Psychotherapy Guidebook

Paraverbal Therapy

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DEFINITION

Paraverbal Therapy is a term applied to a method of observation, diagnosis, and treatment. It uses a variety of expressive media that are on a common level with words. This provides many alternative channels to establish both verbal and nonverbal communication. The method employs a multisensory approach in the treatment of disturbed patients (children and adults) who cannot be reached by traditional discursive means or conventional adjunctive therapies, such as art, music, or dance therapies. Such inaccessible patients require treatment that decreases maladaptive behavior while maintaining a therapeutic relationship.

Paraverbal Therapy, based on psychiatric principles, uses alternate means of communication to achieve therapeutic goals. This multisensory approach can be used when necessary, as a distance, or as a bridge between patient and therapist. It is achieved through improvisational and nontraditional techniques. Media are not used for the purpose of mere creative expression, but as metaphoric symbols for particular behavior.

Paraverbal communication consists of the following:

1. Statements in the form of non-verbal or verbal dialogues

2. Speech cadences

3. Unconventional use of body movement as well as unconventional use of music components (rhythm, tempo, accent, pitch)

4. Improvised or familiar melodies and lyrics (sometimes used projectively)

5. Projective use of psychomotor maneuvers, mime, dramatizations, and art.

Inherent to Paraverbal Therapy are improvisational techniques. These provide patients (in both group and individual treatment), with needed concrete experience in the areas of sensory-motor skills, object relations, and cognitive enhancement. This is done through the use of the patient's intact and preferred means of communication — whether it be auditory, visual, kinesthetic, or tactile. Basic to the improvisation used in Paraverbal Therapy is the fact that a variety of modalities can be used interchangeably as needed, in swift succession. These changes are instituted in response to the ease and shared pleasure of the therapist and patient. This is helpful in building the trust so difficult to achieve with inaccessible patients. Effective behavioral change can only occur if the strategies evolve from an assessment and

observation of the patient's presenting emotional status. The paraverbal method affords the therapist, as participant-observer, many choices of communicative channels that make him less threatening to the patient. The metaphoric expression of material, through many channels, allows them safe symbolic representation of problems, and the development of the therapeutic relationship. This is crucial in reaching inaccessible patients, with numerous shifting defenses. On this account, preconceived notions of which modality is to be used in a session are contra-indicated.

Paraverbal techniques, through their communicative channels, provide interaction on a range of levels. Synchronous and reciprocal response to strategies concretely reveal a measure of the patient's state of development to the therapist.

HISTORY

Paraverbal Therapy had its inception at two institutions where I taught. One was an experimental elementary and junior high school. There I used body movement, music, art, and drama as vehicles for childhood expression and development. The other was Sarah Lawrence College, where I taught student teachers the techniques of using the arts for early childhood development. While observing my demonstrations with the children at the college nursery, staff members, including Dr. Lois Gardner Murphy, as well as

the school doctor, Dr. Benjamin Spock, were impressed with the therapeutic effect of my work with special children. They suggested that I embark on a didactic psychoanalytic course in order to utilize my techniques for therapeutic purposes.

I did this and then obtained a position at Edenwald School for Retarded and Disturbed Children, where I did therapeutic work with children who had communication difficulties. Results were satisfactory, but I felt the need for additional training so that I could become more specific in my therapy. I then went for further training to N.Y. State Psychiatric Institute. Under the supervision of Dr. H. D. Dunton, I treated and researched five hundred cases of inaccessible and disturbed children. The results of this work led to the formulation of the concepts of Paraverbal Therapy. For help in the development of these concepts, as well as for the creation of the name "Paraverbal Therapy" itself, I am deeply indebted to Dr. Sydney G. Margolin, of the University of Colorado Medical Center.

TECHNIQUE

Intimacy and trust are basic to each session. To achieve intimacy, the therapist positions himself as close as feasible to the patient(s). Techniques for achieving trust are noted throughout the following description.

The therapist uses a variety of instruments to arouse curiosity, orient

patients, as well as to command and expand attention. Used are bongos, tambourine, hand drum, floor drum, castanets, autoharp, guitar, a variety of bells. In addition, there may be an easel and chalk, jump ropes, and balls of various sizes. The patient is encouraged to select the instrument of his choice, as a first step in establishing trust and an atmosphere of acceptance.

Paraverbal Therapy has proven useful as a technique for communication with children having the following diagnoses:

1) Elective mutism, hyperkinesis

2) School phobia

3) Schizophrenia

4) Gilles de la Torrette syndrome

5) Learning difficulties

6) Autism

7) Acting-out behavior

8) Depression

9) Minimal brain damage

10) Blindism

The children varied in age from three to sixteen years. They were seen and treated in one-to-one sessions, in mother-child dyads, on occasion with their families, and in group sessions. From a cultural point of view, the technique is useful not only with children from average American families, but as a bridge to children and parents from low-income minority groups.

Their communication needs stem partially from deprivation as well as cultural differences.

While Paraverbal Therapy can be an enriching therapeutic experience for any disturbed child, it is not a treatment of choice for those patients who can make use of traditional therapeutic approaches.

Neutral nonverbal dialogue begins in one of the following ways: the patient improvises (at random) a simple rhythmic pattern, which the therapist immediately imitates four or more times, varying expression with loud, soft, fast, slow, etc, or the therapist may initiate the dialogue by tapping out the syllables of the patient's name: JENNIFER. The patient is encouraged to imitate on his instrument. (For mature patients, popular names of cars, foods, TV programs, etc., are substituted.) The therapist then suggests, "Let's tap together."

The therapist constantly needs to reappraise the response of the patient. It is of the essence that the therapist observes and then administers

just the amount and kind of stimuli needed to maintain the communication basic for treatment. (There are some patients who can utilize only a limited amount of ongoing stimulation from any one specific communication channel.)

The sound of the unusual auditory stimuli coming from the tapped instruments orients the patient and commands attention. It organizes, helps establish identity, and gives recognition as well.

If attention wanders, the therapist then introduces a change in body posture so communication can continue. Changes may vary from sitting to standing, to rhythmic walking, hopping, clapping, and rhythmic chalking to music.

The next technique, improvisation, can be used to move the patient into more intimate communication. Improvisatory use of lyrics, melodies, mime, and dramatization, can provide cognitive, as well as projective, material.

With these paraverbal techniques, therapists and patients can go from the neutral phase of drum tapping, to the more personal phase of body movement, to the still more personal phase of improvisation. For example, in the use of the common folk song “Nobody Knows the Trouble I’ve Seen,” the therapist and patient can deal projectively with such themes of loneliness, sadness, alienation — or the cognitive aspects of up and down (“Sometimes

I'm up and sometimes I'm down.")

Participation, reciprocity, flexibility, and resourcefulness are essential aspects of the therapeutic structure.