Empathy as Dialogical Process and Embodied Understanding
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Abstract: We present an account of empathy in psychotherapy that is based on a more general, multidisciplinary understanding of everyday empathic interaction. We argue that, for two reasons, this approach can contribute to a better understanding of processes of empathy in the therapeutic context. Neurological studies and social psychology research have demonstrated the power and complexity of interpersonal influence on a physical, nonverbal level, a complexity that is sometimes ignored by therapists (Shaw, 2004). Examples of such influences are emotional contagion (e.g., Preston & de Waal, 2002) and automatic vigilance (Wentura, Rothermund, & Bak, 2000). Second, understanding problems in client-therapist interaction requires us to examine how clients both understand and misunderstand their therapists, including their therapists’ intentions, emotions, and other internal states (e.g., Rhodes et al., 1994). These problems are grasped with more coherence when they are described using parallel concepts for the client and the therapist. For example, it is easier to understand and tackle severe communication problems in psychosis treatment when both the client’s and the therapist’s “sides” of the communication are considered (Peters, 2005).

The Empathy Cycle and Embodied Empathy

Empathy in the psychotherapy session is essentially a cooperative, dialogical process that is at the same time vividly grounded in the body, as illustrated in the following example (Bohart, et al., 2002; Diamond, 2001; Wynn & Wynn, 2006).

Nick was an unemployed chef who came to therapy to deal with depression brought on by losing his job. In session three, he described what his work was like for him at its best and what he missed about it. As the therapist listened, he let himself be carried away into the client’s experience: he felt a tickling, tingling sensation in his stomach; he remembered the feeling of his own similar successes (rising sense of excitement, accompanied by a sense of feet planted firmly on the ground); he “ran a movie in his head” of the client striding out of the kitchen, head held high, accompanied by a sense of pride and happiness. He noted how his fantasy matched Nick’s upright posture and firm position in the chair, and how he had shifted into a firmer position himself. During his description, Nick felt that his therapist was interested and—even though the

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therapist had not said anything—he experienced support and an invitation to dig deeper into his description.

Empathy in psychotherapy is dialogical because it is based on the empathic faculties of both the client and the therapist, activated automatically through verbal and nonverbal exchanges, and enhanced by conscious efforts by each to understand the other. Although it involves perceptual, cognitive, and behavioral processes, it is fundamentally grounded in bodily and emotional experiences (Vanaerschot, 1990). Most of these elements have been incorporated in Barrett-Lennard’s (1981) formulation of the Empathy Cycle (EC), still the most influential theory of professional empathic interaction (e.g., Elliott, Watson, et al., 2004). In the EC, client and therapist together search for an accurate expression of the client’s experience, cycling through four steps: (1) client expression of experience; (2) therapist empathic resonation; (3) therapist expressing empathy; (4) client receiving empathy; followed by further client expression of experience. The EC model provides a clear, concise, and useful framework for understanding therapeutic empathy. Empathic attunement is presented as the therapist’s internal representation of the clients’ emotions, intentions, cognitions and physical states (step 2), which allows the therapist to respond (step 3) in a way that helps the client toward more accurate expression. Every new response by the client helps the therapist to better understand the client and allows the therapist to respond from a new, ever-deepening empathic stance.

Putting empathy in the bosom of the therapist, however, deflects attention away from its complement, the empathy of the client with the therapist, and also from the embodied nature of empathy. It is important to realize that most people resonate empathically with others. The effective monitoring of automatic interpersonal influences is a prerequisite for successful social interaction (Ickes, 2003; Decety & Jackson, 2004). Most relevant for our understanding of other people are the emerging feelings, thoughts, and responses of our own that are in line with their own behavior. Others’ movements, eye contact, distance, breathing, and rhythm continuously prime similar motor responses in ourselves, as well as associated emotions, goals, and intentions (e.g., Chartrand & Bargh, 1999; Hood, Willen, & Driver, 1998; Iacoboni et al., 2005; Levenson & Ruef, 1992). Even our understanding of verbal expressions involves motor representations related to their meaning (e.g., Hauk, Johnsrude, & Pulvermüller, 2004). Yet each individual may react differently to this automatically induced convergence. When confronted with a seemingly calm but anxious person, one individual may unreflectively feel uneasy or annoyed. Another individual senses signs of fear in his own body and wonders whether this seemingly calm person is actually afraid. Only the second individual successfully performs empathic resonance.

We have begun to characterize dialogical, embodied empathy as a key concept in psychotherapy, at the same time arguing that it is not the exclusive province of community workers, nurses, or psychological therapists. Empathic resonance is naturally applied in every dialogue. For the rest of this chapter, we will elaborate the
two sides of the empathic dialogue in the context of psychotherapy, beginning with the client’s contribution.

**Client Empathic Resonance**

As clients explore their own intentions and motives, they long for the therapist’s point of view, hoping to gain insight from that perspective even when it differs from their own. They not only value therapist empathy but also other therapist response qualities, and are therefore empathic partners themselves in their interaction with the therapist (Wynn & Wynn, 2006). Bänninger-Huber (1992), studying facial micro-sequences in clients and therapists, showed how clients carefully observe therapist responses in order to monitor their appraisal and the goal and direction of the interaction. When the client has problems resonating effectively with the therapist, then important therapist attitudes like empathy, acceptance, genuineness, and non-possessive warmth (Lambert & Ogles, 2004) may not be noted. The therapist will have a difficult time engaging in an effective working relationship with the client, a condition critical to a positive therapy outcome (Horvath, 2001).

**Client Empathy Problems**

Interpersonal priming, self-awareness, mental flexibility, and emotion regulation constitute the macro components of internal empathy processes (Decety & Jackson, 2004). In addition, effective emotional expressiveness is required to communicate empathic listening. Even minor dysfunction in one or more of these component processes will fundamentally change interpersonal communication. In fact, empathy problems can arise in any client at any point of therapy, as client empathic resonance with the therapist is reduced by client expectations, a phenomenon known in psychodynamic theory as *transference*. For example, acute expectations of rejection or unresponsiveness from the therapist can lead to ruptures in the working alliance (Safran et al., 2005). Clients with such expectations may become withdrawn, demanding, or accusatory, triggering intrusive or attacking responses in the therapist. Most clients will now or then experience difficulties in maintaining a clear distinction between self and therapist, which often confuses the therapist (Diamond, 2001; Ross, 2000; Vanaerschot, 2004). More serious empathic failure has been reported for people who suffer neurological, psychotic, autistic, borderline, antisocial, and language disorders (Adams, 2001; Blair, 2005; Decety & Jackson, 2004; Ladisich & Feil, 1988), as well as for those who suffer from dementia (Dodds, Morton, & Prouty, 2004). In the more severe disorders the display of empathic resonance is very low (Krause et al., 1998), and the higher the symptom load, the lower the quality of the therapeutic relationship (McCabe & Priebe, 2003). It is much harder for the caregiver to develop a personal bond with such patients (e.g., Prouty, Van Werde, & Pörtner, 1998/2002; Vanaerschot, 2004).
Condition for Change

A non-body-oriented approach leads psychotherapists to limit their work to clients who are able to communicate verbally in a meaningful way. A central requirement for meaningful communication between two persons is that they can resonate effectively with each other. This mutual empathic resonance between two persons was termed “psychological contact” by Carl Rogers (1957), who considered it to be the most basic condition for therapeutic change. This position seems to support excluding from psychotherapy clients who don’t communicate effectively. For example, cognitive therapy protocols for treating persons with psychosis or hallucinations require that the patient be able to discuss beliefs and attitudes with the therapist (Hermans & Raes, 2001). Even psychological interventions that aim to increase the empathic skills of clients generally focus on patients who are already performing at a moderately high level of communication (e.g., Alfred, Green, & Adams, 2004).

Yet, an empathic dialogue can occur whenever there is a minimal engagement from the client (Peters, 2005). Even infants try to engage in dyadic interaction, with properties of a dialogue gradually emerging (Stern, 1985; Gergely & Watson, 2002). Their engagement is apparent from the production of emotional responses, seeking of facial stimuli, gaze following, and attempts to imitate (e.g., Hood, Willen, & Driver, 1998). Peters (2005) argues that readiness for interaction is an inborn faculty that remains functional throughout life in all populations, including infants with an autistic spectrum disorder, psychotic adults, and older persons with dementia.

This view implies that an empathic process can be established with almost any client or patient, but only if the therapist can tune into the person’s current, sometimes strange or frightening experiences and physical modes of expression (e.g., Killick & Allan, 2001). To accomplish this, Prouty, Van Werde, and Pörtner (1998/2002) advocate the use of contact reflections in these difficult-to-treat populations. These contact reflections are body-oriented, highly concrete, literal, and duplicative reflections that are at the same time explicit representations of the client’s verbal and nonverbal behavior. For example, the therapist can say “Mary is sitting on the floor,” or “Your arm is in the air.” More concretely, the therapist can put his or her own arm in the same position. When applied consistently over time by one therapist or by all members of the staff on the ward (Van Werde, 2005), these responses expose the client to a “web of contact” that facilitates their own contact efforts.

Therapist Empathic Attunement

Although in most cases both client and therapist will naturally engage in empathic resonance, the therapist’s engagement in empathy deserves a separate description. It is part of the therapist’s task to resonate effectively with the client. Empathic attunement refers to the therapist’s effortful engagement in empathic resonance (Bohart &
Turning to the therapist side of the empathic process, we will now describe the phenomenology, functions, and effectiveness of empathic attunement.

Phenomenology of Therapist Empathy

When we teach empathic attunement, we begin with a phenomenological account of the therapist’s experience of his or her own empathy. The starting point for this account is an understanding of empathy as essentially an imaginative, bodily experience rather than as a conceptual process. A wide range of language has been used to describe this experience, with five bodily metaphors capturing the major aspects: letting go; resonating; moving toward or into; discovering or discerning; and grasping or taking hold (Elliott, Watson, et al., 2004). Each of these metaphors provides only a partial approximation of the empathic attunement process; we offer them in order to provide a variety of potentially useful ways of understanding and developing this crucial attitude. A useful approach to deepening one’s empathic stance is to successively apply these metaphors as an embodiment of the process of understanding clients.

The first aspect of the therapist’s experience of empathy is captured by the image of hands letting go, a metaphor for setting aside preformed ideas, beliefs, or expectations, or previous understandings of the other (Vanaerschot, 1990). This image is reflected in language such as allowing, accommodating, suspending disbelief, bracketing (cf. Husserl’s term *epoché*), or opening up. The therapist is aware of his or her views or preconceptions of the client and tries to let go of them in order to be more open to what the client is saying or revealing in the present moment. In addition, the therapist has to let go (temporarily) of current personal issues, for these will prevent a total opening up to the frame of reference of the client. To support this letting-go process, many therapists employ body-oriented awareness exercises in between sessions, thereby “clearing a space” for the experiences of the client (Nagels & Leijssen, 2004).

Second, the therapist next seeks to actively enter the other’s world, as evidenced by language having to do with moving toward or into the other. Thus, the therapist tries to join, become immersed in, dwell on, feel into (i.e., the source of the word “empathy”), or step under or inside (i.e., the origin of “understanding”) the client’s experience. Chartrand and Bargh (1999) and Sonnby-Borgström (2002) have demonstrated that persons who have the habit of taking other people’s perspectives often mimic their postures, mannerisms, and gestures while listening to them. Some therapists will even perform stretching exercises before the session to increase their receptivity to client motor responses. Therapists may also actively “join” or “pace” the client by deliberately matching or trying out the client’s verbal and nonverbal expressions, intensity, pace, or described internal sensations (Nagels & Leijssen, 2004). Beyond this, some therapists use touch to literally enter the client’s space and get a direct physical sense of what the client is doing on a muscular level (Leijssen, 2006). In other words, in empathizing with
the client, the therapist experiences an active reaching out in order to enter into the client’s world. This may vary in degree from light interest and involvement with what the client is saying to intense states of “deep empathic immersement” (Mahrer, 1989; Wertz, 1983).

Third, the therapist’s experience of empathy includes the image of bodily resonating with the other (Barrett-Lennard, 1981), portraying the therapist as a tuning fork. This metaphor is reflected in language such as tuning in to, being “on the same wavelength,” feeling with (i.e., compassion), feeling the same as (i.e., sympathy), singing in harmony with, or following or matching the client’s experiencing. The therapist opens up to the sensations, actions, feelings, thoughts, and memories that well up in him- or herself while paying close attention to the client (Cooper, 2001). Therapists also feel an experiential understanding of underlying feelings different from those expressed explicitly by the client. For example, as her stomach contracts, the therapist finds herself sensing the fear that is covered up by the client’s expressed anger. The moving toward and resonating experiences seem to complement one another: resonation is somewhat more receptive and entering-into is more active in nature. Given the central role of sensory perception in empathic resonance, it is no surprise that experienced therapists from many orientations maintain a body-oriented attention during sessions (Geller, Lehman, & Farber, 2002; Ross, 2000).

A fourth metaphor is the active, perceptual image of physically sorting through a large pile of something, discovering or discerning aspects of the other, finding, detecting, discriminating, pinpointing, or differentiating what is presented. This image captures the experience of complexity that often confronts the therapist. The therapist at times feels lost, confused, or overwhelmed by the sheer amount and variety of information revealed by the client. It often feels as if the important feelings or messages have been hidden or simply lost, like a needle in a haystack. In these situations, many therapists sustain bodily attention to discover a sense of direction (Gendlin, 1980; Nagels & Leijssen, 2004). The therapist’s job is to see what is most crucial, pressing, or touching for the client.

A final image or component experience is that of actively grasping or taking hold of what is important in the client’s world (Vanaerschot, 1990), as suggested by words such as apprehending, comprehending, getting (the point), assimilating, or perceiving. In other words, having entered into the client’s world, the therapist then latches on to what is central, critical, alive, or poignant, sometimes with a sudden sense of insight into the other. The impression is one of taking some element of the client’s experience inside oneself, thus making it part of oneself. On this basis, therapists will try to express what they think is important to the client, or they will respond in a way that makes sense from what they comprehend. When clients’ responses are welcomed as continuous feedback for the process of attunement, empathic accuracy will increase (Marangoni et al., 1995).
Belief in the therapeutic value of empathic attunement was first put forward by humanistic psychologists, specifically Carl Rogers (1957), and it is still the cornerstone of the humanistic approaches to psychotherapy (Greenberg, Elliott, & Lietaer, 2003). Rogers proposed that a continuous effort by the therapist to empathically understand the client is necessary for therapeutic change to occur. This empathic attitude of the therapist is supposed to communicate a radical acceptance of client experiences, a condition that fosters self-acceptance and a more adequate, though sometimes painful, perception of oneself and one’s life situation (Greenberg, Elliott, & Lietaer, 2003). In the humanistic and the psychodynamic tradition, the client is encouraged throughout most or all of the sessions to explore current or past experiences. The therapist can help to detect emerging experiences and what is deflected, while helping to regulate overwhelming or “fragile” experiences (Elliott, Watson, et al., 2004; Paivio & Laurent, 2001). This self-directed process is believed to lead to more accurate self-understanding and self-expression, more creative adaptation to current situations, a more effective way of interacting with others, a higher sense of self-agency, and ultimately to personality development (Bozarth, 2001; Greenberg, Elliott, & Lietaer, 2003).

In most schools of therapy it is now accepted that empathy is important for the formation of an effective working relationship (Castonguay & Beutler, 2005; Lambert & Ogles, 2004). Besides supporting the client’s self-directed process, empathic attunement is an important way to manage therapist countertransference (Van Wagoner et al., 1991; Gelso & Hayes, 1998). In a classic psychoanalytic formulation, countertransference is the whole set of positive and negative feelings and responses related to the client (Heimann, 1950). Left unattended, these responses can hinder therapeutic progress. When they are explored properly by the therapist, however, they can offer a lead to individual and interpersonal processes that thus far remained implicit. Both empathic understanding (Decety & Jackson, 2004) and countertransference management (Gelso & Hayes, 1998) require the careful application of self-awareness, mental flexibility (discrimination between self and other), emotion regulation, and conceptualizing skills.

**Therapist Empathy and Outcome**

Bohart and colleagues (2002) conducted a meta-analysis of the available research relating empathy to psychotherapy outcome. Based on an exhaustive search of the literature, using previous reviews, research databases, and relevant journals, these authors located 47 studies, including 190 separate tests of the empathy-outcome association, and a total of 3,026 clients. Typically, these studies involved mixed, eclectic, or unspecified types of individual treatment, targeting affective and anxiety disorders. Client measures or observer measures of empathy were more generally used than therapist or accuracy measures of empathy. (Accuracy measures assess empathy by
comparing therapist perceptions to client reports of their experience.) Pearson’s correlation coefficient \( r \) was used as the measure of effect size, and various standard corrections for non-independence and small sample bias were made, including pooling of effects within studies before averaging across studies.

The best estimate of the empathy-outcome association came from using data pooled within studies, weighted for sample size, and corrected for small sample bias: a mean \( r \) of .32. The size of this association was surprising, because it means that, in general, empathy accounted for about 10% of the variance in outcome, a medium effect size. This effect size is on the same order of magnitude found in previous analyses of the relationship between working alliance between client and therapist and outcome (e.g., .26 by Horvath & Symmonds, 1991; .22 by Martin, Garske, & Davis, 2000). Overall, empathy accounts for more outcome variance than does the specific intervention used. This value can be compared to Wampold’s (2001) estimate that between 1% and 8% of outcome variance can be attributed to the mode of therapist interventions. Although this finding derives from a general sample of therapies, it provides a key line of converging evidence supporting the effectiveness of explicitly empathic therapies, such as person-centered and experiential approaches (Elliott, Greenberg, & Lietaer, 2004).

Perhaps empathy is even more important in an intervention-based therapy than in a relational one, in order to provide an effective “ground” for intervention. Bohart et al. (2002) found indications that empathy might be more important to treatment outcome in cognitive-behavioral therapies than in therapies that emphasize empathy. They also demonstrated that client measures of empathy predicted outcome the best, followed closely by observer-rated measures and therapist measures. In contrast, accuracy measures were unrelated to outcome. Ultimately, it seems that the client knows best whether the therapist is resonating effectively (Barrett-Lennard, 1981; Ickes, 2003; Rogers, 1957).

Finally, experienced therapists have been demonstrated to be both better at exploring their own experiences and better at interpreting clients’ nonverbal behavior (Gesn & Ickes, 1999; Machado, Beutler, & Greenberg, 1999). Bohart et al. (2002) found larger associations between therapist empathy and treatment outcome for less experienced therapists, and a smaller association with outcome for more experienced therapists. It is possible that inexperienced therapists vary more in empathy, and that the smaller correlations for experienced therapists reflect a ceiling effect. Alternatively, experienced therapists may have developed additional helping skills (such as personal presence or effective problem-solving) that could compensate for moderate empathic miss-attunements.
Conclusion
We have attempted to outline a case for integrating the cognitive and affective approaches to empathy, grounded in the automatic convergence of physical states. We have attempted to go beyond a view of empathy as a conscious process of the therapist only, in order to sketch a view of empathy as fundamentally interpersonal. This dialogical, body-oriented perspective offers two main advantages: First, it highlights the continuity between therapy and other important human relationships and interactions, allowing us to draw on work in related disciplines. Second, it offers a richer, more complete understanding of empathy, highlighting client agency and providing important leads for therapy and therapy training. These leads include emerging directions for working with clients with severe communication difficulties, using body-based metaphors to learn deeper empathic responding, and drawing on one’s body as a source of empathy. The dialogical, body-oriented perspective on therapeutic empathy is at the same time both more grounded in fundamental lived experience and better located in a wider human context of relationships and social interaction.

References


