Embodied Empathy

Mick Cooper, Department of Psychology, University of Roehampton
mick.cooper@roehampton.ac.uk

Published as: Cooper, M. (2001). Embodied empathy. In S. Haugh & T. Merry (Eds.), Empathy (pp. 218-229). Ross-on-Wye: PCCS Books.

Introduction

In his 1957 paper on the necessary and sufficient conditions of therapeutic personality change, Carl Rogers hypothesised that the greater the degree to which the core conditions exist, 'the more marked will be the constructive personality change in the client' (p.100). With respect to empathy, therefore, the more that a therapist is able to sense her client's private world as if it is her own, the more she will be able to help her client move towards optimal psychological functioning. But how can a therapist come to most fully sense her client's private world? Over the years, a number of authors – both from within, and outside of, the person-centred tradition – have suggested answers to this question. Truax and Carkhuff (1967), for instance, outline a skills-training approach whereby a therapist can learn to respond with 'unerring accuracy' to their client's full range of feelings. Mahrer, Boulet and Fairweather (1994), by way of contrast, invite a therapist to fully merge herself with her client and immerse herself unreservedly in her client's subjective experiences.

This chapter outlines an alternative means for deepening an empathic attunement to one's client. It is a means that draws on, and has parallels with, previous approaches, yet it is unique in that it specifically invites a therapist to bring her *body* into the therapeutic relationship. That is, it suggests that a therapist can deepen her empathic understanding of her client by relating to her as the physical, fleshy, incarnate being that she is. The chapter begins by outlining contemporary 'cognitive-affective' models of empathy, and argues that these models tend to overlook the more physical, somatic aspects of human experiencing. Developing this argument, it goes on to suggest that a therapist can most fully 'know' her client by resonating with her at a somatic – as well as a cognitive and an affective – level, and goes on to propose a number of practical means by which a therapist can come to develop a more embodied mode of empathic attunement.

Cognitive-Affective Empathy

In recent years, numerous psychologists (e.g. Gladstein, 1983; Goldstein and Michaels, 1985; Hoffman, 1977; Strayer, 1987) and psychotherapists (e.g. Basch, 1983; Bohart and Greenberg, 1997) have suggested that empathy can be divided into two key types or facets: 'cognitive empathy' and 'affective empathy'. Cognitive empathy is defined by Gladstein (1983) as 'intellectually taking the role or perspective of another person' (p.468), and by Strayer (1987) as 'either understanding the psychology of others (i.e., their thoughts, intentions, feelings, etc.) or, more specifically, their feelings' (p.218). Cognitive empathy, therefore, can be understood as a mental, thinking act, in which one person attempts to imagine how it is to perceive and experience the world as another person. Therapeutically, this may involve such processes as sensing the client's meanings, bracketing one's assumptions about the client, attending to and comprehending the client's verbal and non-verbal communications, searching for a similar situation in one's own life through which to understand the client's experiences, or attempting to understand the client through some particular clinical, developmental model (Mahrer et al., 1994). By contrast, 'affective empathy' involves 'responding with the same emotion to another person's emotion' (Gladstein, 1983, p.468). That is, rather than *seeing* the world as another person does, affective empathy involves *feeling* the same way as another person does.

Within the person-centred tradition, some practitioners have tended to emphasise one of these facets of empathy over and above the other. Truax and Carkhuff (1967), for instance, write that a therapist should empathise in a cool and disembodied way, stating that, 'It is not necessary – indeed it would seem undesirable – for the therapist to *share* the client's feelings'

(p.46). Rogers, however, as both Gladstein (1983) and Vanaerschot (1990) point out, describes empathy as a process that involves both cognitive and affective facets. He writes, for instance, that an empathic way of being means 'being sensitive…to the changing felt *meanings* which flow in the other person' (1980, p.142, italics added); but that it also means being sensitive to, 'the fear or rage or tenderness or confusion or whatever' (p.142) that the other is feeling.

Experience as Embodied

For Rogers (1980), human experience is fundamentally affective as well as cognitive. By empathising with a client affectively as well as cognitively, therefore, a person-centred therapist can get as close as possible to the totality of her client's lived experience. In recent years, however, philosophers (e.g., Merleau-Ponty, 1962) and psychotherapists (e.g. Gendlin, 1992) have argued that there is an important aspect of human experiencing that lies beyond this cognitive-affective realm, and this is the realm of bodily, somatic experiences.

Within contemporary Western thinking, this somatic realm has tended to be seen as somewhat peripheral. With the dawning of the modern era, humankind's mental faculties appropriated pride of place, and relegated the physical, bodily functions to the sphere of primitive, savage instinct. Indeed, Descartes – one of the most influential philosophers of the modern age – considered the conscious thinking self entirely independent of anything physical, something that could survive the complete destruction of the body (Cottingham, 1997).

Given that Rogers is a child of the modern era, it is no surprise that he, too, tends to marginalize somatic experiences. The word 'body', for instance, is not indexed in any of his major works (Rogers, 1951, 1961, 1980). Nevertheless, in critiquing the 'hypertrophy' of conscious attention and rational effort (Rogers, 1980), and in continually emphasising the importance of the emotions, it is clear that Rogers understood –albeit implicitly – the centrality of somatic experiences to human life. This understanding is no more apparent than when he writes of the 'excellent book' (1980, p.250) by Thomas Hanna (1970): *Bodies in Revolt*.

Bodies in Revolt is a remarkable work. Its style is anarchic and fiercely rhetorical: a call to arms for the body to overthrow the dominance of the mind. For Hanna (1970), human beings, first and foremost, are not 'minds' or 'spirits', but 'somas', and his description of somas highlights his fundamentally body-centred understanding of what it means to be human:

> Soma is living; it is expanding and contracting, accommodating and assimilating, drawing in energy and expelling energy. Soma is pulsing, flowing, squeezing and relaxing – flowing and alternating with fear and anger, hunger and sexuality. Human somas are unique things which are belching, farting, hiccupping, fucking, blinking, pulsing, throbbing, digesting. Somas are unique things which are yearning, hoping, suffering, tensing, paling, cringing, doubting, despairing. Human somas are convulsive things: they convulse with laughter, with weeping, with orgasms. Somas are the kind of living, organic being which you are at *this* moment, in *this* place where you are. Soma is everything that is you, pulsing within your fragile, changing, growing and dying membrane that has been chopped off from the umbilical cord which linked you – until the moment of that severance – with millions of years of organic genetic history within this cosmos. (pp.35-36)

For Hanna (1970), then, to understand human beings, it is essential to understand their physical being; and this physicality extends into realms that are neither cognitive nor affective in nature.

Part of this physicality is the vast array of internal bodily sensations that are not reducible to, or encompassable within, specific emotions. An individual, for instance, may experience a heaviness in her stomach or a numbness in her body – feelings which are not necessarily emotional in nature, but which nevertheless constitute a powerful component of

her experiential field. Sexual feelings and feelings of muscular tension are other internal bodily sensations that do not come under specific affects. There are also 'felt senses' (Gendlin, 1996): physical, somatic sensations, experienced 'in the viscera or chest or throat, some specific place usually in the middle of the body' (p.18). Unlike emotions, Gendlin describes these felt-senses as complex constellations of sensations, difficult to identify and unique to each situation. Alongside these specific bodily sensations, there are also somatic experiences diffused throughout the entire body. Laing (1960), for instance, writes that a schizophrenic experiences her body as an object amongst other objects in the world, something that feels divorced and detached from her authentic, 'inner' being.

Then there is the equally vast array of kinaesthetic, movement-related experiences: the experiences of walking, running, dancing, swaying slightly, lifting one's arm, shuffling in one's seat. As I write this, for example, I am aware that my fingers are tapping against a keyboard, my wrist is moving slightly, and my upper teeth are pressing down gently (or is it aggressively?) on my lower teeth. At every moment that I focus on my physical being, I can become aware of movement. What may seem peripheral has, in fact, the potential to occupy a large proportion of my awareness.

There is also the experience of being in a body, *per se*. That is, the sense of being in a very particular type of body, with a particular shape and form, with the sense of weightiness or lightness, large-ness or smallness that that inhabitation entails. An obese individual, for instance, is likely to experience her 'body-ness' as very different from someone who is thin. Similarly, a man may have a very different experience of being-in-a-body to a woman. Related to this sense of being-in-a-body is a sense of being-in-a-body *somewhere*, at a particular location within a spatial environment. As Hanna (1970) writes: 'man is not simply a creature who exists, but, rather, he exists *here*, he is located, situated and embodied *here* where he stands. I am not a free spirit: I am an embodied spirit who is always situated in a place, and this place – no matter where I may be – is always *here*' (p.35).

Alongside these experiences of 'internal' and 'external' sensations, *per se*, there is also the experience of changes in the intensity of these sensations: what Stern (1985) refers to as 'vitality affects'. Such changes might include 'surging', 'fading away', 'exploding', 'bursting', 'drawing out'. An individual, for instance, might experience a rapid surge in their level of fear, followed by a gradual dissimulation, and then a rapid re-emergence. Stern refers to these patterns of changing intensity as 'contours of activation over time': changes that may be as significant to the total experience as the affect, feeling or sensation itself.

To suggest, however, that an individual's experiential field contains somatic, as well as cognitive and affective elements, is not to suggest that she experiences her world somatically at certain times, and cognitively and affectively at other times. Rather, it is to suggest that her experiencing of the world is always and fundamentally somatic: that she can never experience her world other than through her body (see Figure 1). At every moment of her experiencing, her thoughts and feelings are accompanied by ever-fluctuating internal and kinaesthetic sensations, as well as by a sense of being in a body in a particular place in time.

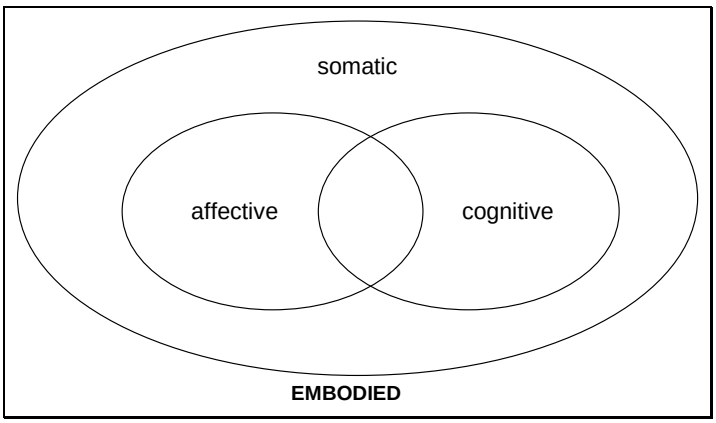

Figure 1. Embodied Experiencing

More significantly, perhaps, an individual's thoughts and feelings are fundamentally infused with, and inseparable from, her bodily being. How she feel towards the world around her, for instance, will be fundamentally coloured by how she feels physically – as anyone who has tried to engage with others through tiredness, hunger, drunkenness, physical pain, disability, 'feeling fat', etc. will know. How an individual thinks and feels can also be affected by their bodily movement and posture. Psychological research, for instance, shows that people made to smile (by being asked, for instance, to hold a pen between their teeth) tend to feel happier (Strack, Martin and Stepper, 1988); whilst people asked to hold 'fearful', 'angry' or 'sad' postures tend to feel more afraid, angry or sad respectively (Duclos, Laird, Schneider, Sexter, Stern and Van Lighten, 1989). An individual's perceptions of the world, too, is fundamentally coloured by her physical locality. As Hanna (1970) suggests, an individual always perceive the world from a particular space and time: she can not stand outside of her body and get a fully encompassing and objective view of the world. Even an individual's abstract thinking is infused with her bodily experience. Without existing on a physical plane, for instance, how could an individual make sense of such abstract concepts as 'higher' and 'lower', 'stronger' and 'lighter', or 'darkness' and 'lightness' (Johnson, 1999)?

As philosophers like Merleau-Ponty (1962) have argued, then, an individual's existence can not be separated into mental and physical realms. Rather, existence erupts into the world in a fundamentally embodied, indivisible way. Metaphorically, one might think of a fountain, whose waters rush up together and then divide as they fall back to earth. The rushing up of the waters is like the immediate, in-the-moment unity of an individual's embodied experiences, only later does it become divided up into 'thoughts', 'emotions', and 'bodily sensations'.

Embodied Empathy

Given, then, that human experience is fundamentally embodied, a therapist can not know the totality of her client's experiencing without knowing something of how it feels to be in that client's body. And whilst cognitive or affective modes of empathising may help a therapist develop some understanding of her client's embodied experiencing, for a therapist to truly 'know' what it is like for her client to be in her body, she must experience something of that lived-embodiment for herself. A young therapist working with an octogenarian client, for instance, may have some intellectual sense of how it feels to inhabit an aging body. She may even be able to empathise with the frustration and sense of powerlessness that that aging body may evoke. But unless she is able, in some way, to experience that sense of aging and fragility down to her bones, to experience the client's sense of physical immobility and tiredness, it seems likely that she will only have a very partial picture of that client's experiencing. Similarly, a therapist working with a client who is of a different sex, differently-abled, or differing in any other physical capacity or state may find it extremely difficult to empathise without entering into that embodied experiencing.

An in depth understanding of a client, therefore, requires a therapist to empathise in a somatic – or what Bebout (1974) has termed 'physiognomic', Vanaerschot (1990) has termed 'resonant' and Neville (1996) her termed 'magical' – way, as well as in a cognitive and affective way. But this does not mean that the therapist should *sometimes* understand her client somatically, *sometimes* emotionally and *sometimes* cognitively. Rather, it means that a therapist can only fully sense her client's embodied experiencing by empathising with her as the embodied whole that she, too, is. In this respect, what is being described here is nothing other than the need for a therapist to be fully present to her client – the essence of Buber's (1958) 'I-Thou' relationship. In this mode of embodied attunement, the therapist is not resonating with specific thoughts, emotions or bodily sensations, but with the complex, gestalt-like mosaic of her client's embodied being, that initial primal thrust of the client's experiencing as it emerges into the world. At this level, the whole of the therapist's body is alive in the interaction, moving and vibrating in tandem with the client's experiencing. She experiences an all over unity and a most basic sense of being there in the world with another. She is, quite literally, 'in the client's skin'.

Whilst such a somatically-orientated understanding of empathy may seem quite radical today, it is worth noting that, in many ways, it is closer to the original meaning of 'empathy' than a cognitive-affective interpretation. Lipps, who is credited with introducing the German term 'Einfűhlung', first translated as 'empathy' by Titchener in 1910 (Goldstein and Michaels, 1985), considered the imitation of another's physical movements a central element of the empathic process (Bavelas, Black, Lemery and Mullett, 1987). Specifically, Lipps proposed that when an individual contemplates an object (of art, nature, etc.) or a person, she tends to imitate, consciously or unconsciously, that person or object's posture. An interpretation of empathy as cognitive understanding or emotional contagion only emerged some years later. Indeed, as Allport (1961) wrote: 'It is regrettable that with passing years the original meaning of empathy as "objective motor mimicry" became hopelessly confused and lost to view' (pp. 536-537).

Embodied Empathy in Practice

How, then, can a therapist come to empathise with her client in a more embodied way? Perhaps the first point to make here is that, as the early empathy theorists have hinted at, a therapist may actually have a natural predisposition to empathise with her client in an embodied way. This is for three reasons.

First, a therapist, like all human 'somas', is a fundamentally somatic being, and as such can not relate to her client other than in an embodied way. From the moment that her client first sits down in her consulting room (and no doubt before), a therapist has a physical, bodily relationship to her. Of course, this does not mean that the bodily relationship will be one of empathy – a therapist may be physically experiencing something very different to what her client is experiencing. But the fact that a therapist is inevitably connected in a bodily way to her client means that the basis for an embodied empathic relationship is already and always there, and not something that a therapist needs to create.

Second, the bodily facets of a client's experiential field – as part of an interconnected cognitive-affective-somatic whole – are implicit in every thought and feeling that a client has (just as each piece of a hologram contain an image of the hologram as a whole). This means that, as a therapist begins to empathise with her client's thoughts and emotions, so the somatic aspects of the client's experiential totality will begin to be re-invoked in the therapist. In other words, even if a client does not directly express what she feels in her body, as a therapist listens to her thoughts and feelings and develops an empathic resonance with them, so she will begin to sense something of the associated somatic experiences. A therapist, for instance, who 'steps into' her client's feeling of shame and self-abhorrence may also begin to experience something of the physical hollowness and nausea that goes along with those thought and beliefs. Her body, in a sense, is completing the experiential gestalt – adding the final pieces to the jigsaw that allow the interconnected whole of the client's experiential field to be reconstituted in the therapist.

Third, there is reason to believe that a therapist may tend towards automatically and spontaneously resonating with her client's physical behaviour. Psychological research demonstrates that people have a natural tendency towards mimicking the posture, gestures, expressions or movement of the people they are looking at – a phenomena that Bavelas et al. (1987) term 'mimetic synchrony'. For instance, empirical research shows that people tend to move their lips more when observing models who stutter and blink more when observing models who blink frequently (Berger and Hadley, 1975; Bernal and Berger, 1976), and sway forward when watching a model strain to reach forward (O'Toole and Dubin, 1968). Other everyday examples of mimetic synchrony include yawning, coughing or laughing when others do so, withdrawing one's hand upon seeing another person touch something hot, or ducking when another person looks as if they are about to be hit in the face. Empirical research has also confirmed the existence of mimetic synchrony within the therapeutic environment. Participants in individual and group psychotherapy sessions, for instance, tend to adopt congruent body postures (Scheflen, 1964). At a more micro level, there is even evidence of a relatively continuous harmony between the body movements of speaker and listener down to $1/48^{th}$ of a second (Condon and Ogston, 1966). Such findings, although lacking empirical

confirmation, support the hypothesis that mimetic synchrony is a natural and automatic response to the experience of being with another, as opposed to a conscious and deliberate attempt at imitation.

Indeed, Bavelas et al. (1987) suggest that mimetic synchrony may be the most basic and primitive form of natural empathy. Studies show, for instance, that infants as young as one day old will tend to cry when exposed to the sound of another infant's crying (Simner, 1971). Similarly, babies between twelve and 21 days of age, and possibly as young as 60 minutes, are capable of imitating adult facial gestures (Meltzoff and Moore, 1977). Furthermore, imitative behaviour can be found amongst many animal species – for instance, the schooling behaviour of fish, the flocking behaviour of birds, and the herding behaviour of mammals (Plutchik, 1987) – supporting the argument that mimetic synchrony is an innate and instinctual human capability.

Given, then, that a therapist may naturally begin to empathise with her client in an embodied way, the question is not so much, 'How can a therapist *develop* an embodied mode of empathising?' as, 'How can a therapist *allow* an embodied mode of empathising to emerge?' In other words, it is not so much a case of what she needs to do, as what she needs to avoid doing.

Perhaps the first thing that a therapist needs to avoid doing, particularly at the beginning of a therapeutic encounter, is trying to say too much too quickly. It is likely to take time for a therapist's body to synchronise with her client's, even more time for the client's thoughts and emotions to reverberate around the therapist's body and evoke the client's bodily-felt experiences, and if a therapist tries to do too much too soon, she is likely to interrupt the emerging embodied attunement.

Similarly, a therapist may undermine the emergence of an embodied empathic attunement by focusing too exclusively on a client's cognitions or emotions. For instance, a therapist may tend to hone in on a client's beliefs that she is selfish and greedy, or her feelings of guilt and remorse. In themselves, such modes of response can help a therapist build up an overall sense of her client's experiential field, but if a therapist focuses on thoughts or emotions exclusively, then she is likely to lose a sense of the client's embodied whole. The more, then, that a therapist can try to stay with the totality of her client's experiences – even if it means that she is not saying anything particularly 'insightful' – the more she will have a sense of her client's overall experiencing. Indeed, it may be useful for a therapist to remind herself that, given the fundamentally embodied nature of her client's experiences, any empathic attunement which does not include a somatic component will only ever be a partial attunement.

A third form of heightened activity that may interrupt the emergence of an embodied empathic attunement is physical stress. This is because the more tense and rigid that a therapist is in particular regions of her body, the less likely it is that those regions will flow in synchronisation with her client. To facilitate an embodied level of empathising with her client, therefore, it may be necessary for a therapist to spend some time relaxing her body before the therapeutic sessions. If the tension is chronic, then body therapies such as Rolfing, Reichian Therapy, or the Alexander Techniques may be a useful way of her attaining the necessary state of relaxation. Indeed, as Marcia (1987) writes: 'To the extent that empathy depends upon motor mimicry, and motor mimicry depends upon a 'freely resonating' physiological structure, it might seem reasonable to include bodywork as part of any empathy training program for potential psychotherapists' (p.97).

To a great extent, then, a therapist can come to empathise with her clients in a more embodied way by putting to one side those pressures and stresses that lead her away from her own natural, embodied attunement. Yet there may also be times when, however much a therapist opens her body up to the somatic facets of her client's experiences, she fails to get any sense of how her client physically feels. It may be, for instance, that her client's somatic experiences are entirely alien to the therapist, or that her client is extremely careful to shroud her somatic experiences. In such cases, it may be appropriate for a therapist to take a more pro-active stance, and, provided this does not take the therapist and client too far away from

an attunement to the whole of the client's embodied experiences – and does not become too directive – it may serve to complement the more 'allowing' process in a positive way.

Where a therapist does not have a sense of what her client is experiencing physically, perhaps the most congruent thing she can do is to simply ask her client what she feels in her body. If a client, for instance, says that she is feeling angry towards her parents, a therapist might ask, 'Where do you feel that anger in your body?' or 'What does that anger physically feel like?' If a client says that she feels it in her stomach, a therapist might then go on to ask, 'What is it that you feel in your stomach: an aching, a burning sensation, an emptiness?' Emotional experiences are particularly rich for such 'unpacking', and have the potential to provide both client and therapist with a great deal of detail about the way in which a client experiences her world. For therapists working outside of a non-directive tradition, this process can be taken even further. Experiential psychotherapist Alvin Mahrer (1983), for instance, says to his clients:

> Something is happening in your body right now. It may be in your throat or chest or head or legs or somewhere. I want to have the same thing in my body. I want to have the same feelings, the same sensations that are going on in your body right now. Describe what the feelings are and what they are like, so that I can have them too, no matter what they are or what they are like. (p.451)

Once a therapist has a sense of how her client feels in her body, she can then try to experience something of those bodily sensations herself. She may try to conjure up, for instance, a feeling of emptiness in her stomach, or a feeling of aging and fragility in her musculature. Clearly, this will not always be easy for a therapist to do, and it is likely that some people are more able to do this than others. But if a therapist is already attuned to her client's thoughts and emotions, and has developed some physical synchrony with her client, then an invocation of the client's bodily sensations may be only one small step further into her client's experiential world.

In some cases, however, it may not be appropriate for a therapist to directly ask her client what she is feeling in her body: a client, for instance, may be very reluctant to talk about her bodily feelings. In such instances, however, a therapist can still use her *imagination* to develop some sense of how her client may feel in her body – a sense that a therapist can then, again, try to conjure up in her own body. At the most basic level, this may simply involve a therapist asking herself, 'What might my client be feeling in her body at this time?' A therapist working with a client who complains of exhaustion, for instance, may imagine for herself the sense of heaviness and lifelessness that such a state might entail. In developing this imaginative evocation, a therapist might find it useful to draw on memories of a time when she has felt similarly: remembering, for instance, how she felt in her body when she went through long periods of tiredness.

Such imaginings could take place within the actual therapy session, but given their ability to distance the therapist from her client, it may be more appropriate for the therapist to carry out such imaginings in supervision. Here, she can spend some time really trying to generate a sense of what her client might be feeling physically, and allowing herself to temporarily 'inhabit' some of those somatic experiences. To facilitate this process, she might also find it useful to actually 'try out' some of the more overt manifestations of the client's physical being, such as her posture, movements, gestures, or expressions.

As Barrett-Lennard (1993) points out, alongside empathic resonance, an essential component of the empathic process is the expression and communication of empathic understanding. He writes: 'Completely unexpressed or "silent" empathic inner response can have no direct impact on the other' (p.5). It is important, therefore, that a therapist not only finds some way of resonating with her client at an embodied level, but that she also finds some way of communicating this embodied experiencing back to her client: for instance, 'I experience a tightness in my chest when you talk about your divorce and I'm wondering if you feel that too.' Expressions of an embodied resonance, however, may also be at a more

non-verbal level: for instance, a clenched fist, a hand over the stomach, tears welling up in the eyes.

A therapist, however, may not find it easy to communicate her embodied empathic experiences to her client. Not only must she have some awareness of how she feels in her body, but she must also be able to judge the extent to which her bodily experiences are 'in tune with' her client, and not something from outside of the relationship. For a therapist to be able to communicate an embodied empathic attunement, therefore, it would seem essential that she has a deep awareness of her own somatic experiences. The more that she can notice every ache, sensation and throb in her body, the more she can communicate to her client what her client might be experiencing. And the more that she knows about her usual bodily experiences and responses, the more she will be able to tell whether her physical feelings are an empathic response to her client's physicality or not. A therapist who always feels cold and irritable with a client, for instance, will be in a much better position to judge whether these bodily sensations are an empathic attunement to her client's feelings if she is aware of how cold and irritable she generally feels herself.

Conclusion

In practical terms, then, three broad ways have been identified by which a therapist can come to develop a more embodied mode of attunement with her client. First, she can try to give her body as much time as possible to build up a natural resonance with her client's embodied being; second, she can focus her attention more fully on her client's somatic experiences; and third, she can develop a greater awareness of her own bodily being. It should be noted, however, that whilst the third of these strategies is entirely compatible with the first two, there is the possibility of a tension between allowing an embodied mode of empathising to emerge and pro-actively facilitating its emergence. Hence, developing an embodied level of empathy with a client is unlikely to be a straightforward process.

Furthermore, the fact that a therapist may be naturally predisposed to empathise with her clients in an embodied way does not mean that it is therefore easy to do so. As a holistic mode of empathising, embodied empathy requires a therapist to temporarily retreat from an everyday I-It mode of relating (Buber, 1958), and return back to a more primordial mode of being-with-another, a mode in which she gives everything that she is. It involves a commitment of her most private, personal realm – her body – to the therapeutic relationship, and, as with all I-Thou relationships, open her up to uncertainty and the possibility of transformation. More mundanely, there is also the fact that a therapist is simply not always able to invoke within herself the somatic experiences that her clients have. A man, for instance, can never fully know what it is like to inhabit a female body, to experience menstruation or birth.

In these ways, then, it is probably unrealistic – and, indeed, unhelpful – to think of embodied empathy as a mode of relating that a therapist 'should' sustain throughout a therapeutic encounter. Rather, it is probably best understood as a transitory approximation, in which a therapist comes as close as possible to experiencing her client's world from her inside, out. The potential significance of such an approximation, however, should not be underestimated. For the first time, a therapist may gain a very close sense of what it is like to be her client. And although such a sense, at an embodied level, may fade, the insights gained from those moments – and the sense of deep understanding communicated to her client – may prove to be essential to the therapeutic process as a whole.

References

Allport, G. W. (1961) *Pattern and Growth in Personality.* New York: Holt, Rinehart and Winston.

Barrett-Lennard, G. T. (1993) 'The phases and focus of empathy', *British Journal of Medical Psychology.* 66, 3-14.

Basch, M. F. (1983) 'Empathic understanding: a review of the concept and some theoretical considerations', *Journal of American Psychoanalytic Association.* 31, 101-126.

Bavelas, J. B., Black, A., Lemery, C. R., and Mullett, J. (1987) 'Motor mimicry as primitive empathy', in Eisenberg, N. and Strayer, J. (eds) *Empathy and Its Development.* Cambridge: Cambridge University Press.

Bebout, J. (1974) 'It takes one to know one: existential-Rogerian concepts in encounter groups', in Wexler, D. A. and Rice, L. N. (eds) *Innovations in Client Centred Therapy.* London: John Wiley and Sons.

Berger, S. M. and Hadley, S. W. (1975) 'Some effects of a model's performance on observer electromyographic activity', *American Journal of Psychology.* 88, 263-269.

Bernal, G. and Berger, S. M. (1976) 'Vicarious eyelid conditioning', *Journal of Personality and Social Psychology.* 34, 62-68.

Bohart, A. C. and Greenberg, L. S. (eds) (1997) *Empathy Reconsidered: New Directions in Psychotherapy.* Washington DC: American Psychological Association.

Buber, M. (1958) *I and Thou.* (trans. R. G. Smith) Edinburgh: T & T Clark.

Condon, W. S. and Ogston W. D. (1966) 'Sound film analysis of normal and pathological behaviour patterns', *Journal of Nervous and Mental Disease.* 143, 338-347.

Cottingham, J. (1997) *Descartes.* London: Phoenix.

Duclos, S. E., Laird, J. D., Schneider, E., Sexter, M., Stern, L. and Van Lighten, O. (1989) 'Emotion-specific effects of facial expressions and postures on emotional experience', *Journal of Personality and Social Psychology.* 57:1, 100-108.

Gendlin, E. T. (1996) *Focusing-Oriented Therapy.* London: Guildford Press.

Gladstein, G. A. (1983) 'Understanding empathy: integrating counseling, developmental, and social psychology perspectives', *Journal of Counselling Psychology*, 30:4, 467-482.

Goldstein, A. P. and Michaels, G. Y. (1985) *Empathy: Development, Training and Consequences.* Hillsdale, NJ: Lawrence-Erlbaum Associates.

Hanna, T. (1970) *Bodies in Revolt.* New York: Holt, Rinehart and Winston.

Hoffman, M. L. (1977) 'Empathy, its development and prosocial implications', *Nebraska Symposium on Motivation.* London: University of Nebraska Press.

Johnson, M. L. (1999) 'Embodied reason', in G. Weiss and H. F. Haber (eds) *Perspectives on Embodiment.* London: Routledge.

Laing, R. D. (1960) *The Divided Self.* Harmondsworth: Penguin.

Mahrer, A. (1983) *Experiential Psychotherapy: Basic Practices*. N. Y.: Brunner/Mazel.

Mahrer, A. (1997) 'Empathy as therapist-client alignment', in Bohart, A. C. and Greenberg, L. S. (eds) *Empathy Reconsidered: New Directions in Psychotherapy.* Washington DC: American Psychological Association.

Mahrer, A. R., Boulet, D. B. and Fairweather, D. R. (1994) 'Beyond empathy: advances in the clinical theory and methods of empathy', *Clinical Psychology Review.* 14:3, 183-198.

Marcia, J. (1987) 'Empathy and psychotherapy', in Eisenberg, N. and Strayer, J. (eds) *Empathy and Its Development.* Cambridge: Cambridge University Press.

Meltzoff, A. N. and Moore, M. K. (1977) 'Imitation of facial and manual gestures by human neonates', *Science.* 198 (October), 75-78.

Merleau-Ponty, M. (1962) *The Phenomenology of Perception.* (trans. C. Smith) London: Routledge.

Neville, B. (1996) 'Five kinds of empathy', in R. Hutterer, G Pawlowsky, G. Schmid, R. Stipsits (eds) *Client-Centred and Experiential Psychotherapy.* Frankfurt am Main: Peter Lang.

O'Toole, R. and Dubin, R. (1968) 'Baby feeding and body sway: an experiment in George Herbert Mead's "taking the role of the other"', *Journal of Personality and Social Psychology.* 10, 59-65.

Plutchik, R. (1987) 'Evolutionary bases of empathy', in Eisenberg, N. and Strayer, J. (eds) *Empathy and Its Development.* Cambridge: Cambridge University Press.

Rogers, C. R. (1951) *Client Centred Therapy*. London: Constable.

Rogers, C. R. (1957) 'The necessary and sufficient conditions for therapeutic personality change', *Journal of Consulting Psychology.* 21:2, 95-103.

Rogers, C. R. (1961) *On Becoming a Person: a Therapist's View of Psychotherapy.* London: Constable and Co.

Rogers, C. R. (1980) *A Way of Being.* Boston: Houghton-Mifflin.

Scheflen, A. (1964) 'The significance of posture in communication systems', *Psychiatry.* 27, 316-331.

Simner, M. L. (1971) 'Newborn's response to the cry of another infant', *Developmental Psychology,* 5, 136-150.

Stern, D. N. (1985) *The Interpersonal World of the Infant.* New York: Basic Books Inc..

Strack, F., Martin, L. M. and Stepper, S. (1988) 'Inhibiting and facilitating conditions of the human smile: a nonobtrusive test of the facial feedback hypothesis', *Journal of Personality and Social Psychology.* 54:5, 768-777.

Strayer, J. (1987) 'Affective and cognitive perspectives on empathy', Eisenberg, N. and Strayer, J. (eds) *Empathy and Its Development.* Cambridge: Cambridge University Press.

Truax, C. B. and Carkhuff, R. R. (1967) *Towards Effective Counseling and Psychotherapy.* Chicago: Aldine Publishing Company.

Vanaerschot, G. (1990) 'The process of empathy: holding and letting go', in G. Lietaer, L. Rombauts and R. Van Balens (eds) *Client-Centred and Experiential Psychotherapy in the Nineties.* Leuven: Levuen University Press.