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THE DANCE OF EMPATHY: EMPATHY, DIVERSITY, AND TECHNICAL ECLECTICISM

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ABSTRACT. An integrative model of psychotherapy is presented in which the therapist can use *techniques and "interventions," but from a fundamentally person-centered stance. It is argued that ultimately all therapy is self-help and that it is clients who heal themselves. However the therapeutic relationship is a particularly useful "self-help space" in which clients can grow. Therapy is therefore fundamentally relational, with technology second. In a relational model of therapy,* empathy *is important and conceived as resonance.***.** *Appreciation of the client becomes a major modality of relating. Techniques can be offered as ways of appreciating empathizing with and relating to clients. Empathy and experiencing are conceived of in fundamentally aesthetic terms f*

INTRODUCTION AND OVERVIEW OF THE ARGUMENT

Our project in this paper is to try to develop a framework, based in a fundamentally empathic, person-centered way of viewing human beings, for integrating diverse approaches to therapy together. How can the therapist, while fundamentally being in relationship with the client, also offer suggestions and procedures for the client to use? We try to develop an answer to this that brings together ideas from a diversity of sources, including recent developments in feminist and multicultural therapy.

The following question frames our discussion. Is the psychotherapist more like a doctor, with technical expertise and who secondarily provides a good bedside manner,(i.e., relationship)? Or is therapy more fundamentally relational? If so, where does technical expertise fit in? This question strikes at the heart of both how therapy is practiced, and at the nature of psychopathology itself. In this paper we argue that relationship is fundamental in therapy, with technique secondary. We suggest a fundamentally different way of integrating technological expertise into therapy, based on the empathic relationship between therapist and client.

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In 1978 Bergin and Lambert wrote: "We believe the hypothesis is supportable that the largest proportion of variation in therapy outcome is accounted for by preexisting client factors, such as

motivation for change .... Therapist personal factors account for the second largest proportion of change, with technique variables coming in a distant third" (p.180). This conclusion, in which technique is de-emphasized, fits with the general conclusion (Lambert, Shapiro, & Bergin, 1986; Smith, Glass, & Miller, 1980) that all therapies, in a general sense, work about equally well.

The general finding of equivalence in effectiveness across different forms of psychotherapy continues to represent the state of affairs in the field (Bergin & Garfield, 1994; Stubbs & Bozarth, 1994). Two recent reviews (Beckham, 1990; Robinson, Berman, & Neimeyer, 1990) have concluded that different kinds of psychotherapy are equivalent in effectiveness with depression. Greenberg, Elliot, and Lietaer (1994) review a number of studies demonstrating equivalence in effectiveness of client-centered and other experiential therapies with cognitive, behavioral, and psychodynamic therapies for a wide range of disorders, from anxiety to depression to personality disorders.

Related to this, Christensen and Jacobson (1994) conclude from a review of the literature that there is a general equivalence in therapeutic effectiveness between professionals and nonprofessionals. The study by Str-upp and Hadley (1978) in which untrained warm and supportive college professors were as therapeutic as experienced therapists is one example. Such findings are in accord with other findings that there is no consistent evidence that experience as a therapist makes one more effective (Lambert & Bergin, 1994). Christensen and Jacobson (1994) also review studies which find equivalence in effectiveness between self-help books and formal psychotherapy for several disorders, including depression. In addition, they review other studies which have found equivalence between computer-administer therapy and therapy administered by a real person.

Along with these findings there is some evidence that self-help, or, as Goodman and Jacobs (1994) now prefer to call them, "mutual-support groups" can be as effective as professional psychotherapy (Goodman and Jacobs, 1994; Jacobs & Goodman, 1989).

Finally in a study of cognitive therapy with depression, Castonguay (1993) found that the degree of therapists' adherence to cognitive therapy principles and procedures did not correlate with whether the therapy was effective or not. Further, he found that what did correlate was the quality of the therapeutic alliance. Using "task analysis," he concluded that the degree to which the therapist empathically related to clients' real concerns about the therapeutic alliance itself was more predictive of outcome than whether the therapist stuck to formal cognitive procedures.

What are we to make of all this? For instance, what are we to make of the finding that cognitive therapy, interpersonal therapy, process-experiential therapy, client-centered therapy, and even medication are all approximately equal in effectiveness in alleviating depression, when their procedures and supposed mechanisms of effectiveness are so widely different? To take off on a related point made by Christensen (1992), we would be dumbfounded to find in medicine that no matter what you did your patients would improve with approximate equal effectiveness. It is hard to imagine a state of affairs where surgery, prescribing antibiotics, telling the client to take aspirin, or simply sitting and listening to the client's complaints would be all equally helpful for a wide range of medical disorders.

Of course, there are also studies that show that procedure X is more effective than procedure Y for problem Z. Specific procedures appear to be important in such areas as the treatment of sexual dysfunction and obsessive-compulsive disorder, for instance. We are not going to suggest that techniques have *no* effect, nor that for specified disorders certain procedures may not be more effective than others. However, more so than for medicine or auto mechanics, these kinds of effects pale in comparison to the much more overwhelming effect of what appear to be the "nonspecific factors" of the client's own active efforts at growth and "self righting" (Masten, Best,

& Garmazy, 1990), and the therapeutic relationship. On the whole, therapeutic approach and use of technique seem to play a minor role in therapeutic effectiveness (Bergin & Garfield, 1994).

While we are biased towards a relational view of therapy, we must acknowledge that even the relationship may not always appear to be essential for therapy to take place. The client's ability to utilize whatever the therapist, self-help book, or mutual support group offers, would appear to be the single most important factor in providing help.

What these findings led us to conclude was that Carl Rogers's basic ideas about therapy were right. There are probably two general factors which account for the majority of the variance in the effectiveness of therapy. Neither have to do with expertise, technique, or theoretical perspective. The first is the active, problem-solving capacity of the client, and the second is the provision of a good therapeutic relationship. We are not the first to draw such conclusions, especially about the importance of the relationship (Patterson, 1984; Stubbs & Bozarth, 1994).

With respect to the client, we believe that it is important to realize that the therapist is sitting across from a whole person - an active organism that is trying to solve his or her life problems, and get his or her life back on track. Yet this factor is ignored in most therapeutic theories, which focus on, (to make an object-relational play on words) "part--persons." There is a presumed breakdown in some part of the person, which therapy is going to "fix." Which part is focused on depends on the theoretical perspective: badly conditioned responses, dysfunctional cognitions, overly rigid defenses, repression, defective ego structures and self structures, dysfunctional self-regulation processes, problems in processing emotional information, lack of self-acceptance, failure to listen to one's feelings, inability to live in the here and now and take responsibility for oneself, poor form of experiencing potential, and so on. What gets lost in all these descriptions is the **person --** the whole person sitting across from us, struggling. What the research seems to suggest is that this struggling whole person is very potent in bringing about therapeutic change, **given the right context.**

The work on self-help books and computer therapy suggests that, given an actively struggling person, there are many possible contexts in which that person can move towards personal resolution. Good therapeutic relationships appear to be one such context: They provide "space" in which the client can mobilize his or her resources to solve problems. The therapist's input is not irrelevant. But it is more like the "aliment" in Piaget's theory of cognitive development - it gives the client something to chew on in order to grow. But it is not the **therapist** who solves the problem.

We therefore suggest that the active client **takes** what is given by the therapist and uses it to grow (Bohalt & Tallman, 1994). Each therapeutic approach, as a "part-therapy," addresses itself to some part of the whole functioning person. Because it is a part of that whole functioning person, that person is able to take whatever **part** dealt with by the particular therapeutic approach, and use it to self-change. The implication of this is that **all** therapy is essentially "self-help."

A good therapeutic context is one which provides good "working space" for the active client to work out his or her problems. Following a suggestion by Hal Arkowitz (personal communication, April, 1992), it is the **client** who is the "integrative therapist." The relationship becomes particularly important in two respects: first, it helps maintain client motivation to pursue whateve “program" the client is following in order to change, and second, it is probably particularly important with clients who are not intrinsically able to take an active role. This would particularly apply to clients who may feel hopeless or overwhelmed.

The conclusion that therapy is primarily the provision of a context which provides space for clients to actively sort out the problems in their lives, that is, for their self-righting capacities (Masten, Best, and Garmazy, 1990) to occur, that the relationship is such a context, and that specific therapeutic procedures and techniques may not necessarily matter a great deal, conflicts

with the current dominant model of therapeutic practice. Most therapists are now eclectic, and an eclectic model of doing therapy is what best fits with the "managed care" approach, which is the dominant model at the present time in the United States. In such a model the therapist, who is in an expert role, diagnoses the client's difficulties, and develops a treatment plan for those difficulties. Ideally this treatment plan is problem-specific. That is, differing techniques and approaches are chosen to "match" the client's problems.

This model of doing therapy is framed in a "medical-like," or perhaps, "auto-mechanic-like" fashion. The expert-therapist diagnoses the problem and institutes procedures to "fix" it. Ideally such procedures will be based on research findings that such and such a procedure works best with such and such a problem (see, for instance, Beutler & Clarkin, 1990; Lazarus, Beutler, & Norcross, 1992). This model is best exemplified by the set of approaches called "technical eclecticism" (Lazarus, Beutler, & Norcross, 1992) in the "psychotherapy integration" literature. In technically eclectic approaches the relationship plays one of two roles. First, the relationship is the background upon which the therapist builds his or her technical interventions. The relationship, in essence, is equivalent to a good medical doctor's "bedside manner " A good relationship provides a context in which presumably potent therapeutic interventions can be utilized effectively. Put another way, a -good relationship increases the probability of client compliance with the therapeutic regimen, just as a good doctor-patient relationship presumably does. Secondly, the relationship itself may be manipulated as a kind of "intervention" in its own right (Norcross, 1993). The therapist deliberately adopts whichever relationship stance will best facilitate treatment. Arnold Lazarus (1993), referring to this, has discussed the therapist as authentic chameleon."

Some, such as Greenberg (1985) have argued that the distinction between relationship and technique is not a meaningful one. However, conceptually this distinction is an important guiding variable in how the therapist conducts therapy. For instance, a concept of relationship, as described above, guides how the technically eclectic therapist conducts therapy. In this concept, relationship (and empathy in particular) is simply a kind of scaffold which supports the use of technical interventions. Furthermore, the distinction between technique and relationship most certainly makes sense in considering the work of the physician or the auto mechanic, where no one would confuse a good "bedside manner" with technical expertise. The very fact that one may question whether the distinction makes sense in terms of doing therapy points at the fundamental ambiguity of what therapy is about.

In contrast to technically eclectic views, in approaches such as client-centered therapy and self-in-relation theory (Jordan, 1991; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991), other humanistic approaches (e.g., Friedman, 1985), as well as to some extent in self psychology, the relationship itself is much more so the therapeutic element. For both client-centered and self-in-relation theory a positive "real" relationship is what is healing, not technical interventions. These are very fundamental theoretical differences in what therapy is about.

The writers from the Stone Center at Wellesley College who have developed self-in-relation theory are one subset of a larger group of psychotherapists who are writing about psychotherapy from- what could loosely be called "diversity" perspectives. These are writers, feminist, multi-culturalist, or gay or lesbian, who are challenging many traditional ideas about psychotherapy, because these traditional ideas largely reflect the perspective of westernized white males. They argue that the therapist must not merely "adjust" his or her "interventions" in order to take the client's experiential background into account, but must **really** listen to their clients and take their world view into account. Therapy needs to he a place where true dialogue between cultures and diverse experiences can meet. All therapy is multicultural (Pederson, 1990), and therapy can be considered to be a "meeting of persons and of cultures." While such dialogic relationships do not preclude the use of technical expertise, they suggest that, once again, a dialogic relationship

between real persons is the base of therapy, with technical expertise being subordinated to what emerges in that dialogue.

The technological model described previously places the therapist in the role of expert who decides what is best for the client, including even the relationship stance, and then picks which technical interventions to use to bring about desirable changes for the client. This is an hierarchical model in which technique is clearly primary, and relationship secondary. In contrast to this model, writers from a variety of "diversity" perspectives argue that the relationship is very important (Koshikawa, Nedate, & Haruki, 1992), and that the therapist must be much more open to the influence of the client than the technological model suggests. This means that the **therapist's** views of self and world may get fundamentally altered as well, and the therapist may end up employing highly nontraditional ideas and procedures (Comas-Diaz, 1992) based on the client's culture.

The issue of relationship versus technique is not either/or. However, it is an issue of what is in the foreground and how to best integrate the two. Is the therapist **primarily** an expert diagnostician, who **secondarily** may also be helpful by establishing a good relationship, such as with an M.D.? Or, is the relationship most often primary, with expertise secondary?

We suggest, integrating research, theory, and recent writings on diversity and psychotherapy, that with most aspects of therapy, relationship should be primary, and technique secondary. What is a good relationship will vary from client to client, just as a relationship with one friend is different than with another. However this should grow out of the dialogue between therapist and client, rather than being an "interventional stance" on the part of the therapist. We think it is important that therapists "lead" with the relationship more so than experts in other fields.

We propose a model of doing therapy which attempts to integrate a focus on relationship with the use of technique and expertise, but in which relationship is primary and technique secondary. In such a model empathy becomes primary, the active struggle of the whole person who is the client is emphasized, and the offering of technology becomes a **form** of relating, rather than a form of an expert "doing to" a patient. This model, as shall be seen, has been influenced by client-centered and other humanistic theorists (Bozarth, 1984; Brodley, 1990; Bozailh & Brodley, 1991; Combs, 1989; Friedman, 1985; Jourard, 1971), self-in-relation theorists (Jordan et al., 1991), and self psychologists (Rowe & Mac Isaac, 1991).

Model of Psychopathology

Our view rests on some perceptions about the nature of psychopathology. In real relationships, one relates to the whole person as a whole person. We assume that sitting across from us in therapy is a whole person who is trying to organize his or her life. This means that this whole person is, in some sense, a complex mind-body ongoing organization process which is trying to coordinate and integrate multiple agendas and goals, with multiple talents and resources, in complex ecological environments. This whole person is trying to chart a course through the multiple purposes that he or she holds, the multiple experiences that have contributed to both these purposes and to how he or she imagines achieving them, the complex social and ecological factors that either facilitate or retard his or her journey, and the complex network of relationships that constitute the person's context of personal meaning. To paraphrase Eleanor Gibson (Kent, 1993), we need to deal with the whole person " . . . functioning adoptively in a dynamic exchange with the world of events and places and people" (p. 12).

This whole person is striving for some sense of coherence and continuity over time, in a manner similar to self psychology's suggestion that the individual strives for a coherent integrated self. However, in our view this is an ongoing integrative enterprise, and includes efforts after integration and coherence with situations, environments, and relationships, as well as within the self structure. Based on some recent work by ourselves (Bohart & Rosenbaum, 1993; Rosenbaum & Bohart, 1993), in which we are developing an aesthetic model of human

experiencing, as well as of psychotherapy, we suggest that the individual is striving to **orchestrate** or **compose** his or her life as he or she struggles with the important issues in it. Within this model, the things dealt with by different therapies are things the client utilizes in this effort at orchestration and composition. Thus dysfunctional cognitions, focusing on thoughts to the exclusion of feelings, utilizing shoulds, avoiding certain areas of experience, seeking support from outside, transferentially perceiving others in terms of one's past, and the like, are all efforts after orchestration and composition. The therapist needs to relate to the whole person in his or her striving after organization and orchestration.

In so doing, whatever the client is doing that is "bad" is an effort after "composition." That is, whatever is "bad" in each person is precisely that which can be "good." It is a matter of that stuff coming out in a "bad form," to use Mahrer's (1978) terms, rather than in a "good form." Thus, in one sense, therapy does not have to "change the person," or the person's personality. Rather, it is a matter of helping them achieve a more coherent, functional **form.** This is compatible with Kohut, who emphasized self structuralization and overcoming disintegration, rather than the **contents** of personality. Added on to this, from self-in-relation theory, form is inherently interactional.. In addition, form is something that occurs over time. This means that form plays itself out in relationships over time. Thus it is not a matter of helping clients achieve a good static form, but helping them maintain good form over time.

Looked at this way therapist interventions are things the therapist does to help a whole person " compose him or herself" and the ongoing flow of his or her life. This means one must appreciate and understand their struggle as it is composed out of the elements that already make up their life. To understand their struggle one must understand their world view. One does not merely then modify interventions to slip them into the client's world view, one fundamentally alters them in the service of the client's efforts after composition framed in terms of that world view.

Appreciating the client in the sense of sensing and relating to the "good form" implicit in their struggle to organize and compose their lives becomes a major therapeutic interaction. Any personal organization can be carried forward in productive, or unproductive ways. We can think of where the client is as a kind of "rough draft" that can be sharpened in positive or negative ways. The therapist relates to the potential good form (i.e. where the client is trying to go in a positive sense) in the client's model and thereby facilitates the client to help him or herself carry it forward. "Interventions" then become ways of responding from such an appreciation - a way of expressing that appreciation. As such, "interventions" *are fundamentally* grounded in empathy.

On this view, **appreciation** becomes one of the best ways of providing a context for clients to achieve good form. If one can appreciate the potential good form in the client, one can help them row. As an analogy, for those who are familiar with James Joyce, the goal of therapy is to help "the artist" find A *Portrait of the Artist as a Young Man in Stephan Hero.*

How does appreciation help? We have already suggested that we must relate to the whole person. Instead of seeing the person as broken, needing repair because a part of them is dysfunctional, we assume that a person's problems are coming out of their overall attempts at personal organization. What gets lost in other models is just this sense of a whole person working to coordinate his or her life, to keep his or her personal experiences and ecology in some kind of balance. Appreciation of this whole person as a whole person then validates this struggle, and helps bring it into focus, *as they experience it* (i.e., in their terms).

Consultant Model

With this model in mind we argue that therapy is a context which provides a good "working space" for the client to work at this effort after orchestration, schemantization, and composition. Empathic appreciation of the client and the client's efforts is the most fundamental aspect of providing this working space. Within this context, suggestions of techniques and use of "expertise" is provided on a consultant basis with the client. The therapist is not like an expert

physician who prescribes treatment, but more like a consultant who dialogues with the client. This is patterned after models developed for community psychological practice in the 1970's, where psychologists were not to go into communities and tell them what needed to be fixed and how to fix it, but rather to go to the communities and offer ideas in a more dialogic form. A major goal is to share power with and thereby to let clients empower themselves, as community psychologists hoped to help communities to empower themselves. On a more mundane level, the therapist functions more like good home decorators, who offer ideas, but in dialogue with their clients.

Within this model therapist ability to dialogue and communicate becomes of primary importance, because expertise is only offered in resonance with client's concerns, (i.e. in dialogue). This is fundamentally different than a "what is good for you" model practiced by an M.D. Therapist ability to communicate and dialogue intrinsically involves empathy, because empathy is the ability to hear client's concerns, to have a sense of "where the client is coming from." Empathy, for the community psychologist (Goodman, 1972), for instance, becomes the way the community psychologist tunes into the concerns of the community, and based on that, molds his or her suggestions in order to be truly responsive to the community's needs and wishes.

Empathy

With this in mind we offer a characterization of empathy. Typical views of empathy emphasize the therapist's ability to internally represent, in some form or the other, aspects of the client's experiencing. This is often stated cognitively as the ability to "see things from the client's perspective." Empathy is the ability to represent within oneself an image of the client's experiencing. In client-centered therapy the therapist is supposed to use this "as if" representation to "mirrorr" back to the client the therapist's understanding of the client's moment by moment experience. In a similar manner empathy is often seen as the ability to represent the client's emotional experience inside, that is, to "feel what the client is feeling." This is what is sometimes thought of as therapist resonance.

However, in our view these are simply components of a full fledged empathic appreciation response to our clients. For us, empathy is a matter of **resonance**, but of resonance defined in a much more broad way. Most fundamentally, we appeal to artistic metaphors to convey our notions about empathy. Along with Rowe and Mac Isaac (1991), we see empathy as operating along the lines of **aesthetic appreciation**. The way one resonates with a work of all is not to "feel what it is feeling," nor to "try to see the world through its eyes," but rather to have a response in resonance to it. Related to therapy, it is the ability to resonate with the client's ongoing process, "where they're going" or trying to go, so to speak, in a way that truly creates a "twosome," a *dialogue,* and there is no dialogue if all the therapist does is "mirror" what the client is already experiencing, or has already experienced.

Using artistic metaphors, empathy is more like a dance, or like a jazz group improvising together. One does not dance with a *part* of another person, one dances **with the whole person.** Dancing involves tuning into the other person in the sense of sensing their rhythm and "where they are going," so that one can "dialogue" with them. An empathic response from our perspective therefore does not merely mirror back to the client what the client has just done or experienced, but carries it forward by "bouncing off it" in a creative fashion.

A model here would be the byplay that occurs between two jazz musicians improvising, where each takes off and goes further from where the other left off in his or her improvisation. Certainly neither musician simply repeats what the other has done, nor tries to intuit or copy in some sense what was going on in the other's mind. Rather, each responds **from themselves** in tune with the other. Each improvisor's response, therefore, can be said to be a **sharing** of experience, in the sense that each response is a **joint product** of the self and what is heard from the other. Empathy, therefore, in this model, is a **carrying forward** rather than somehow a copying or a

representing of the other's experience. Paradoxically, a good empathic response might even be one which apparently departs quite notably from what the client has just been experiencing, just as in jazz one musician may empathically resonate with the prior musician's solo by radically altering the tempo or improvising off in a whole new direction. An example of an equivalent in therapy might be an empathically-generated paradoxical response. Parenthetically, in this sense, an empathic response cuts across the dichotomy between "leading" and "following" therapy responses, because it is both.

Within this model, all other therapy "interventions" become empathic ways of being with the client. If the therapist is in tune with the client, then his or her response need not be a reflection, as long as the response is a real response from the therapist and results from that "in-tuneness" (Bozarth, 1984). Within this context, the suggestion of an "intervention" could represent an empathic response to a client's concerns. Such "interventions" will be more likely to be helpful to the client, because they will be sensitively timed to be in tune with the client's efforts at self-composition and self-organization. They are offered, along the lines of the home decorator or the community psychology consultant, in a resonant manner with the themes the client is "playing." The offering of ideas, then, arises out of a **dialogue** between client and counselor, and is a collaborative enterprise. We submit that good counselors already do this, in an intuitive fashion. Empathy, as a **sharing** of experience gives rise to suggestions which will more likely be sensitively timed to resonate with what the client is doing and experiencing at that moment in his or her quest to organize his or her life and to grow.

Empathy and Experience

Empathy depends on the nature of experience. Experience is something beyond the cognitive-affective dichotomy which is the conceptual framework within which the field works at the moment (Bohart, 1993a). Experiencing is neither cognitive, as typically conceived - as thought, propositional schemas, belief statements, etc., nor affective, as typically conceived of as a emotion. Rather, it is more like what some are now calling "embodied cognition," or even "situated cognition." In some ways the first author would prefer to even call it "ecological cognition," and to suggest that "cognition" here has little to do with thinking, conceptualizing, holding beliefs, rationally analyzing, or forming propositional schemas. Rather it is perceptual and whole-bodied, and includes cognition and emotion as **parts** of an experience. It is immediate and recognitional, and gestalt-like, in that an experience is a complex integration of perceptions, bodily responses, thoughts, emotions, images, etc.

Recently we have been developing a model of the person as aesthetic experiencer, in which we argue that the way people actually experience the trajectories in their lives is more like the way they experience music, the complex flow and unfolding of trajectories over time, than it is like how a "naive scientist" intellectually analyzes what is going on in a situation, forms concepts, makes attributions, and the like.

If empathy is the sharing of experience, then there is something fundamentally aesthetic about empathy. And the sharing of experience, from an aesthetic point of view, is not a static re-presentation of what is going on in the other, but more like a resonating with, an anticipating of what is going to happen next, a sensing of a trajectory, and a responding in tune with that trajectory. One employs one's conceptual models, theories, stored knowledge and techniques, and procedures, in tune with one's aesthetic appreciation of the trajectory developing between self and client in the therapy session, in order to frame effective therapeutic responses. In this sense, therapy is indeed an art, no matter how much it relies on stored scientific knowledge, as indeed is also medicine. But it is an art primarily of "sharing with" rather than of "doing to."

FURTHER ELABORATION OF THE MODEL

Divergent Views of Empathy and Therapy

We now further develop and elaborate the ideas in the previous section. While virtually everyone now agrees that the therapist should be empathic, what therapists mean by empathy, and how they view it as functioning in therapy, is quite diverse. For some, empathy is primarily a matter of being compassionate and "understanding" in the sense of showing awareness of how the client is experiencing the situation. However the therapeutic **work** is done from an "outside" perspective. The therapist demonstrates that he or she is aware of the client's perspective, but primarily in order to establish rapport for the sake of making the therapist's interventions more palatable to the client. For these therapists, empathy works primarily to establish rapport and to help the therapist figure out how to most effectively intervene from his or her outside perspective. If this model were diagrammed with circles, the understanding of the client's perspective would be a small circle included within the larger circle of the therapist's perspective.

For others, the effort after understanding, and the accurate conveying of that understanding, are themselves much more primarily the therapeutic agents. Therapy from these perspectives involves a much more active and thoroughgoing effort to "get inside the client's skin" and try to deeply grasp how they are seeing/experiencing the world. Therefore much more effort is expended in the therapist's trying to see and feel his or her way through the phenomenological world of the client. If this model were diagrammed with circles, the therapist's circle and the client's circle would be of equal size, and they would be intersecting, meeting, and engaging one another.

The first model of empathy is more compatible with a model of therapy which emphasizes the therapist as expert, who "intervenes" to modify dysfunctional client relationship patterns, from his or her expert perspective on the client. In this model empathy is a "tool" of the therapist's. In contrast, the second model, while not excluding the use of expertise, emphasizes the therapist as person and joint experiencer. Therapy is as much more a matter of the human engagement of two persons as it is a matter of any technological expertise that the therapist has. In this model empathy is a way of contacting and sharing experience with another **person,** and as such is a joint activity in which both therapist and client are enriched. In this model therapy is more as a kind of "meeting of cultures" which is mutually enriching for both parties involved.

With the advent of managed care, psychotherapy in the United States has increasingly become formalized. While it has always been a profession, currently it is increasingly moving towards formalized rules of practice, modeled largely after the medical profession. For instance, once upon a time many therapists chose not to take or keep notes, viewing that activity as a kind of violation of the human relationship quality of therapy - a kind of distancing. Now, in an analogy to medical charting, one must take notes, and if one does not, one may leave oneself open in the case of a malpractice suit. Some consider it "unprofessional" not to take notes. Rules governing boundaries between "therapist" and "patient" have also increasingly multiplied. Participating in social events with clients, having lunch with them, giving them rides home, and engaging in more than minor self-disclosure is frowned on by some (Knapp, 1994).

These changes are not surprising as the profession, at least in the United States, is increasingly being subsidized by medical insurance. More and more we are becoming "doctors" who "diagnose" our clients' problems, draw up treatment plans, and "intervene." We are now providers" of "services."

As a result, therapy is becoming more activist and short term. The days of what could be called philosophical" therapy, those of Sigmund Freud, Carl Jung, Carl Rogers, Alfred Adler, and many of the existential therapists, where the emphasis in therapy was on providing a context where clients could modify their basic stance towards self and world, appears to be passing as insurance companies and third party payers focus more and more on "accountability." This leads to a greater and greater emphasis on a model of the therapist as an activist "doer" who will bring in

"results." The model becomes more and more "medical-like" in this respect, and the therapist's role is more and more that of the "expert" who "chooses" which it " that client, in terms of alleviating the client's symptoms.

Approaches which emphasize technological intervention can be contrasted to approaches which emphasize the relationship. We shall give a brief "generic" characterization of an approach which emphasizes technological intervention, and then we will give a generic relational approach. Technological approaches generally view therapy somewhat along the lines of the medical model. While they may not view problems in medical terms, their model of the therapist is akin to the doctor. That is, the doctor in some sense diagnoses or assesses the client's problem, and then chooses an intervention or a set of interventions designed to "fix" the problem. The therapist-doctor is the expert who will guide the client in one way or the other to a solution to the client's problems. This characterization can fit, to varying degrees, a wide range of approaches, from behavioral, to cognitive-behavioral, to strategic, to brief psychodynamic approaches, to recent systematized experiential approaches. The integrative approach called "technical eclecticism" (Lazarus, Beutler, & Norcross, 1992), which we have previously discussed, is a prototypical example.

Empathy plays one of two general roles in models which emphasize technical intervention. First, in approaches such as cognitive therapy, empathy functions primarily as a background characteristic. Its major function is to build rapport, to help the client feel understood, in order that the client be more amenable to the other therapist interventions. In this respect empathy's role is simply part of the role played by the relationship in general. A good therapeutic relationship is primarily a background variable in that it provides the "working alliance" in which the client is likely to try to utilize the therapist's interventions. For these perspectives, it is not by itself a primary agent of "cure." Its necessity comes from the fact that without a good working alliance with the therapist, the "potent medicine" of whatever interventions the therapist is going to use (transference interpretations, confrontations of dysfunctional beliefs, guided imagery and assertion training, paradoxes, gestalt two-chair) would not "take."

In technically eclectic approaches, empathy itself can be an "intervention." For instance, Beutler, Crago, and Arizmendi (1986) review studies which suggest that high levels of empathy with clients who are high in sensitivity, suspiciousness, and reactance against authority may be counterproductive, suggesting the need to deliberately "titrate " one's empathy depending on the client.

We will only note here, but not discuss, that these views depend on a certain view of what empathy is. One could argue, as we shall later, that empathy, defined somewhat differently, is something that a therapist should *generally* be doing. Empathy is not an "intervention" that one "titrates," but rather is a quality of the relationship that should be fundamentally there.

The current managed care zeitgeist is in some sense a reflection of a fundamentally behavioral epistemology in that there is a focus on therapist *actions,* with a belief that we can understand therapy by plotting the trajectories that link various therapist actions, or conglomerates of actions, to various immediate process outcomes, and ultimately to global outcome. Greenberg (1985) for instance, has debated the distinction between "the relationship" as such, and interventions as such, arguing that if we study the actual process of therapy, we shall find that what we call "the relationship" occurs through various therapist actions which can be studied, as with the other actions we call "therapist interventions."

Related to this is the recent interest in developing treatment manuals, which have been developed for brief psychodynamic, cognitive, interpersonal, and experiential forms of psychotherapy. Once again, the effort is after a kind of "rule-based" approach to therapy in which scientifically informed principles of practice guide specific therapist actions, and in which

distinctions between intervention and relationship disappear, because relationship itself is reducible to a manipulatible set of therapist actions.

We have previously mentioned a last, but very important, component of these models. That is that their focus is on **parts** of the person, and **parts** of the relationship. Therapy is seen as the business of modifying the client's core conflict relationship themes, dysfunctional cognitions, dysfunctional behaviors, processing problems at therapeutic markers, personality sturctures, ego functions, or, in the case of strategic therapy, the client's presenting problems. This is consistent with the technological emphasis.

In contrast, there has been a tradition in therapy that has emphasized "the relationship itself" as the primary healing agent. These are philosophically different than approaches which empha**size** technology in that they focus on the whole person relating, as opposed to seeing therapy as primarily focused on fixing some aspect of the person (e.g. a schema, a repressed abuse memory, a dysfunctional behavior, etc.).

As we have noted, the technological approaches considered above see the relationship as playing an important role in therapy, but primarily as a context for their "interventions" without seeing the relationship itself between the therapist and the client as a major change element. What is missing is the actual **sense** that both the therapist and the client really are **in relationship** in the therapy session. The therapist is not merely **using** the relationship as a source of learning for the client, but is **really in relationship him or herself.** And that **being in relationship** is what is therapeutic from a relationship perspective (e.g., Jordan, 1991).

Traditional client-centered therapy is one central example of an alternative, primarily relational model. The goal of client-centered therapy is simply to understand and appreciate the client (Bozarth & Brodley, 1991). People often do not understand the fundamental philosophical difference in client-centered therapy as compared to other approaches. They think the goals are to get the client in touch with his or her feelings, to increase his or her self-acceptance and self-actualization. The therapist does this by being warm, empathic, and genuine. However, especially for Rogers in his later years, the goal is really for the therapist, one whole person, to have a positive, real, dialogic relationship with another whole person. Such relationships form the context within which positive growth occurs, just as the obverse of such relationships are the source of problems in the first place. The relationship is just that "growing space" or "working space" to which we have previously alluded.

In this relationship one whole person (the client) is prized and appreciated and understood, as should happen in any good relationship (parent-child, friend-friend, etc.), by another whole person. Good relating includes being nonexploitative, nonmanipulative, allowing, appreciating, understanding and empathizing with, and, more generically, "sharing." Most fundamentally it consists of the therapist "being there" as a person, and "being present" as a person. Problems which are referred to as "transference" and "countertransference" in other approaches are perceived as relationship problems between two real people in this approach, and their resolution involves communication, dialogue, and self-disclosure (e.g. Gendlin, 1968), as the resolution of problems in any relationship involves the productive use of these same factors.

What this means is that the therapist does not "plan" "interventions" to "make something happen" in the client. Quite to the contrary, such planning would have a manipulative quality to a client-centered therapist. Since the relationship itself is in the foreground, techniques, interventions, and behaviors simply become ways two people can "be together," although techniques are rarely used by traditional client-centered therapists. What we are trying to get at here is the **qualitative difference** between a client-centered and a technological approach. In this regard, Mahoney (1986) has suggested that techniques are primarily ways of communicating messages. And Rosenbaum (1992) has suggested that the function of techniques is primarily to reduce *therapist* anxiety, so that the therapist can be in the relationship with the client.

In this model, the important thing is that the therapist be able to "be real" in this facilitative way with the client and have a "real relationship." Not just any kind of "real" relationship will do, of course. Clearly there are "real" relationships that are destructive and toxic as well as ones that are constructive and growth-promoting. It is the latter which the client-centered therapist hopes to have with the client. However, this ability to relate is not a matter of any kind of professional expertise, and the client-centered therapist does not view his or her capability to relate in this manner as a kind of expertise. What is therapeutic is the **true immediacy** of the real relationship, that is, of two real people being in contact, and this is not reducible to a technology.

There are, of course, limits on such a real relationship. However this is not unique to the therapy relationship. Limits exist in all real relationships. In good real relationships people incorporate important boundaries into the relationship - a good real relationship between parent and child does not include sexual exploitation of the child, In a similar manner in a good real relationship between therapist and client, **through respect for the other** (not through "professional expertise or even ethics") the therapist does not violate important boundaries.

A major "construct" here is the "reality" of the relationship (it is interesting that in science everything loses its reality and becomes "shadow-like" "constructs"). Parenthetically, it is probably accurate to say that psychological science presently does not believe in "real" relationships. Presumably, the behaviors, or sequences of behaviors, that constitute what we are calling a good "real" relationship could be studied and identified. Then they could be trained. People could learn to "do" them on purpose. This is certainly being argued for therapy.

What this would mean is that a person could enter any relationship with a set of goals to achieve, and deliberately manipulate his or her actions in order to achieve whatever effect he or she wanted, including the illusion of "realness." In such a view of relationships, ultimately behavioristic in epistemology, one could learn which sequence of behaviors lead to which consequence, and then knowingly choose to enact that sequence in order to increase the odds of that consequence. Thus in some science-fiction future there would be no such thing as a "real relationship" as people have traditionally thought of them. Rather, each person will have been trained in "relationship expertise," and will enter each relationship situation with strategies for attaining his or her ends. It is in this sense that psychological science could be said to not believe in real relationships.

Contrasting to this view of a "real" relationship, one could argue that once one begins to do things in order to they lose their spontaneous relational quality, and ultimately, their effectiveness, although that is open to empirical test. With empathy, for instance, if it were truly used as an "intervention" we believe it would ultimately lose its effectiveness. One feels "empathized with" only to the extent that one experiences the other person as "really empathizing," but not if we experienced them as "intervening." We do not believe "real" relationships are reducible to technologies (this is not to say that one cannot acquire "relationship skills" which can be included in a real relationship).

It is interesting in this respect that Carl Rogers apparently did not believe that his **descriptions** of the therapy process were meant to be **prescriptions** for doing therapy (Brodley, 1990). Although he observed that when the client improves in therapy that is accompanied by an increased openness to personal experience, he did not take this to mean that therefore the therapist should specifically operate **in order** to facilitate this openness to experience. To do this is to become a technological expert who is focusing on a part of the person.

A clear implication of the client-centered stance is that one is relating to the whole person in a real relationship, and not just to a part of the person. This is clearly untrue in most approaches to therapy which hold that there is some important technology possessed by the therapist which is necessary for client improvement. These include most of the major approaches to therapy, and are not restricted to technical eclecticism.

Neither Beck (Beck, Rush, Shaw and Emery, 1979) nor Ellis (1984) genuinely address themselves to the whole person's concerns. The person says "I'll never have a good relationship," or "I must have a relationship in order to be happy," and the therapist focuses on modifying those thoughts. Certainly they are not taken as an expression of the person's **concern**. In that sense the therapist does not focus on the whole person and what such thoughts mean to the whole person.

Similarly the recent experiential approaches of Mahrer (1989) and Greenberg, Rice, and Elliot (1993) do not in theory at least address themselves to the whole person. Mahre (1989), for instance, does not **really** address the concerns of the client **as the client is experiencing them**. Rather he works immediately to place the client in a vivid, real context, and to elicit strong feeling. This works and is therapeutic, but in this respect Mahrer does not relate to the person as a whole person. Similarly, Greenberg et al. look for "therapeutic markets" of blocked emotional processing, and intervene with appropriate procedures at those points. The focus is on the particular kind of processing problem present in a given moment, rather than on what the whole person is doing or trying to do at that moment.

Psychodynamic therapists of many persuasions view problems as based on "defense" and repression," and focus on interpretations designed to modify such part-processes of the person. Similarl they treat perceptions of others in the client's life as transference (i.e., distorted interpretations). Or they look for dysfunctional relationship themes or interaction cycles. Once again the focus is on dysfunctional **parts** of a person, rather than on how those parts fit into the whole person's attempt at orchestration.

Gestalt therapists focus on the "lack of contact" in the moment, for instance, and on "not taking responsibility." They will take a shortcut around what the client is **saying** in order to focus on whether or not the client is "in contact" and "taking responsibility."

Thus most therapists theoretically do not relate to the whole person as a whole person. This is not to say that they do not relate to the whole person who is the client **in practice**, and from observing tapes of Beck, Greenberg, Mahrer, Paul Wachtel, and many others, it becomes clear that good therapists do transcend their own theories to relate in such a manner.

Those who value the relationship itself as the primary source of growth typically value empathy as a relational characteristic rather than as an "intervention." The function of empathy in client-centered therapy is to convey to the client the therapist's apprehension of the client's immediate, moment to moment experience, "where the client is at" in the moment. Empathy is primarily a way of *knowing the other person* in client-centered therapy. "Knowing" here refers to the kind of knowing we mean when we say we "know a person really well" in contrast to the kind of knowing typically referred to as "knowing about" something. The therapist is to project him or herself into the experience of the client in an "as if" way, and then try to convey back to the client this "as if" understanding. It is thus a kind of a stage-like model of empathy - Stage 1: As client says something, imagine oneself into client's world, and try to sense their experience in an "as if" way, Stage 2: frame this into some kind of response and respond in a manner to share that appreciation of the client's experience with the client, with the primary function of showing the client that he or she has been "heard" and "understood." Barrett-Lennard (1993) has developed this into a more elaborated stage-like model of empathy.

Recently self-in-relation theorists (Jordan et al., 1991) have presented a new paradigm of self, relation, and psychotherapy, which once again emphasizes the primacy of relationship. This paradigm goes beyond client-centered theory in emphasizing a relational model of persons and of therapy. While client-centered therapy always emphasized relationship, it was so that the client could "self actualize." For self-in-relation theorists, the goal could be said to be "relational actualization."

In this empathy is not an intervention so much as it is a **condition** of a relationship, and growth occurs through that relationship. The function of empathy is fundamentally different than it is in "technological" approaches.

Recent developments from those who think in multicultural terms have also challenged the technological model of therapy in general and of empathy in particular. The ability to empathize with one's clients is certainly a highlight of multicultural therapy. Empathy here means to try to step outside of one's cultural frame and sense the meanings within the frame within which the client lives, so that one can begin to have at least a rudimentary sense of what it is like to see the world through those eyes. Therefore, empathy needs to be an omnipresent quality in a multicultural therapy relationship, and not just for technological "intervention."

In more "traditional" approaches to training in multicultural counseling one gets a version of the technological approach to therapy discussed earlier. The therapist must be empathic primarily to make the therapy work. The therapist is still the expert, and empathy/technique modification is more a matter of matching technique to client in order to get compliance and results than it is really empathizing with the client, in the sense of truly meeting them and sharing their struggle and their experience. In some sense, the client's cultural differences are viewed as obstacles to be overcome in "delivering services," rather than as the very stuff out of which the client's growth and development will occur.

In contrast, recent multicultural writings emphasize a kind of egalitarianism of the relationship between therapist and client, in that the therapist does not hierarchically enter the relationship with preset "expertise" which he or she imposes on the client (taking culture into account only in terms of how to best "deliver" this expertise). Rather, in dialogue with the client the therapist comes to truly empathically share the client's world view as much as possible. The therapist may be changed by this, in that that sharing should enrich the therapist's own experience of the world, and possibly significantly alter the therapist's views of what problems are and how to solve them. The result is that the therapist may "intervene" in ways that deviate markedly from his or her preset "expertise" (Comas-Diaz, 1992). Therapy is more like one culture meeting another culture, offering to help people in that culture out with whatever expertise it has, but also being aware that the people in that culture have their own expertise to contribute to the problem, and that it is **in dialogue** between the two cultures that the most optimal solutions will be found.

Once again, having a "real relationship" in the sense of a mutual one becomes important. However, as in any real relationship, which is an experience shared between two people, the nature of the relationship will vary depending on the participants involved. Thus a real relationship between two people from one culture may not look the same from outside as a real relationship between two people from another culture.

Based on these considerations, we propose, most fundamentally, that therapy is primarily a matter of being in a real relationship with the client, and that this is not secondary to the "healing" process, as it is in medicine. However, **in order to be in a real relationship with one's client, one may have to offer technology depending on the client**. That is, the use of technology can be ways of being in a real relationship with the client. Further, they can be used in a way that preserves "realness" in terms of a **sense** of egalitarianism.

In order to explain this we must briefly consider what it is to say a relationship is "egalitarian." Can a relationship be egalitarian even if there is an objective power differential? It has often been pointed out that therapy relationships are not truly egalitarian because the therapist possesses more power in a variety of forms than does the client. However an overfocus on role relationships can obscure the fact that power is not uniformly distributed across all aspects of a relationship. While a relationship may not be egalitarian in some respects, that does not mean it cannot be in others. A relationship can **feel** equal in many respects even if there is an objective power differential. It is one thing to say that from an **objective** perspective a relationship is

nonegalitarian. It is another to ask someone if it feels egalitarian to them from within. The **feeling** of equality has to do with whether or not the person is **treated** as equal in certain important **interpersonal** senses: that is, are they treated as if they are intelligent, as if they have good judgment, as if they are capable of making their own decisions and choices, as if their opinion matters and is valued, and so on. Are they respected? Are their cultural traditions truly respected? Is the relationship mutual in the sense that person A is truly interested in person B? If person B is from another culture: does A truly respect that culture and its differences? Is A truly interested in B, "from within their soul," not just because it is professionally expedient to do so? Is A willing to learn from the other person? If these conditions are present, then there will be an egalitarian "feel" to the relationship even if there is an objective power differential. It seems commonplace to suggest that the realness of a relationship can "shine through" its various forms: parent-teacher, administrator-employee, teacher-student, therapist-client, doctor-patient.

With this in mind we argue that the fundamental modality of therapy is **empathic appreciation** of the client, and within that context, issues of technological expertise become secondary, although they may still be of importance. Empathic appreciation of the other person as a whole is based on the following model, which we have discussed in the previous section. The person is viewed as a whole person actively struggling to try to make his or her life work. He or she is trying to "compose" him or her self. In so doing, whatever the client is doing that is "bad" is an effort after "composition." That is, whatever is "bad" in each person is precisely that which can be developed to be "good." It is a matter of those things coming out in a "bad form," to use Mahrer's (1978) term, rather than in a "good form." In one sense, therapy does not have to "change the person," or change the person's personality. Therapy is a matter of helping clients to help themselves achieve a more coherent, functional form. This is compatible with Kohut, who emphasized self structuralization and overcoming disintegration, rather than the **contents** of personality. Additionally, because humans are fundamentally relational, and meaning is fundamentally relational, the achievement of good form inherently involves connection to others. In addition, form is something that occurs over time. This means that form plays itself out relationships over time. Thus it is not a matter of helping clients achieve a good static form, but helping them maintain good form over time.

Take for example a client diagnosed as "borderline personality disorder," and discussed at a case conference. The client is a young woman, who is reported to engage in self-mutilating behavior, among other things. The young woman has agreed to attend the case conference. When she comes in one learns that, among other things, she is a musician, who writes songs. As she describes this, she exhibits, for the moment, a clear sense of identity, as well as a sense of agency and energy. Suddenly we have a very different image of her than as a "self-mutilating borderline." We imagine her using her songwriting and music to try to find some sense and coherence in her life experience. We get the image of someone trying to put it all together, to bring her life into some kind of coherent order. She probably feels alone, different, chaotic. Her problems arise as she tries to integrate her life, to find some order, meaning, and coherence. In other words, it is her attempt at "meaning-making" (or "meaning-discovery, as we discuss later) which we are confronted with. We need to understand this effort of this whole person: writing music, trying to have relationships, trying to create some meaning in the world through her art, trying to share her experience, getting desperate and self-mutilating as part of her attempt at coherence-making or meaning-making. The key idea here is that the person is trying to put her life together, and her borderline "pathology" is part of this effort at orchestration. We need to relate to this person as a whole, to her life as a whole, to help her trace the implicit vision underlying her efforts, and how difficult her efforts are to orchestrate discordant pails,just like a composers or a writer trying to bring order to a manuscript. It will be harder to orchestrate if there is more discordance: life circumstances, rejections, biological problems, life history problems, feeling different and having different values, having a different vision, etc.

Thus appreciation becomes the fundamental "intervention." We imagine appreciating this client, her experience, her struggle. Appreciating means also looking for the positive, and appreciating the good in her life. It includes focusing on her music, her perceptions, her values, and her observations. It also includes looking for when she did things well, and empathizing with her failures and disappointments.

As an example, consider the following possible interchanges (written from three different therapeutic perspectives):

C: "I'm no good."

T: "So *you* think you could be better." [note: this is responding to the whole person rather than treating this as a dysfunctional cognition to be challenged]

"I sure could."

T: "How could you be better? What would it look like?" [strategic "intervention" as empathy]

T: "Could you try something? Talk to yourself. Tell yourself how you could be better." [Gestalt two-chair as empathy]

Such "interventions" fit in with the client's attempts at self-orchestration. Saying "I'm no good" needs to be seen as an attempt at orchestration.

This means one must appreciate even client's deep experience of negativity.

For example:

"I'm so disgusted with myself. I got depressed again and I cut my legs with a razor again."

"You're so fed up with yourself doing this horrible thin(, to yourself."

Empathy

Empathy in this model is **resonance.** While others have spoken of empathy as resonance, they have typically equated resonance with "having the same feelings as the client." Yet this is a more narrow meaning of "resonance" than the word implies. One can resonate with another person's experience **without** having the same feelings. Resonance is therefore a broader concept than has heretofore been proposed for empathy.

Resonance is based metaphorically on the idea of two strings resonating with one another. In general we shall use artistic metaphors to convey what we mean. As a matter of resonance, empathy involves "tuning oneself to the same wave length," as the client, to "vibrating together." It is *neither* the process of "imagining oneself into the other"; cognitively trying to perceive the world as they perceive them; *nor* trying to feel their feelings, or intuit their feelings. *Both* of these *are content-focused.* They rely on a model of empathy as a "jumping the gap" between two monadic, isolated individuals, whose worlds are fundamentally unknown to one another, a perspective that is being challenged by many, including client-centered theorists (Barrett-Lennard, 1993; Bohart, 1993b; O'Hara, 1984).

Resonance is most fundamentally nonverbal, although verbal elements can certainly be included. It depends on the rhythms between two people. It is most like Neisser's (1988) description of two young animals playing with one another, resonating with one another in an immediate, flowing, rhythmic manner. Neisser points out that the two animals "know" immediately the interactional meanings involved in a directly perceptual way. In this kind of empathy the literal content matters less than that the therapist's response is "in resonance" with the client's experience. A good example of a resonant response is Stern's (1985) example of a mother doing a shimmy in response to her infant's excitement.

Analogies may help clarify this. It has often been said that performers performing together, when they reach the highest levels of their art, are being "empathic" with one another. No matter how programmed, a dance between two people will form more of a flowing, unified whole if each

dancer is "in empathy" with the other, sensing and sharing the trajectories in each other's actions in such a way that subtle adjustments can be made so that the overall effect is as if they were **sharing** a space or an activity together. It is as if they were "in that space together," rather than in two separate spaces relating to one another. It is similar in good improvisatory jazz performances, where empathy among the musicians is crucial for a good performance. However empathy is not somehow "representing" to oneself what the other is seeing or feeling, but **responding** in a resonant manner to "where the other is going," what the other is developing, and so on. It's a "picking up" of the developing theme in "where they are going" and responding in a manner which both intuits where they were heading, yet creatively elaborates on it and carries it forward in a way which is both original and unique, but yet retains a sense of the theme as originally developed by the first player. In a good jazz group, or in a good dance, each partner will resonate off one another in an ongoing, continuing dialogue, building on each other's creativity. If we think of an empathy response in this manner, then it does not need to match in content, or in affect, what the client has just said or experienced. In fact, to be most effective, it must creatively vibrate at some close, but different level, in order to truly resonate and carry forward the dialogue.

An empathic response, therefore, need not "match" the client's response, or even the client's experience, to any given degree of closeness in terms of content or affect, as long as it "fits" in a carrying forward manner with the developing themes of the client's experience. And in a good resonating relationship, each person resonates off the other in an upwardly spiraling manner. That is, each resonates off the other-'s thread in a positive direction. This does not by deliberately trying to alter the flow, but by resonating with the implicit structure of the "composition."

At the same time, technically, in therapy, sometimes the words do matter/help. But we see this as secondary and more "task specific" in Greenberg et al.'s (1993) sense. Otherwise it is the **act** of responding in resonance with, the nonverbal sharing, like the jazz musician, in a "dance" of interaction patterned over time, which is healing. It is the process of "dancing with" - from one point to another, during which the client learns to "step" more accurately into the future.

This act of "dancing with" promotes an internal "dancing with" in the client. Although not necessarily the goal, it focuses the client inward, **but in a certain way**. The client learns to listen to him or herself in a resonant manner, and a productive dialogue between thinking and experiencing is set up. In such a dialogue, the person is able to hear all possible "reverberations" of the meanings being attended to, and to sense and intuit how they may begin to rearrange themselves in more productive ways. In other words, it is the **way one attends to oneself** which is therapeutic, in that it allows a certain kind of internal resonating process which allows creative rearrangement. It is like getting a composer to listen to his or her rough draft nonanxiously, for the novelettes that allow further development, rather than for what is going wrong

In developing our description we will resort to further poetic language. In so doing we do not want to alienate the more "scientific" of our readers. We wish to reassure them that we are using poetic metaphors only as a preliminary to turning these concepts into more boring, scientific, researchable language!

When a therapist gives a good reflection, in the context of "dancing with" the client, in terms of an ongoing resonance of trying to "be with" them, the words act like dancing around a tune, playing with the meanings, ringing changes on the meanings. It causes a kind of "shimmering" of the meanings, the meanings begin to seem less fixed, more "playable." Like notes in a symphony, the person comes to see that they can be played differently, with different emphases, pace, tempo, pitch, timbre, and the meanings become more fluid. This is why the content matters less than how things are being "played." It does not matter if one is "here and now" in one's reflections, or if one is "past oriented," as long as whatever meanings are voiced resonate with the current flow of experience, as kinds of "changes" on that flow.

Thus empathy is not **just** getting the client to focus inward, it creates a **quality** of self-relationship as well, a kind of inner appreciation of the good threads in the internal composition.

A male client says: "I'm really mad at her. Here I go to all that trouble to arrange a surprise party for her on her birthday, and she gets mad at me for not being sensitive to her wishes! She says she was hoping that I would do something romantically alone with her!"

Therapist: (meaning-content) "You believed you were arranging a pleasant surprise for her, and you're seeing her as totally not appreciating your efforts.

Therapist: (Emotional-content): "You feel angry and disappointed and misunderstood. Here you go to all this trouble and all you get is criticism." Or: Therapist: (Self-disclosure as empathy): "As I listen to myself listen to you what I feel is both anger and disappointment. I'm wondering if that's what you feel."

Therapist: (past-content, based on previous explorations with the client): "It reminds you a lot of how your mother used to ignore you when you would go to all that trouble to fix breakfast for her - there's that same sense of being ignored and unappreciated -- and it is very disheartening and deflating."

Therapist: (resonating): "Such a pisser! You probably would've liked to do something romantically with her too! Life can sure be a pisser at times!"

Therapist (resonating): "So what are you going to do? Are you going to talk to her about it? Or what?" (This response might or might not be resonant, depending on the context. In another context it could easily be nonempathic).

These last two responses respond "in tune" with the story, not to either the emotional content nor to the cognitive content. Both resonate with an implication of what the client is experiencing. They respond to the **composition**, to the dance. It is as if the client-dancer makes one move and the therapist-dancer makes a complementary move that carries their dance forward. The first two responses given follow a more traditional "empathy" format, in trying to "re-present" the client's experience to him. While they, too, respond resonantly to the client's "story," the point we are trying to illustrate is that there are other ways to do this empathically without "representing" the client's experience back to him.

A major implication of this perspective is that empathy is something that is shared (Jordan et al., 1991; O'Hara, 1984). It is not something that the therapist has for the client, but rather, something that therapist and client share with each other. The therapist's empathic response to the client in a resonant fashion not only conveys something of the therapist's understanding of the client back to the client, but is a sharing of **therapist** experience as well. The client comes to know the therapist through the therapist's empathic resonant response. In this sense, therapy becomes an activity of co-construction or co-composition.

When the therapist offers a response that is in resonance with the client, and the client "takes off" from it in a resonant manner, the therapist will feel as empathized with by the client, as the client feels with the therapist.

From this "resonant" perspective, many of the issues concerning relationship versus technique become irrelevant. It does not matter if the therapist is supposed to be the expert, or a companion, uses techniques, or not. In this sense we have come by a roundabout route to Greenberg's (1985) perspective that there is no ultimate difference between technique and relationship, at least in terms of doing therapy. If the therapy situation is one real person relating to another real person, then technological interventions can become modes of relating, or modes of appreciating. In empathic resonance with the client at a given moment the therapist may suggest a technique, challenge a dysfunctional cognition, make a transferential interpretation, or whatever.

Techniques, in this view, become tools for helping the client "compose" him or herself. That is, they are not things the therapist does to the client. Nor are they "interventions" to "facilitate certain kinds of client processes." This kind of mechanistic view makes therapy sound like surgery. Nor are they therapist actions which are the antecedents to good moments, because a goal of therapy is not the production of good moments, (Mahrer- & Nadler, 1986) per se, any more than the goal of composition is a crescendo. Good moments are important in therapy, but only as part of "the whole composition."

An Aesthetic View of Human Experience

This relates to a view of therapy, and of life itself, as essentially aesthetic in nature (Bohart & Rosenbaum, 1993; Rosenbaum & Bohart, 1993). If we conceive of the practice of therapy fundamentally as artistic, then one might not need "treatment manuals" per se, nor would one be interested in "standardizing" the way therapists do therapy. There would be no big surprise if two cognitive therapists, such as Beck and Meichenbaum differed radically in how they "did" cognitive therapy. In this view, theoretical frameworks are guiding philosophies, but not specific injunctions for procedures. The "art" of the therapist comes in how he or she puts this framework into operation, or interprets it, and this could thus differ significantly from therapist to therapist, just as all baroque composers were not alike. From this view, training should help each therapist learn his or her way of "composing."

By saying therapy is an art, we do not want to say that therefore it is not "studyable," nor that it is purely a matter of intuition. There are decision rules in art, and there are formal structures which can be studied. However, what we are saying is that the processes involved follow fundamentally different rules than formal, mechanistic models. Therapy relies on the equivalents of rhythm, melody, and harmony for its operationalization. Rhythm has to do with the flow and pacing of the therapy session, melody with the sense of continuity, and harmony with the issue of bringing disparate elements together.

The essence of an *artistic* approach to psychotherapy is, as we have said, appreciation. One must appreciate the evolving form in the client, their struggle to achieve form. In this model techniques are employed in empathic response to the client rather than from an expert-medical-like stance. Research findings that specific procedures are useful with specific client problems, or at specific times in therapy are not ignored. However the information is used to heighten therapist sensitivity and empathy with client experience in the moment, rather than being applied programatically. Similarly, knowledge that certain "reactant" clients do better with relatively less directive therapists is not used to **program** a therapeutic relationship, but can be used to facilitate accurate empathy for "where the client is at," leading to a spontaneous and automatic adjustment on the part of the therapist as part of the therapist’s "being with" and "sharing with" the client.

Experience

No discussion of empathy would be complete without a discussion of the nature of **experience,** because it is with the client's **experience** that therapists empathize. Experience is more complex than the typical cognitive/affective views that are used to describe it. Recently one of us has been developing a model of what experience is (Bohart, (1993a), similar to emerging "experientialist" views in cognitive science (Johnson, 1987; Lakoff, 1987), and originally derived from Gendlin (1964). These all fit with the increasing emphasis on related concepts such as "embodied cognition," and "situated cognition." All of these emphasize the idea that we cannot study how we come to know and understand things in a disembodied, cognitivist way. Knowing is intimately tied up with the fact that we are embodied creatures situated in living contexts of meaning, and that cognition originally developed to help us "navigate" our bodies through this concrete, situated ecology, of which a primary component is relationships.

Learning is embodied and intimately based on the flow of interaction with one's immediate environment. Learning consists of learning how to detect important meanings in both one's

physical and interpersonal environment. Whether- or not Gibson's ecological theory of perception is correct at a "deep" level, it is a good description of how we function at the level of the whole organism interacting with its environment. That is, we are continually trying to detect meanings in our immediate environments so that we can flow with them. To argue that we are "creating" these meanings is to take a step backwards into abstract theory and into presumed "underlying mechanisms." It is unlikely that anyone trying to figure out if someone loves them or not experiences that process as "creative meaning." Rather, they experience it as detecting meaning. Someone trying to figure out whether to change jobs or not or get married, does not see themselves as creating meaning, but rather, trying to **detect** currents and trajectories **in meaning** in order to make good choices.

Real learning then, most primarily consists of embodied perceptions and actions - how to cope with, learn, and survive in an ongoing interactive flow between goals and purposes and ever-changing and shifting situations. Discovering meaning, uncovering meaning, fleshing out meaning, following the twists and turns of meaning as it reveals itself more and more to you, and from that, learning how to continually modify one's course, is a better model for how the organism as a whole is actually functioning than one which assumes it is "creating meaning,." (This is not to say that describing it as constructing meaning at some more basic underlying level may not be true). *Dialogue* becomes a model for all learning.

Learning in this sense is not learning concepts, which come later, but rather the detection of complex interactive patterns, "flows," and trajectories. It is primarily the learning of **implication.** But it is not a logical semantic implication (which in fact is derived from experience) but a sense of implication more like the "flow" in music. In this sense of implication, what there is in any given moment does not rigorously imply the next step, but implies a set of possible or probable next steps (Jones and Boltz, 1989). This is based more on apprehending the **form** of something than on semantic content. Psychoanalytic theories have well articulated this nature of experience in preverbal early childhood. Stern (1985), for instance, sees the early sense of self as experiential more so than conceptual. However, in typical western fashion, it is assumed that as soon as the child becomes both verbal and conceptual, these "higher" aspects dominate. Instead Bohart (1993a) has argued that learning through experience (embodied cognition, situated knowing) remains the predominant modality of knowing. Further, it too develops, as does conceptual knowing. One's ability to subtly and differentially experience the patterns in one's fife develops.

There are clear examples of this in terms of virtually any activity we think about. We become more adept at immediately **detecting** patterns in our clients through ongoing experience. Art critics can detect subtle shifts in patterns, such as the differences between one Toscanini performance of Beethoven's third, and another. It is a mistake to see these as primarily conceptual. It is true that in writing an article about the differences, the critic may frame them conceptually. But that is an **after the fact** phenomenon. First the differences are detected, then they are cognized, verbalized, and conceptualized (and hopefully tested by being checked back against experience).

In keeping with the thi-ust of this essay, experiencing follows laws and rules more in keeping with aesthetics than it does laws and rules in keepinc, with concept formation, looic, and scientific anal sis and hypothesis testing. One can learn to detect similarities anionc, Baroque composers simply through repeated listening. A locical, conceptual analysis in a music class may help '.sharpen" one's ability to apprehend "Bai-oqueness," and lead to more subtle differentiations. However, even there, the conceptual analysis merely "calls attention" to the patterns to be detected. The actual learning is still through experience.

We do not have space to discuss the relationship between what Mahoney (1992) has called "mediate" and "immediate" experience, or, "thought" versus "direct experience." Suffice it to say that in a functioning human being these are intertwined in a continuous dialogue, and can only be

conceptually separated for purposes of scientific understanding. Experiencing as direct sensing of relationships feeds into thought, conceptualization, and verbalization, and those activities, as experiences themselves (one experiences oneself talking, thinking, and conceptualizing) then feed back into sharpening further pattern detection. What has been called "intellectualization" in therapy is conceptual activity which does not feed back into new experiencing, for whatever reasons. Most typically it is arriving at an intellectual conceptualization of one's problem, and then **stopping** and expecting felt shifts in experience to occur- as a result of having found "the right" conceptualization, instead of using that conceptualization to explore further experience, as an art student would with conceptualizations learned in class.

In any case, empathy is itself an experiencing. It is the apprehension of the pattern/implications in the experience in the therapy session. This characterization makes an important point: Empathy is not empathy of the **client,** but is always an interactive sharing. One's empathic experience is of the flow of the interaction between therapist and client. To use O'Hara's (1984) term, is not getting within the "skin of the client," but in the "skin of the relationship." That is, empathy is an experience of the flow of the interaction itself. Part of that flow, of course, is the sensed patterns of meanings that constitute the client's "life" and "life problems." But in this sense, empathy goes both ways **even if** it is only the therapist who is "resonating" with the client. Empathy therefore lies "between the space" between the two individuals, not "in" one or the other. Empathy in that sense is a contextual variable. If I empathically resonate/appreciate you, that is going to feed back and affect me. Gradually as the client feels resonated with, he or she will begin to resonate back with me, and there will be a mutual resonance. If we consider empathy along the lines of empathic immersion or appreciation of art or music (Rowe & Maclsaac, 1991), then it can be seen that empathy is a sharing of experience. The experience of being empathized with resonates "in" the experiencer. Thus empathy is always shared, and not just a "message" from the empathizer to the empathizee.

This view of empathy obviously poses important empirical problems. **Judging** when something is empathic from this perspective in a research sense becomes more difficult, although we have models of such judgments - artistic judgments, athletic judgments in gymnastics, dance, and ice skating. No one therapeutic response could, by itself, be judged empathic. Rather episodes in an interaction, or the interaction itself, could be judged as empathic. However we operationalize this, a good criterion test would be to have the client look at the tape of the therapy episode or session and rate the degree to which he or she felt understood in that episode. We would predict that clients might feel understood by therapist "interventions" (e.g. strategic, for instance) that from the outside do not necessarily appear to be empathic as traditionally conceived.

In sum, we believe that the distinction between technology and relationship can be transcended. However, psychotherapy is more uniquely a relational enterprise than is medicine, lawyering, or other professions. The real relationship between therapist and client is more important with matters of the heart, spirit, relationship, self, behavior, values, performance, etc., than it is even with matters of the body. In contrast to medicine, the relationship itself is a **primary** rather than merely supportive healing factor. With this in mind empathy between therapist and client becomes a primary, pervasive factor in therapy. Empathy is not merely a therapeutic action, but a "way of being with" the client, and manifests itself in empathic appreciation and resonance with the client. Resonance is neither a matter of an "as if" cognitive appreciation of the client's inner world, nor a matter of apprehension or experiencing of client emotion, although those may be included. Rather, resonance is a response by the therapist to the client: a response "in resonance with" the client. The analogy of dancing together, or playing music together, better captures this image of empathy than a more cognitive, conceptual one. Therapist "interventions" and techniques become matters of expressing that empathy, resonating with client concerns, and sharing with the client in a real relationship, rather than "experts" doing things to clients. This

view of therapy is based in a view of experiencing as artlike or aesthetic, instead of cognitivistic, with therapy itself being seen as following artistic principles.

We believe this view is compatible with person-centered theory, and also resonates with recent self-in-relation views, Self Psychological views, and multicultural views. The client is viewed as a "work in progress." His or her dysfunctional behaviors, schemas, or the like are not treated as "broken parts" of the person to be fixed, but as parts of the whole person's attempt at self-orchestration or self-organization. Empathic appreciation and resonance of the whole person's efforts at self-composition help the "work within" come more to the fore, help the rough draft of the person's life, done with "bad form," become more well-formed.

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NOTES

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