

## Paralinguistic communication in the therapeutic relationship

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### Summary

The author, on the basis of literature and his professional therapeutic experience, describes the meaning of vocal signals in diagnosing patients' problems and improving communication during a therapeutic dialogue. In the article the author also shows the influence of voice vocal features on evoking many non-specific therapeutic factors as well as accelerating the insight and overworking process. The great importance of metasignals, i.e. information concerning emotions hidden in patient's utterance has been noticed. A therapist is able to recognize them by careful listening to all vocal signals, particularly to: speech rhythm, voice height and verbal intensifiers.

The author indicates that vocal signals themselves may often influence the content of transmission and give a lot of reliable information about patients. Patients' reactions on a therapist's behaviour are highly influenced by the reception and evaluation of his/her vocal signals. Therefore, a therapist should more thoroughly analyse voice features present at a therapeutic interaction and become their conscious sender and recipient.

### voice signals / therapeutic relation

### INTRODUCTION

Paralinguistic communication – also called paraverbal or proto-language communication – includes vocal, but extra-verbal aspects of communication properties, such as voice power (volume), the rate of speaking, variations, errors and other distortions of speech fluency, setting or level of voice, and its quality. „Paralanguage”, which is not fully a verbal or extra-verbal message, at the same time, tries to „register” communication on various levels, and therefore seems to complement well the signals at the subject (verbal) and the emotional (non-verbal) lev-

el; the way in which the words can be uttered, acts on these two planes. Therefore, the paralinguistic messages may provide additional information about how much the extra-verbal message is honest, and to what extent it is distorted. The therapist, when interpreting parallel features of voice, accompanying the speech content of a patient, with his „body language”, can better predict the consistency or its lack in the simultaneously transmitted content, in both – verbal and non-verbal channels. It can also determine which of these two channels is currently leading, and thus which is the one, you can rely on more. Since, for example, when a patient in his uttered words, more strongly emphasizes the issues that are important for him, he manifests a high attention to the tone of voice, its volume, speed and clarity of speech, then it must be assumed that the information transferred by the subject plane (content) are quite reliable. In a situation, however, when the verbal utterance is dominated by

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different non-language sounds (without verbal content), such as sighs, groans, munching and grunting, it is more reliable connected in terms of communication that the signals may be sent at an emotional (relational) plane. In the first case, the patient is focusing heavily on the fact that his words were the most expressive; somehow he is not able to a similar extent to take care of his „body language”. In the second case, however, the occurring sounds which characterize some difficulty in expressing something in words, activate other media channels, including the ones which cover the relational plane (facial expressions, gestures, posture) most [1].

### **META-COMMUNICATION IN PSYCHOTHERAPY**

The starting point for the discussion about the importance of diagnostic and vocal communication signals must be undoubtedly the reference to the studies of a famous group of researchers and therapists of Palo Alto. The people gathered in it, of a stature as P. Watzlawick, G. Bateson and V. Satir, were one of the first to recognize that the decisive role in the reading of the communicated content by a patient plays „meta-communication framework”. According to this assumption, the framework contains guidance on how the message can be interpreted. A therapist is provided with clues, that allow him systematize his perception and understand the meaning of words spoken by the patient. These researchers have taken the trouble to determine how these frames are clearly communicated. It was obvious that this must occur in some form of „meta-communication.” In other words, they assumed that any information at the same time includes tips on how to understand it. In the case of communication in the therapeutic relationship (and also interpersonal) it suggests that such clues can be expressed:

- verbally (for example, by saying the sentence: „I think you are crazy, but this is obviously just a joke”);
- contexts (for example the question: „How are you?” may be understood differently if by the application of the same non-verbal means the expression is uttered during a chance encounter in the street when meeting somebody you

know, or at the beginning of a psychotherapeutic session);

- non-verbally (for instance, when the sentence: „You have lost your mind” is accompanied by vocal signals in the form of a friendly smile or a humorous tone [2].

Meta-communication contained in vocal signals is the main subject of analyses and discussions included in this paper.

### **META-COMMUNICATION AND THE PROCESS OF THERAPY**

The following two hidden layers of meaning can be found in the messages formulated by the therapist and patient: it is the transfer of specific words, and the second - meta-communication - which is a message referring to emotions. According to P. Watzlawick, J.H. Weakland and R. Fish [3] the therapeutic interactions without meta-communication would create a chain of mutual misunderstandings and conflicts. Any comments, any discussion of the contentious state of affairs, any additional question about whether the words that had been heard were understood correctly, comprise meta-communication. The ability to invoke meta-communication in a situation of overt conflicts and disturbances of relations with patients belongs to the professional competence of the therapists. It is the base of all successful compromise.

Meta-announcements can cause difficulties at any stage of therapy, starting from conclusion of a therapeutic contract, through the use of certain procedures (e.g., therapeutic interventions) and ending with the completion of therapy. Sometimes a seemingly clear and logical statement with a positive tinge, can, through an improper meta-announcement, express a negative attitude. For example, if a therapist at the time of the conclusion of the „therapeutic contract” first utters the sentence, „I’m going to help you”, and then s/he adds the verbal modifier „only”, at the same time stressing and uttering it with rising intonation, then an entirely different message arises. Now the words „I’m only going to help you” take the form of a signal expressing an attack or a defensive attitude or a grudge. Moreover, the use of such meta-announcements – especial-

ly demonstrating disapproval and anger – is not easy to neutralize. If the addressee of the meta-announcements formulated this way is a patient, then the defence harmful, negative content, included in them, can be even more difficult. An additional problem is the fact that on the one hand the creation of such meta-announcements easily gets out of control, and on the other, the attack that is hidden in them is usually so subtle that often the sender (here: the therapist) is not aware of the harm caused to the recipient (here: the patient). Similarly, the addressee (here: the patient) may often be unaware of this, how s/he has been hurt. For example: a patient admits that s/he often changes his/her therapists which are commented by the current clinician as follows: „Presumably, I'm not your last therapist". The modifier „presumably" and the accent on the word „last" make that the message means: „You are a psychotherapy addict" or „You lack motivation to overcome the problems," or even „The complaints are so serious that no therapist is able to help you". A therapist, in formulating such a statement with good intentions, in order to encourage the patient to work intensively on him/herself, obtained the opposite effect. As a consequence, to the end of the session, the patient may feel discomfort and anxiety, yet having no idea how it came to the deterioration of his frame of mind. Consequently, this may trigger a „resistance" in therapy, and even pose a risk of its premature failure („drop-out").

For this reason, every therapist should make an effort to learn the skills of control over their own meta-announcements and to cope with negative meta-announcements created by patients and by those people who are „implicated" in therapy (e.g. family members). According to P. Watzlawick [4] taking into account the fact that communication is an aspect of content, and the aspect of the relationship (the second out of the five axioms of pragmatic communication) can be very helpful in this respect. The interpretation of what was essentially told by the patient, in a decisive extent, depends on how it was said. I would like to add here that the ability to read correctly the meta-announcements contained in the paralinguage is to increase awareness of how they are constructed, while paying more attention to rhythm and pitch of voice.

### Pause and silence

According to the first pragmatic axiom of communication P. Watzlawick [4], which states that „it is impossible not to communicate", even short interruptions and moments of silence also may communicate something. Many junior researchers of psychotherapy are so much afraid of silence that they begin to speak before they can understand why the patient remains silent. Meanwhile, the cause of this silence may be that: a) the patient is thinking intensely, b) s/he experiences strong emotions, c) s/he does not want to talk or talk about what s/he is thinking, d) is concerned about the reaction of the therapist, e) the patient is trying to get a grip, f) s/he is not able to choose the right words, g) s/he is concerned that the conversation will be overheard, h) s/he is wondering whether to reveal what was up to that moment carefully hidden, kept in secret, etc. [5].

### Voice characteristics and mental disorder

A strong connection between the characteristics of voice and certain psychopathological states has been documented. For example, depression is accompanied by speaking in a slow and long manner, full of pauses; schizophrenia, however, is characterized by flat and monotonous voice. The voice of patients suffering from these symptoms usually sounds very sad, especially when faced with the necessity to refer events from their own past, both kinder and depressing, or overwhelming. In addition, patients with depression and schizophrenia show a noticeable lack of ability to express emotions in their tone of voice. This applies, in particular, to the former: because it is much more difficult to recognize the emotional tinge in paralinguage communications emitted by patients with depression [6] you can see, therefore, that the acoustic characteristics of voice can be a source of discrete monitoring of the patient. However, Ellgring and Scherer [7], Ostwald [8], Heaton [5] and many others, basing their assumptions on the measuring procedures of the vocal properties, gathered a reliable material to confirm the fact that the voice characteristics significantly af-

fect the formation and development of a therapeutic relationship.

### Communication of emotions

The need for knowledge of the principles guiding the proper use of the paralinguistic elements also arises from the fact that they are an important means of communicating emotions. Already in young children it manifests itself through whistling, screaming or babbling; being at this early stage of pre-verbal development, they can thus communicate their emotions. Later, over the years, in the juvenile and adult life, it serves the manner in which we pronounce words. J.R. Davitz [9] showed that, based on vocal signals, we can accurately identify emotional states such as anger, frustration, sadness, happiness, sympathy, satisfaction, fear and love, jealousy and pride. The provided sequence shows at the same time, which of these states are the easiest to read (the first four items), which are a bit harder (the next two items), and those that may cause the most problems (the last four items).

The research by M. Argyle [1], J. Burgoon [10] and many others, seem to positively verify the popularly-sounding thesis that the voice is „more leaky” than the face. This should be understood that the true emotions, the most deeply hidden, can be explored by „paralanguage”. For example, people with depressive tendencies, or the ones who already suffer from depression, usually speak slowly, with low and declining tone of voice. Talking fast, rough, with excited and breathy tone of voice, with plenty of slips of the tongue, in turn is a „paralanguage” that is characteristic for frightened people, who are afraid of some people or situations. But the tendency for frequent use of independent vocal expressions („gap fillers”) such as „uu”, „ahh” or „uuh” is seen as a sign of irritability and nervousness. The indicator of emotional state can also be the „speech range”: for instance, the lack of harmonization of voice might suggest anger, and purity of tone contentment [11].

It is noticeable, therefore, that messages can be used at simultaneous paraverbal communication of emotions and attitudes towards a person or situation. For example, anger and contentment can on the one hand be transmitted by

vocal emotional states, but on the other hand, their purpose may also be to communicate attitudes towards certain people. In addition, you need to be aware that emotions are communicated sporadically through a single trait of voice. Therefore, in order the therapist was able to assess what kind of emotions are communicated by a patient with the application of the „paralanguage”, s/he must perform a combined interpretation of as many parameters of his/her voice as possible. Otherwise, it may turn out that there is a large discrepancy between what is actually communicated by the patient paraverbally, and how it is perceived by the therapist. Similar differences can occur when paraverbal signals express emotions much related to each other such as „jealousy” and „pride” or „satisfaction” and „joy”, which in turn makes it difficult to clearly determine which are the ones that are actually communicated paralinguistically. It must not be forgotten that there are large individual differences in the ability to encode and recognize emotions expressed with „paralanguage”. The therapist must strive to be able to accurately identify the emotions expressed by the patient vocally, and also that s/he could become an effective communicator who can use „paralanguage” to express his/her own emotions. With this ability, it will be much easier for him/her to create the right atmosphere during therapeutic meetings, interactions with patients.

### Non-specific therapeutic factors

Paralinguistic signals may become an important element actuating „nonspecific therapeutic factors”; positive expectations and hope for achieving effective assistance [12]. Paraverbal messages characterizing the competence of the clinician can significantly increase the patient’s confidence in the effectiveness of the therapist’s treatments. The vocal signals, aptly chosen, adequately to the information transferred by a verbal and nonverbal channel (facial expressions, gestures or proxemics), can make that the faith of the patient in the therapist and his „healing” process will strengthen. The therapist who speaks with the standard, general and literary (metaphoric) dialect at the time of informing the patient about the cause and type of the disorder

and, most importantly, that it is something quite common and that it can be „cured”, may considerably increase the credibility of his message. Similarly, getting the patient familiarized with the therapeutic techniques and procedures that are to be used may be more convincing if the clinician will do it with the proper setting of his/her voice and at appropriate volume [13].

Paraverbal signals may also contribute to strengthening of the ritual actions of the therapist, detailed steps the aim of which is to restore health. The clinician, using, e.g. modelling techniques, such as the dual therapy (individual), thus providing the patient with role models, will become more credible when some content will be respectively distinguished (stressed) [14].

No less important in the process of modelling the behaviour of the patient is the therapist's prestige, s/he becomes a kind of authority for the patient, since only then the strategies for optimal overcoming of the difficulties presented by the clinician will win plaudits of the patient; simply with more desire and motivation s/he will proceed to imitate patterns of behaviour suggested by the therapist, perceived as an important and competent person. Certainly, it will not happen – at least at a greater extent it is possible – when the therapist will not speak smoothly, will use frequent pauses, unwarranted changes in formation of sentences, repetition of words, or stammering and stuttering, not finishing sentences, slips of the tongue occurring frequently, butting in chaotic sounds in a kind of smacking with the lips, grunting and sighing. This can not only greatly hinder or even completely prevent the process of modelling of the desired behaviour patterns, but also can introduce „chaos” in the therapeutic relationship. It is a proven fact that from the perceptual perspective, the lack of liquidity in the consciousness of the recipient is strongly identified with high levels of anxiety and fear [15, 16].

### Control over the „paralanguage”

That last statement about the dreadogenic impact of the lack of liquidity during speaking requires to some extent therapists to control their „paralanguage”; to comply with the rules regarding the correct application of the paralin-

guistic elements when communicating with the patient. What is important here is the awareness that the voice plays a substantial role in strengthening, creating a proper ambience during the course of therapy. The clinicians, who do not know or ignore the rules related to the „paralanguage”, may lead to an unequal distribution into a dominant (omniscient, overly directive) therapist and a submissive and obedient patient. Unnecessarily, hypercorrectly emphasizing uttered words, intensively chanting some sentences, speaking too fast and too loud can make the patient feel dominated. Numerous experiments seem to indicate that the voice is more important than the face in formulating judgements about the domination of a particular person; the face in turn is more important than vocal signals in forming of judgements about likeability [17, 18].

### CONCLUSIONS

Communication is an interactive process, and thus consists of a continuous exchange of information between the therapist and the patient; it imposes a need for proper use of the „paralanguage” by the clinician. Because also the patient may negatively perceive the therapist as s/he is abusing the paralinguistic messages which mark the lack of credibility in communication. Certainly, the clinician who can properly intone the important content, who can provide the patient with most rapid health feedback (without pausing for too long), who speaks smoothly, ensuring appropriate diversity of volume and clear speaking, and who can speak at a relatively fast pace, will be perceived as a much more competent than a therapist who presents too monotonous vocal signals.

Undoubtedly, the importance of vocal signals in the therapeutic relationship is multilateral: they both aimed at controlling the course of therapy, and diagnosing the patient, as well as strengthening and developing the therapeutic relationship.

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