

Unconscious Role-induction: Implications for Psychotherapy

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An apparently healthy 34-year-old man with a 2-year-old daughter is suddenly stricken with cardiac symptoms and requires triple bypass surgery. At home, the father has been asked to hold a heart shaped pillow to his chest as part of his recovery. His daughter comes to his room each morning to ask caringly if he is holding his “heart” as he should. She leads him to her room (the hospital), where she “professionally” pretends to take his blood pressure and pulse. For several weeks, as part of the daily routine, she insistently asks, “Daddy, did you take your pills?” He says to himself (and to anyone who would listen) “If I were alone, I would have become depressed. With my daughter, how could I get depressed?”

The 2-year-old daughter told her father through her nonverbal behavior that she needed him to be healthy for her.

Our social brains (see the article by Drs. Viamontes and Beitman on page 243) are constructed to create and maintain relationships. Along with adequate diet, exercise, and sleep, good-enough relationships are life enhancing and help to prevent illness.¹ Good-enough relationships are based upon effective communication, which relies upon the spoken word and a complex set of nonverbal signals whose neural basis we are only beginning to comprehend.

In this paper we highlight a fundamental aspect of human communication: Most interpersonal communication includes unstated requests for the receiver to respond in a certain way. In addition, this role induction request is most commonly made nonverbally, and speakers are often unaware that they are actually making the request. Furthermore, receivers are often unaware that they are being induced to respond in a certain manner.

We will clarify the definition of meta-communication (comments about communication) and introduce the new term paracommunication: the summation of nonverbal signs intended to create a response in the receiver. The nonverbal signs may be compared with instruments in an orchestra, whose purpose is to play a song that enraptures the audience. We emphasize the effect on the audience more than the means by which the multiple instruments create their effect.

When wading into the muddy waters of linguistic analysis, words can come back to haunt us. For example, we will be drawing lines with words to create categories that may not be sharply delineated. Where does “verbal” end and “nonverbal” begin? Where does “denotation” (the explicit meaning of a communication) end and “connotation” (the implicit meaning of the communication) begin? Clinicians can ill afford journeys into such nuances

unless they provide practical cognitive tools that help patients to change. We ask your indulgence as we explore this uncharted terrain because there will be many intellectual loose ends. Our aim is pragmatics—the practical. We are very interested in your comments on the concepts presented in this paper. Please contact us at beitmanb@health.missouri.edu.

Our primary premise is that nonverbal behaviors that accompany spoken words direct how the speaker wants the listener to respond.^{2,3} This intention is usually, but not always, outside the speaker’s awareness. The implicit communication of interpersonal intentions characterizes human interaction and is central to how the brain functions.⁴ Unconscious processing dynamically predicts the immediate future (see Viamontes and Beitman in this issue, page 244) and prepares the body to respond.⁵ With each communication, the sender and receiver are each unconsciously preparing a response to the other.

Not all nonverbal behavior is intended to generate a specific response. Sometimes, for example, a yawn is simply a commentary upon the yawner’s level of arousal, not a statement about being bored by the speaker. We apply the term paracommunication to those nonverbal behaviors, which are intended to create a response from the listener (for example, the yawner is requesting silence or a changed

subject).

When two people are in a relationship, one of them may verbally comment upon their relationship either as it is in the moment (eg, “You are making me angry”), or over time (eg, “When I show need for you, you become angry and withdraw”). Explicit verbal commentary on the relationship has become known as “metacommunication.”^{3,6,7} The usual intention of a speaker who uses metacommunication is activation of the self-awareness of the listener to elicit a more desirable response in the future.

In their different ways, one verbal and the other nonverbal, meta- and paracommunication are both comments upon the relationship with the intention of altering it. We will elaborate upon these definitions, then apply the concepts to psychotherapy and map them onto conscious and unconscious brain processes. We will discuss possible mechanisms by which para- and metacommunication influence brain function, each altering in significant ways the listener’s role-related neural circuitry.

DEFINITIONS OF PARACOMMUNICATION AND METACOMMUNICATION

Watzlawick et al,² building upon the work of Bateson,⁸ began to define metacommunication. It is the level of communication where “the subject of discourse is the relationship between the speakers.”³ These authors outlined general principles by which speakers induce roles in listeners. However, they used the term metacommunication for both the verbal and nonverbal commentary. Subsequently, most writers appear to use metacommunication to refer to overt, explicit verbal commentary. They usually mention in passing the nonverbal commentary but rarely differentiate the two.^{6,7} To clarify this important distinction, we introduce the term paracommunication to describe the role-induction aspects of nonverbal signals that parallel and accompany spoken words.

Paracommunication

In any attempt to send verbal messages to others, one might expect that the speaker would like to have the listener respond in a certain way. This expectation derives from the self-evident idea that the speaker wishes to create in the listener some optimal response. The remarkable thing about this observation is that the requests for the roles are generally outside of the speaker’s awareness, hiding in plain sight. To be aware of what one is saying, as well as the response one is trying to induce via nonverbal communication, requires significantly more here-and-now self-awareness than most of us have developed. The difficulty arises because the nonverbal request for a specific role relationship is usually made simultaneously with speech rather than sequentially. The speaker implicitly attempts to induce in the listener a particular role or attitude towards the speaker’s words. Examples of such paracommunicative messages are: “I want you to agree with me or praise me or like me.” Or in the long term: “I want you to want to be with me again.”

Linguists employ many overlapping terms to describe nonverbal and voice-variant aspects of communication.⁹⁻¹¹ These nonverbal variants are summarized in Sidebars 1 and 2 (see Sidebar 2, page 262).

Paracommunication is embedded within the fabric of interpersonal relating. In a more general sense, context, that which accompanies the text, participates in role induction and can be considered an aspect of paracommunication. Context for this discussion may be operationalized as “the demand characteristics of the situation.” In other words, what behavior does the situation (persons, place, time) appear to be requesting from the receiver? In addition, we extend the definition of paracommunication to include nonverbal signaling that may not directly parallel speech, but nevertheless significantly defines the nature of the relationship. Our extended case example will illustrate how words spoken

at one time seem to directly contradict behavior at another time to create role-expectation confusion in the receiver.

Paracommunication: The Request Continuum

Bateson³ and Watzlawick et al² called the nonverbal role-inducing (paracommunicative) signaling the “command” aspect and the verbal communication the “report.” We wish to modify the severity of the term “command” by defining a “request continuum.” Nonverbal signals help to calibrate the interpersonal request continuum — to define the range of intensity with which the speaker is attempting to elicit a specific role from the listener. This continuum maps the strength of the request for a certain role and response. As illustrated in Figure 1, the continuum may be characterized by words like “plea” at the weak end and “command” at the strong end.

The position on the request continuum is a function of the intensity of the “received” nonverbals and not necessarily of their externally observed intensity. For example, a loud, angry burst may simply be a request for the listener to pay greater attention, although a slightly raised eyebrow, and/or a slowing and deepening of speech, may be experienced as an ominous threat that demands assumption of a subservient role. Silence by a patient in psychotherapy may communicate several possible intentional qualities, including a demand or coercion for a response, conciliation, a breather, a tension creator, uncertainty, or an attempt to create peace or play.⁴

Because the speaker is usually unaware that he/she is attempting to induce a role-response from the listener, he/she may be perplexed by the other person’s response. Yet these are inevitable aspects of interpersonal relatedness. These unconscious maneuvers often seem to be attempts to both fulfill personal expectations about the relationship and to confirm our own opinions of ourselves.⁶ This hypothesis creates a startling possibility: we can sometimes

see in others' responses to us both how we view ourselves and the role expectations we are trying to create in others. If this is true, then we can help patients see themselves by explaining our reactions to them. We clinicians might also see, through the responses of others to us, how we think of ourselves and the roles we are trying to induce in others.

To begin to illustrate paracommunicative influences, we begin with the concept of the demand characteristics of situation. Each interpersonal situation creates a context that makes certain demands on us. Consider the statement, "Would you like something to drink?" The context will strongly influence the range of potential responses by the receiver. Compare, for example, a mother at home talking to her 8-year-old child who is just home from play with a man who is in a bar and talking to a woman. The mother may be attempting to create a satisfied, grateful response in her child by demonstrating her maternal capacity, while the man may be trying to create a temporary companion or a willing sexual partner. Context, along with other nonverbal signals, creates demands for a restricted range of responses.

Most interpersonal communication includes ongoing attempts by each participant to define their roles with each other — an implicit negotiation about boundaries, control, competence, power, self-worth, and status.¹³ Role negotiation is an iterative process during that the participants seek a good fit between themselves, which will eventually allow predictability and stability. Stability in a relationship may emerge from implicit and possibly explicit agreement about individual roles, with additional agreement about how to keep inevitable changes and challenges from modifying the agreed upon roles.

Relationships continuously evolve through positive experiences but also through carelessness, errors, and hurts, and may require periodic readjustments.⁴ Such readjustments require that the pair "work on the relationship." Because of the

many possible interpretations of nonverbal signals, clarification of their interpersonal impacts can help achieve stability and continuation. "Manipulation" is the experience of being implicitly requested to assume an unwanted role. The receiver may feel uncomfortably pulled, for example, to rescue, to blame, to seduce, to reassure, or to praise.

At times, these implicit negotiations become more important than the content of their discussion. For patients with borderline personality disorder, repeated comments upon these nonverbal negotiations (metacommunication) by the patient may dominate the content of the therapeutic discussion and may serve as a clue to the borderline diagnosis and to potential treatment pitfalls.¹³ If the patient repeatedly comments upon ongoing observations of the therapist and the therapist's interpersonal impacts, then the patient begins to assume additional control in the relationship. The one who comments upon paracommunication tends to achieve a greater degree of control because it legitimizes his or her personal standards and perspectives.⁷

Discussion of paracommunication begins with the effects of nonverbal signals on the receiver. Often, the receiver is unaware or perplexed and is not adept in identifying the incongruous feeling of role-induction. As a result, he or she is not able to pinpoint and comment upon the signals that are inducing the response. Consider the following situation: A man and a woman have been dating for more than a year. The relationship has drawn closer and closer. Yet to the woman, something seems amiss. He is standing at the door about to leave on a 10-day business trip. The situation demands that he say something. He says, "I'll miss you." And then he leaves. She is left with an empty feeling. What is it? She reviews how he said it and how he looked when he said it. He had looked away from her, conveyed little emotion in what he said, and there was something else she could not identify.

The key, however, is her feeling: "What else is he saying about the relationship?"

Metacommunication

Metacommunication involves explicit verbal comments about the intentions of paracommunication on interpersonal roles and relationship. The comments may be about the intentions and/or effects of what has been said, how it has been said, or both. Metacommunication can be experienced by the participant's positively or negatively. Many men, for example, feel threatened when the woman in their lives says, "We need to talk." She is implicitly demanding that he agree to talk about their relationship. Requests to metacommunicate can often be experienced as threatening because such discussions imply a desire for change in the current relationship. Requests for change implies criticism, rejection, abandonment — central fears for most of us.¹⁴

Sometimes explicit statements about how the receiver is reacting may enhance a relationship. For example, two friends living in different cities had been planning by email for a dinner together. Three days before the planned dinner, the in-coming friend emailed, with regret, that he could not make it. Could they do breakfast? His company had made last-minute demands on him. She was hurt but did not say so directly (however, emails carry so much emotion that sometimes they seem to drip with feelings). Her plans included introducing him to her best friend, who had a strong interest in one of his passions. He, in turn, was hoping to interest the friend's friend in investing in a project. As new plans were being formulated, she asked him to describe his accomplishments. He listed the well-known schools he had attended, his athletic accomplishments, the contracts he had negotiated, the businesses he had started, and the books he had written. After two long emails listing of his many accomplishments, previously unknown to her, she exclaimed, "You are making me laugh!" The disappointment

from the failed dinner meeting seemed to be dissolving. Her metacommunication about being made to laugh indicated that the earlier problem was dissipating — the relationship was moving from negative to positive again, and the pair had regained their previous positive footing.

Patch⁷ used scenario judgment studies that tested metacommunication in two different contexts: friends or casual acquaintances. Subjects were shown two different scenes in which one person made a selfish request and then the other commented upon the verbal behavior of the first by saying, “Please look at what you are doing. You are not listening to me.” The study found that comments about communication made by friends caused more problems than those made by casual acquaintances. Among close friends, metacommunication increased interpersonal tension and was experienced as rude and less acceptable. Among acquaintances, such comments were more acceptable.

Metacommunication may remain a relatively remote option in everyday life because it threatens a change in role expectations. People, therefore, rely on nonverbal signs to define their relations, despite the fact that the ambiguity inherent in them is too often open to misinterpretation.⁶ This ambiguity can lead to incorrect assumptions about the intentions of the other, which then leads to spirals of mutually offending behavior that can only be interrupted by effective metacommunication.

Examples of metacommunicative statements are listed in Sidebar 3. Readers may note that the last four statements commonly appear during psychotherapy. The broad permission to comment upon the patient’s stories that the therapist obtains from the treatment situation may constitute a crucial, implicit rule that makes the psychotherapeutic relationship qualitatively different from other relationships.

THE INTERPERSONAL CIRCLE

How then to categorize the many ac-

tion-reaction role-inducing paracommunications that re-occur in human relations? Watzlawick et al² described two basic forms: symmetrical and complementary. In the symmetrical form, the partners tend to mirror each other with minimization of differences between them. In contrast, in the complementary form, each person assumes opposing positions, which maximizes differences. (These terms are intended to be without connotations of good or bad, strong or weak, and instead should function as relatively pure descriptions.) For example, the symmetrical form, which minimizes differences, may be useful in therapy when equality in roles is essential for progress: “We are two people on a journey of discovery.” Increasingly angry responses to each other may also be considered symmetrical as each escalation is matched by a similar level of anger from the other. Domination of one person over another through power differentials serves as a common example of the complementary form. The therapist acts as the authority for a patient who wishes to submit to external power. Among our most frustrating patients are those who wish to follow our directives (complementary) and then argue for another alternative (symmetrical).

Leary¹⁵ developed the Interpersonal Circle (see Figure 2, page 263). It elaborated upon these two primary categories with further refinement by Kiesler.⁶ The Interpersonal Circle¹⁶ is constructed under the assumption that all interpersonal behavior represents a blend of two primary motivations: the need for control (power, dominance) and the need for affiliation (love, friendliness). As persons interact, they are continually negotiating how friendly or how hostile they will be with each other, and just how much one will be in control of the other. The interpersonal circle places control (dominance-submission) on the vertical axis and affiliation (friendliness-hostility) on the horizontal axis. Any interpersonal act represents a blend of these two factors — a certain de-

gree of affiliation-hostility and a certain degree of dominance-submission. In general, complimentary responses are pulled for on the dominant-submissive dimension (eg, submission pulls for dominant). Symmetrical responses are pulled for on the Hostile-Friendly dimension (eg, hostile pulls for hostile). The interpersonal circle provides a guideline and set of approximations to the content of any metacommunication about the roles individuals might be enacting with each other. (For a Basic Guide to the Interpersonal Circle please email beitmanb@health.missouri.edu).

PARACOMMUNICATION DURING PSYCHOTHERAPY

Patients often attempt to influence the therapist’s view of them.¹⁷ Through their responses to therapist interventions, as well as to the demand characteristics of the therapeutic situation, they paracommunicatively attempt to shape their role relationships. Patients often try to strengthen, maintain, and repair the working alliance.¹⁸ They also may shift the content of the therapist’s questions, try to avoid a feared subject by distracting the therapist, or try to please the therapist by commenting upon one of the therapist’s perceived favorite subjects. A subset of these inevitable maneuvers may become the focus of therapeutic attention.

Disturbed interpersonal relationships are indicated in two different ways: 1) the patient repeatedly experiences enduring and unaccountable negative feelings in relationship to others (dysphoria, confusion, sadness, fear, anxiety); and/or 2) their interactions consistently lead to negative responses from significant others (criticism, rejection, anger). The source for these problems may often lie in the paracommunicative messages sent by the patient. For example, in many problematic communications, the patient sends “mixed” signals, meaning that nonverbal and verbal behavior push and pull the listener into conflicting roles. A patient may say, “I’m lonely”

but paracomunicates, “Don’t try to get too close to me.” A not uncommon frustration is the following: The speaker politely inquires: “Would you like to visit Aunt Sally?” The accompanying voice tone, inflections, facial expression, and gestures all quite clearly state that the speaker has decided to visit Aunt Sally and the listener had better agree. The polite question signals openness to either course of action. Paracomunications, in contrast, indicate firm insistence upon agreement with the choice embedded in the question. The therapist may also become the object of these confusing messages and respond as do others in the patient’s life — feeling trapped, irritated, angry, rejected, and despondent.¹⁹

Therapists have developed multiple perspectives on the role-inducing tendencies of their patients. Cashdan²⁰ described three role-relationships commonly attempted by patients: seductive, dependent, and martyr, to which the therapist is implicitly requested to respond. The seductive patient seeks to elicit a lusty other; the dependent patient, a savior; and the martyr, a respecting and admiring other (see Figure 3 and Figure 4, page 266).

Unconscious role induction makes use of neural mechanisms for social cognition and communication. The following vignette is a theoretical discussion of some of the neural activations that might be in play as an unconsciously seductive and dependent female patient maneuvers through her first session with a male therapist (see Viamontes and Beitman on page 243 for references on the various processes described; note that the brain mechanisms presented are for theoretical discussion only and have not been measured specifically in this setting).

The patient is tall and slender with shoulder-length blond hair. She is wearing a cashmere coat over a black wool suit, with an open-white lace shirt and a diamond pendant around her neck. She is not wearing a wedding ring, although her clinical chart indicates that she is married.

Her own autonomic arousal as she meets the therapist is evident from her dilated pupils and reddened cheeks. She waits for the therapist to open the door and to help her with her coat. Then, while they are still standing close, she stares directly into the therapist’s face, touches his arm with both hands, and says in a soft voice, “Doctor, I really need your help.” The aroma of her perfume wafts into the therapist’s nostrils, courses through his olfactory bulbs, and excites his orbitofrontal cortex, which heightens his autonomic tone. He feels a slight dampness in his hands, and a flushing of his cheeks. He sits down and, as he looks into the patient’s eyes, realizes how unusually beautiful she is. His ventral striatum and orbitofrontal cortex fire in unison as he is presented with this compelling visual stimulus. He feels a tension in his muscles and a slight queasiness in his stomach. His unconscious ocular saccades, mediated by superior colliculus circuitry, seem to defy conscious efforts to not stare into her face. The patient goes on to describe her inability to escape a physically abusive relationship. She makes demonstrative body movements as she describes the physical abuse, and as her movements are recapitulated in the therapist’s mirror neuron system, he senses her helplessness in protecting herself from the abuse. The frightened expression in her face activates the therapist’s amygdala and increases his autonomic arousal. He feels angry at the woman’s abusive husband without ever having met him. As the therapy session draws to a close, the therapist finds himself looking forward to the next session, and feels a strong, inner determination to help this patient escape her plight.

As this vignette illustrates, signals that induce others into assuming specific roles can be subtle and compelling and often have a more powerful effect than the actual words that are exchanged. In psychotherapy, attention to the paracomunicative material that emerges from the patient, as well as the therapist’s own reaction to it, is an essential component of both evaluative and curative processes.

Borderline patients are well known for their ability to induce roles in others. Frequently, these patients create aggrandized or depreciated responses in their therapists. Also, many borderline patients tend to overinterpret the paracomunications of therapists and others. Such communications are by nature ambiguous and can be interpreted in several different ways. Many see rejection in minor interpersonal slights and react with such anger and despair that one would think they had been totally abandoned. As mentioned earlier, patients with borderline personality disorder tend to make therapist-like process communications (metacomunications) on the therapist’s paracomunication that may dominate the interchange and subvert possible content discussion.¹³

The psychoanalytic concept of projective identification may be explained by paracomunication. The patient unconsciously induces the therapist to assume an unwanted feature, characteristic, role or interaction pattern, which is an aspect of patient themselves. The role is usually derived from a person whom the individual knew previously. The patient “nudges” the therapist to take on this role as a way to rid themselves of it. As described by Gabbard, “Subtle interpersonal pressure is placed on another person ... (who then) ... begins to behave, think and feel in keeping with what has been projected.”²¹ (Also see Dr. Gabbard’s article in this issue, page 269.)

Here we continue the earlier example in which the woman was perplexed by the way the man said, “I’ll miss you.” As the story unfolds, his conflicting, role-inducing, nonverbal behavior does not occur simultaneously with speech, but alternates with it.

At one time, the woman felt deeply loved by this man, who repeatedly said that he loved her, missed her, and thought frequently about her. When he said these words, she often felt that he was indirectly asking her to be his wife. They talked regularly by phone, shared emails about daily events, and made tentative plans to see each other. At first, they met often,

but over several months, he became less and less available. Gradually, he could not meet her because of many “good reasons,” including an emergency business meeting, a call from his troubled brother, a church request, and a need to leave town to see a client. He also “forgot” more than once to keep previously arranged dinner dates. Currently, he no longer suggests times to see each other. Nevertheless, he continues to make his deep declarations of love. When she mentions how hurt she is by his avoidance of her, he becomes angry. Over time, the woman finds herself confused, sad, and obsessed by his apparent ambivalence. He rarely sees her anymore. Their primary contacts are by telephone at his convenience, and she begins to complain that all he will give her are “scraps of his time.” She vaguely detects that he wants her to continue to love him deeply but expects her to make no demands on him. She is being induced by the accumulation of his nonverbal behavior to stay away until he wants her but not disappear.

At the urging of her therapist, she attempts to metacommunicate with him. He very reluctantly agrees to see her for the discussion, claiming, as usual, multiple time constraints. She begins by acknowledging that such discussions often provoke anxiety in him: “What I am going to say is likely to make you feel guilty, but I am trying to say this in a way that minimizes your guilt. I just want you to know how I am feeling. Maybe you can advise me how I can handle these feelings. Maybe I just have to accept the way it is between us.”

He haltingly agrees, and she proceeds: “You say in many different ways that you want to be with me. But we get together only when you find time that is convenient for you —your leftover scraps of time. Things keep coming up that get in the way. I want to be with you, too, but I feel caught up in this continuing uncertainty.”

The discussion leads her to conclude that his failure to create opportunities to see her is a paracommunication of his

desire to hold on to her but to maintain a great distance in time and space. He wants her to love him from far away. She very sadly realizes that she must begin to grieve the loss of their relationship and all she had imagined it promised.

COMMUNICATING ABOUT COMMUNICATION DURING PSYCHOTHERAPY

Without activation of our observing selves,²² we are puppets of the paracom-munications of others. By beginning to know that each of us attempts to induce varying mixtures of affiliation and control, therapists can be better equipped to respond to patients’ unconscious interpersonal requests. There are three potential responses to the roles implicitly requested by patients: 1) the therapist acts in ways different from the role the patient is attempting to induce; 2) the therapist offers direct feedback about the role into which the patient is attempting to place the therapist; and 3) the therapist directly addresses the patient about his or her intentions behind role-inducing attempts.

We will present a brief description of each intervention, with the caveat that there must be some agreement between patient and therapist that such responses are permissible within the scope of their interaction. Such comments are in many ways asocial, which means that they are not common in our daily interactions. They may be seen as threatening because, like many other therapeutic interventions, they carry with them an indirect suggestion that there is something to be changed. The patient may feel criticized and possibly rejected. By metacommunicating, the therapist is paracommunicatively attempting to put the patient in the role of self-observer, with particular attention to the patient’s unconscious manipulation of the therapist and others.

As suggested by Kiesler,⁶ Cashdan,²⁰ and Mahalick,²³ the first stage in laying the groundwork for metacommunicative comment requires that the therapist be-

comes engaged or “hooked” by the patient. In such a situation, the therapist can anticipate being hooked into a role that fits the patient’s unconscious role expectations of others. Using personal self-awareness, the therapist scans the interpersonal pulls being elicited and begins to disengage by answering the key countertransference question: “How much of my response is because of the patient’s paracommunication, and how much of arises from my own personal problems and history?”

The next stage offers the opportunity to become “unhooked,” with potential benefits to the patient. There appear to be three possible responses to the patient’s paracommunicative efforts, which are summarized in Sidebar 4:

1. Therapists may act differently from the role the patient is attempting to induce in them. The therapist does not accept the role being assigned by the patient’s paracommunication, but instead responds with verbal and nonverbal signals that indicate the assumption of another role. These asocial responses may serve as corrective emotional experiences. Many standard therapeutic techniques can also perform this function: non-judgmental empathy, silence, a homework suggestion, or an interpretation. Patients are then induced to assume a different role. If the therapist is induced to be rejecting, then the therapist strives to be accepting. If the therapist is induced to be authoritarian, then the therapist may seek to act with more equality. If the therapist is induced to become defensive, then the therapist may become more open; if hostile, then friendly; if submissive, then more directive.

2. Therapists may also report the impact message: how the patient’s behavior is affecting the therapist. “The therapist discloses to the patient his or her perceptions of and reactions to the patient’s actions as experienced by the therapist in the specific relationship.”⁶ Therapists usually assume that the role response the patient is implicitly requesting generalizes to other significant relationships and is maladapt-

tive. In this way, the consulting room becomes a laboratory in which to study the impact of the patient on the role-relationship of another person. This form of meta-communication may serve as a model for the patient in interactions with willing persons outside of the office.

This form of self-disclosure requires therapists to study their own reactions to patients, and to differentiate their own idiosyncratic responses from the responses patients commonly induce in others. In psychodynamic terminology, these differences can be described as therapist-induced countertransference versus patient-induced countertransference.²⁴ The distinction can be clarified by using several questions, including: How much of this reaction is derived from my own personal history, and how much is coming from the patient? Or how much of this reaction is from me, and how much is from my patient? Or would most of my colleagues in the same situation with this person also be reacting the same way? Kiesler described the effects of paracomunicative signals on the therapist as “an interpersonal pull.”⁶ The patient, through various nonverbal means, is attempting to place the therapist in a role, which the therapist experiences as unnatural, unwanted, or uncomfortable.

3. Therapists may also use a paracomunicative inquiry: “How are you intending for me to respond to you now?” This question goes to the unconscious heart of paracomunication. In this way, the therapist encourages the patient to look directly into automatic programming, to define their intentions with the purpose of recognizing that these intentions might need re-examination. The manner in which the paracomunicative inquiry is spoken (namely, its own paracomunication) will influence the patient’s response. The greater its non-judgmental quality, the more freedom the patient will have to look inward and report his or her findings.

For patients with a low capacity for self-observation, this inquiry may be

problematic. The question requests them to not only activate their observing selves, but also to examine their paracomunicative intentions. With little practice in self-observation, such patients are unlikely to have looked at their own interpersonal intentions, especially in the here and now.

Psychotherapy has evolved to an understanding and acceptance of the vulnerability, frailty, and humanity of each and all psychotherapists. Sometimes we are in error; sometimes we fail; sometimes we miss crucial opportunities and inadvertently impede or harm therapeutic progress. Sometimes patients notice. Therapists, too, need to be able to comment upon their own paracomunication, because at times, the problem may be more with the therapist than with the person seeking therapy.

CONCLUSIONS

Hidden in plain sight, paracomunication has evolved as a bedrock of human communication based in brain functions we are beginning to comprehend. As we learn the brain basis of unconscious role induction, we will find a new place from which to observe these regular interpersonal occurrences. With our verbal capacity, we can begin to describe and organize the varieties of these difficult to grasp everyday events. With the metacomunication ability to comment upon unconscious role induction, we take a step toward reducing interpersonal conflict and increasing interpersonal understanding.

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