# Beyond Empathy: Attunement and Presence

By

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In 1967 I was selected as the psychotherapist for a group of nursing students in Chicago after a mass murderer had entered the student's dormitory and killed several of the student nurses. I provided individual and group psychotherapy for the 19 and 20 year old students who were experiencing stress reactions that included a myriad of relational problems, learning difficulties, a lack of goals and orientation and a mixture of fatigue and restlessness. At that time in my professional life I knew little about post-traumatic stress disorder. Over the ensuing years, a number of clients have repeatedly taught me about the relational importance of attunement and presence in healing the wounds of both acute and cumulative trauma.

During the two years that I provided psychotherapy for the nursing students I was fortunate to have supervision four days per week with Robert Neville who was an associate with Carl Rogers at the Counseling Center of the University of Chicago. Bob Neville focused the supervision on the importance of empathy, congruence and my being non-directive in the therapeutic process. He emphasized that the quality of the client-therapist relationship was crucial to the effectiveness of the psychotherapy. Although I didn't realize it at the time, I was in the early stages of learning about attunement, interpersonal connectedness and presence. I went on to study Gestalt therapy, Transactional Analysis, body therapy and psychoanalysis and I still consider what I learned in that two year period of supervision as the bedrock of how I practice a relational psychotherapy. I have integrated many concepts into my therapeutic practice, but the most important one has been the opportunity to relearn from a number of clients about the absolute importance of attunement, presence and the quality of the client-therapist relationship.

*Attunement* goes beyond empathy: it is a process of communion and unity of interpersonal contact. It is a two-part process that begins with empathy---being sensitive to and identifying with the other person's sensations, needs or feelings; and includes the communication of that sensitivity to the other person. More than just understanding (Rogers, *1951)* or vicarious introspection (Kohut, *1971),* attunement is a kinaesthetic and emotional sensing of others --- knowing their rhythm, affect and experience by metaphorically being in their skin, and going beyond empathy to create a two-person experience of unbroken feeling connectedness by providing a reciprocal affect and/or resonating response. Attunement is communicated not only by what I say but also by my facial or body movements that signal to the client that his or her affect and needs are perceived, are significant and make an impact on me. Attunement is facilitated by our therapeutic capacity to anticipate and observe the effects of

our actions on the client and to focus away from our own experience in order to focus on the client's process. Yet, effective attunement also requires that the therapist simultaneously remains aware of the boundary between client and therapist as well as his or her own internal processes.

The communication of attunement validates the client's needs and feelings and lays the foundation for repairing the failures of previous relationships (Erskine, Moursund, &Trautmann, *1999)*. Attunement is often experienced by the client as the therapist gently moving through the defenses that have prevented the awareness of relationship failures and related needs and feelings. Over time this results in a lessening of internal interruptions to contact and a corresponding dissolving of external defenses. Needs and feelings can increasingly be expressed with comfort and assurance that they will receive a connecting and caring response. Frequently, the process of attunement provides a sense of safety and stability that enables the client to begin to remember and endure regressing into childhood experiences. This may bring a fuller awareness of the pain of past traumas, shaming experiences, past failures of relationship(s) and loss of aspects of self (Erskine, 1993). The process of attunement can be categorized according to the resonance and reciprocity required for contact-in-relationship. The attunement may be to rhythm, nature of affect and level of development.

*Rhythmic attunement* occurs when I pace the therapeutic inquiry and involvement at a tempo and cadence that best facilitates the client's processing of external information and internal sensations, feelings and thoughts. In my experience, the mental processing of affect often occurs at a rate different from cognitive processing. In the presence of intense affect, the use of perception or cognition may be slower than when affect is not intense. For example, the compounded affective components of shame often make the processing of information and the organizing of behavior occurs at a diminished rate. Shame is a complex process involving the disavowal and retroflection of anger, the sadness at not being accepted as one is, the fear of rejection because of who one is, and confluence and compliance with the relationship-interrupting humiliation (Erskine, 1994). The affective, perceptual, cognitive, behavioral and physiological reactions occur at differing rhythms than would otherwise occur in the absence of shame.

Some clients are quickly aware of visceral and kinesthetic sensations while others process them slowly. Internal interruption to contact or any of the complex psychological defenses, such as desensitization, disavowal, denial or dissociation, disrupt the natural rhythm of processing physical sensations, affects, perceptions and thoughts.

*Affective attunement* refers to one person sensing the other's affect and responding with a reciprocal affect. It begins when we value the other person's affect as an extremely important form of human communication, are

willing to be affectively aroused by the other person and respond with a resonating affect. The resonance of one person's affect to another's provides affective contact that I believe is essential to human relationship. Affective attunement is the resonance with the other's affect that provides non-verbal interpersonal contact --- a unity in the relationship. When a client feels sad, the therapist's reciprocal affect of compassion and compassionate acts complete the interpersonal contact. Relationally, anger requires the reciprocal affects related to attentiveness, seriousness and responsibility, with possible acts of correction. The client who is afraid requires that the therapist respond with affect and action that convey security and protection. When clients express joy, the response from the therapist that completes the unity of interpersonal contact is the reciprocal vitality and expression of pleasure. Symbolically, attunement may be pictured as one person's yin to the other's yang that together forms a unity in the relationship.

Affective attunement involves non-verbal communication from the therapist that acknowledges, validates and normalizes the client's affect. My affective presence communicates to the client that his or her affect has an important function in our relationship --- a communication of unconditional positive regard or "You're OK with me."

*Developmental Attunement*. Attunement to the client's developmental level of psychological functioning and organization of experience is essential in a contact-oriented, relationship-centered psychotherapy. The purpose of the developmental focus is to respond to the client at the age level at which there was a lack of contact-in-relationship, when fixations occurred in the representational system of self, others and the quality of life.

When I am attuned to the client's developmental needs, I am attempting to listen with a "third ear" or watch with a "third eye" the words and behaviors of the client in each moment to sense what may be the communication of a "child." Often based on the age when a particular trauma occurred, or when a script conclusion or survival reaction was made, I begin to develop sensitivity for the client's "child" unconsciously manifested in our transactions. My having a sense of this "child" and the "child's" relational-needs, developmental challenges, ways of thinking and organizing, and unique vulnerabilities guide me in my inquiry, interpretation and interaction with the client.

As an example, in response to a client who is expressing frustration at her inadequacy in finding ways to talk about her feelings, I commented that learning to use language brings a child two different experiences. On the one hand, words allow for an increased communication and understanding which is gratifying and fosters closeness. On the other, as the child experiences that words do not adequately convey feelings or experiences, there is a greater sense of separateness and sometimes aloneness (Stern, 1985). The tears in the

client's eyes convey that I had understood her developmental frustration and at least one significant aspect of her lifelong difficulty with relationships – that unspoken experience of aloneness.

Attunement to the developmental level is easiest when the client enters a regressed state or is able to describe his or her childhood experiences. A subtler, and sometimes more powerful experience, occurs when I am attuned to the client's developmental needs, level of functioning and childhood experiences while the client is completely unaware of them. For example, with a client who grew up anxiously trying to please his separated parents and who used compulsive checking to ward off anxiety, it seemed important not to make an issue of his consistent lateness until he was able to identify and express his anger at his parents. Near the end of therapy he talked about how significant it was to him that I never confronted his lateness, thereby making his therapy a place of safety in which he could be free of his compulsions.

By being attuned to the archaic level of a person's functioning and placing it directly in the context of our therapeutic relationship, I hope to make it possible for the fixated ways of being and relating to be integrated into a more dynamic and healthfully functioning whole.

*The Story of Kay*. Kay was a 54 year old woman who worked as an accountant. She came to psychotherapy because of a deep sense of loneliness, as well as her anger towards those she perceived to be controlling of her. She had never married and had never had a boyfriend, although in high school and in college, she had some distant crushes on a few young men. She had been in therapy with two previous therapists. The first therapist had helped her set some goals and to attain a good job, while the second therapy as ended in a "disaster" because she experienced the therapist as "controling." She was often very talkative about current events but would lapse into silence when I would inquire about her phenomenological experience, such as her feelings, bodily sensations, fantasies or hopes. I was attempting to connect with her deep sense of loneliness but she often managed to distract me by talking about the news or her job situation. The obvious transference with me was in her constant fear that I would abandon her. She distrusted my phenomenological inquiry. It seemed that she often lacked the concepts, or even the vocabulary, to describe her feelings and internal experience. She had only vague memories of her early childhood and most of those centered on her family's religious activities.

In the second year of therapy a remarkable event occurred when a spider slowly descended from the ceiling on a long silvery strand and then proceeded to climb back up and drop down again over and over. She had a little girl's thrill and fascination and I could feel myself emotionally moved in resonance with her excitement of the spider's activities. But, within about 15 minutes, she became distant and silent. As I adjusted to her slow rhythm, she

commented that she had always liked spiders since the time she was in the hospital. I was surprised since in our intake interview and in subsequent conversations she had never mentioned being hospitalized. Kay had never thought to tell me or the two previous therapists that she had spent two years in an Iron Lung recovering from polio between the ages of two and four. When I learned of her two year hospital confinement, my heart went out to her. In subsequent sessions, I often imagined taking that young child out of the Iron Lung and holding her in my arms. Several times Kay described how her only "friend" during that time was a spider that had made its web on the ceiling above her Iron Lung. She spent hours being entertained by its movements and I spent hours attuned to the importance that the spider had in this young girl's life.

Kay eventually talked about how the nurses would poke and prod her and how she hated being manipulated by them. Prior to each session I found myself looking forward to talking to the four year old who was in the Iron Lung. We cried together about her loneliness. I took her anger seriously as she described being a "prisoner." Kay talked about how she would pass the hours of the day watching a large hospital clock tick the seconds away. In several sessions, she described how the second hand makes a different clicking sound as it drops from 12 to 6 than it does when it ticks from 6 to 12.

As the therapy progressed, she was less descriptive of her hospital experience. She had no vocabulary to express her affect or needs. There were long periods of silence and sadness. I sat closer to her where we could reach out and touch our fingers together. We played the finger game of Itsy-Bitsy Spider over and over. We laughed together at our silliness. Then she would cry as she experienced the juxtaposition between our playfulness and her years of loneliness

She would often use her fingers and face muscles to describe the agony of being confined to the Iron Lung. She would silently rage at me with her facial movements and hand gestures when I didn't match her rhythm or respond with the appropriate affect. She was nonverbally telling me the story of her developmental needs, loneliness and abandonment. Together we co-created both a nonverbal and verbal narrative of her experiences between ages two and four. My involvement was to validate repeatedly her sadness, fear, anger and sense of abandonment as affective expressions of real events. We developed a vocabulary and created meaning for the physiological and affective experience of her cumulative trauma. We normalized her developmental needs. My sense of presence was expressed in the combination of affective, rhythmic and developmental attunement that was central to our relationship. In the ten years since the therapy, Kay has still not formed a romantic relationship with a man. But, she reports that she is "in love with the children" at the hospital where she volunteers three days a week.

*Presence* occurs when I am able to provide sustained, attuned responses to both the verbal and non-verbal expressions of the client. It occurs when my behavior and communication at all times respect and enhance the client's integrity. Presence includes the therapist's receptivity to the client's affect, to be impacted by their emotions, to be moved and yet to stay responsive to the impact of their emotions and not to become anxious, depressed or angry. When I experience presence, it is an expression of my full internal and external contact that communicates my sense of responsibility, dependability and reliability within the relationship. More than just verbal communication, presence is my attempt to create a communion between client and me. Presence is enhanced when I separate from my own needs, feelings, fantasies or hopes and center instead on the client's process. Presence also includes the converse of decentering, which is, being fully contactful with my own internal process and reactions. Each of our personal histories, relational-needs, sensitivities, theories, professional experiences, own psychotherapy, and reading interests, all shape our unique reactions to client. Presence involves bringing the richness of the therapist's life experiences to the therapeutic relationship as well as decentering from the self of the therapist and centering on the client's process.

My embracing the process of attunement is what makes it possible for me to stay focused on what the client needs within our therapeutic relationship, particularly when working with clients who were either acutely traumatized as children or who bore the burden of cumulative trauma. Presence includes allowing one's self to be manipulated and shaped by the client in a way that provides for the client's self-expression and continued growth. As effective psychotherapists, we are played with and genuinely become the clay that is moulded and shaped to fit the client's expression of his or her intrapsychic world, toward the creation of self and self-in-relationship (Winnicott, 1965).

## References


Erskine, R.G. (1993). Inquiry, attunement and involvement in the psychotherapy of dissociation. *Transactional Analysis Journal,* 23, 184-190.

Erskine, R.G. (1995). A Gestalt therapy approach to shame and self-righteousness: Theory and methods. *The British Gestalt Journal*, 4: 108-117.

Erskine, R.G., Moursund, J.P., & Trautmann, R.L. (1999). *Beyond empathy: A therapy of contact-in-relationship*. New York: Brunner/Mazel.

Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.

Rogers, C.R. (1951). *Client-centered therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.

Stern, D.N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Winnicott, D.W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. New York: International Universities Press.

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