5

Nonverbal Behavior Research and Psychotherapy

MARThA DAViS

A HISTORICAL PERSPECTIvE

In spite of . . . difficulties in conscious analysis, we respond to gestures with an extreme alertness and, one might almost say, in accordance with an elaborate code that is written nowhere, known by none, and understood by all.

(Sapir, 1968, p. 556)

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.

(Freud, 1905/1959, p. 94)

There have been many assertions of the importance of body movement, facial expression, voice tone, and other aspects of nonverbal behavior in face-to-face interaction. And, if one includes research from anthropology, communication, and ethology as well as psychology, there is now an extensive and fascinating literature on bodily communication

MarTHA DAViS • Department of Mental Health Sciences, Hahnemann University, Philadelphia, Pennsylvania 19102. The author's recent research has been sponsored by Hahnemann University in Philadelphia, aided until 1982 by grants administered through the Institute for Nonverbal Communication Research, New York.
that is of potential value to the clinician (M. Davis, 1972; M. Davis & Skupien, 1982).

There are now some excellent anthologies and research overviews of nonverbal communication (F. Davis, 1973; Harper, Wiens, & Matarazzo, 1978; Knapp, 1978; LaFranca & Mayo, 1978; Weitz, 1978). And the clinician interested in nonverbal communication can also find many specialized texts such as on facial expression (Ekman, Friesen, & Ellsworth, 1972), skill in perceiving nonverbal behavior (Rosenthal, Hall, DiMatteo, Rogers, & Archer, 1979), ethological and quantitative assessment of face-to-face interaction (Duncan & Fiske, 1977; Kendon, Harris, & Key, 1975), periodicity in communicative behavior (M. Davis, 1982; Jaffe & Feldstein, 1970), nonverbal correlates of power relationships (Henley, 1977), gender and nonverbal communication (Mayo & Henley, 1981), as well as books devoted to nonverbal communication in psychotherapy (Scheffen, 1973; Waxer, 1978).

From the 1930s until recently the network of nonverbal communication researchers has been intricately interrelated. The zeitgeist for the current "movement movement" was germinating as early as the 1930s when psychiatrist Harry Stack Sullivan and linguist Edward Sapir were close associates (Sullivan, 1939) and anthropologist Birdwhistell people was working with psychiatrist Erich Lindemann on the measurement of therapy interaction rhythms (Chapple & Lindemann, 1942). It can be seen growing at the anthropology department of Columbia University where Franz Boas, who made some of the earliest attempts to study cultural movement styles from film, would directly influence Gregory Bateson and Margaret Mead. The culture of the Balinese (Bateson & Mead, 1942) and David Efron's classic analysis of Jewish and Italian gestures (Efron, 1942/1972). It shows in the influence of Sapir and linguist Trager and Smith on anthropologist Ray L. Birdwhistell, and in the impact of communications in the mid-1950s among Frieda Fromm-Reichmann, Birdwhistell, and several important linguists attending the Palo Alto Institute for the Advanced Study in the Behavioral Sciences—from which Bateson, Birdwhistell, and later Albert E. Schellen would be spurred to examine communication in psychotherapy (Birdwhistell, 1970). By the mid-1960s Charny (1966), Condon (1968), Lomax (1968), Byers (1972), and many other would confer intensively with Birdwhistell and begin various lines of kinesic research, while Chapple was directly influencing Feldstein, Jaffe, and a growing number of psycholinguistic researchers. And by the 1960s Bartenieff (Bartenieff & Lewis, 1980) would be bringing Rudolph Laban's work on movement analysis and notation to bear on her studies of psychiatric patients with this author (Bartenieff & Davis, 1975), examination of infant movement patterns with Kestenberg (Kestenberg, 1975), and cross-cultural studies of movement with Lomax and Paulay (Lomax, 1968).

At a larger level the movement movement appears one manifestation of the trend encompassing communication systems research, interpersonal theories of psychiatry, and efforts to diffuse distinctions of mind-body, right and left brain hemisphere functions, and behavioral form-content. And the current respect for visible behavior is surely a powerful expression of the impact of film and television.

A therapist surveying this field may be struck by certain clinical potentials that are very close to being realized. First, the field is a remarkable source for operationalizing key psychological concepts that have largely eluded empirical assessment, such as bonding, regulation of intimacy, interpersonal trust, empathy, rapport, repression of affect, and splitting. Many of the research examples to be discussed are in effect studies of the visible manifestations of these processes. For example, it is conceivable that, if very complex movement observation assessments such as those done by Kestenberg and her associates can be standard­ized, movement rhythms and muscle tension analyses may empirically confirm Freud's theory of psychosexual stages. Kestenberg (1975) has found "tension flow" rhythms in infants and young children that correspond to specific forms of drive discharge, "oral," "anal," "phallic," and "genital" motor rhythms that appear in a stage-specific way in the first 4 years of life, and rhythmic predominances that reflect specific fixations. I hope to show with later examples that very diverse intra­psychic and interpersonal processes can be observed in movement depending on what details of it the researcher studies.

Another general impression from this field has been strongly asserted by Kiesler:

The most crucial place to search for relationship is in the nonverbal behavior of the interactants. [The total available methodology of assessment for paralanguage, kinesics, proxemics, touch, etc. is crucially relevant for assessment of client and therapist relationship factors. (1979, p. 303)]

Early research regarded bodily expression as a royal road to the unconscious with affective states and emotions expressed from "within" the individual "outward" to the perceiver. The crude and often contradictory beginnings of facial recognition research are now supplanted by highly sophisticated, empirically validated research on the face and emotion (Ekman & Friesen, 1975). But the last 20 years of nonverbal communication research have been most notable for discoveries of how
subtly and complexly kinesics and proxemics convey “relationship messages” as well. Not coincidentally, Kiesler (1979) has written a position paper stressing the importance of nonverbal behavior in psychotherapy within an interpersonal, Sullivanian framework. Finally, the clinician surveying this literature may get a disconcerting feeling that there is something too elusive about the subject. How can it promise so many insights and yet be so neglected in therapy practice and training? How can it excite and fascinate at one level yet seem so trivial in the real world? How can someone like Reich present such a rich analysis of character from the way his patient walks and sits whereas one’s own patients appear motrically indistinct, unremarkable, bland? In actual therapy practice what is its relevance? Despite protestations in the literature that the goal is not to someday read body language like a book with the aid of a dictionary of precise definitions, there is a concerted effort perceptible throughout the research to delineate specific motions and positions and then to determine, or at least try to approximate, the most context-free, commonly shared meaning(s) of them. This requires that the action, posture, movement, or vocal characteristic have a perceptible “discreteness” and specificity. Positions, instrumental actions, the signs of American Sign Language, and certain hand gestures (such as what Ekman and Friesen have called “emblems”) have this property of discreteness and specificity.

By now it is possible to construct a glossary of specific meanings from the literature on facial expression of emotion (Ekman & Friesen, 1975), postures and attitude expression (Mehrabian, 1972, 1981; Kendon, 1980; Morris, Collett, Marsh, & O’Shaughnessy, 1979), and, of course, formal sign language (Stokoe, 1972). In this literature discrete movements and positions with their respective meaning(s) become the figure; and the “display rules,” “blends” (Ekman & Friesen, 1975), individual and cultural variations, that is, the qualifications, become very much the ground.

Certain features of nonverbal behavior that are highly discrete and specific, such as facial expressions of happy, sad, disgust, anger, fear, and surprise, have highly specific interpretations both in their “pure” forms and as identifiable elements of facial blends. Specific emotions can also be decoded from types of voice tone (Ostwald, 1963; Scherer, 1979), although not as yet with the weight of the empirical evidence produced for facial recognition.

Once the observer attends to more diffuse, continuous, difficult-to-demarcate activity such as fidgeting, postural shifts, degrees of tension, and so on, the interpretations become more general. For example, Waxer (1978) has demonstrated that observers can distinguish anxious and depressed patients from soundless videotapes, and he can tease out of their reports what clusters of movements appear to contribute to their impressions. But the nonverbal referents are not nearly so specific and particularizing as those for discrete facial expressions or even voice quality. The glossary becomes disappointingly general (e.g., depressed patients display longer averted gaze and lowered head positions). Although there have been advances in decoding facial, vocal, and postural cues of potential value to the clinician, a great deal of the clinically valuable research is not and cannot be so concrete. The interpretation of the meaning of specific body movements is greatly influenced by the knowledge of the context (Birdwhistell, 1970; Schefflen, 1973). There are also notable differences in the ability to decode (perceive and interpret) nonverbal behavior. Rosenthal et al. (1979) have offered evidence that individuals will be more or less accurate in interpreting alternative meanings of the expressions of a person presented in soundless film segments or content-obscured sound tapes. With the PONS (Profile of Nonverbal Sensitivity) test they can generate individual skill profiles indicating what aspects of nonverbal behavior one more readily perceives than others. To further complicate efforts to specify what a movement means, there is the enormous complexity referred to in the literature as “channel discrepancy”—the numerous ways movements may anticipate, contradict, amplify, or slant speech content; the discrepancies between what one says and how one says it—in short, the complexity of deciphering ongoing behavior from diverse “channels.”

The research on specific meanings of discrete expression is based primarily on the reliable judgments of detached observers or listeners who are not in the situations photographed or taped. There is a vast difference between the perceptions of one looking at a photo or videotape and the experience of the interactants. And this difference—“detached decoding” versus “participant observation”—is crucial to the clinician.

There is now a sizable experimental literature on observer judgments of nonverbal behavior in simulated interviews and psychotherapy sessions (Waxer, 1978). Counseling psychologists in particular have shown a strong interest in nonverbal communication and have contributed considerably to this literature (Gladstein, 1974). It is directly related to earlier facial recognition research in that experimental subjects, often college students, are asked to judge photographs, films, or videotapes in terms of what affect(s) or attitude(s) are expressed in the facial expression, visual behavior, and positions of the interactants. This literature
would seem a good place to start for a clinician interested in nonverbal behavior in psychotherapy; yet for a number of reasons it can be a misleading and very limited source for the clinician.

First, one would not necessarily be learning about nonverbal behavior in psychotherapy. One would be reading about recognition and interpretation of contrived behaviors presumed related to psychotherapy. Frequently, the behaviors to be judged are so contrived as to generate either clinically trivial or artificial findings. For example, the “therapist” is to sit forward or back at controlled points in a simulated interview to examine perceptions of rapport with the client.

Besides problems inherent in experimental manipulations and use of naïve judges, there is another drawback to the decoding research that is crucial to the clinician. It cannot safely be assumed that the client or therapist will interpret kinesic, proxemic, and paralinguistic patterns as raters do because there is a profound difference between impressions by one separate from the interaction and impressions as a participant in the interaction (Bakken, 1978). In fact, we know very little about how the perception of nonverbal behavior varies by context. There is, however, a great deal of indirect evidence that perceptions while in the interaction are dramatically different from those of a naïve observer or a researcher viewing a videotape.

For this decoding research to be of clinical value the research must honor at least some of the clinician’s needs—namely, that the behavior examined is relevant and important to therapy; that there are some data offered about the patterns of its frequency and occurrence in therapy; that the analysis of the behavior is not so gross and simplistic that it adds nothing to what the clinician would intuitively grasp anyway; that the researcher is consistently clear as to who is rating what with what terms and for what ends, and does not split too readily into unwarranted generalizations to therapy.

Because nonverbal behavior is ubiquitous and visible and has such important psychological valence, because it is in a sense at the nexus of social perception, social expression, and “presentation” and experience of self, it affords a way of empirically examining relationships between perception of “the other” during interaction versus detached “objective” observation versus “subjective” experience of one’s behavior and manner. For the therapist this could elucidate such important clinical concerns as transference-countertransference reactions or parataxic distortions.

For example, in the research on posture mirroring there are clues as to what new insights could be generated from study of these multiple perspectives. “Objective” onlookers offer a “group consensus” that mirroring reflects heightened rapport (Trout & Rosenfeld, 1980). Charny (1966) found that the client’s verbal behavior was more “positive” and “bound to the therapeutic situation” during periods of mirrored positions. Sequelen (1973) has noted the interesting alternations in and out of mirrored positions that relate to shifts in alliances during a family therapy session. LaFrance (1982) presents evidence that posture mirroring precedes the interactants’ experience of rapport and may be a mechanism for establishing it. But it would also help to learn about the patient’s and therapist’s experience during periods of mirroring, both when aware and when not conscious of it. In other words, it should be possible to examine “subjective” and “objective” reactions in relation to naturalistic occurrences of psychologically cogent nonverbal behaviors such as posture mirroring and to learn much more than that they “mean” rapport.

MOVEMENT AND PERSONALITY

I shall consider here, particularly, ways of thinking and perceiving, ways of experiencing emotion, modes of subjective experience in general, and modes of activity that are associated with various pathologies—...it is clear that there are many interesting aspects of style that cannot even be touched on here—for example, body-movement styles (Shapiro, 1965, pp. 1–2).

Shapiro’s passing reference to movement style is an appropriate footnote to the scattered literature on movement and personality. Beyond Reich’s classic essay on movement and character development (1949), it is not woven into the mainstream of literature on personality and psychodiagnosis. Before the 1930s, texts on differential diagnosis of dementia praecox, mania, and depression gave ample space to descriptions of motor symptoms (M. Davis, 1972). Within early analytic writing, patterns of inadvertent actions and styles of body movement were readily considered part of the “psychopathology” of everyday life, and it has been argued (Murphy, 1976) that Freud did not take issue with Ferenzi’s or Reich’s formulations on the analytic importance of body motion, but with the introduction of active techniques of intervention or in Reich’s case with the political direction of his work. In experimental psychology, Allport and Vernon (1933) completed an ambitious study confirming with various mechanical quantitative measures that individuals have distinctive motor styles that persist over time and task and that appear cogently related to personality. Yet after the 1930s the subject is addressed
by a very few isolated writers, most of them psychoanalysts reporting clinical observations.

Individual differences in activity type from infancy have long been recognized (Fries & Lewi, 1938), and the persistence through childhood of these manifestations of temperament can be found in the developmental research (Escalona & Heider, 1958) postulated a motor phase of development around age 2 and presented numerous clinical examples of the crucial importance of movement in ego development. Reich (1949), Lowen (1958/1971), and more recently Kestenberg (1966, 1975) have formulated elaborate theories as to the role of movement in the early evolution of psychological defenses, drive discharge, and psychosocial phases in early childhood. And recent microanalytic film research on mother-infant interaction has shown the crucial role of motion in bonding (Beebe & Stern, 1977). As Pine (1977, p. 77) has said, “this mutual preverbal cueing and its consequent shaping effects is the earliest clue of the object tie.”

Yet experimental research examining relationships between personality and movement, posture, breathing patterns, and other bodily expressions is very sparse (Allport & Vernon, 1933; Christiansen, 1972; Takala, 1975). In their 355-page synthesis of nonverbal communication research, Harper et al. (1978) devote only 2 pages to personality variables and body movement and 5 pages to individual differences in proxemics. And the research they cite is on very specialized topics (e.g., while they are interacting with a male interviewer, daughters of widows display more “uncomfortable” and less “interactive” nonverbal behavior than daughters of divorced parents, Hetherington, 1972).

The notable paucity of research on movement and personality does not seem to stem from poor evidence of this subject’s importance. No doubt there are many problems in systematically examining such a complex subject, yet complexity has not dissuaded other personality researchers. There is the fact that the current relevance in body motion research has developed primarily in relation to interpersonal and social psychological topics. Personality is not at all a popular research topic in nonverbal communication research, although Rosenthal et al. (1979) have extensively pursued individual differences in nonverbal similarity and decoding skill. Whatever the reasons for the paucity of research on movement and personality, it would seem important to clinicians interested in nonverbal behavior. This section will conclude with some clinical and research examples demonstrating the clinical potential of this subject.

Descriptions of movement correlates of personality can be divided into two types—those that focus on specific symbolic actions (Deutsch, 1952, 1966; Mahl, 1968, 1977, 1978), and those that focus on analysis of movement style including chronic features of posture, facial expression, and breathing (Christiansen, 1972; M. Davis, 1970; Lowen, 1958/1971; North, 1971; Reich, 1949). Deutsch (1966), for example, describes specific actions and positions clients assumed on the couch and their relationship to identifications, resistances, and intrapsychic conflicts. Mahl (1968, 1977) describes how specific actions in repressed themes, and he draws on extensive clinical observations of this anticipatory phenomenon to elaborate a theory in which kinesthetic experience or awareness of the action plays a major role in making unconscious material conscious. For example, Mahl (1978) describes the transference significance of a client’s proclivity for curling up on the couch. She assumed a curled-up position on her side during the third, fourth, and fifth interviews and then reported a dream that included an image of a “beautiful Italian girl” lying curled up on a couch whom she covers with a blanket. Intense recurrent curling up was accompanied by “unconsciously” described wishes to regress and finally to tell her a story about how an illness of her mother when she was 3 years old meant she went suddenly from maternal overdindulgence to strong pressures from her father to be self-sufficient. The patient never assumed a curled-up position again after describing this traumatic separation.

Mahl (1977) has asserted that what he calls the “A—B phenomenon” in which certain actions anticipate subsequent verbalizations is not a rare event, and he has even estimated that clear-cut examples occur about once every 3 or 4 analytic hr. He contends that such sequences stem from “the most important aspects of the person’s life” and may occur during “significant phases of the analytic process.” Within the enormous complexity that is psychoanalysis and the ability to attend to what is “most” essential or urgent at any one time is an art. Behaviors that reflect key dynamics of the moment would be of interest to therapist and patient, and, if Mahl is correct, specific A—B, action—verbalization sequences deserve particular attention as cues to what is most urgent. In general, there is the implication within the literature that movement idiosyncracies and striking symbolic actions often prove to reflect essential personality dynamics; that the therapist concerned is able to focus on among many details would not be distracted by trivia in attending to this nonverbal behavior.

A classic example of the value of attending to movement style in analysis is presented by Reich in his description of a man he described as an “aristocratic” character:

The patient is good-looking, of medium height, his facial expression is reserved, serious, somewhat arrogant. What is striking is his measured, refined gait. It takes him quite some time to get from the door to the couch.
MARTHA DAVIS

plainly, he avoids—or covers up—any haste or excitement. His speech is measured, quiet and refined; occasionally, he interrupts this with an emphasized, abrupt “Yes,” at the same time stretching both arms in front of him, and afterwards stroking his hand over his forehead. He lies on the couch in a composed manner, with his legs crossed. His dignified composure hardly ever changes at all, even with the discussion of narcissistically painful subjects. (1949, p. 180)

Reich, most of all, conveys the importance of such impressions, the “character armoring” function of movement and voice patterns, and their genesis in early experience. These are notions that now so permeate the theory and practice of psychotherapy that one can easily lose track of where they were first clearly articulated. In this example, Reich describes how his first impressions persisted until he “found himself”, telling the patient that he was playing the role of an English lord. And the patient then related a very significant element of his family story, a fantasy, based on fragments of family lore, that he was in fact of aristocratic lineage in contrast to his father. Reich then describes the evaluation of his fantasy from 4 years old, its relation to oedipal themes, and its translation into his demeanor by adolescence. “His arrogant behavior”, then, had the structure of a symptom: it served the purpose of warding off of a drive as well as its satisfaction” (in this case sadistic urges). There is now a considerable literature extending this part of Reich’s work. Clinical case examples with fine attention to motion, posture, and breathing can be found in Murphy (1976), Lowen (1958/1971), Kestenberg (1966), Mahl (1988), and Keleman (1980).

In the 1940s Chapple and his associates reliably demonstrated that we can differentiate depression, mania, hysteria, paranoid states, and anxiety neuroses from the activity rates of patients and the patterns of interruption and silence during interviews. But efforts to systematize movement and posture analysis in order to more rigorously examine relationships between movement and personality are as yet too cumbersome and elaborate. Kestenberg (1975) has developed an observation method for obtaining “movement profiles” based on concepts from the movement analysis systems of choreographer Rudolf Laban and from her own investigations of “tension flow” patterns first visible in the diffuse activity of infants. She has conducted longitudinal studies of a few children that indicate that individual motion patterns visible in early infancy can be traced to adulthood. Kestenberg has trained a number of psychoanalysts, teachers, and dance therapists in her movement analysis method, and efforts are being made to test the reliability of the observations.

Several movement analysts influenced by Laban’s work have developed individual profile methods (Bartenieff & Davis, 1975; North, 1971; Ramsden, 1973), but these also lack reliability. However, the author (M. Davis, 1970) developed a movement diagnostic inventory for psychiatric patient and preliminary reliability data suggest it is a more feasible and manageable observation instrument than most Laban-based movement profiles. With this inventory it is possible to generate profiles of highly specific types of movement disorganization, constriction, and exaggeration that appear to correlate with differential diagnoses.

Psychodiagnosis from movement would seem a relatively minor clinical asset compared to the potential of such observations for assessing change and enriching perception of the ongoing process of therapy. For example, the author (M. Davis, 1977) completed an intensive film analysis of a family therapy session in which the movements of the designated patient corresponded dramatically to momentary changes in his mental status and manifestations of thought disorder. Gestures that involved very large spatial sweep of the arms (yet little or no visible movement in the torso) accompanied belligerent, paranoid outbursts. Long series of perseverative, “monotonized” gestures (one type of accent repeated in one plane, another dynamic limited to another direction) accompanied incoherent, rambling speech. And phases in which he was listless and his movement was integrated but without intensity paralleled depressed but coherent statements.

RELATIONSHIP MESSAGES

Earlier examples of symbolic actions and individual movement patterns may seem deceptively simple. We are used to looking at what individuals do, and we have a sense, however peripheral, of how distinctively they do it. Clinicians or researchers citing examples of dramatic actions and movement styles have distilled these observations from enormous complexity; they are so literary, so recognizable that they can be read as all that is important of the nonverbal channel. Entire books have been written on individual movement characteristics of patients with little report of what actually occurs in the sessions apart from the dramatic “productions” of the patient.

But 1 hr viewing a film or videotape of a therapy session without sound can impress one with a sense of how difficult it is to “distill out” individual characteristics and delineate symbolic actions, to perceive patterns in the interaction, and to determine what details to focus on.
One is confronted with the details of greetings and leave-takings, positions assumed through the session, listening behavior, eye contact patterns, the complexities of gestulation, patterns of fidgeting, manipulation of objects, and a myriad inadvertent actions such as nose wipes, hair playing, and lip biting. In time the observer may perceive relationships between the movements of patient and therapist. A clinician who is fortunate enough to have a videotape in which the camera is focused throughout the session on both the patient and therapist in full-body shots will probably still focus on one interactor at a time. From Darwin through Reich, the focus was on the individual “in vacuo.” Anthropologists attending to body motion, however, shifted the focus to what occurs between speakers, to the interaction and “coactions” of two or more people in a face-to-face encounter.

Chapple (1949) appears to have been the first to put observers on one side of a one-way screen to record the interaction of two people in terms of the patterns of turn taking, pauses, interruptions, and monologues irrespective of speech content. Because we think of conversation in terms of speaking turns, it is easiest to attend to alternations such as A speaks, then B speaks, then A speaks, and so on, rather than to focus on the constant simultaneous actions of both. Describing interaction as alternating turns lends itself, however, to linear, causal renditions of the event in which A’s actions are perceived to “cause” B’s which in turn “trigger” A’s and so on. Birdwhistell (1970) and Scheflen (1973) have eloquently argued against linear action–reaction descriptions of social behavior. In fact, Chapple did not succumb to this; he attended to a cogent aspect of social behavior, the patterned alternation of speaking and listening activity, the interaction rhythms perceptible in turn taking. Alteration of actions as in turn taking, and coactions as in the complex coordinations of positions that Scheflen describes (1973), are not contradictory perspectives. They complement each other, and both offer important insights for the clinician.

One of the finest examples of interaction research is the work of Daubenmire and her associates in the Ohio State University School of Nursing (Daubenmire & Searles, 1982). In the early 1970s they video-taped medical patients in surgery recovery rooms and in private hospital rooms. A patient could be taped all day for weeks interacting with various staff in this attempt to examine relationships between therapeutic interaction and favorable medical outcome. Daubenmire and her associates drew from diverse kinesics and communication research to evolve their observation methods, and their synthesis of behavioral observation and computer pattern assessment represents an increasingly occurring marriage in the seventies between ethological description and quantitative analysis. It is hard to appreciate the depth of this study because it is hard to imagine 25 columns of speech and motion details coded at 1-sec intervals for several weeks of videotape. In one aspect of the data analysis the researchers completed computer analyses of patterns of similarity and convergence of behaviors between patient and nurse. Daubenmire and Searles (1982) illustrate how this analysis elucidates therapeutic interactions with a description of a 20-min exchange between a nurse and a man dying of cancer:

For the first 7 minutes RN3 is standing in the patient’s exploratory space, a distance of 7 to 12 feet from the patient. Verbal exchange includes evidence of entry and approach behaviors and a discussion on mouth care to relieve some of Mr. B’s discomfort. During minute 7, Mr. B. mentions he slept well and was able to get six to eight hours without much pain. At this point, RN3 moves into the patient’s interpersonal space, a distance of 4 to 7 feet from the bed and sits down facing the patient. She also verbally recognizes Mr. B’s comment and Mr. B. discloses his concern about taking morphine. . . . Patterns for eye contact, limb and body movement show an increase in similarity from minutes 7 to 10. The discussion of pain medication also continues until minute 10 when Mr. B. attempts to change the subject and RN3 directs him back to the discussion by a question about how he plans to “stretch out” the time between medications. . . . [After a brief interruption by another nurse] RN3 once more returns the conversation to the topic of Mr. B.’s pain medication. From minute 12 to 13, there is a measurable increase in similarity of eye contact, or increased mutual gazing. By minute 15, the S [similarity] value + 1 indicates continued mutual eye contact. Patterns for limb and body movement also show a shift to + 1 similarity. This total similarity for all three variables lasts until minute 23. . . . During minute 23, the nurse moves toward Mr. B and touches his arm. The conversation centers around how Mr. B. will specifically talk with his physician about nausea from chemotherapy and his concerns about spacing dosages of morphine. . . . From minute 26 to 29, Mr. B begins to express his feelings about how difficult it has been for him to live during the past several years. . . . Nurse responds, “You and I can do something about the quality of your life and what you do with your life. You have that choice in determining what it is that you will do with your day.” . . . During this conversation, Mr. B. continues to look away from the nurse. The break in eye contact, increased limb and body movements, and verbal content suggest Mr. B. was very uncomfortable talking about these problems. This shift in similarity during minute 23 is somewhat similar to the shift observed in minute 10. . . . In both patterns, there appears to be a period of self-disclosure which lasts for several minutes, the patient apparently becomes uncomfortable with the conversation, and similarity of eye contact and movement decreases. (1982, pp. 312–313. Reprinted by permission of Human Sciences Press)

Careful analysis of such therapeutic interactions reveals a remarkable capacity on the part of the therapist to tune in, accommodate to,
pick up on, and participate in interaction sequences that seem above all devoted to building rapport. One cannot describe this as something the therapist does, and certainly he or she does not do it consciously. Nevertheless, I think that such examples of therapeutic intervention—such as those of good nursing from Daumenrie's study, or examples of psychotherapy sessions with very experienced psychotherapists such as Scheflen has described (1973) and more recently this author has been studying (M. Davis, 1974)—compel one to conclude that therapists establish rapport with patients at the nonverbal level by a process of attuning to the patient's communication style and toning down their own, evolving periods of posture mirroring, exquisitely pacing their comments and interventions, modulating their inquiry when the patient withdraws or shows distress, and sustaining concentrated focus on the patient while “softening” this direct gaze with head tilts and subtle variations in head noddling.

Scheflen (1973), for example, describes the intricate way two family therapists varied their positions in relation to the mother and daughter they were interviewing. He discovered that one therapist would unconsciously pace the intervention of the other with a series of pipe-smoking actions. At another level he discerned a rhythmic alternation in emotional orientations—mother with daughter, then daughter with one therapist, then back again to mother with daughter—as it reflected a momentary “loosening” of the rigid mother—daughter attachment.

The following example of nonverbal interaction analysis (M. Davis, 1974) also illustrates therapist sensitivity and an exquisite ability to nonverbally tune in. It involves a disturbed paranoid young man videotaped 10 months into his therapeutic work with the late Harry Shapiro.

The session begins with the patient agitatedly shifting his position until he bends over, elbows on knees, with his head down so his face cannot be seen. He does this just as the therapist sits down (synchronous or echoing position shifts are common in therapy). The therapist assumes two fairly typical therapist listening positions in the first 10% min, but what is interesting is the correspondence between the type of position and the mental status of the patient. In the first half, the more open and oriented therapist position corresponds to a phase when the patient is most agitated and disorganized; when the therapist is sitting in a more aloof, contained position, the patient gradually collects himself. At 10% min into this 22-min session the therapist gets up and leaves the room. (He had gone to check for the patient that no staff member was watching him beyond the one-way screen, although the patient did not object to the videotaping for research purposes.) This divides the session almost exactly in half. The patient again goes through an agitated phase as if unable to settle into a position while he waits for the therapist. This time, however, he sits up and places his hands on his lap when the therapist sits down in a position that is turned slightly away with arms tightly folded. The patient stays for a while at his most integrated—terms of movement and body posture turn out from later analysis of the speech—at his most verbally coherent.

At this point the therapist dramatically shifts toward the patient and sits with his right hand to his face. The patient momentarily appears unnerved and begins to laugh, then assumes the same arm position. He again becomes disorganized verbally and nonverbally, but throughout this phase their positions become more and more identical until the therapist seems to gradually modulate their hand in hand until it is in exactly the same hand-finger configuration as the patient. It is as if the therapist has upped the ante—saying literally and figuratively, “You progressed to a coherent, appropriate way of relating to me when I turned away, can you when I move closer?” The therapist does not shift positions again until he signals the end of the session. The patient's position shifts now define the phases of the session as he gradually works toward the last phase in which he is most coherent and appropriate, one that is again characterized by sitting in a simple, hands-on-lap position. The graphs at Figure 1 also indicate subtle relationships between the movement patterns of patient and therapist, and perhaps a “deeper” level of attunement. Note, for example, how the therapist’s movement is most spatially precise and complex when the patient’s movement is most disorganized, and is less intense when the patient is more organized.

In no sense can these patterns be read simply as causal relationships. The time of position shifts and the subtle fluctuations in movement organization, intensity, mobility, and spatial complexity shown in Figure 1 defy a simple action–reaction interpretation. Exquisite timing, mirroring, and careful modulation of intensity and spatial direction appear manifestations of the therapist’s ability to empathize and create a context in which the patient could become more integrated and tolerate painful self-disclosures. As Freedman describes in the introduction to an excellent book on psychoanalysis and communication research (Freedman & Grand, 1977, p. 8), “the microscopic analysis of communication behavior may provide a more operational view of the integrative process.”

Scheflen (1973) has argued that what is regarded as “crazy” behavior can be seen to fit coherently within the context of the interaction. He has described (private communication, 1967) splicing together different sections of a film of a patient to evoke different diagnostic impressions. Conceivably this could be done with film segments of the three different movement themes described earlier (M. Davis; see p. 99).
Each one seen in isolation would evoke a different diagnostic impression: severe depression or chronic undifferentiated schizophrenia or paranoid schizophrenia. Perhaps this does not constitute evidence of the unreliability of the nosological system so much as it demonstrates the potential contribution of nonverbal communication research to behavioral assessment. When the camera (and the observer's orientation) "pans back" from the patient to allow focus on the interaction, the behavior takes on new, clinically important meanings. In the film analysis just cited, the patient's behavior meshed with a family constellation and therapist interventions in such dramatically visible ways that etiology, diagnosis, and prognosis could be sketched from nonverbal behaviors displayed in this one session.

Studies of miscommunication and disturbed behavior are, of course, as potentially valuable to the clinician as analyses of peak therapeutic interactions. Drawing on Scheflen's observation methods and theoretical orientation, McDermott and Gospodinoff (1979) have shown how "rational" and ordered the disorderly behavior of a child in a classroom appears after careful analysis of the behavioral contexts in which it occurs. Lafrance and Mayo (1976) have demonstrated that eye contact patterns of blacks during listening and speaking are almost the opposite of those for whites such that interracial pairs must suffer a serious interactional mismatching. Erickson (1979) has carefully analyzed interview behaviors and presented dramatic evidence of when and how the organization of eye contact, head nodding, and vocal inflection patterns serving smooth turn taking and flow of conversation can break down in interracial interviews.

The relatively rare film analyses of nonverbal interaction described here have as yet limited value for psychotherapy process research. Most are single cases and some took as long as 4 years of continuous film study to complete (Scheflen, 1973). Ways have to be developed to speed up the analyses as well as to make them reliable and replicable. The author is currently testing out a systematic and replicable nonverbal process coding method that would capture interaction patterns such as Scheflen, M. Davis (1975a), and others have discovered working on films or videotapes in isolation.

There is a considerable literature on nonverbal interaction process research if one includes more than studies strictly related to psychotherapy. And this area—systematic interaction process analysis of actual encounters—does promise to make a significant contribution to psychotherapy research. Into this group should be included microanalyses of mother-infant interaction, such as those of Beebe and Stern (1977), ethological studies of the organization of social encounters and conversational behavior (Kendon et al., 1975), Gottman's marital interaction
research (1979) and Horowitz’s method for therapy process analysis (1978), as well as the more purely kinesic studies described earlier.

The early literature on movement and personality illustrated how it is impossible to tell the dancer from the dancer. In the interaction analysis diagrammed in Figure 1, the patient is unmistakably the patient, and he would take his movement style with him out of the consulting room just as the therapist’s movement style could be recognized elsewhere. But for the 22 min they interacted, their movements also reflected the shape of their relationship and their bodies changed form and tempo and articulation together. It would seem clinically very useful to understand how body movement reveals and is part of the person. It would also seem clinically very valuable to understand what a few minutes of nonverbal interaction can reveal about the therapeutic relationship and how it engenders—or does not promote—psychological integration and personal growth.

**IMPLICATIONS FOR THERAPY TRAINING AND PRACTICE**

However compelling the illustrations of the importance of nonverbal behavior in psychotherapy, the loop back to actual practice is far from completed; the best interaction analyses are single-case studies that cannot be readily generalized. And, as discussed earlier, much of the recognition or observer judgment studies are of dubious value to a clinician. Clinicians are not likely to arrange their chairs 30 in. apart because they find that students found comfortable with an interviewer (Knight & Bair, 1976); touch clients on the back of the upper shoulder as they enter because in one study this correlated with deeper self-exploration (Pattison, 1973); smile and lean forward in more open positions to enhance rapport and trust, and so on. In fact, covert manipulations of kinesic and proxemic behaviors are seriously done to effect behavioral change according to literature on “neurolinguistic programming” and hypnotic techniques (Bandler & Grinder, 1979). But many therapists would object to such covert manipulations on ethical and clinical grounds.

Presumably, most therapists would not be comfortable with *active* and *explicit* intervention at the nonverbal level either. There is a rich literature of dramatic case examples that suggest how powerful “body therapies” such as bioenergetics or dance/movement therapy can be (Chaiklin, 1975; Lowen, 1959/1971; Murphy, 1976; Schutzenberger & Gelfroy, 1979; Siegel, 1973). But no one seems to adopt such active interventions simply from reading about the importance of nonverbal behavior or the value of body therapy techniques. Conceivably, unless

a “traditional” or dynamically oriented therapist trains with someone experienced in such interventions, he or she will not likely incorporate them into practice even if their efficacy is someday reliably demonstrated. Some psychoanalysts who believe in the value of the body therapies are frustrated by the lack of therapeutic collaboration in which the patient may work with a body-oriented therapist while also in traditional analysis or intensive psychotherapy (Braatoy, 1952; Kestenberg, 1973; Solnit, 1973).

Less controversial but equally untested is the value of videotape replay as an active intervention that can help patient and therapist focus on details of visible behavior that are out of awareness (Berger, 1978). It has been found useful as feedback to the patient (especially if done immediately after the session, Kagan, 1978), and as an electronic cotherapist who can help the therapist be objective about his or her own subjectivity (Whitaker, 1978). At the very least, videotapes of actual therapy sessions—that focus on both patient and therapist in full-body shots throughout the session—would seem valuable for training. But there is no guarantee that turning off the sound and carefully training one’s eye to be more sensitive to nonverbal details will actually affect one’s practice of therapy. It could atomize one’s perception, distracting the therapist and disrupting his or her participant observation. The effectiveness of active interventions, videotape replay, and formal training in nonverbal observation for psychotherapy practice is still to be rigorously assessed.

Intuitively, though, we suspect that listening with the third ear is largely a matter of seeing more and even kinesthetically feeling more; that the third ear is in large measure eye and muscle. Jacobs (1973) describes cases where awareness of his own actions while listening to a client alerted him to important dynamics. For example, as a patient described an anxiety reaction, Jacobs found himself tucking slightly on his belt as if it were too tight. Reflecting on this uncharacteristic action led to an association to the patient’s reminiscence regarding abdominal surgery. Relating this interpretation to the client produced a flood of associations to these early experiences. Jacobs’s article is one of the few discussions of the value of consciously trying to heighten one’s kinesthetic awareness and utilize it either in the service of providing clues to the meaning of the patient’s communications, or in facilitating the recognition of previously undetected attitudes and feelings in the analyst himself. (1973, p. 92)

The loop back to practice is most likely made in one’s training experience. Good training tapes based on actual sessions, extensive seminar discussion of the nonverbal level, and supervision with clinicians who have experience in consciously attending to and in some coherent
way utilizing perceptions of nonverbal behavior are essential. Equally essential are many more relevant, sophisticated, and well-illustrated studies of psychotherapy from the nonverbal communication researcher.

ACKNOWLEDGMENTS

I am deeply grateful to Dr. Israel Zwerling of Hahnemann, who first encouraged me to pursue this research 20 years ago and whose support has been crucial to the development of my work over these years. Dr. Zwerling’s support—in terms of both providing dynamic settings in which to work and ensuring the freedom to pursue unorthodox lines of research—has been pivotal to the careers of a remarkable number of authors cited in this chapter. In addition, I wish to gratefully acknowledge the support of the Board of Directors of the Institute for Nonverbal Communication Research, and of the late Harley Shands, M.D., of the Roosevelt Hospital where the psychotherapy research project was initiated. My thanks also to Rachel Hott and the members of the observation coding seminar at INCR who helped me clarify my recording methods.

REFERENCES

Aggression and Psychodynamic Therapy
From Theory to Practice

STEPHEN WORCHEL AND JASON WORCHEL

Man's inhumanity to man has perplexed psychologists for decades. Through human ingenuity the instruments of aggression have been refined to such precision that there exists the real possibility that humans will succeed in accomplishing the feat that has eluded disease, predators, and natural disasters: They will succeed in destroying the human race. Freud (1930) expresses a similar concern:

The fateful question for the human race seems to me to be whether and to what extent their cultural development will succeed in mastering the disturbance of their communal life by the human instinct of aggression and self-destruction. . . . Men have gained control over the forces to nature of such an extent that with their help they would have no difficulty in exterminating one another to the last man. They know this and hence comes a large part of their unrest, their unhappiness, and their mood of anxiety. (p. 92)

Freud and some other investigators (McDougal, 1908) of his time argued that the human animal came prewired with a set of behavioral tendencies. Among these tendencies or instincts was aggression. According to this view, aggression is propelled by forces internal to the individual. This reasoning suggests that attempts to eliminate aggression

STEPHEN WORCHEL • Department of Psychology, Texas A & M University, College Station, Texas 77843. JASON WORCHEL • Virginia Institute of Short-term Dynamic Psychotherapy, Charlottesville, Virginia 22901. This chapter was prepared with the support of a grant from NIMH (5R01MH133468-02).