles to healthy interpersonal relations.

In order to make judgments about the effectiveness of interventions, therapists must constantly evaluate the significance of the changes manifested by the client. These changes should be related to the expected outcome or goals of intervention. For example, in the impulsive client, fewer instances of interruption of others' conversations and activities is an appropriate change. Other significant changes can be that the client will use more time in problem-solving, or that the client will actually carry out plans that are discussed.

The behaviors of depression may be placed on a continuum from the mild transitory affects of feeling low to a severe, psychotic depressive state. Depressed people find themselves unable to experience pleasure from activities which are ordinarily enjoyed (Anthony & Benedek, 1975). They may feel ineffective, powerless, or helpless. Tears and crying may be evident. Feelings that are suppressed or repressed tend to manifest themselves in other behaviors. Thoughts (cognitions) tend to be slowed and interests narrowed. Concentration may be difficult for the client and indecisiveness is common. Thoughts tend to be ruminative, going over and over the same issues and content with no movement toward or recognition of alternative solutions.

The depressed person feels empty. Somewhat paradoxically, there is also a feeling of great heaviness (Crumb, 1964). Movement and speech behaviors are slow (Psychomotor retardation) and every task is a burden. Every fiber of the body may ache. Weakness and fatigue

persist despite rest. There is little energy available for grooming and self-care. Frequently there is high sensitivity and concern over organ functioning. For example, a person may experience something disordered about the heartbeat or about breathing, digestion, elimination, or any other organic function, while health professionals are unable to find medical evidence of anything wrong. Oral intake varies, with some inclined toward excessive eating and drinking, others toward anorexia and weight loss. In some cases motor activity is considerable, as seen in constant walking, repetitive cleaning, or some other seemingly purposeless activity.

The depressed person tends to be slow in speech and to have a paucity of verbal output. The limited verbalizations are generally self-deprecatory and ruminative. The communications of depressed people may center around the constant repetition of a given life experience (Johnson, 1946). In relating events, depressed persons may manifest a kind of inflexible attachment to their self-deprecation. For example, one man related that he had been silent about the illegal act of a friend. The act allegedly cost both of them their jobs when the act and his knowledge of it were discovered. The man also went on to talk obsessively about morality in general. He asked for reactions from others but was unable to accept either a positive or a nonjudgmental acknowledgement of his experience. He then repeated all his previous remarks, and tenaciously held to his self-deprecatory view.

The thoughts revealed through the depressed person's limited

verbalizations may contain gross misinterpretations of reality. Delusional thinking may be present, and serve to categorize an individual as psychotic. The delusions confirm the person's feelings of worthlessness, guilt, and powerlessness. These delusions serve a punitive role and defend the person against a pleasant reality. For example, a deeply depressed person may believe that a body organ is missing or malignantly diseased. This thought is in contrast to the mildly depressed person's experience of heightened sensitivity to body function.

The motor activity and body movement of the severely depressed client may be at a standstill (vegetative), or may consist of rapid, agitated, purposeless movement. These clients do not maintain self-care or provide self-nurturance. Without intervention, there may be a marked loss of weight. The client often feels worse in the morning but better as the day progresses. Posture is poor; when resting, clients often sit slumped or curled up. There is an inclination to stay in bed and to avoid social relationships. What may appear to be a simple task will possibly be viewed by the client as very complex and insurmountable.

Respect is expressed in diverse ways as the therapeutic relationship evolves. During the early stages of therapy, the therapist can convey the intention to listen to the client. Analogic behavior designed to encourage talking (head nods or "uh-huhs") lead the client to believe that the therapist will listen without judging them, depreciating them, telling them how they ought to act, or demanding their

compliance with some expectation. The therapist's responses suggest confidence and trust in the client's ability to act in his or her own behalf and to come to a successful resolution of difficulties. Within this climate of acceptance and trust, clients may feel free to engage in deeper levels of self-exploration.

Throughout the therapeutic process, the therapist experiences feelings toward the client and/or the relationship. The therapist's analogic messages may indicate these feelings to the client and are therefore important and need to be recognized. Genuine expressions which convey the therapist's reactions to the client can be used by the therapist to further the client's self-exploration. Feelings of attraction, warmth, and concern are common reactions to a client; negative responses, such as discouragement, resentment, boredom, guilt or anger, are equally typical. Incongruent messages from the therapist generally have the effect of eliciting defensive responses from clients. Congruent messages, on the other hand, enhance rapport.

The mutual recognition of the client's troubled world, acquired during the initial phase of the therapeutic relationship provides a foundation for deeper inquiry. The therapist's empathic expressions are intended to assist the client's clarity, and extend the meaning of their experiences. When the problem is better understood by the therapist than the client themselves, the therapist can make tentative statements aimed at calling attention to relevant, though previously unexplored thoughts and feelings. Thus, the therapist prepares the way for clients to experience and fully express feelings which were up to

this time, unacknowledged. The results of this intervention, as demonstrated in Table 4, indicates the importance of recognizing and utilizing the client's analogic communication as a method of exploring the client's experience and the messages (congruent or incongruent) that they are communicating.

Therapy generally has as it's goal personality change, but change can also be brought about by the best possible utilization of what the client already has. It is not necessarily true that the therapy that produces the most change is the best therapy. It is possible to make the opposite assumption and deliberately set the therapeutic goal as "minimun-change". The therapist would try to help the client discover some unblocked path in which he or she could move forward, develop their own personality, and thus transcend, rather than delve, into the anxieties and conflicts in which they may now be enmeshed.

This process may be defined in terms of a change of direction rather than in terms of distances or amounts. The difficulties being experienced can be thought of as indications that the client may be headed in an inappropriate direction. A relatively minor shift in the psychological direction in which a client is moving may well change their life considerable over a long period of years. It is possible for therapy to be shortened considerably without making it any less valuable.

More emphasis than is ordinarily placed on a positive diagnosis may be implied. The therapist can ascertain where the client's weak areas are; but also important is the diagnosis of strengths. Clients

TABLE 4

CONGRUENT MESSAGES AND THERAPIST RESPONSE

	Client's Message		Therapist's Verbal Response		
	Verbal Message	Nonverbal Message	Reflecting	Reinforcing	Advising
Affective Verbalization	"I'm so mad at him that I could just scream!"	Kicking foot, loud voice, clenched fists, gritting teeth	"This situation has made you really angry."	"I'm pleased that you recognize how you feel."	"You might want to let your husband know how you feel."
Behavioral Verbalization	"Everything is working out so well that I'm quitting my job."	Smile, relaxed posture, hands open and palms down, slow respirations	"You seem really pleased to be leaving your job."	"You appear very relaxed after making such a difficult decision."	"It's important for you to use what you have learned about putting off decisior
Cognitive Verbalization	"I think I've made a decision; I'm getting a divorce."	relaxed posture, eye contact, no hesitations in speech	"So you've made the the decision to get a divorce."	"It's pleasant to see you taking care of yourself."	"An appropriate step in taking care of yourself is feeling confident with your decisions."

INCONGRUENT MESSAGES AND THERAPIST RESPONSE

Client's Message			Therapist's Verbal Response		
	Verbal Message	Nonverbal Message	Confronting	Supporting	Advising
Affective Verbalization	"I'm so mad at him that I could just scream."	Smiling, relaxed posture, soft voice.	"It appears that you're pleased that you caught him in this situation."	"Sometimes it feels good to you when you're sure that you are right."	"It's been my experience that when someone smiles and says they are angry simultaneously that they're pleased in some way."
Behavioral Verbalization	"Everything is working out so well that I'm quitting my job."	Tense forehead muscles, reddish face, clenching and unclenching hands.	"This situation did not work out quite how you wanted it to."	"I'm pleased you've made a decision even though you would like to have stayed."	"You might be interested in the difference between what you have said and what your physical activity tell me."
Cognitive Verbalization	"I think I've made a decision; I'm getting a divorce."	Tense, shifting posture, soft & choking voice, dilated pupils.	"I can see that this is not what you really want to do."	"Even an uncomfortable decision is a step in making a comfortable one."	"Sometimes speaking like you are means that a situation is hard to swallow."

who know their real strengths and are clear about their basic values may be able to turn away from anxieties that would ordinarily be very difficult to change.

The therapist is more likely to become aware of the client's strengths by observing analogic behavior than by asking them questions. Some of this meaningful behavior occurs in the interview situation itself. For example, when a client flashes a sudden smile as they recall the amusing aspects of a particularly humiliating social experience, the therapist knows that the client possesses an asset that may be of considerable use. In social situations and in personal emotional adaptation to the vicissitudes of life, a client's ability to laugh at predicaments will be a valuable asset. Other assets frequently observed where hostility, doubt, guilt, and anxiety are the main themes include moral principles of which the client is absolutely certain, demonstrated courage in the face of adversities, or loyalty to those they love. Whether or not it is advisable for the therapist to reflect or interpret such expressions at the time they occur is not as important as the therapist's taking mental note of them and using this knowledge to facilitate change.

For example, a client may speak of having had a long talk with his wife the night before therapy, an action unprecedented in his previous experience. Another client, who has always been an anxious, perfectionistic procrastinator, may say that she has handed in, on time, an assigned paper for a course she is taking. Or the therapist may note the change in the incidental observation that the usually nervous

client is talking while sitting in the chair quite comfortably. When the client has a Coke with a girl, the therapist knows that the client has taken the first step toward overcoming the paralyzing shyness of which he has been complaining. A small change in the direction of closer emotional ties with one's family or greater willingness to assume responsibility is the kind of change that can have a profound effect on later development.

Summary

This section has discussed common analogic communications of clients experiencing various therapeutic problems. The therapist can facilitate changes in clients through recognition of both congruent and incongruent messages and through an interpretation of the client's "total" communication. It is also important for the therapist to be aware of his or her own messages, and how therapist congruity or incongruity may be interpreted by the client. A Table illustrating typical client messages, and appropriate therapeutic responses was presented. The type and extent of change necessary for adequate therapeutic results was also considered.

DISCUSSION

This paper has focused on nonverbal communication and the ways in which it may be employed to facilitate change in the context of psychotherapy. The anthropological, psychological, and medical literature was reviewed, and an overview presented of the relevant research on nonverbal communication. A strong implication of the literature is the importance of recognizing nonverbal behavior as a reflection of affect in any interpersonal interaction. The literature provides substance to the recognition of certain repetitive nonverbal behaviors as characteristic of particular personality structures. A major portion of the research deals with the scientific examination of the message and function of various nonverbal behaviors. The remaining literature provides reason for doubt as to the appropriateness of these research methods of explaining nonverbal behavior and the various messages that are associated with it. Instead, this literature views nonverbal behavior as relevant only within the context of interpersonal interaction, and the verbalizations which take place within those interpersonal interactions. A Table was provided which compared the complementary functions of nonverbal and verbal messages.

A consideration of the material presented earlier in this paper allows one to form several conclusions about nonverbal communication and its role in the field of psychotherapy. It seems clear that a therapist should make use of a combined language (verbal and nonverbal)

which is productive and understandable to the client in order to communicate with that client with more purpose and meaning. The client who is experiencing anxiety and is in conflict to such a degree that there is a tendency toward psychic disorganization will typically express this state of disturbance concomitantly in all areas of personality. The verbal and nonverbal behavior will similarly show this tendency towards disorganization and/or disturbance. This alteration of function may be recognized by an examination of the client's "total" communication. In examining this "total" communication, it is critical for the therapist not only to recognize areas of congruency and incongruency, but to evaluate the communication for its positive or negative content.

Once the communication described above is observed and interpreted by the therapist, he or she has a significantly improved information base from which to respond to the client. Such responses may take the form of a content-oriented verbal response, a purely nonverbal response, or (perhaps most commonly) a verbal and nonverbal response. Such responses are directly influenced by the training and experience of the individual therapist, and must be mediated by a consideration of the personality and problems of the particular client being seen for treatment. Similarly, the type and depth of change attempted in the therapeutic relationship is also dependent on the interaction of a number of factors peculiar to the individual therapist and client under consideration. At a more general level, however, we may note that a combination

of verbal and nonverbal messages opens up a large number of possibilities for communication between therapist and client. Through a recognition and interpretation of the client's nonverbal communication the therapist can better understand that client. The therapist may then use both verbal and nonverbal communication to assist that client with tools for overcoming isolation, increasing self-respect, and cooperating with others.

In conclusion, nonverbal communication forms a critical dimension in the overall communication in the psychotherapeutic interaction. Effective interpretation of the client's nonverbal behavior provides information valuable for understanding one's clients and the problems that they experience. The utilization of meaningful nonverbal behavior by the therapist can greatly facilitate the client's change into more healthy and constructive modes of affective, behavioral, and cognitive functioning. Additional research on specific psychotherapeutic applications of nonverbal behavior is necessary to expand current understandings of this phenomenon. Such research will aid in the development of more effective modalities of psychotherapeutic treatment in the future.

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