Empathic Resonance and Differential Experiential Processing: An Experiential Process–Directive Approach

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In this paper, an experiential process–directive approach is presented in which the therapist is guided by the Rogerian core attitudes for offering a therapeutic relationship and for intervening in a process–enhancing way. I elaborate on how interventions that originate in the therapist's empathic–resonance process influence the client's experiencing in a process–enhancing way. A process–diagnostic model, based on distinctions among different aspects of the experiential exploration process, forms the framework in which the various interventions are classified according to dominant process intention. Three major process intentions are distinguished: becoming aware of experiencing, regulating (increasing or decreasing) the intensity of experiencing so that it becomes possible to hold the experience in attention, and exploring that leads to further unfolding and change. Therapy excerpts illustrate this approach.

INTRODUCTION

In this paper I present an experiential process–directive experiential approach in which the therapist is guided by the Rogerian core attitudes both for offering a therapeutic relationship and for intervening in a process–enhancing way. This view is in line with the evolution of the last two decades within client–centered psychotherapy, from a non–directive to a process–directive approach (Gendlin, 1996; Greenberg, Elliott & Rice, 1993; Elliott, Watson, Goldman & Greenberg, 2004). In this process–directive approach, the main task of the therapist is to facilitate an experiential exploration process in the client. The empathic–resonance process is the breeding ground for a variety of interventions that not only communicate the therapist's understanding—as was the case in Rogerian

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client–centered therapy—but also promote the client's experiencing and facilitate the client's processing (Vanaerschot, 1993).

I will first briefly discuss the client–centered view on the experiencing process, and proceed with a description of the resonance process as an experiencing process with specific characteristics. Then I will describe a microprocess diagnostic framework consisting of interventions that originate within the therapist's empathic–resonance process, point at specific processing difficulties, and have a process–enhancing effect on the client's experiencing process.

EXPERIENCING: AN INTERACTIONAL PROCESS

Experiencing is the process of attributing implicit, affective meaning to the bodily felt interaction between a person and the environment. It refers to the way a person knows and senses his or her situation. It means perceiving something and noticing how that something makes an impact on you (i.e. how something moves you or "gets" you). The result is an internal, fully felt sense of yourself in relation to the situation (Gendlin, 1968, 1970, 1996).

Two levels of interaction can be distinguished in the experiencing process (Gendlin, 1970). The first level refers to the bodily, implicitly felt whole, which concerns a situation and originates in the interaction between a person and a situation or environment, thus, the way a person takes in various situations. This bodily feeling is called *felt sense.* For example, late one evening a young woman enters a parking garage to get her car. She does not hear anybody; the garage seems deserted. Suddenly, someone appears from a dark corner and approaches her. She becomes frightened. Then she notices that the person appears to be a man who needs change for a parking meter. Arriving home, she tells a friend the details of what went on in her mind during the few seconds after the man appeared and before she knew what he wanted. Her listener probably wondered: "And you thought all this in a few seconds?" Of course, she did not "think" all this in this few seconds, but she had all this experience, and perhaps much more, inside of her in an implicit, bodily felt way. Experiencing is a process, anchored in the body; it is an act of the sentient body. The interaction between body and situation gives rise to an implicit, bodily felt sense, which is preconceptual and undifferentiated. It is a knowing without words. It is a knowing that precedes words and from which words emerge. It is concrete because anyone can experience it and have direct access to it. The bodily feeling of the interaction, the feeling of oneself in the situation, is implicit, not only in the sense of not explicit but also in the

sense of implying more or further—implying something that presses for expression. Thus, the woman in the above example is likely to express the reaction—at first a primarily bodily one—as "I became frightened". Chances are that during the ride home, the feeling persisted. Perhaps the feeling still existed when she arrived home, and it may linger as long as she does not verbalize it. Implicit meaning is incomplete, it is the feeling of something unsolved, it is something that seeks completion through interaction with verbal symbols.

This leads us to the second level of interaction, which is the one between the felt sense and symbols (such as words), through which explicit meanings are formed from the preconceptual, implicit, and incomplete meanings. When this interaction occurs, access to the conscious knowledge takes place. Once the implicit is explicated, the person experiences in a new and more complete way because the implicit meanings are now understood. Through symbols such as words, the felt sense unfolds further.

The felt sense contains many more meanings than those made explicit. The explicit meaning is not a previously hidden or repressed one that becomes clear, but it is one formed in the interaction between felt sense and symbols. A correct verbalization is one that brings about an experiential effect, such as a physical feeling of relief and a more intense and precise awareness of a facet of the felt sense. And a correct verbalization arises from a shift at the implicit level—the new meaning as bodily sensed knowledge. In this sense, verbalization is a by–product. A new sense forms following a correct symbolization, a new implicit feeling of oneself in the situation. This process of forming anew follows a particular order. Only after putting into words one aspect of feelings can new aspects be felt and become available for interaction and symbolization. This is a step toward change. In this way, experience is carried further and is completed. Change comes about by many small steps carrying the experience forward.

HEALTHY MENTAL FUNCTIONING: AN ADEQUATE EXPERIENCING PROCESS

Healthy mental functioning implies a constant and flexible move or going back and forth at both levels of interaction, which continuously carry the experience further. An adequate way of experiencing is characterized by reflective attention to the felt sense about a situation.

To function in a healthy way, one should not view experiences "as if they were set, shaped units with their own set structure" (Gendlin, 1970, p. 154). Instead, one should view experiences as temporary constructions

to be transcended by further experience and to be changed or replaced by new constructions. Thus, in an adequate experiencing process, symbolization always results in a hypothesis that needs to be tested.

In healthy mental functioning, what has been learned and experienced in the past functions implicitly in the present, concretely felt experience. Implicitly functioning experiences are felt as a complex preconceptual whole, carrying a multitude of implicit meanings that can fluidly interact with the present situation. In healthy experiencing, past experiences play a role in experiencing the present, but these do not distort the present. Previous experiences that do not function implicitly interfere with the fresh, rich experience of the present moment; the present is distorted by the past. The manner of experiencing is then structure–bound, and to the extent that experiencing is structure–bound, the person experiences the same thing over and over.

PROCESS FUNCTIONING AS BASIC CONDITION FOR EMPATHY

The empathically listening therapist's inner process, which we call empathic resonance after Barrett–Lennard (1981), implies a specific way of being or functioning that differs somewhat from the "usual" interpersonal contact. The difference does not lie in the therapist putting the self aside—as Rogers' (1975) description of empathy as "putting oneself aside" could perhaps erroneously suggest—but rather in a way of using the self. Indeed, the therapist "uses" himself or herself to be maximally receptive and open to being corrected by what the client presents (Vanaerschot, 1990). This presupposes a process–like way of experiencing.

Empathic Resonance: Eliciting A Felt Sense

Empathic resonance refers to a way of experiencing whereby what the client expresses (what is said, what is not said, how it is said, and what the body language is) elicits a bodily felt sense in the therapist. This implies that certain aspects of the therapist's implicit experience come to be in process and thus, can be felt in awareness. The therapist will then focus on his or her own felt sense and try to explicate aspects of it. This is then submitted to the client for testing. An empathic process can take place only when this interaction develops between the client's symbols and the therapist's implicit experiencing.

Congruence as Upper Limit

The quality of a therapist's process of empathic understanding is determined by the extent of his or her contact with constantly changing, ongoing experiencing. While seeing clients, therapists should ensure that

they are open to their own experiencing: they should be congruently present. A therapist will, of course, try to develop this process quality mainly outside the sessions, through personal therapy or supervision, but being attentive to one's own experiencing during the session remains crucial. Thus, an important aspect of any empathic therapist's listening attitude is reserving time and space to feel how the client's words affect him or her. In this way, the therapist develops a felt sense that is in tune with the client's discourse.

Incongruence, Lack of Containment, and Structure-Bound Functioning

Often, a therapist has difficulties in allowing the process of empathic resonance to occur because of an inability to admit certain feelings, leading to incongruence, which is a structure-bound way of experiencing that imposes rigid, preset structures of meaning. The quality of the therapist's empathic understanding is largely determined by the degree that his or her experiences are not structure bound, but are "optimally implicit". Not only does the therapist then have thousands of implicitly functioning aspects of meaning at his or her disposal for interaction, but he or she also remains open to correction from new information—in this case new symbols coming from the client. And this is precisely what is needed to arrive at a new meaning or in the case of empathy, at the meaning that the client is trying to convey. On the other hand, the more structure bound the therapist's manner of experiencing, the less attuned his or her felt sense will be to the client's, and the less possible it will be for him or her to correct his or her understanding as a function of the client's new symbols. In this sense, structure-bound manners of experiencing are the source of countertransferential reactions.

CHARACTERISTICS OF EMPATHIC-PROCESS FUNCTIONING

Typical of empathy is the therapist's attempt to attune his or her implicitly felt sense to the client's felt sense. Therefore, the therapist's felt sense should correspond to the felt sense from which the client speaks. The word *correspond*, however, does not mean "be identical to". Should the therapist's felt sense be identical to the client's, then therapy would be impossible. Indeed, therapy can be effective only if the therapist is capable of living the situation differently—and often more fully—than the client. What this amounts to is that empathic functioning is essentially the therapist putting his or her proficiency in process experiencing at the client's disposal; the client is offered a more adequate way of experiencing in those areas where the functioning is structure bound or where thes

experiencing process does not come to completion. In an analogy to Wexler's therapist as "surrogate information processor" (Wexler, 1974, p. 97), I would call the therapist a "surrogate experiencer".

PROCESS DIAGNOSIS AND MODES OF CLIENT ENGAGEMENT

The empathic process–directive therapist lets himself or herself be guided by his or her inner empathic–resonance process for engaging in a process diagnosis. This process diagnosis is not from a detached, observing position but from an empathic attunement to the client's momentary experiencing. The therapist's sensitivity for, and his or her empathic attunement to, the moment–by–moment, changing nature of the client's manner of experiencing, enables the therapist to identify (sense, feel) dysfunctional ways of experiencing or of specific processing difficulties. The process diagnosis also enables the therapist to intervene in a way that is the most process facilitating at that moment. Based on this process diagnosis, the therapist facilitates different types of experiential processing at different moments.

Clients engage in four different modes of processing (Greenberg, Elliott & Rice, 1993). These four modes of engagement are:

1. **Attending and awareness**—This mode is the root of "bottom–up" processing and involves making contact with basic sensory data about the self, the external reality, and the interactions between both. From this information, the client construes further meaning.
2. **Experiential search**—This second mode of client engagement involves a deliberately turning inward of attention in an attempt to access one's own complex inner implicit experiencing and to symbolize it in words.
3. **Active expression**—Expressing one's own experiential reactions facilitates the discovery and owning of what it is that one is feeling. Hereby, the action tendency is allowed to run to completion and connects feelings to their appropriate objects.
4. **Interpersonal learning and contact**—In the therapeutic relationship that is characterized by the therapist's empathic attunement, unconditional prizing, and genuine presence, clients learn to trust their own experiencing and to accept their feelings. They also learn that they can be themselves in relation to another person. They can experience that their old fears, e.g., of destroying others with their anger or being destroyed by others, do not correspond with reality. Or they can experience that being weak or helpless will not necessarily be punished, but on the contrary can be accepted by others.

These different client modes of engagement are useful—and even necessary—at different times for the resolution of particular types of problems. One of these modes can dominate an individual's processing style. The facilitation of these different modes of client engagement during therapeutic exploration and processing is the task of the therapist. This implies a continuous sensitivity for the impact, moment by moment, of each therapist intervention on subsequent client responses.

MICRO PROCESSES WITHIN AN EXPERIENTIAL EXPLORATION PROCESS

The model presented here is based on two pillars: the described modes of client engagement and a view on micro–processes within a process of experiential exploration. In experiential client—centered therapy, experiencing is made the object of reflective attention. Reflective attention for what is perceived inwardly is the basis for the capacity to engage oneself in specific processing activities that make constructive processing possible. The therapist facilitates these processing activities by interventions that invite and help the client to *become aware* of his or her inner experience, *to attend to it with reflective attention*, to *focus on* his or her experience *through holding it in his or her attention*, to *symbolize it in words*, and to *explore* it further, which means: giving words to what is implied, sensing and naming new aspects of the client's inner experience. . .

1. **Becoming aware**—First, experiencing must be perceived under a sufficiently high degree of arousal and concentration (and every clinician knows that this is not always the case). Experiences are often inaccessible to conscious attention and they determine behavior though the client is often unaware. A *first group of interventions* aims at helping the client to perceive his or her experiencing, put otherwise: at *promoting the client's awareness.*
2. **Attend with reflective attention, hold the experience in attention**—Experiences are sometimes hard to hold on to because they are too intense and overwhelming or too vague or unformed and consequently shadowy and fleeting. Regulating the intensity of the experience is the goal of a *second group* of interventions. Hereby we discern between *interventions that intensify the experience and interventions that diminish the intensity of the experience.*
3. **Symbolize and explore**—A constructive experiential process implies, finally, that the person can symbolize in words new, or not yet processed, aspects of the experience. Exploration and making the different aspects of the experience more explicit, are needed. To

create new meaning, it is crucial to bring the client's attention to aspects of experiencing that are unclear and not fully known, aspects "at the unclear edge" (Gendlin, 1996). So a *third group of interventions aims at promoting exploration.*

INTERVENTIONS WITHIN A PROCESS–DIRECTIVE FRAMEWORK

The process–directive interventions are classified and described according to the dominant process intention. With "process intention" we refer to the specific experience–promoting impact at which the therapist's intervention aims. The process intentions are based on the above described micro processes for experiential exploration and are facilitated through interventions that are realizations of one or more modes of engagement.

The model aims at helping therapists draw their own and client's attention to the most appropriate process intention or process task at that particular moment. This implies a moment of process diagnosis: is the client showing a lack of inwardly turned attention or awareness? Or is the client too distant from his or her inner experience, in other words, is the intensity of the experience too low? Or is there too little distance, and is the client overwhelmed by experiences that are too intense? Does the exploration process stick or does it run with too little depth? And what has this deficient exploration process to do with? And what (which therapist intervention) does the client's process need in order to proceed, to deepen and to unfold? The answers to these questions will determine what process intentions will be put on the foreground.

Table 1 gives an overview of possible therapist interventions and their underlying process intentions. This overview shows how a particular intervention can serve more than one process intention. Interventions are classified according to their most obvious effect on the experiencing process. This list contains the standard interventions that are used by client–centered experiential psychotherapists, but it is not exhaustive.

Interventions That Promote Awareness

Primary Relationship Factors

Dysfunctional manners of experiencing or specific processing difficulties often have to do with the existence of "old" experiences that cannot be integrated (or "dissolved" like sugar dissolves in coffee) into the here–and–now experience of the situation. Previous, unintegrated experiences interfere with a fresh and rich experience in the present moment. The manner of experiencing is then structure–bound. The present situation (or certain aspects of it) evokes a formed experience pattern with a

Table 1. OVERVIEW OF INTERVENTIONS WITHIN A PROCESS-DIRECTIVE FRAMEWORK

Interventions	Process Intentions			
	Promoting awareness	Intensifying	Decreasing intensity	Promoting exploration
Primary relationship factors	xx	x	x	x
Attend to inner experience	xx	xx		
Setting boundaries	xx	x	x	
Contact reflections	xx	x	xx	
Attention to body sensations	xx	x		
Concretize	x	xx		
Empathic selection	x	xx		x
Empathic reflection of expressed feeling	x	xx		x
Empathic evocation	x	xx		xx
First person reflections	x	xx		x
Intensifying non-verbal aspects	x	xx		x
Calm defining presence	x		xx	
Metaphorically creating distance	x		xx	
Safe place	x		xx	
Empathic reflection of underlying feeling	x	x		xx
Empathic conjecture	x	x		xx
Empathic exploration	x	x		xx
Integrating reflection				xx
Exploratory and checking questions	x	x		xx
Process-directives	x			xx
Dialogical search for words that fit				xx
Confrontation	x	x		xx
Exploration-promoting nonverbal presence	x			xx

xx highly applicable
x applicable

fixed unchangeable and repetitive structure. Because the experiencing is structure–bound, the person experiences the same thing repeatedly. Returning to our example of the woman in the parking garage, suppose the young woman had recently been the victim of assault, which she had not yet come to terms with. Chances are that a suddenly emerging person would reactivate the experience of the assault. It would not be surprising if she ran away, yelled, or prayed for the man not to hurt her instead of waiting and hearing the man's innocent request. Her experience of the present would be distorted by the past—she feels and reacts as if she were being assaulted again, and the man would have to go through considerable trouble to convince her of his innocent intentions. The experience of the assault is like a frozen whole. While the frozen meanings are not perceptible in the bodily felt sense of the present situation, they are responsible for a structure–bound, old and distorted manner of experiencing of the present situation. The situation or particular aspects of it elicit a fixed pattern of experiencing that cannot be influenced by the actual aspects of the here–and–now situation. These old, unresolved "frozen" affective meanings manifest themselves as unchangeable, sometimes incomprehensible and strange, emotional or behavioral reactions. Such frozen experiences are not (immediately) accessible. But once dissolved, they may become implicit and thus, felt in awareness. Fixed, rigid experiences thaw, and affective meanings revive and are felt, when the client is influenced by primary relationship factors of contact with a person who is genuinely interested in, validates, and affirms the meaningfulness of the client's psychic inner life. For this dissolving process to happen, the therapist must be empathically, respectfully, and genuinely attending to the part of the client's experience that is still implicitly functioning. For only from that can the necessary steps arise for the meaning aspects to become unstuck within the safe relationship. Therefore, experiential client–centered therapists attach great importance to helping their clients reflectively attend to their implicit experiencing instead of trying to influence rigid beliefs or behavior patterns, since these are manifestations of structure–bound experiences.

Attend to Inner Experiences. Experiences sometimes are not immediately in awareness and perceptible, because the client simply passes them over. This is often the case with clients who are uncertain about having the right to an own inner psychic life. In that case, drawing the client's attention to his or her experience mostly will be enough to get the client in touch with it. Asking the client what he or she is feeling while telling

about something, is a very simple question that can draw the client's attention to his or her inner experiencing.

Setting Boundaries

Another aspect of the interpersonal relationship that can promote awareness is boundary setting. This includes the formal boundaries of the therapeutic frame as well as the limitations set by the congruent presence of the therapist: the client meets "somebody". For example, only to the extent that the client's longing for a bodily contact with the therapist is not met, can the client become aware of his or her desire and the meaning of it. Specific interventions through which boundaries are communicated are, amongst others, self–disclosure and disclosure of the here–and–now experience of the therapist (also called impact disclosure), feedback, process information, and inclusion of the client–therapist relationship as a subject of discussion.

Contact Reflections

As described by Prouty (1998), contact reflections are a fourth group of awareness promoting interventions and are very helpful at fostering awareness with psychotic or dissociated experiences. Prouty's pretherapy [ed. note: see Pre–Therapy: The Application of Contact Reflections, this issue] describes interventions that are helpful in developing or restoring psychological contact. He discerned five very literal and concrete responses that work well with client's pre–expressive levels of communication and behavior.

> *Situational reflections* develop or restore the client's contact with a situation or environment.
>
> *Facial reflections* help restore affective contact, and *body reflections* can help the client to get in touch with what he or she is expressing through his body.
>
> Then, there are the *word–for–word reflections*, which help restore the communicative contact.
>
> And, finally, there are *reiterative reflections*, which embody the principle of "recontact": contact reflections that were successful in producing a response are repeated.

Attention to Body Sensations

A last process–directive intervention I would like to describe as awareness promoting is drawing attention to body sensations. It is a process–directive, for example "Can you focus your attention to what you are sensing/experiencing in the centre of your body?" Such process–directives are used in experiential focusing to help a felt sense develop.

Interventions That Intensify The Experiencing

Characteristic of a low intensity experiencing process is that the client tends to bypass experiencing. The therapist can intervene in several ways to help to intensify the client's experiencing. This means making the client's experience more lively, intense, poignant. Sometimes it is enough to draw the client's attention to his or her experiencing through questions or process instructions, for example: "Can you take a little time to feel in your body what you are talking about?"

Concretize

When a client talks in a rational way (thinking about himself or herself or analyzing his or her motives) consider it as a marker for drawing the client's attention to a specific situation that represents the problem trying to be resolved. For example, the therapist might ask following simple questions: "Can you make this more concrete?" "Can you remember a specific situation in which this problem did occur?" "You say that you feel uncomfortable with women. I, too, am a woman; can you feel this uncomfortable thing also in contact with me?"

Empathic Selection

Another possible intervention is empathic selection. Draw the client's attention to what is, at that particular moment, the most lively or poignant in his or her story. Often, the therapist literally repeats in his or her reflection those words that seem to have emotional connotation to the client.

Empathic reflections of expressed feelings

These may bring the client in touch with what he or she is saying and feeling, with the affective meaning of what he or she is trying to express, or with the full emotional connotation his or her words imply.

Empathic evocation (Rice, 1974)

Through evocative and metaphorical language is a fifth form of intensifying intervening. Empathic evocation is done through reflections that elicit the client's reaction in a specific situation so that the experience can be felt concretely and intensively. Typical is the use of images and metaphors.

First–Person Reflections

Reflections in the first person intensify the experience. Invite the client to speak of him– or herself in the first person if s/he uses the second or third person for self–description.

Intensifying Nonverbal Aspects

The therapist can use nonverbal aspects and paralinguistic aspects, such as facial and body expression or intonation to make the client's story more intense and lively. For example, if a client talks about extremely painful experiences without showing any emotions, the therapist may nonverbally reflect emotions that fit with the awful experiences, e.g. by grimacing.

INTERVENTIONS THAT DECREASE THE INTENSITY OF THE EXPERIENCE

The calm, defining presence of the therapist is in itself intensity–regulating. Actually the therapist does this by speaking and behaving calmly, by altering the physical distance when needed, by letting his or her presence be known if the client is losing contact due to overwhelming experiences.

Metaphorically Create Distance

The therapist may use contact reflections as well as images and metaphors to help clients decrease the overwhelming nature of too intense experiences. For example, in case the client is overwhelmed by the re-experiencing of a violent experience, the therapist can suggest that the perpetrator is behind a glass wall, so the client can actually see him but the perpetrator cannot come closer. Or the therapist can suggest to look for a colour and a shape that matches the overwhelming experiences, to draw it and to put the drawing on a distance whereby the client feels safe and comfortable.

Safe Place

Suggesting the client to imagine a safe place to go to has an intensity–regulating impact.

INTERVENTIONS THAT PROMOTE EXPLORATION

Exploration of different experiences consists of three sub processes:

- holding experiencing at attention, thus staying in touch with it;
- focusing attention on aspects of experiencing and affective meanings that are implicit, "at the edge" of consciousness, vague or unclear, not well understood by the client, have meanings the client is scarcely aware of (but once explicated the client can recognize), and are growth hindering or on the contrary, are on strong aspects of growth direction;
- explicating new aspects of experiencing to test if a new symbolization (a specific word) exactly phrases the experiencing, and integrating

affective meanings that are articulated as separate to make connections a them.

A variety of interventions can facilitate these sub processes.

Empathic Reflections, Explorations, and Evocations

Empathic reflections of expressed and *of underlying feelings* help the client to hold on to experiencing and to get in touch with aspects of experiencing "at the edge".

Empathic conjecture is meaning offered to the client based on the therapist's own vicarious feelings. In empathic conjecture, the relationship is a dialogical one: client and therapist together look for new symbolizations that can unfold the client's experiencing.

Empathic exploration questions and points attention to what is vague and unclear or to what is most lively and meaning loaded or to idiosyncratic meanings that need to be further differentiated or to what is hindering or blocking any further unfolding or to growth directions.

The empathic–evocative reflection also promotes further exploration because it elicits a multitude of associations and brings many different aspects of experiencing in attention to the client than the client alone could explicate.

Integration Promoting Reflections

When the therapist offers the client better information organization, information processing, and further exploration is facilitated. Integration promoting reflections try to show the overall meaning that is evoked by different separate experiences (Wexler, 1974; Toukmanian, 1990).

Exploratory and Checking Questions

Furthermore, there are exploration–promoting and testing questions that invite and stimulate the client to question his or her felt sense. For example: "What does this to you?" "What is happening now inside?" "How does what you are saying right now feel?" "Can you feel if this word fits?" "Does it feel like that?"

Process Directives

Suggestions to point one's attention or to make a particular mental operation are process directives. They stimulate the questioning of the inner experiencing, as in the questions "Could you linger a little while over this?" "Could you ask yourself this question in a friendly way?" "Take your time to find the right words . . ."

Dialogical Search for Words That Fit

Another important intervention that can foster the exploration process is to help the client to symbolize, that is, offering words or images in a tentative way or engaging in a dialogical search for words that can unfold the felt sense.

Confrontation

Furthermore, in my experience, challenging and deregulating interventions such as confrontations can facilitate the exploration process when offered in a relational context where the client can accept it.

The *exploration–promoting presence* of the therapist, as it is communicated nonverbally through silence and through a questioning intonation, is very important in facilitating this process.

ILLUSTRATIONS

If I bear my fate in silence . . .

In this therapy excerpt, a client explores her fear and uncertainty about ending therapy.

Client 1: When I say about this therapy: 'let's go on with it', then I think . . . It is as if I always, well . . . that I am also stopping myself from making progress or something like that. I don't know how to say. It is like there is something in me that makes me say that, hum . . . yes . . . (22 seconds of silence) yes, sometimes something like . . . I must get attention or so, it seems . . . And I am also asking myself . . . well, what then is this, what should I do with it, with this attention . . .?

Therapist 1: As if you feel yourself in a kind of dilemma between needing that attention and just so . . . allowing yourself to be in doubt of effectively making a move, of going forward and improving; and on the other side that longing for actually moving forward and walking on your own legs. (integrating reflection/empathic, conjecture/empathic evocation). Something like that? (checking question)

Client 2: (doubting) *Yes. . .*

Therapist 2: Not quite (empathic reflection underlying feeling). Look again . . . (process–directive) (8 seconds of silence). It has something to do with attention and with not having to make a move (empathic reflection expressed feeling).

Client 3: Not be obliged to go forward, well, sometimes I think: 'do I want this actually?' Yes, to improve, what is this actually? Just behaving normally, I don't know how to say. As if nothing had happened, something like that. As if I always, yes, it is as if I have always that idea, that . . . hum, if I behave normally with people or so, that they would think that

everything is fine with me and that they shouldn't any longer . . ., well, it is as if I always need something or so.

Therapist 3: As if you are a little bit afraid to leave your injuries really behind you because that would deprive you from the right to get care and attention? (integrating reflection/ empathic reflection underlying feeling)

Client 4: Yes, it is something like that I think . . . (26 seconds of silence).

Therapist 4: As if only injuries would give you the right to get attention and care? (Integrating reflection) (12 seconds of silence)

Client 5: Yes, I don't know it for sure . . . Yes . . . (19 seconds of silence). Yes, it is something like that.

Therapist 5: Take just a little while to feel . . . (process–directive). It actually has something to do with: if I would behave normally or live my live further, if I would make a move, do I then still have the right to get attention and care? (empathic reflection expressed feeling) Or should I then have to do it all on my own? (empathic reflection underlying feeling)

Client 6: Yes, it is especially that leaving behind.

Therapist 6: That leaving behind, leaving behind those injuries (empathic reflection expressed feeling) (15 seconds of silence). What does this evoke? (Exploratory question) (12 seconds of silence)

Client 7: Yes, just the sense that I . . . (22 seconds of silence) that I have always bore that with me, that it kept me busy all the time. From the time on that I still lived at home, I think, it already kept me busy. Also how I thought that my mother actually knew it, that I also had the feeling that she was towards me, well, I don't know, it wasn't 'more concerned' but she had rather always something like . . . (12 seconds of silence).

Therapist 7: She had rather something like? (exploratory question)

Client 8: Yes that I always thought . . . (7 seconds of silence) so actually, as if she, yes . . . (26 seconds of silence) not that she could alleviate it or so, that wasn't so, but as if she always gave me the feeling that . . . I don't know, that for sure she knew it or so . . . Or I have always had the illusion that for sure she knew, as I sometimes think now. Well, the illusion, because I don't know where I've got it. If I would tell her about it now, I can imagine that perhaps she would awfully turn pale, that she knew nothing at all about it.

Therapist 8: Suppose that your assumption would not tally, suppose that she really didn't know anything about it, what in you would possibly be met by wanting to, having to feel it this way?. . . Suppose it would be like that, what in you would be affected, disappointed, pushed back? (exploratory questions)

Client 9: Maybe I also needed it to think that she actually knew.

Therapist 9: What in you needed this? (exploratory question) (28 seconds of silence)

Client 10: I don't know... (25 seconds of silence) If she would be completely taken aback, then I would feel totally alone or so. Then something would be gone.

Therapist 10: You would feel alone and it would feel as if something were gone... (empathic reflection expressed feeling). As if you actually feel something like getting support if you don't talk about it (**C: yes**) but getting no support if you do talk about it? (Integrating reflection)

Client 11: Yes, as long as I don't talk about it... (She gives examples about how sharing something difficult with her mother always clashed on disbelief and how she felt silenced by her mother's answer: "You should know all the things I went through, a lot of absolutely awful things")

Therapist 11: Almost as long as I bear my fate in silence and don't talk about it, I get attention and I am loved. But if I would ask attention for it, then I would be sent away (integrating reflectlon/empathic evocation).

Client 12: Yes... I always felt it that way, yes... Strange actually...

This excerpt illustrates how to guide an exploration process by a mixture of the described exploration–promoting interventions. In this excerpt, a process of dialogical search develops. Sometimes the therapist (T) is too far ahead and offers meanings that the client (C) does not recognize or that are not getting to the core of the story (T1; T3). These interventions are expressed tentatively and/or are followed by an explicit invitation to check the intervention on the client's inner, vague and unclear but nevertheless definite perceptible felt sense. The therapist notices that the client does not recognize the offered affective meanings and backs away (T2; T5), and she tries to help the client to feel if something fits by expressing it more sharply (T4). Then she invites the client to look for what is actually fitting (T2: "look again"; T5) and challenges the client to an inner search "at the unclear edge" of what has been worded and known (T2; T5). In C6 the client expresses more clearly what her thoughts are about and the therapist guides her search with empathic reflections of expressed feelings that help the client to stay on her inner track (T6; T10) and with exploratory questions (T6; T7; T8; T9). And so the exploration process is carried further. In T10 the therapist intervenes once again with an empathic conjecture that this time is indeed recognized by the client (C11). In T11 the therapist restates the same experience in an evocative way in order to intensify the experiencing, so as to give the client the possibility to check if this more intense and sharper restatement phrases exactly what she is feeling.

CONCLUSION

We saw how therapist's empathic–resonance process interventions influence the client's experiencing process in a process–enhancing way.

Interventions act on the experiencing process precisely in those areas in which it had not proceeded adequately. I developed a process–diagnostic model based on the distinction among different relevant aspects of the experiential exploration process: being able to become aware of experiencing, regulating the intensity of experiencing so that it is accessible to awareness and conscious attention, and exploring and making explicit different (aware and scarcely aware) aspects of experiencing. The process–directive therapist promotes each of these subprocesses for the experiencing process to proceed. Central in this approach is differentially drawing cattention to the most appropriate subprocess. I described different interventions that can promote each subprocess.

I would like to emphasize that it is not my intention to motivate therapists to do a type of "cookbook therapy". I hope the excerpts make sufficiently clear this is not the case and that the therapist's empathic–resonance process is the breeding ground for experience–promoting interventions. I hope that this process–diagnostic way of looking at treatment will make therapists more sensible to the client's experiencing process needs at any particular moment so that they may help the client to proceed and to unfold.

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