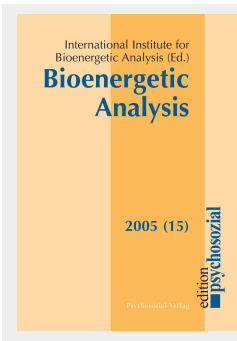


*Robert Lewis*

# The Anatomy of Empathy



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# The Anatomy of Empathy<sup>1</sup>

*Robert Lewis*

## I. Introduction

Today my topic is »the Anatomy of Empathy«. I will use the masculine pronoun in this paper for purposes of simplicity. We will look at our traditional Bioenergetic model and more recent developments as they bear on empathy. Although my title implies that the science of empathy has evolved to the point where I can draw you a map of the muscles and synapses that are involved, I will conclude that even with exciting recent advances, being empathic is still very much a clinical art. State of the art brain imaging confirms that the right brain is mediator of empathy, but does not yet help us to better intervene clinically. The behavioral anatomy data of facial expression, gaze behavior, vocal rhythm coordination and body posture is more immediately relevant to our topic. So empathy is complex. In this paper, building on the insights of Lyons-Ruth (1998), Stern (1985), Tronick (1989), Beebe and Lachmann (2002) and many others (Sander 1977, Weiss 1970 Fogel 1993), I will distinguish between explicit and implicit knowing, in order to better comprehend empathy. We will look at the limits to our explicit knowing, and the extent to which the implicit can be made explicit. I will also argue that a non-linear, dyadic systems view best captures the split second, bidirectional quality of empathic communication. Finally, I will touch on the paradox that the very wound which has led us to become therapists, both attunes us to our patients and interferes with our truly being with them. I will attempt to illustrate the above issues with clinical vignettes.

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<sup>1</sup> Morning Lecture given on October 11, 2003 at the XVII th IIBA conference in Salvador Bahia Brasil.

## II. Definitions

A) *Empathy*: The word empathy is derived from the Greek »empathia«, meaning affection or passion. The Webster's new World College Dictionary (fourth edition) defines empathy as: »The projection of one's own personality into the personality of another in order to understand the person better; ability to share in another's emotions, thoughts or feeling.« Some therapists, Tansey and Burke (1989), for instance, embrace a broad definition; we are being empathic, they say, when we respond to the patient's need, when we give him what he needs in order to get better – even if that means failing him (so that he can re-experience and master his internalized traumas); we are responding empathically, when we receive the patient's projective identifications – projections that shape our experience as they deepen our understanding of the patient. For others, Stark (1999), for instance, this more inclusive definition obscures a crucial distinction between, on the one hand, the empathically positioned therapist who responds to something inside the patient's awareness – something that is experience-near and, on the other hand, the relationally confronting therapist who responds to something outside the patient's awareness.

But I do not want to discourage you so early in my talk ... perhaps later. Most of you might agree that while empathy is not easy to define, you know it when you experience it, you know what it feels like when you are in its presence ... is this true for you? ... I ask because a colleague told me of a recent study which suggested that the perception of empathy was just as effective as the real thing! This might bring to mind a colleague, with whom some of you are familiar, who commanded good fees because his patients perceived honesty and sincerity in his clear blue eyes. His fees climbed even higher as his hair turned gray and his patients perceived wisdom in his graying locks. And then finally, his sessions became priceless when he developed hemorrhoids and, as he sat with his patients, they perceived him as truly feeling their pain.

One last definition, one that feels right to me from Peter Kramer (1989) of Prozac fame: He says, »I became that part of me that was closest to him [his patient]« (p.138). If we think about what Kramer describes, (repeat the phrase) it makes sense that being empathic is a somewhat different process for each of us. There probably is a common neurobiology in our

right orbitofrontal cortex that allows us all to amplify the resonant chord in us that is struck by our patient's experience. But we are so complex and unique, that the part, for instance, of ten different therapists, the resonant cord that is, which would be closest to a particular given patient, would be felt by some therapists in their guts, by others in their heart, etc. Some therapists would be fairly comfortable with the feeling, others would struggle to tolerate it, and so on.

B) *Implicit/explicit*: I believe it will help us to grasp empathic phenomena if we distinguish between the explicit and implicit modes of knowing. They rely on different neuroanatomic pathways and are defined as follows (Beebe and Lachmann, 2002): Implicit memory refers both to emotional and procedural memory, which are outside of awareness. The first two years of our lives are lived on a largely implicit level, which is why we usually have limited explicit recall for them. Procedural memory includes non-symbolically encoded action sequences which guide behavior (i.e., how to ride a bicycle). Explicit memory, as I am sure you will remember, is intentional recall of symbolically organized information and events.

C) *Dyadic, nonlinear, systems view of therapy*: My talk today is based on this view of therapy and empathic process. In it each member of the dyad is seen as simultaneously regulating both itself and the interaction. As Jaffe et al. (2001) put it: »At the nonverbal level of action-sequences, at every instant, any action in a dyadic relationship is jointly defined by the behavior of both partners.« Finally, Fogel (1993) tells us that in a systems model, »all behavior is simultaneously unfolding in the individual, while at the same time each is modifying and being modified by the changing behavior of the partner«. An example would be a young child that is too aroused by a mother's facial approach and who then looks away and/or touches himself to self-regulate his level of arousal. The child has simultaneously both soothed himself and sent a message to his partner. Research has shown that parents are well-attuned or empathic only twenty to thirty per cent of the time. But securely attached children have parents that within two seconds at the most, being themselves secure and well-attuned, can allow the child the space and freedom to down-regulate both them (the parent) and the interaction. The interaction has been »repaired« (Tronick,

1989). Research has shown that this same implicit, nonverbal split-second dyadic regulatory system operates throughout the life cycle.

### III. Remember that we have the bioenergetic tools, but never forget that we ourselves are the instruments

Bioenergetic Analysis has traditionally said that we have the tools to see a person's story engraved in the form and motility of their body. This was one of Wilhelm Reich's (1933, 1945) original and profound contributions. One could spend years debating how much of a person's story we can see in their body, how much the sequencing of amino acids in their chromosomes is also a part of their story, and how much is stereotyped perception by the observer (Frey 1999). For an empirical study in this field see Koemeda-Lutz & Peter (2002). We, however, will limit our discussion to the relevance of Reich's insight for the empathic therapist. But first, let me just tell you some short stories.

The three Bioenergetic teachers with whom I first bonded and who therefore had a deep impact on me were Al Lowen, John Pierrakos, and Bill Walling. They were the giants on whose shoulders I stand today. They were the original three founders of the Bioenergetic Institute. Being male myself and having been taught and in therapy with all three of these men, there is a massive lack of female perspective in what I bring to you today. Thank God that Helen will have the last word tomorrow! Since Bill Walling was my first and main therapist and since he died while we were still working together, I probably do not, even after all these years, have a clear view of him. So let me share a bit of my experience of Al and John. Like many of us from that era, I felt that they complemented each other in a deeply beautiful way. Al was the brilliant, explicit man who could see so clearly and deeply the person before him. He never said and I never sensed that he focused much on his own most personal feelings in grasping the essence of his patient. Rather, as he once told me in a session when I was the patient, he listened to my words, but what he really was tuned to was the moment when, out of awareness, my deeper, nonverbal self would reveal itself to him in a fleeting gesture of my eyes, my torso, and

so on. John, on the other hand, was the deeply intuitive man who literally closed his eyes when he wanted to know what was going on within you. As I sat with him, I often had the impression that he was finding me somewhere deep inside of himself. All of you know that Al Lowen's name is synonymous with Bioenergetics, but those of you who are younger may not know that both John and Al had an enormous impact on Bioenergetics in their twenty plus years of passionate work together. My story underlines two points for us today: (1) Bioenergetics does give us tools to see and feel the psychosomatic truth of a person, and Al and John were both master clinicians. But ultimately, we ourselves are the unique instruments which attune to the other's psyche-soma. (2) My second point is that (at least in my own experience of them) Al and John, in their preferred way of understanding me, tended not to be responding to aspects of me of which I was aware, and in this sense, were not being empathic.

#### IV. What are the limits to how much we can consciously (explicitly) see of a person's story as opposed to (implicitly) sensing its depths and nuances

Let me start with a vignette about learning to trust your own intuition, which is a necessary but perhaps not sufficient condition for being empathic. Many years ago when the Bioenergetic Institute was young, there was a big workshop in New York where Bill, John and Al each worked in a different corner of this huge room – I cannot remember who worked in the fourth corner. Participants would move around the room and be worked with by each of my three idealized attachment figures. It was both frightening and deeply relieving to discover that Bill, John and Al each focused and worked on completely different issues with the same person. The message landed: Either there was not a story that could be read in the form and motility of each workshop participant's body, or *that story was so complex*, that each of my three mentors trusted themselves to work with that part of the story that spoke to them at the moment.

Regarding how much anyone can know of another person's story, I hope you will not fear that I have taken leave of my senses if I ask you

(show poster) why *Mona Lisa* is smiling. This is, of course, a question that has been pondered for almost five hundred years, so forgive yourselves if you do not have the answer.

Although I have no expertise in the field of fine arts and am therefore not at all qualified to say what makes *Mona Lisa* the masterpiece it is, I believe Leonardo da Vinci has something to teach us about empathy, about how much we can fathom the experience of another. Leonardo is said to have been both a consummate master of the details of nature and a man fascinated by the enigmatic in life. In *Mona Lisa*, according to E.H. Gombrich in *The Story of Art* ([www.artchive.com/artchive/L/leonardo/monalisa\\_text.jpg.html](http://www.artchive.com/artchive/L/leonardo/monalisa_text.jpg.html)) Leonardo employed a technique which he himself had invented called »sfumato«. In »sfumato« the blurred outline and mellowed colors allow one form to merge with another and always leave something to our imagination. Gombrich, the art critic, describes how Leonardo has deliberately left two crucial features of *Mona Lisa*'s facial expression indistinct: the corners of her eyes and the corners of her mouth. This, says Gombrich (and many other experts), is at least part of why *Lisa* looks so amazingly alive: »She really seems to look at us and to have a mind of her own. Like a living being, she seems to change before our eyes and to look a little different every time we come back to her« (p. 1). So Leonardo has created a work of art which both challenges and illuminates the clinical art and science of empathy. With these two crucial areas of facial anatomy indistinct, we are never quite sure in what mood *Mona Lisa* is really looking at us. Her expression always seems just to elude us. And naturally, each time we stand in front of her we receive an expression that is colored by the state and mood we are in at the moment.

Of course, as Bioenergetic therapists we work with the expression of the entire body, not just the face. However when we look to most recent state of the art clinical research on implicit, empathic communication, they involve head orientation, visual gaze, vocal behaviors and facial expression. Ekman et al. (1980), for instance, created a system for coding all possible emotional expressions of the facial muscles. Once you have explicitly learned this system, they claim that you will be able to read what is on the heart and mind in the fleeting nuances of facial expression ... an ability which comes naturally only to the occasional person with a special intuitive talent. So, in a way, the five hundred people in the world who have



been certified in the facial action coding system could be called »Bioenergetic specialists of the face«. This system has been around for over twenty years, and is quoted extensively in the literature. But why have more therapists *not* flocked to a system which claims to enable us to read minds? Some therapists are just too lazy to learn another system, but others probably agree with Irwin Yalom's (1989) conclusion in an essay entitled *Two Smiles*. Yalom speaks to the dilemma at the heart of being an empathic therapist. While we desire to know another deeply, whether it be our child, our lover or our patient, they remain ultimately unknowable. Yalom's patient smiles twice; each time the smile expresses such a nuanced, complex reality within her that no one could possibly grasp its meaning without knowing many interlocking details of her current and past life. Even Ekman et al. would not have known what Yalom's patient was smiling about. Yalom makes the further point that a patient is diminished if we assume that we can fully know them. I agree with him. In fact, if neuroscience ever advances to the point where it can take pictures of the secret recesses of our minds, we may have to throw away the pictures.

So too with the workshop participants in whom Al Lowen, John Pierakos and Bill Walling each saw something different. Perhaps even more than the Mona Lisa, being alive, they changed from moment to moment, and as they met the gaze or did not meet the unique gaze of Bill, John or Al, in split second time, a nonverbal limbic conversation suggested the material for the next »session«.

Finally back to *Mona Lisa*. By now most of you have probably figured out why she is smiling. She is smiling because A) she thinks it is funny that people are trying to figure out why she is smiling B) she is grateful that Leonardo with his genius and his »sfumato« has given her such richness and complexity. Lisa is not unlike the real people who come to our therapy rooms. The more we realize our conscious, explicit grasp of them is just the tip of the iceberg (or better yet – dialectic diagram with explicit/implicit systems), the less their implicit mysteries will elude our grasp.

## V. What is the quality of or capacity for presence which allows us to understand the experience of another?

The answer is that we do not exactly know, although we know a lot and what we know is coming closer to a somatopsychic unity. We can demonstrate, for instance, that the quality of attunement between a mother and child becomes the balance or imbalance in the parasympathetic and sympathetic branches of the child's autonomic nervous system. The child's attachment experience, as Allan Schore proposes, has been hard-wired into his right limbic system as a model of relationships to come. We can describe the empathic process on many levels of organization, and they are all valid. There is *empathy as »limbic resonance«* (Lewis et al. 2000a, p.63), empathy as a »conversation between limbic systems« (Buck 1994, p. 266), empathy as feeling the patient's physical sensations in your own body (Havens 1979), empathy as becoming that part of you which is closest to the patient (Kramer 1989). As we get down to the neuroanatomical level, let me digress briefly to note that Allan Schore (2003) has creatively integrated an impressive body of neurobiological research on the empathic process which points to the right limbic and orbitofrontal cortical areas of the brain. It is his specific hypothesis that empathy involves a right-brain to right-brain conversation. The right orbitofrontal cortex, anterior cingulate (?) and amygdala for instance, are critically and directly involved in evaluating facial expressions, direction of eye gaze and other nonverbal s that reveal what is going on in another person. This information, plus the autonomic state of one's own body is integrated by the orbitofrontal cortex with other cortical areas. To understand much of the original neuroscience research from which Schore builds his hypotheses requires a technical background which I do not have. Schore helps us by borrowing from the field of physics:

»In physics, a property of resonance is harmonic sympathetic vibration, which is the tendency of one resonance system to enlarge and amplify through matching the resonance frequency pattern of another resonance system« (p. 79).

Happily, Schore tells us on the same page, tells us in clinical terms how to do »harmonic sympathetic vibration«:

»The attuned, intuitive therapist, from the first point of contact, is learning the moment-to-moment rhythmic structures of the patient and is relatively flexibly and fluidly modifying his/her own behavior to fit that structure« (p. 79).

Let me give you an example of how I, Bob Lewis, do this, or rather how this happens to me:

My patient, for instance will bring up material about how depraved he feels, or how cosmically alone he feels or how wildly grandiose – the common factor being that the quality or attribute he presents is not one with which I can readily identify. It is beyond the confines of the image of Bob Lewis that I ordinarily entertain. So my initial inner reaction is something like, »wow, what an awful problem *that* person has!« Then, as moments or minutes go by, I slowly get in touch with aspects of myself that indeed are resonant with my patient’s issue. For instance, Paul, a very sad lonely patient of mine in his early forties was lamenting with self-loathing that, not only had he never had sex other than with a prostitute, but that he had never had whatever it took to suggest the same to any woman. As you might suspect, I was initially comfortably ensconced in an image of myself as nothing like this unfortunate man. At first what came to mind were youthful adventures that attested to my virility. But then, as I sat resonating with my unhappy patient, I slowly remembered that I knew exactly what he was talking about. When I was about fourteen years old, just beginning high school, I was afraid to kiss my first girlfriend, I shall call her Susan, at the end of our dates ... even though her younger brother, at Susan’s asking, had told me in the locker room at school that his sister Susan really liked me a lot. So, as I surrender my defenses and ideal images to my patient’s material, I am more in touch with my vulnerabilities, which enhances my capacity to be empathic. I did not tell Paul about the painful recollection of Susan which had brought me closer to him. I would have been far too ashamed. But perhaps something silent did come back to him from my facial expression and a change in the timbre of my voice.

Beebe and Lachmann (2002) have done extensive mother-infant research on facial mirroring. They relate the following data to early experiences of empathy:

»How each partner's face attracts and responds to the other's is one of the foundations of intimacy throughout life ... to the degree that facial mirroring interactions are positively correlated, so that the partners are changing in the same affective direction, the infant represents the expectation of matching and being matched ... (the concomitant arousal pattern and mode of self-regulation are part of the representation), the infant represents the experience of seeing the mother's face continuously changing to become more similar to his or her own; the infant also represents the experience of his or her own face constantly changing to become more similar to the mother's face. These »matching« experiences contribute to feeling known, attuned to and on the same wave length. Each partner affects the other so as to match affective direction, and this matching provides each with a behavioral basis for entering into the others feeling state« (p. 98).

What is some of the extensive evidence that, as we all intuitively know, »timing is everything«, not only in infancy, but across the life-span? Actually, it was adult studies that first suggested that timing and rhythm alone, irrespective of the content of behavior, were powerful organizers of communication. Vital messages are sent between partners in this temporal code. Beebe and Lachman (2002) report, for instance, that when:

»Asked to converse about a neutral topic, unacquainted adults were found to match the purely temporal rhythms of dialogue, irrespective of the content of the speech ... Of special relevance was the finding of a relationship between matching rhythms of dialogue, and empathy and affect. When the adult strangers matched rhythms, they liked each other more and perceived each other as warmer and more similar than they did when their rhythms did not match. Thus similarity in the temporal pattern of communicative behavior is associated with interpersonal attraction and empathy.

Conversely, a speaker who speaks very rapidly and barely pauses long enough for the partner to get a word in edgewise powerfully interferes with the exchange: The partner may become frustrated and »tune out«. Subtle changes in timing, such as hesitation or interruption, also affect the listener's experience of the relatedness. In adult conversation we depend on the matching of temporal patterns to know that the other is »tuned in« and to take turns smoothly« (p. 99).

In addition to the crucial importance of head orientation and direction of gaze, Beebe and Lachmann cite Trout and Rosenfeld (1980) as finding that during psychotherapy sessions (therapist and patient sitting, facing each other), a report of higher rapport by patient and therapist is associated with a higher incidence of leaning the upper bodies toward each other and holding the limbs in mirror image postures. One may infer from this that rapport is disturbed if either partner displays any degree of orientational aversion.

How better to close this section than with a vignette from Donald Winnicott, an early and past master of implicit empathy. Here he is in procedural mode:

»The detail I have chosen for description has to do with the absolute need this patient had, from time to time, to be in contact with me.

A variety of intimacies were tried out, chiefly those that belong to infant feeding and management. There were violent episodes. Eventually it came about that she and I were together with her head in my hands. Without deliberate action on the part of each of us there developed a rocking rhythm. The rhythm was rather a rapid one, about seventy per minute (c.f. heart beat), and I had to do some work to adapt to this rate. Nevertheless, there we were with mutuality expressed in terms of slight but persistent rocking movement. We were communicating with each other without words« (p. 258).

## VI. To what extent can the implicit and procedural become explicit?

Jeremy Holmes (1993), the author of a wonderful biography of Bowlby which illuminates attachment theory, starts us off on a somewhat fatalistic note, depending on whether you are a good therapist or a bad one. Good therapists, he says, »find themselves automatically mirroring their patient's levels of speech volume and their posture« (p. 156). Peter Fernald (2000), a Bioenergetic colleague, says the following about his attempts to respond empathically:

»I try to position myself, my body, physically or imaginatively in a manner that closely resembles my client's bodily state – his or her depth and rate of breathing, clenched fist, frozen pelvis, and so forth. I try my best to embody my client's experience, to walk in his or her psychological, emotional, body-armored footprints.« (p. 3–4).

Peter is describing what most of us try to do, each in our own way. Helen Resneck-Sannes (2002) in her recent article, attunes to and resonates with her client's body. The Southern California Training Program encourages its students, from the first moments, that they look at and listen to their dyadic partner, to assume the bodily attitude of the person and feel his or her story in their own bodies. I myself have learned to trust and value the empathic implicit knowing in my hands. They often know how to be with my patient before I do. I have also learned to watch the hands of my patient, as they often tell me, in the moment, what I cannot otherwise see and what my patient cannot tell me. We must not forget, however, that to confront our patient with implicit information that is beyond what they are willing or able to tolerate, is to be unempathic (but this is another vignette).

Turning to some empirical data, Beebe et al. (1997) working on »Mechanisms of Facial Mirroring and Precursors of Empathy« find that:

»Similarity of behavior implies a congruence of feeling, a relationship between matching and empathy. How might this work? Two areas of study suggest potential mechanisms for the precursors of empathy and ways of translating matching behavior into the sharing of subjective states. The work of Ekman (1983) and Zajonc (1985) shows that matching the expression of the other is highly correlated with matching the physiological arousal pattern. Ekman showed that a particular facial expression is associated with a particular pattern of autonomic activity. *Reproducing the expression of another person produces a similar physiological state in the onlooker.* This mechanism of empathy is facial matching, which is *correlated with physiological matching. This mechanism of empathy may be equally relevant to adult face-to-face therapy interactions*« (p. 161).

Beebe (2003) is both humble and optimistic about how much implicit process can be consciously focused to improve the empathic quality of our clinical work. Beebe tells us that she happened to see herself in a videotaped

session with a traumatized patient, Dolores. She, Beebe, discovered that she does a great deal of what Freedman et al. (1978) call self-regulatory touching. Beebe explains:

»I did know that at times I rub my hands together, particularly when they hurt a little, but I did not realize how much I do it ... it is very unlikely that I would ever have become aware of this behavior without the aid of the videotape. Such behaviors may remain out of awareness of both patient and analyst but nevertheless are perceived at a subliminal level and operate as information to both ... During an episode in the treatment of Dolores, when I felt her to be inaccessible I began to rub my feet together. I recognized it as a gesture that I had used throughout my childhood to put myself to sleep at night. I commented to Dolores that I noticed that I had been rubbing my feet together. Dolores was then able to come forward and make the observation that it happened just when she was refusing a comforting interpretation that I was giving her, so I comforted myself. I very much appreciated her observation. A very intimate moment followed in which we both felt closer, and she expressed regret at having been so inaccessible« (p. 133).

I find that Beebe's nonverbal behavior was brought into Dolores' focal awareness by Beebe's explicit comment. This willingness to explicitly share what is usually private information seems to have touched an empathic cord in Dolores – empathic to the discomfort that she was causing Beebe. Dolores then delivered back to Beebe an implicitly sensed, explicitly phrased, empathic gift. Beebe (2003, in press) goes on to cite Karlen Lyons-Ruth, another exciting mother-infant researcher, and member of the Boston Process of Change Study Group. Lyons-Ruth (1998), coined the term »implicit relational knowing« to better describe what goes on in the empathic process. Beebe tells us that:

»Because implicit relational knowing is predominantly outside of awareness, and rarely in focal attention, Lyons-Ruth argues that much of the subtlety and complexity of what the analyst knows is never put into words. It is for this reason that my examination of the videotaped interactions revealed much about my behavior that I could not have described without them, and why it was difficult to find a language to describe them« (p. 58).

Beebe's patient, Dolores, told her that she had also gotten something valuable from viewing the videos:

»In watching the video Dolores discovered that I was seeing what she herself ›carried‹ in her face and body, or ›sensed‹ about herself, without being able to describe it verbally. Seeing my face seeing her, and hearing my sounds responding to hers, alerted her to her own inner affective reality ... Dolores would find herself ›putting on‹ my facial expressions while watching the video. By ›wearing‹ my face Dolores became more affectively aware of her own inner experience, presumably through the proprioceptive feedback of her face, ... as well as the feedback from various physiological arousal systems« (p. 49).

So, finally, it is not easy for Beebe to say what she has explicitly learned. The video helped by confronting her with how little she was aware of what she was doing when she was with her patient. Beebe also says that »much of my nonverbal behavior with her (Dolores) was based on what the infants had taught me« (p.58). Beebe concludes, »We can teach ourselves to observe these implicit, nonverbal interactions simultaneously in ourselves and in our patients, expanding our own awareness and where useful, that of the patient.« (p.58). Not being a professor, I can say this more simply. Our implicit and explicit selves become more user-friendly with each other. Some of you, perhaps many of you at this conference, already do this. Actually it is not so much about **doing** anything as it is about learning to be with ourselves and patients in a different way. We cannot directly look into the face of God, or even into the sun. But we are excited and we become more resonant when an explicit glimpse:

»reveals our lives lit by the diffuse glow of a second sun we never see.« (Lewis et al. 2000b, p. 111).

## VII. What are the implications for bioenergetics of recent research that puts implicit, relational, nonverbal process at the heart of our therapy endeavor

A) *A time to feel proud*: Most of us body-oriented therapists feel confirmed and validated by empirical research that stresses the enormous importance



throughout the life-span of the non-verbal, sensory-motor encoding of experience. Everyone seems to be discovering that experience from the first few years of life or at any age, if the experience has been traumatic, can best be accessed implicitly, on a body level. The meaning is in the rhythm, the music beneath the words. Many of us have suffered considerable shame that we do allegedly aggressive, sexual, generally noisy therapy. Our work has generally not been accepted as serious, legitimate, mainstream. Perhaps it is quite different in Brasil, but in Europe and North America a therapy that values the body as highly as the mind or the spirit is out of line with the larger culture.

So, I agree that it is more than time to be proud of our heritage. I agree with Helen Resneck-Sannes (2002) in her recent article that we have been trained to be aware of the tension and form and flow and sound and warmth of the body; its sensory-motor language should be more in our awareness than that of our non-body-oriented colleagues.

Indeed Helen's clinical vignettes in the same article set a high standard for anyone. The nuanced manner in which she attunes to her patient's tolerance for arousal, nearness, preferred mode of communication, and to her own bodily cues, are of a high caliber. There is similar case material in the excellent, above cited book by Beebe and Lachmann (2002). They also focus their awareness on the intensity and duration and rhythm of gaze behaviors and speech pattern and posture and orientation. They seem much more limited, however than Helen and most somatically oriented psychotherapists, in that most of what goes on below the neck is still taboo.

B) *But not too proud*: Although I could stop here, let me get myself into some trouble, by challenging us not to congratulate ourselves too quickly. Regarding the validity or legitimacy of our work as perceived by the larger community, I have three quick points: (1) First, let those of us who have the ability, strive, as Christa Ventling (2002) urges us to in her journal article, to bring more empirical research to our work. (2) Second, let us be careful how we use words like »energy« which we define in a way that contradicts the laws of physics and third, it is my own feeling that we should all, myself included, read the literature and cite it when we use others' material.

Back to empathy's biggest issue ... if I really grasp that the conscious, explicit process is the tip of the implicit iceberg (earth's core is perhaps a

warmer metaphor than iceberg ... and that core to core messages travel in fractions of a second ... *then I never know anything clearly for more than a moment or two* ... I have no choice but to »live in the question« (Michael Maley 1995). There is a deep paradox for us here. We need to question what we do and strive to empirically validate its efficacy. It is wise to expect our Bioenergetic students to have a reasonable explanation for their interventions, an explanation which they can state explicitly. At the same time, the students must learn that their perceptions and behavior are being influenced by an almost instantaneous process moving, largely out of awareness, between them and their patients. This is a humbling process for me after thirty-five years of practice. It cannot be that easy for a beginning student who wants answers to quell his anxieties. Helen Resneck-Sannes (2002) once again strikes a note of optimism here: »Because somatic therapists are trained to be aware of their internal body processes, what is unconscious for the analyst, exists to a greater degree in the conscious awareness of the Bioenergetically trained Analyst.« (p. 115).

I am less certain than Helen about this for a number of reasons:

- I) First, Helen was barely born when I began my Bioenergetic career, and I am a prisoner of my generation's perspective. For many years Bioenergetic Analysis was taught as a one-person psychology. Show me, for instance, a place in one of Alexander's books where his awareness of his own internal body process helps him to sense the depth or specificity of his patient's body problem. Of course what we have experienced and been taught in our Bioenergetic careers varies from place to place, and we each approach our craft with our own models and innate preferences. It is true that a second and third generation of Bioenergetic therapists and teachers have brought more of a two-person psychology into our work (Schindler 2002). But it is also true that, as we speak, our Institute is struggling to integrate this newer relational perspective without losing the power of our psychosomatic approach.
- II) Second, just a few years ago, when I was one of the faculty, during the final, »supervisory« part of a Bioenergetic training program where the advanced students did »sessions« in front of the group, I found that, under the pressure of being observed and judged, it was the rare student that felt safe enough to tune into what he was

feeling and sensing about himself, his »client« and the interaction. Instead, he went up into his head and tried to figure out what to do, and predictably, what he »did« was not well-attuned/empathic for his client. The big news here is not that the students could not stay with the moment-by-moment process between them and their »clients«. The big news is that most of us, even after thirty years do the same thing as the students whenever we are threatened by what our patients bring to the therapy. The kind of primitive, chaotic, visceral (gut-wrenching) material that has no words and is delivered into the room sensory-motorically, tends to be threatening to most of us. It is to me.

- III) Thirdly, the problem is even more basic than this. We are the problem. Have you forgotten that, as Bob Hilton (1988–89) once said, »we have all been broken« (p.74)? Have you forgotten that, as Michael Maley (1995) reminds us, we are wounded healers? I find that whenever I become engaged in trying to be a good therapist and to capture the alive interaction in my mind, I tend to miss being in the moment with my patient. I did this often years ago, long before I described the syndrome of cephalic shock. But my implicit knowing, even then, tried to help me with the shock in my head, the shock which was keeping me from a more full-bodied attunement with my patients. Moments after the patient would leave my office, both in the same instant, my hand would slap my forehead like this (gesture) and I would realize that I had missed the obvious while I was thinking.

Of course, we do also have to think and talk to our patients. At times we have to stop the split-second action and figure out what has been enacted between us and the patient. But I speak of the basic wound in us which limits our empathic contact with our patients. With many variations, this wound is about our not being a good enough, valuable human being. Thus, often without realizing it, we try to redeem that broken self by being a good therapist. We can try to become a therapist who is most implicitly attuned to subtle sensory-motor cues in ourselves and our patients. But if we also remember that we have been broken, and are still deeply wounded, we will find, as Bob Hilton (2000) put it so beautifully, »... that piece of me that had been hiding behind my therapeutic mode of interaction, namely the value of my real self to another person« (p. 10).

So I earlier presented the vignette where I felt safe enough with my unlovable self to allow it to come into the room with Paul, my similarly inadequate patient. In fact, I usually come out looking like a pretty good therapist in my vignettes. But wouldn't it be refreshing if I got real and presented a string of empathic failures, or at least some disruptions and repairs. The latest research shows that even mothers and children who will later test as securely attached, spend only about one third of their time in matched states. However, within two seconds, 70% of the unmatched states returned to a match, and both the mothers and infants both influenced the repair! The child's implicit neurobiology is organizing the expectation that it can participate in repairing affectively painful disruptions (Tronick and Cohn 1989). Something like this also happens in an adult therapy situation when things work out.

In this next vignette things did not work out. The patient presents with oral symptoms, collapsed bony chest, shallow breathing. You suggest breathing deeply to give him more charge in his upper body. He tells you that he hates the suggestion, that whenever he has tried it in the past, he feels light-headed, but nothing happens ... it feels mechanical and manipulative to him. He elaborates further: »My breathing«, he says, »has to come from something that I am doing, something that feels alive and genuine. I will breathe when I feel fucking ready to breathe!« Being an empathic therapist, you stop your suggestions and ask what might feel »alive and genuine« to the patient. He seems quite stunned, then increasingly touched that you are interested enough in him to drop your breathing agenda for the moment. Then, as he lies back across the stool and some minutes go by in silence, you sense a deadness in his stillness ... his breathing is barely discernable ... you sense the deadness in your own chest, and, although you are quite frightened ... you are not comfortable with death ... you tolerate the still, empty sensation and your fear, and you notice that your breathing has become very slow and shallow ... slowly, to your amazement, your dread begins to lessen and you even sense a kind of peacefulness come over you ... after several more minutes, your patient turns to you and can barely find the words to thank you for allowing him, he says, to luxuriate in his apnea (not breathing).

As it happens, I can tell you the patient's name: Bob Lewis. The name is real, but the session is a fiction. It's the session Bob never had. As he lay across the Bioenergetic stool, Bob never had the courage nor the words to

tell his Bioenergetic therapist how ashamed he was of the deadness in his chest ... to tell him that he hated him for not realizing what he needed but could not tell him: that his inner flame was very low. That he, Bob, would not or could not breathe from the dead place in his chest unless his therapist could be with him in the Valley of the Shadow of Death. The words he never found were: »Approach me in a soulful way ... my spirit will quicken if you nourish its flame ... and I will breathe from within.«

In my closing vignette, I am the therapist, and I appear to have learned, after many empathic disruptions which were *not* repaired, how to be with my patient Florence in a way that *would* have been helpful to Bob Lewis and his Bioenergetic stool. Florence was not easy for me. Typically, we would seem to be conversing in left hemispheric, explicit, adult language, but I would become confused, annoyed and anxious as the room filled with primal, visceral, intense rage, pain and futility. My typical attempt to defend myself was to try to regain my equilibrium via a quick retreat to my left hemisphere from which I would point out in a voice both plaintive and irritated something inconsistent, something that did not make sense to me about Florence's words and feelings. Florence would be stunned by my empathic abandonment and things would escalate beyond repair.

However, Florence and I both suffer from unrelenting hope, so we are still working together. We recently had a session that suggested that there may be a realistic basis for the hope. Florence was in the midst of a deep experience of mourning that neither I nor her father had been able to give her more of what she needed. Perhaps most importantly, she needs to be able to scream the enormous feelings of rage and disappointment and let her body twist in »agony«, as she puts it afterwards, without having to worry about me. So I need to be able to feel my face become twisted and to tolerate the heat and heaviness in my head and chest. As Florence's »agonized« feelings about having been failed by both me and her father fill the room, I can feel emptiness, sadness and pain in my own (rather oral) rebuilt chest, essentially the same Bob Lewis chest that lay over the Bioenergetic stool thirty-five years ago. Once or twice Florence says, »I wasn't touched«. As I hear a particularly raw cry from Florence and notice a slight resonant tender sound come out of me, I tell her that I do not know if physically touching her would be for my need or for hers. I am not sure whether my touch would interfere with the fullness of her experiencing having been failed. Florence tells me

how precious it is to her that I share my not knowing. After a few minutes, I decide to put my hand on her left shoulder, near her heart. After a while Florence moves my hand away, indicating that it is not helpful. As she resumes the painful grieving, I notice my hands are clasped together in a gesture that both surprises and comforts me. The gesture feels very strong. My hands, clasped together in an act of solidarity, seem to be bringing me comfort and a sense of unity. They tell me how fragmenting it feels to stay with Florence's helplessness to be helped and my helplessness to help. They reassure me that I am whole and worthwhile even as a failed healer.

The session with Florence that I just shared, demonstrates the implicit use of my hands to better regulate myself (I felt attuned to by my hands) so that I can maintain better empathic contact with my patient. But I did not intentionally clasp my hands together. That may be the best I can do in explaining empathy: Somehow, in immersing myself in this shadowy subject, my focal awareness has expanded to include more of my implicit behavior. My empathic resonance becomes deeper and wiser when I surrender to the shame of not knowing and not seeing clearly. Only then can I, and all of us, sense »the diffuse glow of a sun we never see«. (Lewis et al. 2000b, p. 111).

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