

Chapter One

The History of Dynamic Psychotherapy Its Para-Verbal World

THE NEW THERAPIST AND THE VIDEOTAPE

The universe of dynamic psychotherapy has undergone slow, but ultimately dramatic change, since the 1970s. Now a new psychotherapist has taken up residence in the office. This book tells the story of what we found when we studied that new therapist directly, by watching her work, on videotape or through extended case excerpts. Here we learn that today's counselor's thoughts, words and behaviors sharply set her in contrast to her counterparts of just twenty-five years earlier.

The videotape, for the first time, reveals to us the verbatim spoken exchanges, but also the bodily messages: the tones of voice – the facial expressions – the gestures of patient and therapist as they choreograph their interaction. When we begin to examine the therapy participants as embodied speakers, at this moment we find ourselves on the outskirts of mostly untrodden territory. We sense an evolutionary advance perhaps about to take place on the screen, because we can now choose to study all the extra-verbal information, as well as the verbal, in the therapy interchange.

We write for an audience of professional therapists, junior or senior, and psychotherapy researchers, but all practicing clinicians. We have a proposition to test. If we examine and systematically score, line by line, the para-verbal behavior of client and therapist on the video screen, will we discover a new layer of communicative bond unfolding between the participants, as seems likely in our three introductory cases so far.

When we start down this path, the therapist will find herself confronted with an entire range of fresh questions. How would I note, and perhaps directly remark upon, the para-verbal messages sent by my client? How do I observe my own non-verbal participation? Might I shift my approach by including more emphatic extra-verbal messages from my side of the office, and how might I ascertain the reciprocal effect on my client?

We suggest, first, that the psychotherapy interaction already carries with it a universe of para-verbal data which the participants continually exchange. We, the researchers, and our readers, need to learn much more about this information. Secondly, as she becomes more comfortable with the extra-verbal perspective, the therapist might want

to change her mode of practice to make more full use, in specific ways, of these non-verbal currents that swirl around and through her and her client. The balance of our book will grapple with these two questions.

However, to grasp the meaning of this possibly imminent shift, as we may welcome para-verbal data into our psychotherapy scholarship, we must understand the history of the two psychodynamic evolutions which have preceded this third development. As well, others have touched on the issue of extra-verbal communication in therapy, and we need to review their contributions.

Finally, we must consider the mechanisms through which changes in outlook and practice actually take place in our field, to prepare ourselves for this potential next evolutionary move. We can't, in other words, just begin to analyze videotapes and case vignettes from a para-verbal standpoint, without first grounding ourselves in the core issues of today's and yesterday's therapy world (Wachtel, 2014). We also need to understand the earlier work on non-verbal communication in psychotherapy, contributed by others.

As resource data, we'll study and score a total of four single session videotapes from three clinicians who differ in gender, age and theoretical approach, though all are very experienced therapists – Jim Donovan, PhD, Kristin Osborn, LMHC and Paul Wachtel, PhD.

First, we need to review some important earlier developments, tracing how we arrived, as a field, clinically and theoretically, at our present position, mid 2015. We'll discover that at first the dominant momentum tended to banish the study of para-verbal data, but now that trend may have shifted toward a different emphasis.

Dynamic Psychotherapy: 2015, the Relational Stance

All of us encountered the modern practitioner first in the literature, so, we'll start with that writing before we turn to any video or case history data. Unlike the situation in the late 70s of a Kernberg (1975) or a Kohut (1971), no single figure has emerged in the past quarter century, whose individual ideas have radically shifted the arc of our field, so the recent developments we currently observe perhaps appear the less pronounced. Rather, many have cooperated, at a lurching and stuttering pace, to construct the position we now call "Relational" psychotherapy, probably the predominant theme in our psychodynamic world of 2015.

For psychotherapy study, we cannot perceive exactly when a season shifts and the wind starts to come from a different direction. If, however, we leaf through a text from the 60s or 70s, even an

outstanding one, Greenson (1967), for instance, or Kohut (1971), and then turn to today's, or to yesterday's, equally well done piece, for example, Maroda (1991, 1999, 2010), Wishnie (2005), or Wachtel (2008), we're startled. The description of the therapist's voice and behavior, of the underlying theories of change, and of the preferred therapeutic technique, don't just seem astoundingly different from 25 years before; they are shockingly different.

Somewhere in the volumes by Mitchell (1983, 1988, 1995), Casement (1985), Stolorow, Brandschaft and Atwood (1987), Maroda (1991, 1999, 2010), Wishnie (2005), Wallin (2007) or Wachtel (2008) or still others, we will find the emergence of that relational therapist at first appearing, then disappearing, but now here to stay. We could profitably focus on all these contributors, and many more, to get to know today's practitioner and his or her basic assumptions and approaches to the work. However, to study this modern clinician directly we need to map, historically, the recent evolution of the field up to today, where we can glimpse the para-verbal therapist maybe just entering our landscape.

We'll pursue how each change in therapeutic approach arose and how new thinkers helped evolve one viewpoint into the next. We ask the reader to accompany us on this path, for a bit, because we need to understand how the para-verbal position might now start to unfold within our evolution at this particular time.

Only if we survey this road, more thoroughly and our present position on it, can we know what work we need to take on to integrate the next shift, perhaps one that includes an emphasis on extra-verbal relating. We are mindful, too, that psychotherapy schools beyond the psychodynamic one have continued to evolve over the last two decades, in their understanding of patient/therapist interactions. In Chapter 2 we'll also catch up with the spectrum of these non-dynamic outlooks.

METHODS OF THERAPEUTIC INTERVENTION:

SOME HISTORICAL PERSPECTIVE OF THE LAST FORTY-FIVE YEARS

Martha Stark in Modes of Therapeutic Action (1999), has captured the subtle, though inexorable, evolution of the contemporary psychotherapist as clearly and thoroughly as anyone. Now in the very early 2000s, Stark explains that the modern dynamic therapist can assume one of three possible stances (or any combination thereof) toward her client.

She can, at level 1, interpret the patient's unconscious life according to Freudian Drive Theory or, at level 2, she can provide the client with the missing good object (following Kohut's self-psychology (1971) or Winnicott's "transitional object" position (1971) or, at level 3, she may enter into an intimate fully relational interaction with the client to address, little by little, the damage wrought by childhood traumatic interchanges. (Mitchell and Greenberg, 1983; Ehrenberg, 1992; Mitchell and Black, 1995; Aron 1996; Wishnie, 2005; Wachtel 2008)

We'll take time now to study these three possible therapeutic positions in some depth, since they bear directly on our research. What place non-verbal communication with any of these approaches? We'll revisit these stages of therapeutic advancement in historical and theoretical sequence. This survey will ultimately take us deeply into Level 3, relational work. Here we'll find a therapist just beginning to focus and practice with a para-verbal emphasis.

Level 1

To understand our present location, we have to go back before we go forward. Let's retrace our steps. Prior to the 1970s, level 1 therapy, interpretation of instinctual drive, ostensibly represented the primary accepted psychodynamic strategy. Psychoanalytic institutes and dynamic psychology training programs espoused this approach, as did the symbolic leaders of the field, originally Freud of course, but also the important contemporary figures of that time, Greenson (1967) for example.

When I (Jim) left my psychodynamic graduate school program in 1970, my peers and my teachers shared the idealized picture of an omniscient, older, white, male therapist-analyst, impeccably dressed, empathic but rather distant from, and ambiguous in personality to, his patient. He often sat out of sight and sent well formulated, carefully timed interpretations of oedipal strivings and transference wishes, across the gulf that he had constructed between himself and his client.

We practitioners in training, identified with this complex caricature of the psychoanalyst. When we sought therapy ourselves, we often encountered that same formal, distant, interpretive, purportedly blank screen therapist greeting us, not very warmly, at the office door, caricature perhaps, but also a description of how real and respected practitioners, at that time, often did proceed.

This figure, of course, sent strong para-verbal messages of his own: ironically perhaps, emphasizing distance and propriety, but we rarely

dared remark on this restrictive atmosphere in the room. He certainly never did. He seemed intent on reducing non-verbal communication, between patient and counselor, to a minimum. For him it appeared all about the spoken words. Over the next few pages we'll see that the tide is now beginning to flow in the opposite direction, towards studying more para-verbal connections.

EVOLUTION NUMBER 1: OBJECT RELATIONS INTERVENTIONS

Though few of us held much inkling of such things in the late 60s, ideas quite at odds with this stereotyped, level 1, approach had already begun to bubble under the edges of the broad surface of our field. Visionaries: Ferenczi (1931), Reik (1948), Searles (1965), Racker (1968), Balint (1968, 1972), Winnicott (1971), argued, early on, that the doctor must provide the client something far deeper and more human than a punctiliously crafted, rational, verbal interpretation of his unconscious conflict.

Their therapist, corresponding to Stark's level two provider of today, made powerful relationship offers, some couched para-verbally, in addition to, and in tandem with, insight oriented clarification. The crucial conceptual leap here is that the therapist represents the missing good object both theoretically and in clinical practice.

When we read Fairbairn (1952), Racker (1968), Balint (1968, 1972), and Winnicott (1971) in the original, we feel them reach toward us across time and space. We cannot miss the freshness and the authenticity of their words and actions, as they offer us their brilliant grasp of the therapeutic interchange, and of the corresponding therapeutic process, at its core. These remarkable thinkers sound as if they wrote in 2015, not five decades earlier.

If we return to our three introductory scenarios on page 1, we begin to realize that in each instance our clients have offered us a para-verbal dilemma, i.e., 24 year old Pat won't speak. To respond productively, we're probably going to have to act strongly on some non-verbal, not just verbal dimension. These early object relationists gave us some hints of how to proceed.

For example, a young, adult, female patient, sometime in 1967 or 1968, crippled with uncertainty, complained once again to Michael Balint of her paralyzing inhibition and confessed that she could not even attempt a somersault as a child, although she badly wanted to try one. Balint suggested, "What about it now?" She got up, and to the

amazement of both, did a perfect somersault across the office floor. (recounted in Mitchell 1988, p. 154 – originally in Balint 1968, pp. 128-129) These gymnastics marked a turning point in her treatment. Moreover, this new humanly available, unquestionably supportive, practitioner began to change our entire understanding of psychotherapy.

Here Balint became the encouraging, giving parental object who accompanied his patient in her experiment to lift a deadening defense of self censure. Any weak paragraphs we might add, cannot define a level two object relations therapist better than Balint's liberating offer to his patient – "What about it now?". Clearly, in this response to this client, a rational, carefully formulated interpretation would account for only part, maybe a small part, of the therapeutic leverage. For one of the first times historically, we cannot miss the extra-verbal dimension to Balint's intervention, a remarkable departure in technique. He suggests a somersault. We can see our subject of para-verbal relating now just entering the stage.

I remember the initial thrill of holding the books by Fairbairn (1952), Racker (1968), Balint (1968) and Winnicott (1971), and slowly reading through their pages. They seemed as startling as Technicolor. The therapist became personally alive. For me and for many others, these authors opened an entirely new vista into the process of psychotherapy. Explore the relationship first of all and then, perhaps, the unconscious verbal meanings. As the 1970s closed and the 1980s started, this powerful current had begun to sweep us along in a fresh direction, although maybe not many of us realized it at the time.

We'll describe this first evolution in dynamic therapy in a bit more depth. Stark (1999) and Mitchell (1988), before her, document a developmental stage in our psychotherapeutic thought that we may often forget. We did not jump, in one long move, from a drive-oriented, insight-oriented, interpretive orientation, to the relational treatment we look at today. The object relations position provided the bridge between the two.

It arrived with the work of the original Level 2 Therapists some of whom we've just named, Balint (1968), Winnicott (1971), Fairbairn (1952), Harry Guntrip (1968, 1975), Kohut (1971) and Massud Khan (1974). These thinkers not only realized that the client's core difficulty revolved around an empathic relationship, missed in childhood, but they also concluded, in a next brilliant paradigm-changing step, that the treatment must make good on the childhood loss and provide, maybe

for the first time, some aspects of the primary holding relationship which the client could then take in as her own.

Balint (Balint, Ornstein and Balint, 1972) for example offered us a landmark case in which he treated the Stationary Manufacturer, a middle aged man, fighting off a paranoid decomposition, fueled by his obsession with his wife's possible prior sexual involvements. Balint volunteered nary one interpretation in his therapy but carefully allowed the Stationary Manufacturer to use him as "a sounding board", the client's term.

In Balint's skillful 27 session therapy, carefully spaced across a two year period, the client recovered his equilibrium and remained relatively symptom free thereafter. Psychotropics were undeveloped in 1970 but, in any case, Balint made no use of medications in the supportive treatment of this very distressed man. His intervention was about the interaction. We guess, but cannot know, that this patient/therapist exchange included para-verbal signs of calm understanding from Balint, perhaps a warm smile, a re-assuring tone, and hand gestures with an open palm. Unfortunately he does not report directly about any of these behavioral offers.

This next sentence summarizes the thrust of Balint's case and the rationale of object relations dynamic psychotherapy. The therapist becomes the missing object and proffers a relationship (level 2 intervention) not only an interpretation (level 1). The field had started to change forever. The pioneers showed that we could push away from level 1 and move, in addition, toward a level 2 approach, whenever appropriate. More para-verbal therapist involvement may well have accompanied this shift in therapist stance, but, as noted, unfortunately we have no direct evidence of this.

EVOLUTION NUMBER 2: RELATIONAL THERAPY

We need to pay careful attention to Stark's next distinction. Object relations theory might, and we think does, almost inevitably usher in the age of relational therapy, in which we presently find ourselves ensconced in 2015. However, relational therapy differs so importantly from object relations treatment that this change represents another evolution. We'll take a moment now to spell out the architecture of that next major step.

To recapitulate, the object relationists and the self-psychologists, Stark's Level 2 therapists, focus on what the parent did, i.e., acted as a harmful intrusive influence, or did not do, i.e., failed to provide a caring

holding relationship. The goal of therapy thus moves directly from making the unconscious conscious (level 1) to introducing a relationship (level 2) that the patient can internalize to begin the repair of his personality issues. (Stark 1999, p. xvii.)

However, as Stark observes, level 2 therapy, although strongly empathetic, acts in only one direction. The therapist provides a holding interaction and understands her client in a way that she vitally requires. The counselor encourages the patient to use her for support and understanding, but the therapist does not participate as another full human being. If we study Kohut's case reports, for example, we consistently find the sympathetic, available listener, ever alert for, mirroring and idealizing transferences, but we do not find a fully present relational partner who freely allows many sides of his own self to enter the exchange.

The relational therapist assumes that the client requires a distinctively fuller, two way interaction, to address his issues. If object relations treatment is a "one and a half person" therapy – the patient entirely there, coupled with some aspects of the therapist's personality fully in the office, relational therapy represents a complete "two person" endeavor.

In this new relational mode, both participants are transparently present. (Stark 1999, xxii). The personal feelings, memories and spontaneous responses of the therapist potentially become part of the matrix co-created by the client and by the practitioner (Maroda 1991, 1999, 2010; Wishnie 2005; Wachtel 2008). Moreover a potentially para-verbal exchange now slides towards more central focus since both participants become more open to each other.

We can't move on, though, and leave insight and object relations behind, as vestigial parts of the field. Stark reminds us that we need to draw on all three modes in constructive sequences. We try to impart to our client fresh self-knowledge (Level 1 therapy) and a holding, empathic, relationship experience, at Level 2, in each session.

When, as entire persons, we function at Level 3, we stay open to the patient's questions and misgivings about us, and we may share our own positive or conflicted feelings about that client, as well as something of our own personal histories and memories. We can laugh with, directly encourage and maybe even cry with, and get angry with, that patient. Note the non-verbal emphases in this last sentence "laugh", "cry", "angry". When relational therapy moves toward center stage, para-verbal technique may soon follow.

The Birth of Relational Therapy

Guntrip (1975) has provided us a unique view into the actual work of Fairbairn and of Winnicott. He participated sequentially in analysis with both. In Guntrip's monograph we can observe the very beginnings of relational therapy, and we can see, in detail, how it evolves from the object relations position.

Fairbairn, one founder of the object relations theoretical school (1952), in practice, was actually quite distant from Guntrip his client. He sat impersonally behind his imposing desk and made object relations interpretations to Guntrip based on his understanding of his patient's particular oedipal dynamics.

On the other hand, Fairbairn also did offer Guntrip the experience of a generous accepting object because, off camera, after the therapy sessions, or in written correspondence between meetings, Fairbairn became the "good human father" (Guntrip, 1975, p. 148) and engaged in co-equal, collegial, theoretical discussions with Guntrip. Fairbairn now assumes a more open para-verbal position.

Despite these helpful personal offers from Fairbairn, Guntrip realized that he would not penetrate to his deepest, most repressed memories in this treatment. He phased out the therapy with Fairbairn in 1960. Fairbairn died at the end of 1964, but he had introduced Guntrip to Winnicott, through the post, in 1954.

Guntrip began an analysis with Winnicott in the mid-1960s. Now we meet Winnicott, face to face, in perhaps the only verbatim record of his work. Guntrip, at different points, quotes him word for word. We encounter both the object relations and the relational therapist embedded within just a few paragraphs. For example, at the end of the first session with Guntrip, Winnicott offered "I've nothing particular to say yet, but if I don't say something, you may begin to feel I'm not here." (p. 152)

At the second session, with astounding insight, Winnicott continued:

... You know about me but I'm not a person to you yet. You may go away feeling alone and that I'm not real. ... (Guntrip, 1975, p. 152)

Here we see Winnicott offering himself as a deeply supportive present object and speaking in a very personal tone. At this moment he's the embodiment of the level 2 object relations therapist, providing

the earlier parental support that Guntrip had so sorely missed growing up.

However more followed. By the close of the treatment, Winnicott also transformed into the prototypic Level 3, relational therapist (circa 1969), who didn't formally begin to emerge in the literature for 15 more years. Now Guntrip returns to his highly energized "hard talking" in the therapy; Winnicott responds using his full self.

'It's like you're giving birth to a baby with my help. You gave me half an hour of concentrated talk, rich in content. I felt strained listening and holding the situation for you. You had to know that I could stand you talking hard at me and my not being destroyed. I had to stand it while you were in labor being creative, not destructive, producing something rich in content. You are talking about object relating, using the object and finding you don't destroy it. I couldn't have made that interpretation five years ago.

...

... 'You too have a good breast.' You've always been able to give more than take. I'm good for you but you're good for me. Doing your analysis is almost the most reassuring thing that happens to me. The chap before you makes me feel I'm no good at all. You don't have to be good for me. I don't need it, and can cope without it but, in fact, you are good for me.' (p. 153) (all italics ours)

In this paragraph Winnicott reveals many of his own feelings and needs, as he enters into a full two person relationship with Guntrip. "Here at last I had a good mother who could value her child so that I could cope with what was to come." (p. 153) Winnicott has now become more than a good object but an equal, when he tells Guntrip of his own dilemma with a patient whom he sees earlier in the day, and when he lets Guntrip know how nurturing, but not life sustaining, the relationship with Guntrip has become for Winnicott himself.

At the close of the therapy Winnicott has clearly personified a two person, Level 3 relational therapist. This moment, sometime in 1969, marks the birth of the Level 3 relational therapist.

Guntrip, 40 years ago, emphasized the difference in the physical positions his two analysts took in the office. Here we pick up the first hints of the para-verbal interaction which they arranged. Each posture

sent a clear non-verbal message. He tells us that Fairbairn sat behind a gigantic desk in a large chair, by Guntrip's description, "in state". Winnicott sat next to the patient in a small chair so that the client, while prone on the analytic couch, could turn and see him. In addition, Winnicott's spoken words clearly include a transparent supportive tone, "You are good for me.", not so Fairbairn. Winnicott sounds para-verbally connected – sitting close by, speaking gently.

However, beyond these important contrasts in the office arrangement and the different voice inflections of the counselors, Guntrip rarely emphasizes further extra-verbal interventions, offered by Fairbairn or Winnicott, beyond their actual words. However for the first time in their literature Guntrip's description of Winnicott communicates the consistently warm presence of the therapist.

Now We Need a Videotape ... We've Arrived
at the Center of Our Subject

Regrettably we do not have available the potential connecting link between Winnicott's relational therapy and our studies of para-verbal communication. Had we a video of Winnicott or of Balint, which we sorely miss, we might hear their, bonding, open voice tones, slow supportive prosody, and observe their relaxed inviting, calming bodily positions that could well have contributed a great deal to their impact as therapists. We certainly have examples of Winnicott's inclusive engaged phrases – "You'll be afraid I'm not here" ... Or from Balint "What about (a somersault) now?"

CURRENT DYNAMIC THERAPY

Extensive research evidence on psychotherapy supports the general position that a successful treatment likely includes a supportive self object therapist and a positive, mutually caring and respectful, relational alliance. See for example Greenberg, Rice and Elliot (1993) and Bohart and Tallman, (1999)

In two comprehensive reviews, Wampold (2001) and Norcross et al (2002, 2014), summarize the results of hundreds of outcome and process studies and argue that psychotherapy does not represent a purely level 1, quasi-medical procedural treatment, in which only, the experience and the technique, and not the person of the therapist, influence the success of the enterprise.

Rather therapy apparently reflects a "contextual" undertaking in which the personality of the therapist and the quality of the personal

alliance count for significant proportions of the variance in outcome. The personal characteristics of the well trained vascular surgeon presumably make no difference in the success of his procedure. If that doctor, and his/her clinical team, have the skills, the patient usually successfully recovers, but undertaking psychotherapy evidently requires a deeper level of personal involvement by the practitioner.

After reading Greenberg et al (1993), Bohart and Tallman (1999) and Norcross and Wampold, we can only come away with the “evidence based” view that psychotherapy involves a technique but also a relationship (see, as well, Wachtel 2008, 2009, 2011) between two persons (and between their para-verbal selves?). Norcross and Wampold’s studies support the Stark and Wachtel theoretical positions – successful therapy requires more than insight (Level 1) alone.

Now Wither the Field?

If we could chart our progress as psychotherapy scholars, up to this point, and then stop, our world would look something like this. We live and work in 2015; relational therapy seems here to stay. We need to continue to study this set of principles. How do patient and therapist co-create an atmosphere in which the former can feel held by the therapist as a whole person, while he/she experiences, and affectively works through, previous relationship trauma? These issues have become increasingly important not only in relational psychotherapy therapy but in the affect focused, non-directive, collaborative and cognitive behavioral approaches. (Greenberg et al, 1993; Bohart and Tallman, 1999; Wachtel, 2014) Can we anticipate the next move?

A THIRD EVOLUTIONARY STEP?: THE MISSING PARA-VERBAL DATA

If we review Stark’s three modes of therapeutic action, we’ve already noticed that the therapist becomes more personally and bodily involved at each developmental step. This means that para-verbal communication also becomes more critically important at each succeeding level, whether or not this change in style draws any direct mention.

If the relational therapist is present as a full person – what does she actually communicate as an embodied person, as well as with her words. Here we re-find the focus of our book. One can interpret affect and resistance and keep the exchange within the realm of verbal insight, but as soon as we become giving “self objects” or “relational

partners”, our non-verbal selves, and inevitably those of our clients, too, begin to take important focus. From page 1, recall Marvin’s disdainful tone and body language toward me, and my initially irritated response back to him – much extra-verbal content here.

Empathic, Level 3 therapists often speak gently, look directly at their clients, perhaps sigh, definitely smile. Their patients may return those gestures with grateful or relaxed looks, as they become recognized persons. Of course, either participant might also display sad or angry facial expressions, or frightened tones of voice or other troubled body language, at different points in a single hour or in a series of therapy sessions. We have to track all these non-verbal messages.

Relational therapists laugh, raise their voices, shrug their shoulders, open their hands and arms in accepting gestures, but sometimes look upset or confused, all of which contribute markedly to the relationship and to the process of its continuing formation. Jacobs (1991), Beebe and Lachmann (2002), and Wishnie (2005), have begun to discuss the implications of this para-verbal world for psychotherapy, but as a general field, we’ve just started down this path of investigation. In sum, the realization begins to sneak up on us that a therapist, present as a full person is there in her complete body also, not just in her words, and so is her client. (see also Ogden and Fisher, 2015)

Case summaries in the literature still report little about the patient’s appearance, gestures, timbres and rhythms of speech and rarely describe the therapist’s para-verbal self: opened or closed hand gestures, smiles, or gentleness or flatness in vocal tone. (see Allen, 2013)

Many powerful factors account for these omissions. For the most part, we simply haven’t had the data, or haven’t looked at much data that we did have, to explore the para-verbal aspects of psychotherapy. If it’s relational, that has to mean that, for both counselor and client, voice tone and rhythm, smiles, frowns, and bodily positions play a central role in the interaction, so where’s the specific information? The answer is that we don’t have much of it in any useable form, as yet. However, in Chapter 2 we’ll review the important emerging research in the study of non-verbal messaging.

In 1991 Jacobs began to describe his patients’ physical actions on the couch and the meanings those gestures seemed to have for the treatment. Ms. C, an apparently passive/aggressive female patient, for example, evidently angry, dropped into silence and turned to face the

wall, but she never verbalized any of her feelings at that point. Simultaneously Jacobs felt his own body tense, constrict and move back from his client. The two engaged in an intense interchange but with not a word.

They later had a chance to discuss their interaction; the client revealed her previous anger. Jacobs closed by concluding that his contribution represented only the introduction to our topic, to the region of non-verbal communication in therapy. He assured us that further research projects would advance this knowledge. (Jacobs, 1991)

In the intervening 25 years, with a few significant exceptions, that we'll mention shortly, the field hasn't started this "further research". What happened, and what didn't happen? Why did we get deflected from the promising momentum, to study para-verbal phenomena that Jacobs provided?

First, why so slow to pick up Jacob's challenge and study extra-verbal happenings in therapy? For one reason, we haven't had the para-verbal information available to us to research such areas – where would we find it? But even if we did have that data, we also lack a vocabulary to convey our observations about these phenomena in any sensible fashion.

How do you verbally communicate about the para-verbal? How do you describe a smile, a hand gesture, a grimace, a drop in speech tone or a slowing in its prosody? Our usual lexicon doesn't help us very much here at all. We're going to have to invent new phrases to capture these happenings and use these phrases deftly enough so that others will find our descriptions recognizable and useful.

Secondly as Ekman (2001, 2003) has so frequently reported, many facial and bodily movements, shift in micro-seconds. Malcolm Gladwell's popular science book *Blink* (2005) suggests, over and over, that para-verbal data registers so quickly that we're usually completely unaware of its great influence. Did the African-American man in the Bronx, facing the white police officers in a darkened doorway, take a gun, or a large set of keys, out of his pocket? This non-verbal, split second, perceptual moment carried life threatening significance for all the participants. (Gladwell, 2005) We have to remain very alert to para-verbal messaging or it will slip by us.

Third, we can pretty easily grasp that if we're going to study extra-verbal happenings in psychotherapy, we require an actual visual record of events to study slowly and carefully. We're going to need videotape data, information not easily obtained. Moreover we must find some

way of organizing and scoring that material to capture the rapidity and complexity with which it unfolds.

This book is about what happens when you study videotapes, or detailed case reports of psychotherapy, and analyze the para-verbal communication which you can observe. Later in this chapter we'll return to our strategy for gathering and codifying that taped information.

PARA-VERBAL DATA IN PSYCHOTHERAPY: TWO SECTORS OF CLINICAL DISCOVERY

Two areas powerfully illustrate the importance of para-verbal nuance for our work, but we've perhaps overlooked their significance in this respect so far: 1/ the mother-infant research reports and 2/ the treatment of patients with non-psychotic personality disorder. Developments in both spheres begin to confront us with the role of non-verbal communication in therapy.

A. The Mother-Infant Communication Studies

From the late 80s psychoanalytic scholars studied and wrote about the relational aspects of therapy more and more closely. Meanwhile another series of research reports, from an entirely different group, began to emerge which carried great meaning for our work in psychotherapy, and, in fact, for all investigations of interpersonal relationships – the mother-infant communication studies.

Stern et al (1985, 1998, 2010), Lyons-Ruth (1998, 2005), Beebe and coworkers (2002, 2005), and Tronick (2007), pursued ingenious methods of observing and describing the mother-infant exchange, by definition a (partially) para-verbal phenomenon, since one participant could not talk, although it turns out, the baby sure does communicate. This research exclusively used the microanalysis of videotaped material. Very few, if any, psychotherapy studies, even now in 2015, focus on this kind of second by second visual research design.

What Did Stern, Beebe, and Tronick Discover?

Beyond words, how do two people interchange? How do they recognize each other's feelings and respond to them? How can they know if they remain in touch with each other, if they cannot express this verbally? As we ponder this non-verbal information, we realize we're now approaching basic questions about the epicenter of human relatedness. How do we achieve real intimacy with another person,

with or without words? We're also inevitably engaging with what happens at the heart of the psychotherapy exchange.

We'll review the specific mother-baby communication research findings at length in Chapter 2. In briefest summary, Stern, Beebe and their colleagues concluded that the mother and infant interacted in a complex choreography to sooth, regulate and provide safety for each other and to construct a space in which more complex growth and learning interactions could continue to occur ... much more in Chapter 2 and in subsequent chapters. We'll build our book around these observations of para-verbal interchange, first conceptualized in the parent/infant studies, the conclusions from which we then apply to our videotapes.

Now we'll consider why this mother/baby research hasn't informed psychotherapy more deeply. The parent-infant duo appears so obviously an analogue to the psychotherapy pair that we might predict much fertile crossover research, not much so far, however.

Many circumstances contribute to this curious disconnection between the two fields. First, in human relations applied research, much time inevitably passes before laboratory findings ever impact practice. For example, one original thinker from the Stanford Graduate School of Education, whose name escapes us now, reflected that it took 50 years for a new idea, conceived and tested in the Stanford graduate program, no matter how helpful a concept, to become accepted in the average elementary school in Terra Haute, Indiana.

Psychodynamic therapy with all its historical quirks, to say nothing of the personal cults surrounding Freud and later luminaries, hardly represents the ideal proving ground to respond readily to new research information sent from the outside.

Also, in most cases, academics and clinicians usually reside in different professional camps with surprisingly little communication between. When asked about the implications of her research for adult psychotherapy, Beatrice Beebe, a practicing psychoanalyst herself, noted that applying the mother/infant findings directly to psychotherapy represented a new and major challenge even for someone, like herself, well versed in both disciplines. (mentioned during her address on Infant Research and Adult Treatment at the Harvard Medical School Conference, Boston, MA March 26, 2009).

Finally, clinicians and pure researchers lead different kinds of intellectual lives and hold different action values. They think and speak literally in different languages, although often about similar concepts.

For example, a clinician may ask, “How do I use these para-verbal findings to understand this particular patient now?” The researcher might follow new non-verbal discoveries wherever they led, ignoring any immediate practical clinical application for a specific client. We can’t overemphasize how these disparate stands, in general intellectual orientation, contribute to the difficulty inherent when one wing of the field attempts to transact with another.

However, we feel that we cannot allow these very real and long standing obstacles to hinder us. That’s why we began our project. We’re faced with simply too much evidence that non-verbal happenings play a major role in the psychotherapy exchange. We want to explore these phenomena with our readers.

We’ll start Chapter 2 by reviewing some of these extra-verbal data in detail. We need to investigate the significance of the para-verbal exchange as fully as possible, so that we can gain a further grasp of the therapeutic approaches that we already use. Our understanding remains incomplete as of now. Moreover, we don’t just include dynamic treatment. Almost every psychotherapy involves the counselor sitting face to face with one or two clients in a helping situation. We want to know as much as possible about the less obvious non-verbal aspects of this exchange.

We’ll see that we probably need to include detailed descriptions of the patient’s appearance, gestures, voice tones, eye contact, etc. We also require the same attention to the para-verbal presence of the therapist. What her speech tone or prosody, body position, facial expressions etc.?

As we’ll clarify in Chapter 2, others have already made strong forays into this thicket of questions and research challenges, particularly the Boston Change Process Study Group (BCPSG, 2010); and Beebe and colleagues, (2002, 2005). We’ll document their findings and their arguments at length, as well as the contributions of others.

Investigation into the para-verbal interaction may represent a third evolutionary advance in psychotherapy. This potential move forward to study more non-verbal interaction, follows in the steps of the object relations and the relational therapy developmental progression.

This exploration of para-verbal phenomena seems already underway, as the findings from the mother-infant communication studies just now begin to push hard into the perimeter of our field. Establishing that non-verbal communication demonstrably takes places

in therapy, and assessing its influence on the interchange, constitutes the primary focus of our research narrative.

B. The Psychotherapy of the Non-Psychotic, Character Disordered Client

The non-psychotic character disordered patient and his treatment represents another illustration of an emphasis on para-verbal communication entering the field, but again slowly and through the side door, in the same manner in which the mother/infant data now seem to seek a place at the table. We return to our principle that once we invite particular ideas, or particular clients, into the office, unintended, at first unrecognized, major consequences can follow.

What happened when we decided to include, in our psychotherapy, the spectrum of personality disordered patients? We'll see that para-verbal exchange with these individuals becomes all important, and it's almost a necessity to add this perspective into our understanding of their treatment. Marvin, the angry dismissive man, from our introductory cases on page 1, probably demonstrates signs of moderately serious personality disorder, for example. If we ignore his non-verbal messages, we'll never understand Marvin in a helpful way.

Historical Perspective

After absorbing so fully, now in 2015, the influence of Balint, Kernberg, Kohut and Winnicott, it's hard to remember that the question of accepting into the therapy clients, with challenging character issues, provoked such heated debate in the 1960s, but, it did.

In 1965 I (Jim) entered a psychodynamic graduate program in clinical psychology. My teachers, made much of the oedipal versus pre-oedipal distinction. The latter purportedly formed a poor alliance and a chronically ambivalent transference. They seemed prone to shallow or rageful relationships. Most distressing of all, they could rapidly regress into bouts of poor reality testing in the unstructured therapy situation. They sometimes seemed poorly regulated and to not have a cohesive self.

These clients might participate in successful treatment, maybe, but only if the practitioner introduced certain "unanalyzable parameters" into the therapy, such as extra support, controlled free association, restricted use of the couch, interpreting at slow pace and at minimal "depth". Clearly such people did not represent ideal treatment cases and certainly not the ideal candidates to become therapists in training.

Five to ten years later, however, in the 1970's, Kernberg (1975), Kohut (1971), and Maltzberger and Buie (1974), and many others more routinely began to extend the application of dynamic therapy to clients who displayed these same non-psychotic character issues (Wishnie 2005, p. 18). The fascinating story of how and why this era in our field unfolded, and continues to develop, represents too complicated a narrative to follow here in the detail that it deserves. We'll radically summarize.

The explorers in this new area of treatment reported one common conclusion; clients with greater or lesser personality disorder put exquisite pressure on the therapist through their strenuous use of 1/ acting out and 2/ projective identification. In the former mode, the patients notoriously enacted their conflicts behaviorally, and non-verbally, rather than investigating them with more regulated verbal inquiry. They might cancel sessions precipitously, walk out of meetings, yell at the therapist, threaten self-destruction, the destruction of others, the destruction of the therapist, etc.

In the second problem area, projective identification, (Scharf and Scharf, 1991, pp 55-59), the client projects his unacceptable feeling into the therapist, who then unconsciously carries it for them both. The client treats the therapist as if that feeling actually arose in that therapist, as if she actually does display rage at, or uncaring indifference, toward the client, for example.

Buffeted by projective identification in this way, the therapist may begin to respond with her own counter-aggression and mounting annoyance. The counselor can then become guilty, frustrated, perhaps angry, and feel that the patient has set out to hurt her or blame her, which in a way he has. The therapist might then project back annoyance at, or fear of, the client.

If this process remains unacknowledged, the office can quickly transform into a Dutch oven on boil: a cauldron of anger, guilt, despair, revenge and misunderstanding, all propelled by projections this way and that, thus the Maltzberger and Buie unforgettable title "Counter-Transference Hate in the Treatment of Suicidal Patients". (1974) Both acting out and projection immediately usher in unmistakable paraverbal signs – raised voices, looks of sour disappointment from the patient, annoyed or guilty chagrin on the face of the therapist, bodily frustration on both sides of the room, and so on.

Maroda (1999, 2010), and Wishnie (2005), in particular, have offered helpful guidelines about how we therapists can work to unravel

our feelings in the midst of these stressful clinical showdowns and slowly help the client to understand himself and to settle in with us. In Chapter 2, when we review the work of Tansey and Burke (1989), we'll explore in detail the role of counter-transference and projective identification as important therapeutic phenomena.

Inviting these character challenged patients into the practice turned out, a fateful decision indeed, because once we became more experienced in this work, many more clients seemed to have some form of borderline or narcissistic condition than we had ever guessed at the start.

Personality disorder clearly represents not a discrete state but occupies an ever shifting place on a continuum of emotional functioning. (Howard Wishnie, personal communication, Sept. 8, 2009 and J.G. Allen, 2013) In other words, it becomes clear that some hold these discrete severe diagnoses, in full force, but many more display sub-diagnostic traits of these conditions, for example, a subtle, but important, chronic ambivalence over intimacy (Jennifer Dotson PsyD, personal communication, April 20, 2009), .

The changes in technique demanded of the therapist, once these more intense clients entered the office, has led some practitioners to redefine the role of verbalizable insight in psychotherapy. Stern et al (1998). Stark (1999). Maroda (1999), Schore (2003 a&b), Wishnie (2005, p. 31), Fonagy (2006, 2014), Wachtel (2008), and many of the rest of us, have discovered that often, to improve from therapy, or even to continue in the work at all, the client must know that the therapist captures and feels in herself some crucial emotional experience of that client. Sometimes it's no longer about insight, if it ever were. The therapist must show para-verbally, behaviorally, her connection with the patient.

Failing this basic affective connection, the treatment with these more inaccessible people, may fall flat or drift along a meandering, confusing, sometimes boring path. The client complains of the same symptoms or interpersonal conflicts, and the therapist suggests some possible meanings or clarifications, which sound more and more hollow, even to her, no matter how sincerely she tries to engage with her client.

Glacial progress and ennui represent one important challenge here, but some of these treatments, lacking a crucial emotional connection, can become outright dangerous, to either client or therapist, and quickly. Now para-verbal signs abound in the office – screaming or

angry, silent, disgusted patients, perspiring, confused, agitated therapists and on and on. Consider my physical response to Marvin's provocations. I sat up rigidly in the chair, fixed him with my gaze and asked a somewhat sarcastic comment but also productive question. "Why would you return to someone so inept?" We have to learn to work with these bodily reactions, in both of us, across the spectrum of patient acuity.

In chapter 4 we'll encounter an almost always frustrating, and often frightening, Asian American lady who used all her para-verbal force ostensibly to defeat Jim, her therapist, and to render impotent his attempts to offer any help. Both participants enacted an intricate series of extra-verbal responses and counter responses in this harrowing therapy which we'll carefully review in that later chapter. At one point this lady slashed her arm the night before our meeting and arrived to wave her wounds in my face, demonstrating to me my abysmal shortfall as a helper. In this one dramatic flourish she communicated how I had failed her and in how much danger she remained.

ENACTMENTS, IN CAPITAL "E" AND LOWERCASE "e"

These sometimes intense Enactments, with a large E, can become the focus of the therapy. Clients on the personality disorder spectrum introduce many such confrontations into the office. They also react to the treatment in an often puzzling fashion. My chronically suicidal Asian patient, just above, repeatedly refused offers of a medication consult, DBT or day hospital and also rejected any interpretation connecting her despair to the rest of her life, particularly to her relationship with her harsh abandoning grandfather.

She said she couldn't comprehend how any of these additional interventions or psychological observations might help her. I don't think this simply resistance. I think she really didn't see or feel any relevance to her situation. She did grudgingly admit, as the treatment progressed, that she felt more calm in her life, but she had no picture of how that greater peace had come about. These clients may denigrate the treatment, but also keep coming and often improve. The therapist however, is forced to fly blind using only her internal reactions as a guide, with no positive feedback whatever from the client.

I think she improved because my relaxed (sometimes), jousting with her sarcastic putdowns and my capacity to listen to her unrelenting despair, helped her, para-verbally, to "self-regulate" and to "soothe" herself in Beebe's words (2005).

I was also inadvertently offering coaching in “mentalization”. What feelings did she have? What did they mean to her? How did they differ from mine and how did she perceive her life, or anyone else’s, in an emotional way? (see J.G. Allen, 2013) Almost all of our work then fell “beyond interpretation”, the title of John Gedo’s 1979 book, one of the first efforts to explore, extensively, this para-verbal, pre-verbal world, that we’re still pursuing 40 years later, perhaps with less progress than we had hoped.

My patient and I developed a teasing debate, over the value of my suggestions, an interchange which we both enjoyed, mostly, and which probably represented a key element in the therapy. She could tell from my joking and grinning that I liked her, no matter how frustrating I found her and no matter how little she often liked me or herself. There was affection and connection, as well as consternation, from my side of the office.

Our interaction became a highly para-verbal one; smiling, grimacing, waving our hands to emphasize a point, raising our voices in a very animated way. As we’ll later see, I think our therapy may also have represented a fumbling, non-insight oriented, highly extra-verbal, bootstrap DBT strategy to help her gain increased self-management. If I could understand her and stay with her emotionally, her fury would not seem so frightening to her and she could gain some acceptance and control over it. My approach modestly succeeded in those goals, goals of which I remained consciously unaware until recently.

Lowercase “e” Enactments

It’s a mistake, however, to over-emphasize the significance of these major confrontations the like of which I’ve just described. For one thing, perhaps we can’t put them out of our minds, but, thank God, they happen infrequently. However, I think that they may often influence us to look in the less helpful direction for meaningful therapeutic non-verbal enactments, toward the distant most extreme stretch of our experience, rather than toward the proximal end, our day to day therapy exchanges.

Certainly these Capital E Enactments force us into a para-verbal interaction and teach us just how important extra-verbal communication can loom in psychotherapy, a major contribution to our knowledge base. More importantly, they introduce the question that if the non-verbal connection feels so crucial within these highly charged confrontations, perhaps that para-verbal dimension also plays an

important, although less obvious role, in the more quotidian exchanges that typify so many treatments. Most of our interchanges with clients are not deeply upsetting, but many of them do include some form of important para-verbal interchange. What if we followed those subtle communications more precisely?

A majority of enactments, in fact, come with a lower case “e”, i.e., relational, often non-verbal exchanges, sometimes, at first below awareness to one or both of the participants. Nevertheless for one of the first times in the literature, these extra-verbal engagements may bring great influence to the therapy, as we’ll see in a minute.

Even a non-therapist can’t miss potentially catastrophic confrontations, blatant suicidal threats and the like. That observer could instantly spot the arrival of some momentous development, a knife ripped arm, for example, although he might not know how to respond to it. But we offer, as the main thesis of our monograph, the necessity of not overlooking less obvious, smaller gauge para-verbal exchanges that regularly occur throughout our everyday treatments. What if much change in psychotherapy comes about partly through these hardly observable non-verbal interchanges?

Subtle facial expressions, hand movements, shifts in voice tone, or in rhythm, compose the stuff of psychotherapy each session and each week, not the occasional high pitched, shouting face offs. The tapes and case vignettes, which we’ll study, offer example after example of these below-the-radar exchanges.

Beebe et al (2002, 2005) and Stern et al, (2010) track these para-verbal communications and argue that they might mark the center of our understanding of the therapeutic relationship and of change in psychotherapy. We agree and will investigate how the Stern-Beebe approach helps us make sense of our observations about para-verbal interchange.

For instance, at the start of Chapter 5, we introduce a videotaped consultation interview, in which I (Jim) meet with a soft spoken, wispy, 22 year old young lady, at the time almost literally the age of my oldest daughter, of whom I’m very fond. The client, in turn, reports a close, supportive relationship with her 30 year old brother.

I like my young patient right away and as her heart-rending story unfolds, my respect for her grows. Also I’m used to talking to women of her age because I chat with my daughter and her friends as much as they’ll let me. As the tape runs, the observer cannot miss my interested, friendly, protective, avuncular tone and relaxed body language with

her. The scoring systems we use (see Chapter 3) capture this style in the therapist and likewise reflect that this young woman sits increasingly comfortably exchanging with me. Maybe I remind her of her nurturing older brother.

By the second half of the interview, she decidedly opens up, in both body posture and in the expressiveness of her voice, emphasizing her points with hand gestures and using a new sharp tone, with increasing emotional force. She speaks more powerfully, gets more involved, and lets us both see how upset she can get. She becomes more intimate and transparent in the content of her verbal communication as well.

I, too, speak with more intensity and authenticity. I point my hand, talk more loudly, raise my voice strongly at one point, lean toward her and do not turn my gaze away. She inclines toward me. Our eyes lock. On one occasion, I finish an important sentence that she begins.

We synch through these smaller “e” enactments. If we weren’t studying our non-verbal communication, we might overlook many of these signs on the video. However, we see a trusting relationship that surprisingly quickly builds, verbally, but also behaviorally, between a 46 year old male therapist and my 22 year old female client, whom I’ve never met previously.

If we analyze the tape carefully, we cannot miss that this move to greater depth between us, is mediated with words, obviously, but also with gesture, with body language and with verbal tone. We co-create a surprisingly authentic engagement, with one another, in a short time and work toward a productive culmination to the interview, “a moment of meeting” in Stern parlance (see Chapter 2). Analyzing this kind of developing interchange, from the non-verbal perspective, represents the focus to which we regularly return.

This, and other cases, suggest that we might track para-verbal joining to understand and guide the interaction, not just in extraordinarily high amplitude confrontations but in our daily therapies. We may need to turn away from too exclusively studying the words, only, and look also at the subtle shifts in body position and verbal inflection through which the participants, mostly unconsciously, conduct their relationship.

THE THREE INTRODUCTORY CASES

If we return to our starting place, we can understand these three scenarios a little better now.

In case #1 Marvin and Ann – Marvin gives signs of personality disorder. He has few or maybe no friends, has retired early from his profession, seems to ignore his wife on purpose and angrily picks fights with family members, strangers and me.

Now I feel mad and insulted by Marvin. It's not just his words; it's his disgusted tone. I reviewed the case with myself and with others, and I decided that I need to initiate a "real relationship" intervention with Marvin. When they come in the next time, I ask him his reaction to the last session, and he dismisses my question, that's the way he feels what should he do? Lie and say he's satisfied. I tell him I feel angry and abused. Does he want to repair our relationship?

He says no, and I ask him if he's has similar interactions in his private life. Ann says that he does, and she can't stand it. I ask him if he can remember any relationship that worked smoothly. Ann volunteers that he and his demented grandfather did very well together. Marvin treated him with great respect and patience, and they genuinely enjoyed each other's company. I turn to Marvin and say "Marvin, everybody's grandpa." The room begins to calm down.

I conclude with "So Marvin feels saddled with a clown (his word), for a counselor. Ann is desperate, and I feel angry and ill-treated – (all the while I'm smiling at the absurdity of the situation) – so how about another session everybody?" We all chuckle and arrange another meeting. We agree that we'll schedule the sessions one at a time.

I have to take a para-verbal action here. My tone and facial expression tell Marvin he has hurt me, but I also want contact with him. He waves me off, but he listens a little more intently for the balance of the meeting. He may return to his derisive self next time, but I'll interrupt him with "everybody's grandpa, Marvin, even me". I'm implying, but not stating, that he's capable of enjoying those who don't threaten or disappoint him. I'm also demonstrating that he has little to fear from me.

Case #2 Pat, the silent veterinarian – I approach Pat, "I'll sit with you as long as you need. I'm sorry you're suffering." (verbal and para-verbal offer of my continued presence, delivered in a gentle tone) Finally in the seventh session, he confronts me, "How could I excuse him from his cowardly act of deserting his dog? What kind of person does that make me?" I smile and reach my hands toward him, "It was my honest answer that you had no choice. You can let yourself off the hook." He disagrees but begrudgingly begins to speak again. In a soft

voice, with slow prosody, I tell him I was worried about him, wrapped up in his angry silence, and that it seemed to me that he, at that time, hated himself. He grins back a little. A real relationship, beyond the words, a concerned mostly non-verbal connection, at last, has eased our impasse. I could wait out the troubling test of six silent sessions. He feels I care for him even if he sometimes can't understand why.

We go on to complete a productive therapy. He graduates, leaves town to continue his training and sends two letters to me over the years. In the first he says he's married to a woman whom he'd brought to our therapy for a few meetings during termination. In the next he announces the birth of his son.

Case #3 Pamela and Fred – I suggest to this couple that her smile had tender feelings behind it, that I could see she really cares for Fred. Fred continues to feel frustrated by her tentative shyness. I offer Fred, “Never mind how much she talks, just watch for that smile – if you get it – you're both in good shape.” He grins broadly but still wonders why she doesn't converse more. I answer, “Look at her face; she's interested in you.” I smile broadly. The atmosphere in the room warms. This interaction represents almost entirely a para-verbal one. We discuss smiles and exchange those smiles back and forth between the three of us. Nancy and Fred leave, arms around each other. We'll certainly require future interventions, but we've moved to a new level of acceptance and affection for this couple.

Para-verbal offers from the client seem to beget para-verbal responses from the counselor and to and fro. We'll learn more about these non-verbal puzzles as we continue into Chapter 2 and particularly in Chapters 4 to 7, which center exclusively on the details of the non-verbal exchange between real clients and their therapists.

RESEARCH STRATEGY

Beyond simply asserting that non-verbal messaging represents key information in the therapy interchange, we clearly need a method of data analysis, a scoring system which will specify and differentiate these extra-verbal communications. This we introduce in Chapter 3.

In Chapter 2, next, we outline a model of the treatment relationship grasped at an instant in time, based on the findings of many previous students of psychotherapy, most of whom we've mentioned in passing, here in Chapter 1. In subsequent chapters, we then carry this matrix

forward to organize the clinical material that we discover through each videotaped interview or case excerpt.

We'll study, at length, a total of four videos depicting the work of three experienced therapists. These investigations, and the study of a number of additional clinical vignettes, compose the subject matter of the book and begin in Chapter 4. Along the way, and particularly in our final chapter, we'll develop suggestions about potential alterations in technique that we can devise using a para-verbal focus.

As the reader works her way through the text, a list of questions will probably come to her mind: First, does this line of inquiry, about non-verbal therapeutic interchange, make intuitive sense? If so, how can I, the therapist, describe the shifts in my client's extra-verbal behavior and in my own? Does this series of unsaid exchanges trace a different, sometimes deeper, certainly more subtle, parallel intimacy developing between us, than any record of simply the actual spoken words? Should I call attention to my client's extra-verbal communications, when and to what end?

Should I directly comment on my own non-verbal messages, and should I alter these to influence the treatment in important ways? When and how might I do this? It's with this matrix of challenges and reflections that we want to engage our reader, as she considers, more thoroughly, the significance of the para-verbal world which may suffuse the psychotherapy in which she takes part.

In Chapter 1 so far, we've touched on the broad sweep of the evolutionary history of dynamic psychotherapy in the past 45 years. We're offering our beginning hypothesis that a next step may involve the more careful study of mutual para-verbal relating between client and therapist. In our project we're trying to contribute to that movement forward.

THE ANATOMY OF EVOLUTIONS

We've also learned, a little, in general, about how change tends to come about in our field. Evidently for paradigm development to occur, three sets of conditions need to take place roughly at the same time but in no particular order. 1/ New types of patients clamor for admission into our clinics, earlier we observed what happened when those with personality disorder requested and received services. (Wishnie, 2005; Allen, 2013) Now the newcomers represent the less educated, possibly immigrant, possibly gay, Latino and African-American people, all of whom quite appropriately request services.

2/ We observe a shift in the cultural zeitgeist. In the 1960s a new egalitarianism was afoot. In 2015 we see about us a societal change supporting personal availability, transparency and informality. The President of the United States appears regularly on television in his shirt sleeves. Clients may seek and expect a less formal more present therapist. 3/ New theories of treatment arrive which support modifications in technique. For example, Attachment Theory (Allen, 2013; Fonagy, 2014), the New Neurobiology (Cozolino, 2014; Schore, 2014) and thirdly physical interventions to treat psychological ills, i.e., Sensorimotor Psychotherapy (Ogden and Fisher, 2015) and Therapeutic Yoga (Emerson, 2015) all have recently come upon the scene.

We're perhaps on the cusp of another paradigm shift in psychotherapy. This one reaching more toward the physiological foundations of behavior, for example brain function, than previous schools of thought. Para-verbal relating fits within this wave. Physical action – speaking loudly, leaning toward one another, all express, reflect and beget shifts in brain activity, heart rate and the like. Our research, like a good deal of contemporary work, focuses on the body as well as on the mind and sees these as a unity not a polarity.

In addition the bodily presence of the yoga practitioner, the sensory motor counselor and, particularly of, the para-verbal therapist, takes a more central focus in the treatment room. What influence will this more active counselor bring to the therapy?

Amidst this welter of emerging approaches, though, our book turns on one, basic, question. What do you discover when you analyze a treatment session from a para-verbal viewpoint? A new perspective may open. How will we find ways of incorporating this fresh knowledge into our extant treatment techniques?

In chapter 2 we study the research data which constitute the scientific foundation for this exploration of para-verbal phenomena within the psychotherapy encounter.