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Extending empathy to physical symptoms

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ABSTRACT

In this article we advocate for extending our concept and practice of empathy to include both physical and psychological symptoms, and the personal presenting meanings encoded in them. We make the case that when clients present medical symptoms in therapy, these should be explored and empathized with. First we explore the meaning and function of physical symptoms and potential therapeutic benefits of attending to them. We discuss the mirroring of these symptoms in the therapist's body, via a process of embodied empathy that we refer to as *physical empathy*, understood as an automatic intuitive process in the body, one of three types of empathy evidenced by neuroscience research. We argue for a wider paradigm of therapy that would encompass physical symptoms as expressions of self. We accept human nature is embodied and physical symptoms are better understood as a kind of unverbalized body memory. We propose that PCE therapists practicing in medical settings adopt a phenomenological model when working with physical symptoms, by engaging in a process of physical empathy. Within this framework, person-centered experiential therapies may be particularly useful in preventing physical symptoms developing into complex, difficult to treat physical syndromes. We call for training therapists in physical empathy.

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From a person-centered perspective, 'physical symptoms' can be understood as difficulties presented and understood by clients in medicalized terms, for example, various forms of chronic pain or puzzling, distressing physical complaints like hyperventilation in panic states. The realization that physical symptoms have imbedded personal meaning and that these can be mirrored in the therapist's body grew from the first author's personal experiences of developing her practice as a person-centered therapist (PCT) in medical settings, including psychiatric and general hospitals, for over thirty years. Her early work with 'patients' (as they were always referred to in such settings) excluded physical symptoms, because in a medical setting these were seen as the exclusive domain of doctors. Psychotherapists tended to approach patients' symptoms as psychosomatic and to work with their physical symptoms indirectly by trying to resolve underlying psychological issues. However, because the patients were focused on their health problems, they were generally not interested in their psychological processes, especially when their

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symptoms were pressing or when they were hospitalized. This proved to be frustrating both for the therapist and her patients and she realized that she needed to re-assess her perception of meaningful communication in therapy so as to help her difficult-to-engage patients talk about their feelings.

The first author realized that, contrary to the medical norm that physical and health issues being the domain of the doctors, she too needed to listen to patients' talk about their health issues and symptoms, such as their pain, disabilities, stress of impending operations and fear about prognosis or disease progression. In addition, other patients were fighting medicalized problems like substance abuse or weight loss due to cardiac problems, while still others were experiencing phantom limbs following amputation or felt possessed by obsessive thoughts or disowned states of depression or anxiety. When the therapist attended to the frustration she experienced when clients engaged in dialogue about medical symptoms, she came to an emerging awareness that she had blocked herself to her clients' full experience. This inability to immerse herself fully in her clients' experiences slowly revealed itself as a blockage in the bodily channel of her empathic resonance. Rogers (1967) considered congruence as an integral part of the therapeutic encounter and the most basic of the three core conditions. It was only through the process of her increasing ability to accept her own incongruence in the relationship that she experienced an increased capacity to accept her client. As Gendlin (1962) proposed, congruence and incongruence is a dynamic process that cannot exist in isolation, but in relation to the other person. It was through this incongruence that the therapist also realized that this lack of empathy within the therapeutic encounter may have contributed in her clients' sense of stuckness. Working in the medical context it became more apparent that when the client spoke of her medical symptoms the therapist had to attend to these physical symptoms with acceptance and offer embodied empathy (cf. Cooper, 2001) to each of these. It was only through the process of receiving Unconditional Positive Regard the client became more open to messages encoded in the body and congruent to her own experience.

In psychotherapy research, empathy has been found to be a robust moderately strong predictor of positive therapy outcome (Elliott et al., 2018). Although there is currently no single agreed definition of empathy (Batson, 2009; Bohart & Greenberg, 1997), broadly speaking empathy refers to 'the capacity to understand and respond to the unique affective experiences of another person' (Decety & Jackson, 2006, p. 54). In this paper we draw from Barrett-Lennard's (1981) operational definition of empathy in terms of three perspectives: that of the therapist (empathic resonance), the observer (expressed empathy), and the client (received empathy). In this article we emphasize therapist empathic resonance, advocating for extending and deepening of that resonance to *all* client experience, including what we are calling *physical empathy* (i.e. embodied empathy for client physical symptoms). At the same time, we recognize that more deliberate, conceptual processes are likely to be important for translating physical empathy into conceptualized and verbally expressed empathic responses offered to the client.

There is strong evidence to suggest that the mirror-neuron system (MNS) is associated with the affective processes that support empathy (Pfeifer et al., 2008). From these findings, researchers have proposed that MNS activity involves internally mirroring the affective responses of others and may constitute a process that allows individuals to literally feel what others feel. Both emotional and cognitive empathy have been found to

be moderately correlated with MNS activity (Bekkali et al., 2020). As the first author began to extend her own practice of empathic resonance to her clients' experiences of their physical symptoms, she found that talk about physical symptoms (and disowned, physicalized psychological symptoms) was as much a portal of communication as were words about mental states and feelings; both could communicate feelings and significant events in a person's life. This opened up her own channels of experiencing physical empathy through mirroring the physical symptoms in her own body, which she could then offer more empathy to her clients, thus opening up new exploration of encoded, implicit meaning.

Case study: physical empathy with medically unexplained symptoms

To illustrate our understanding of the meaning of symptoms and their mirroring in the therapist's body via physical empathy, we will share an example of one of the first author's female clients ('Cathy'), seen as an outpatient at the hospital. With this case study we show growing awareness of physical empathy through the experience of the therapist, in relationship to client, when the relationship is situated within a medical model setting. We offer this case study to highlight the importance of training PCE counselors in physical empathy, particularly those who work within a medicalized framework.

The first time the first author realized that she wasn't being effective with a hospital client was with a 43-year-old married homemaker. Cathy presented with headaches, and complained of a constant 'noise' in her head. The noise included intrusive and obsessional thoughts, which would 'stick' in her head. Along with the headaches, she had accompanying pins and needles in her head, confusion about reality, and a feeling of 'stuckness' that prevented her from concentrating. She would go through bouts in which she felt could not do anything ('apraxia'), wouldn't leave the house, and neglected her duties as a mother and wife. At times she felt better and was able to function. Like many other clients within medical settings, she had had numerous tests done, including a CAT scan. Cathy had also been seen by many specialists, including an otorhinolaryngologist, a neurologist, a pathologist, an endocrinologist and a couple of psychiatrists; these all disagreed on her diagnosis and consequently her medication had been changed many times. Unfortunately, nothing seemed to work, so she was always coming back to the hospital either in emergency (when she got frightened of her thoughts), or she would book repeat appointments with these doctors, and also with new specialists, such as pathologists or psychiatrists, for additional complaints about her spinal cord, her leg or general weakness.

As was common practice in Greek public hospitals, the 'patient' was eventually referred to the first author for therapy, an option often reserved for patients who did not 'get better' through medical treatment. She was employed as a clinical psychologist with post graduate training in person-centered counseling to provide therapy to 'patients'. We began our first session exploring what brought Cathy to therapy. When she was asked about her life, her marriage, or her relationship with her son, her physical symptoms became central. She would say that she couldn't think, that she had a headache and that all she wanted was to be told whether she was 'crazy' or not. This was the reason she had come to therapy: While her whole attention was on her physical complaints, the psychiatrists and other doctors had said that she had mental problems, which she interpreted as

being 'crazy'. Any other topic would result in the above symptoms, which created an impasse between client and therapist. After the second session the therapist became aware that she had started feeling stuck too, and had developed a headache also, something like pins and needles, with her head very full of 'something', which wouldn't let her think. Initially, she thought this was due to her failure to communicate with the client; at the time she did not recognize this experience as physical empathy.

In subsequent sessions, the therapist began to sense that Cathy was using her symptoms to block any real conversation. These encounters circled repeated themes and when the therapist used exploratory questions to focus Cathy on inner emotions and feelings, instead of deepening her experience these led to further talk about her physical symptoms. After five sessions the therapist sensed that Cathy wouldn't be coming back for long; the only thing she really wanted was to be told if she was crazy or not. The therapist felt blocked and helpless, just as the client did. The therapist had a growing sense of listlessness during the sessions as if she didn't have the strength to make the effort it would take to push Cathy to talk about emotional issues. As a result she just let the client talk on and on about her symptoms and how they had changed her personality and the way she functioned. The therapist began to sense her body internally, noting that her affective responses appeared to be mirroring Cathy's physical symptoms: Her head ached; she experienced a sense of brain fog; she felt drained of energy and had a dull sensation at the core of her body. In desperation, she offered her physical empathy experience to Cathy within the encounter and for the first time they held each other's gaze. She felt the psychological attunement, as Cathy wept silently.

In the following sessions, having given up on guiding Cathy toward what the therapist had considered a more productive exploration of her inner experiences, she found herself being more receptive to listening without judgment to what the client had to tell her, no longer with resentment and frustration. She found her head clearing and engaged in clear psychological contact with the client. At this point she began spontaneously to ask about these symptoms, when they started, what it was like to feel this way, and how the symptoms had changed from the beginning, not from a diagnostic perspective, but simply out of a desire to know the client better as a person. She responded to this and started to describe the beginning. Exploratory questions about her symptoms and empathic reflections came naturally to her and she asked whom the client had told at the time and who helped her. She described her odyssey with the doctors and their not believing her, and the different diagnoses and medications she had been given. She said that at home her husband and mother didn't believe her either. When at the end the session Cathy asked the therapist if she thought she was crazy, the therapist was able to share her experience of the client, but now from the perspective of being able to hear and offer warmth and acceptance to Cathy's own pathologized embodied distress. Within this shared encounter the therapist turned her focus inwards to her own body, to get an emerging body sense which was a feeling at the edge of her awareness. She took a risk and offered Cathy her congruent body empathy, 'Deep inside me, in my body, just here, I have a feeling of tightness, like a knot twisting deeply around inside my stomach' (She made a twisted gesture with her hands at the center of her body.) Again, they held psychological contact in the moment. 'Crazy, no, but you seem to be very frightened'. For the second time, Cathy wept silently.

When Cathy came to the next session and talked about the symptoms again, the therapist found herself more able to listen and more congruent in the encounter; she started to feel both Cathy's desperation and again the sensation of the pins and needles in her own head. Her body was telling her something that she could not suppress. She was receptive to this physical empathy and understood that it carried a message. She became curious, she had to listen to what it was saying inside her. This increased congruence led her to wonder to herself, 'What has happened to you?' She then asked Cathy what turned out to be the magical question: 'What was going on in your life when this all started?' Cathy then revealed to her that she had cheated on her husband, who was always absent both physically and mentally. She had never told anybody before. She was so frightened when she told the therapist that she immediately had thoughts telling that she was a very bad person and that she would die. The therapist kept listening to all the symptoms and found herself able to care about each of them. Through the curative process of offering UPR to each of her symptoms, Cathy was able to reveal a little more each time. As soon as it was too much for her she jumped back to a physical symptom. The therapist sensed the client's fear of punishment, her panic attacks, and her guilt.

With her own growing openness to her congruent responses to her own body, Cathy became more receptive. She was able to tap into her physical empathy and offer these tentatively to Cathy within the relational encounter and to see how the client was able to use these for her own sensory exploration. Cathy felt that her inner voices were her executioners; she was terrified. The therapist felt Cathy's panic in her head and offered her physical empathy: 'My head feels like there is a tornado spinning inside', as she felt the client's subjective experience of the symptoms. Her body responded to Cathy's description of her symptoms of how she was trapped by her guilt and the critical voices and didn't know what to do. The therapist then offered more physical empathy: 'My head feels like its trapped in a vice and it might explode'. This resonated with Cathy and she explained that this is why she ran to doctors for help, to stop her dying, hoping they might be able save her life.

Cathy came for 12 sessions over the course of four months. She did find a way to forgive herself and to understand why this had happened. She came to symbolize that the voices were her guilt about her affair but also the guilt she felt toward herself for not pursuing her happiness. She was suffocating and the symptoms were reminding her of her former self and better times (a clear expression of her actualizing tendency). On the other hand, the symptoms were also trying to deflect her attention away from her marriage and her unhappiness because she was economically dependent on her husband (what Mearns & Thorne, 2013, refer to as 'social mediation', another aspect of the actualizing process). She saw that her symptoms were trying to help her to maintain her status quo ('I'm crazy and therefore no one needs to listen to my concerns') and on the other hand became the reason for her to ask for help ('Find help or you will go crazy'). She admitted to herself that her marriage was empty and that she therefore needed to find other sources of meaning and satisfaction in her life. She became a good mother, and found a job (the job was the reason she could not continue coming). As Cathy became more congruent with her internalized experience, her physical symptoms subsided, except for occasional headaches; however, she was not frightened of them, and took no medication. She thought the headaches were referring to her marriage, which was indeed a headache for her. She remained in her sexless marriage, and the headaches were

reminding her that she needed more. She owned the critical, fearful voices as being manifestations of her inner self that were trying to help her; the more she decoded their meaning, the more she understood herself. Consequently, the voices and tingling subsided.

The problem with this way of expressing of one's inner conflicts is that it can lead a person on a deteriorating path; Cathy could easily have ended up as a psychiatric inpatient. Within the medical setting physical symptoms when taken together as a constellation are viewed a diagnosis ('somatoform disorder') and form the basis of a treatment plan. Working therapeutically within such a setting, the therapist herself learned that she needed to bracket the medicalized framing of the client's physical complaints. She had to recognize her own impatience as her internalized incongruence within the relationship, in order for her to be more flexible and to understand how important it was for her hospital clients to be offered a relational approach by being listened to and respected. She became aware that she needed to be curious and open to her clients' symptoms, to body memory, and the possible encoded meaning these contained, if she wished to engage with them and help them unfold the mystery of their medicalized difficulties. The initial conversation about symptoms can also bring some relief to both the client's physical symptoms and their psychological distress, because the person feels validated and taken seriously. It is also important to listen to symptoms because they open up the possibility of accessing the subjective personal meanings encoded in them. The therapist also learned that human beings are able to communicate and empathize with others on multiple levels. She discovered how she could be open to her own body awareness as embodied empathy and how to use this therapeutically within the relationship.

Mind and body in therapy

Understanding physical manifestations as communication containing valuable personal meaning is an observation first made by Breuer and Freud (1895) when treating Anna O for what was then labeled as hysteria. They came to see that medically unexplained ('hysteric') symptoms such as paralysis could have personal psychological meaning. In her treatment by Breuer, Anna O. (1955) originally came to understand and resolve her symptoms by detailed remembering of the circumstances in which they first occurred (cf. the case of Cathy presented earlier, but also Rice's unfolding of problematic reaction points; Rice & Saperia, 1984). However, when Dora (1905) later saw Freud for a range of somatic symptoms (migraine, loss of voice, coughing, breathlessness, bad moods, an aversion to life), he concluded that the meaning of bodily symptoms could be revealed by interpreting unconscious conflicts, which could influence all body parts and organs. Thus, Breuer and Freud demonstrated with these patients that physical symptoms were not void of meaning but expressions of nonconscious processes that could be understood through accessing memories of the origin of the symptoms as well as free association and dream work. (By referring to Breuer and Freud's work, we are not advocating the use of therapist expert interpretation, which from our perspective we see as both ineffective and potentially interfering with the client's actualizing tendency.)

As early as 1933, Wilhelm Reich posited that the way the body moves expresses the person's personality (Reich, 2013). His work influenced many later body-oriented

therapies, including Lowen's (1994) Bioenergetics, Rosenberg's (1985) Integrative Body Psychotherapy, and Boadella's (1987) Biosynthesis. Although there are conceptual and practice differences among different body therapies, they all question the idea of a mind-body duality and share the belief that the body can express the emotions and vice versa.

Our point here is that although it is unlikely that any therapist would doubt the power of the psyche on the body and vice versa. Thus use of the body in psychotherapy has been influenced historically by a lack of consensus about the use of touch and the complex ethical and clinical issues surrounding its use (Durana, 1998). These complex issues have influenced training and practice in relation to the focus on the body, possibly because of the potential harm to the client through risk of acting out inappropriate sexual feelings between therapist and client or because nonverbal interventions like touching may violate the boundaries of traumatized patients. Indeed, this was the experience of the first author when she first began her practice and even until her encounter with Cathy, detailed in the case described in the previous section. However, as she learned, these objections did not justify her 'deafness' toward the meaning of body-expressed symptoms that her clients were bringing to therapy.

We suggest that the PCE approach has much to offer here in ways of experiencing body awareness, and one such way is through physical empathy. Since Rogers, humanistic experiential psychotherapies have attempted, with varied success, to incorporate the body and its nonverbal communication into therapy. Indeed, Rogers (1961) linked prolonged incongruence with a range of psychological difficulties, including bodily symptoms and even in some people psychotic processes. For example, Prouty (1998) used patients' nonverbal or idiosyncratic language as well as their behavior as a means of establishing psychological contact. Thus the person's vocalizations or movements were treated as a means of communication and reflected back to them, helping to engage and connect with patients who drop out of psychological contact through dementia or psychotic processes.

Gendlin's (1978) Focusing includes the body in therapy as a compass for experiencing the inner voice that indicates the direction for change. Gendlin (1982) recognized that body symptoms and their quality were the language of unspoken, pre-conscious processes, which could be used to guide the therapy process and unlock important experiences for the client. He concluded that experiencing the bodily felt sense improved therapy. Focusing became a way of helping people access their felt sense, with relaxation techniques and guided imagery to facilitate nonverbal bodily awareness. Focusing provides a structured process in which therapists help people set up a kind of dialogue between the bodily and conceptual aspects of self, bringing that which is at the edge of awareness into awareness. Gendlin (1996) categorized physical symptoms as either central or peripheral. He stressed the existential importance of paying attention to the quality of physical sensation in the center of the body, i.e. in the throat-chest-stomach areas of the body. When paid attention to, the personal bodily meaning in the felt sense (which he posited as a preconscious physical sensation) is a step toward freeing the person's energy. Gendlin differentiated between *central* and *peripheral* symptoms. The latter are physical sensations in other parts of the body, e.g. a shoulder pain which incorporates a whole mass of experiencing. According to Gendlin (1996), a pain in the shoulder can have meaning; however, the exploration of peripheral symptoms is useful only if a parallel sensation manifests itself in the center of the body in relation to the

shoulder pain, because it allows the felt sense steps that can carry the person forward. Energy is released and so the pain in the shoulder will be relieved. According to Gendlin peripheral symptoms are more likely to be peripheral indicators that advancement has been made rather than sources of change.

As an extension to Rogers and Gendlin, we are proposing that all body sensations, regardless of where they are in the body, can be empathized with directly through physical empathy as well as mediated by imagery or preparatory relaxation exercises. We suggest that all presenting physical symptoms can provide potentially useful lines for exploration. Listening to clients' bodily experiences has been variously described as 'resonance' (Gendlin, 1978), 'empathy' (Rogers, 1957) and 'attunement' (Cooper, 2001). We are not advocating for therapists to adopt physical empathy as an expert-centered interpretive process. Rather, in accordance with trusting the actualization tendency, physical empathy is used within a unique collaborative hermeneutic process, helping the client to find their own meaning in decoding – in the sense of *unfolding* (cf. Rice & Saperia, 1984) their own puzzling symptoms. We are suggesting that PCE training and post qualifying PCE counselors could benefit greatly from learning how to attune to ones embodied empathy.

A theory of the significance and function of physical complaints in psychotherapy

We are proposing that bodily symptoms can be productively viewed as nonverbal carriers of important personal information; the brain is part of the body. However, if our training primarily emphasizes verbal communication there is a risk that we may end up paying little explicit attention to nonverbal communication in therapy unless explicitly expressed by the client through acts of crying or extreme outbursts of anger. This stance underestimates the importance of an innate form of communication. With the majority of communication being expressed nonverbally, it has been claimed that for perceiving positive emotional effects in communication, people rely 7% on the words spoken, 38% on vocal elements and intonation, and 55% on facial cues (Mehrabian, 1971). The intricate reading of others' feelings through nonverbal communication is a key aspect of normal communicative competence and is essential for everyday communication. People tend to be naturally empathic to each other's expressions of physical pain and feel sorry or concerned for people who are ill or injured; we also empathize with and at times strongly identify with others' physical suffering or pain (Davis, 2018). Yet in therapy if a physical problem is brought up, we may ignore it, or just acknowledge it in passing, because it is seen to be outside our domain of competence. We tend to pay attention to psychological symptoms when the resultant behavior becomes dysfunctional (e.g. obsessional compulsive difficulties or self-harm activities such as binge eating, cutting, or substance misuse) and takes up large amounts of the person's (and others') thoughts and time. However, what we see is the behavior or 'disorder' and not the personal meaning of these manifestations or what function the pain and discomfort serves in the person's life. We speculate that within the PCA there can be a primary focus on spoken communication, and that at times PCE training tends to focus toward listening and reflecting back the content of the words or their implicit meaning, more than their embodied experience. We propose that when dealing with medicalized problems empathy needs to be more

embodied or emotion focused, such as physical empathy as we are describing it here. In this regard we view existential ontology as having much to offer PCE training, specifically with its philosophical grounding on how the person lives out their body, and person's sense of the role of their embodiedness in their psychotherapy practice, to facilitate their communication and self-expression, their experiences and expressions of their gender and sexuality, and their sense of health and illness (Hersch, 2015).

At present in modern medicine and psychiatry, psychological manifestations and psychosomatic complaints are seen as a standardized cluster of symptoms representing different levels of physical illness or psychological distress and devoid of personal meaning (DSM-V: American Psychiatric Association, 2013; ICD-11: World Health Organization, 2018). We propose physical symptoms can be more usefully seen as coded experience or lost knowledge about the self that needs to be heard, understood and, in a relational context, offered the core conditions. However, these experiences may not be available for immediate use by the client or therapist, because the symptoms are still a form of deeply implicit communication reminding the client that something is not right.

In this perspective we draw from embodiment research, more specifically body memory with its phenomenology of the lived-body (Merleau-Ponty, 1962) and its dynamic aspects (Fuchs, 2000). Body memory takes various forms and six forms of body memory have been distinguished: procedural, situational, intercorporeal, incorporative, pain, and traumatic memory (Fuchs, 2011). Of particular importance to physical symptoms are intercorporeal, pain and traumatic memory. First, each body forms an abstract of its past history of experiences with others that are stored in *intercorporeal memory*. Embodied interactions are determined by earlier experience and unconsciously affect every encounter with others. As soon as we have contact with another person, our bodies interact and understand each other. Merleau-Ponty (1962; 1989) first termed this sphere of pre-reflective bodily understanding as *intercorporeality*. Second, we can all reflect upon *painful experiences* that have led to fear and avoidance of fear-related situations. Painful experiences are effectively inscribed into the memory of the body. These can also lead to psychosomatic illness. Research has found that up to 50% of all patients diagnosed with 'somatoform pain disorders' have suffered severe pain or violence in their childhoods (Fillingim et al., 1999). These psychogenic pains can become chronic as people unconsciously learn that their expressions of pain are rewarded with attention by their family members. Third, and the most enduring impression in body memory is caused by trauma, which may not be coherently synthesized and integrated into a meaningful context. Avoidance processes may serve to dissociate from, forget, protect, isolate or otherwise become incongruent toward *traumatic memory*. The trauma event itself may fade from conscious recall, but remains present and vigilant in lived body memory. When the person comes across a situation that evokes the trauma, the body recollects the trauma as if it was occurring it in the present (structure-bound process; Gendlin, 1996).

We view the therapist's capacity to use physical empathy to be important in the process of change in psychotherapy. Having an understanding of these forms of body memory and their dynamic aspects (Fuchs, 2000) is important for working within health settings where patients often present with medically unexplained physical symptoms. We argue that therapists could benefit from adopting an approach which is situated within a person-centered phenomenological model when working in health care settings. One such national-level dissemination programme, Improving Access to Psychological

Therapies (IAPT), receives around 1.25 million annual referrals and delivers psychological treatments following stepped care principles (Bower & Gilbody, 2005). We speculate that many clients who receive psychological therapies through health care systems similar to the IAPT programme are likely to present with medical symptoms. Here we suggest PCE therapy could be a more robust psychological treatment within such medicalized intervention programs if practitioners knew how to work with physical symptoms. Further, we argue that training therapists in physical empathy could enhance the fit of PCE therapies provided in health care settings. We propose that unfolding the different types of body memory is of particular importance for therapeutic approaches working with bodily experience. As such it is of key importance for therapists to be trained in understanding body memory and incorporating physical empathy into their practice, which may promote positive outcomes.

The development of self-other awareness is dependent upon the intersubjectivity between infant and caregiver dyads (Trevarthen, 1979). This affective interpersonal attunement underpins the later development of narrative structures and is inherent in concrete social interaction process before it achieves linguistic expression (Bruner, 1990; Elliott et al., 2021). Furthermore, it is the emotional quality of these interactions that is the foundation of infant mental health and wellbeing, leading to an ongoing process of narration from cradle to grave (Bråten, 1998). From this intersubjective perspective, the quality of parent-infant interactions has an effect on children's psychological wellbeing, which is also dependent upon the capacity of the parent to adapt to and help modulate the specific characteristics of the child, such as their temperament, behavior and general psychological functioning (Stern, 1995).

Frequently, experiences that were part of one's life before the full development of language and self-awareness have been coded as somatic sensations (Fogel, 2009; Fuchs, 2012b). For example, a child may get tightness in the stomach as a result of being shouted at by a parent. As a small child, they may not be able to name the emotion as 'fear' or relate it to their parent's anger, but the experience and emotion may be stored, for example, as a tight sensation in the stomach. Of course, this way of processing these unverbalized experiences is an expression of the actualizing tendency (Rogers, 1957). As the child grows older they are able to rationalize their feelings about being reprimanded (in order to cope with the fear and to justify their parent), but the tightness of the stomach will remain as a nonverbal reaction and a kind of nonverbal note to themselves, to avoid the fear of being shouted at and punished. Later on in life, the reaction in the stomach may become generalized to situations that give rise to similar fears and appear in therapy as a feeling of nausea/stomach discomfort when a particular person or situation is mentioned. Deeply incongruent, the association is not remembered, thus leaving only the symptom as a marker of a subceived experience. Somatic markers cause changes in the body and brain, which together make up an emotion (Damasio, 1999). According to the somatic marker hypothesis, emotional processes can consciously or unconsciously impact decision-making by creating biomarkers or somatic markers (Damasio et al., 1991). Further, these somatic markers can be triggered by the person's perception of external or imagined events and can include changes both observable (posture, facial expression) and unobservable (endocrine release, heart rate).

Even more precarious is when the symptom changes from stomach tightness and nausea to a generalized physical reaction accompanied by inflammation (e.g. colitis, ulcer,

constipation). Research suggests the body pays a heavy price through experiences of early childhood neglect and trauma, which can lead to a multiple health complaints, both psychological and physical in nature (Rothschild, 2000; van der Kolk, 2014). Following the initial complaint, the symptom may change by acquiring more and different symptoms over time (e.g. migraine, blood pressure or obesity). This leaves a trail of incongruent experiences in the form of symptoms to be decoded. This concept of embodied knowledge or body memory emphasizes its basis in the lived or subjective body. In order to decode these physical presentations, PCE therapists will want to develop an understanding of the different types of individual body memory, such as, procedural, spatial, situational, intercorporeal, pain, and traumatic body memory, (Fuchs, 2011, 2012). Earlier, we proposed intercorporeal, pain, and traumatic body memory as of particular significance for decoding (or unfolding) physical symptoms. Further, physical symptoms can arise through the formation of perceptual-affective-interactive schemas (also known as emotion schemes; Elliott et al., 2004) based on the infant's earliest experiences of how they have been held, comforted, guided, and reacted to by their caregivers; these are imprinted in their implicit or body memory (Hauke, 2018).

The original function of the symptom may be a fear response that is encoded in the body, but lost to awareness. The person's need to cope or actualize is met indirectly through the physical symptoms and fear of health problems. The person will visit doctors frequently, do tests, take medication, change diet but will have lost the original association, which was once a warning but is now a time-consuming health problem. These symptoms typically exist prior to therapy and often lead the client to ask for help. The person is in a state of incongruence, which is a bodily-experienced phenomena (Grafanaki, 2013). If physical symptoms are nonverbal communication and empathy is a complex nonverbal innate human capacity, then we can extrapolate that physical empathy is trainable, just as other forms of empathy are trainable, although training may involve unlearning bad habits of ignoring our innate body reactions to our clients. Therefore, we argue that physical empathy and attention to physical symptoms are rightfully part of the PCE practice, especially in medical populations. This includes emotion-focused therapy (EFT; Elliott et al., 2004), and in fact our formulation overlaps with EFT's view of secondary reactive emotions and self-interruptive processes.

At the same time, however, it is important to point out that, as we see it, specific physical manifestations do not have standard interpretations. Two people can have numbness but the imbedded personal meaning may be different because the personal subjective meaning has been coded and stored in the body within a social-cultural and personal context. Zatti and Zarbo (2014) propose a psychosocial explanation for this process: they see clinical conditions, including the manifestations we are considering here, as produced by the interaction of the person with their social context and culture (exbodiment) and the person's own subjective bodily experience of the world (embodiment). These authors propose that interaction between the person and their culture is a two-way process, where exbodiment refers to how a person enacts their embodied cultures, how the body expresses ideas, which are not similar to the ideal of society (Zatti & Zarbo, 2014). In this paper, our case study is drawn from therapy delivered within a Greek psychiatric hospital. However, we consider physical empathy to be applicable to socially and culturally diverse contexts. We propose the teaching and practice of physical empathy as part of a broader attunement to clients that offers person-world-centered

ontological depth and panexperiential breadth (Felder & Robbins, 2021). As we describe physical empathy we have drawn from PCT and existential phenomenology, which we propose can help therapists to sensitively open the door to exploring client's individual (human) being as well as their sociocultural-being-in-the-world (Felder & Robbins, 2021).

To further understand how social context and culture affect physical manifestations, an awareness of family and other systems theories is potentially useful for training PCE therapists, to help them understand how culture and family context can factor in the development of particular clients' physical symptoms. For example, Minuchin et al. (1975) developed a conceptual model of psychosomatic illnesses in children who presented with brittle diabetes, psychosomatic asthma or anorexia, which they saw as a result of family organization and processes that encourage somatization, where the child is involved in parental conflict and has a physiological predisposition. Similarly, Broderick and Weston (2009) see depression as the result of relationship struggles in the family. From a broader socio-cultural perspective, Levitt et al. (2022) argue that cultural and clinical empathy (including physical empathy as we are describing it) are intertwined and deepen each other.

We postulate that physical symptoms may initially provide mental relief from stress through experiential avoidance (incongruence) but upon repetition can themselves become a continuing health problem, often leading to a long career and new identity as a medical patient. The person has engaged in repeated patterns of interaction which become familiar and result in a prereflective sense of their way of being in the world, of how to get along with others, and how to elicit attention. This can be viewed as implicit relational or intercorporeal memory (Fuchs 2012a), that is, an organized body memory for rhythm, dynamics, and level of presence that affects interactions with others (Stern, 1995). Therefore, when the client arrives at the therapist's door they are likely not to fully engage in psychotherapy and will tend to question its purpose and usefulness, because it is inconsistent with their well-established understandings of their symptoms.

These implicit relational styles are also expressed in how the client is with themselves and the therapist. Often, they may prefer to use medication or try other types of solutions (alternative medicine, religion, surgeries, self-medicating behavior). They can become obsessed with the symptom, setting up a positive feedback loop, so that it becomes a habitual self-damaging and self-perpetuating activity from which the person has great difficulty escaping. The symptoms block and consume the person's attention, making it difficult for them to think of anything else. The person may lose insight into this process, commonly resulting in a psychiatric label, such as 'histrionic personality disorder', 'hypochondria', 'alexithymia', 'opioid abuse/dependence', 'somatoform disorder' or 'obsessive-compulsive disorder'. At this point, the person is locked into stuck or blocked process (Gendlin, 1996). This is why it is most useful to tap into symptoms at early stages of expression before they become stabilized and chronic.

Discussion

Most PCE therapists today are sensitive to medical terminology and to the philosophy of the medical model toward patients. The reductionist view that a diagnostic label attaches to our clients is viewed as pathologizing and is often rejected as part of the therapist-client relationship. We hold with this view. However, our position is that if we do not

acknowledge physical symptoms as potentially containing body memory with encoded meaning then we run the risk of our clients leaving therapy in a continued state of incongruence. If only words are the substance of therapy, if we do not attend to the presenting physical symptoms and rely instead primarily on verbal communication for understanding our clients' thoughts and feelings, then we are missing an important channel of experience and communication. Therefore, there is a need to expand and enrich the definition of communication in therapy to include physical symptoms or manifestations, especially when the client brings these to therapy. The actualizing tendency is after all the theoretical foundation stone of the PCA, the idea of human potentiality (Murphy & Joseph, 2019). We are present within the therapeutic encounter, offering the core conditions to all aspects of our clients, which results in growth, development and greater autonomy for the individual (Rogers, 1961, 1963)

In fact, we unwittingly collude with the medical model in our PCE practice when we close the door on these experiences. In the PCA we have for too long left such difficulties to psychodynamic therapists, ignoring the explanatory tools (e.g. incongruence, subceived experiences, actualizing tendency) and therapeutic approaches (e.g. systematic evocative unfolding, narrative retelling, empathic listening, unconditional regard, authenticity) offered by our own tradition. Just as doctors are generally blind to the psychological meanings of physical symptoms, so are therapists who accept the partitioning of the person into mind and body and ignore the latter as out of their jurisdiction. In our view, physical symptoms are a form of communication that is brought to therapy by the client. They are markers that tell us where to look, flagging an important event or meaning in a person's life which they have disattended to but enact in their relationships with others, the world and themselves (Fuchs, 2011). This opens up the possibility that the body may keep the score and that difficult memories, emotions and feelings may be stored or accessible throughout the body (van der Kolk, 2014).

In general PCE therapists believe that medical terminology disempowers clients and deprives them of personal agency. This has the unfortunate consequence of estranging us from medical and other health practitioners. Sommerbeck (2003), in her early days of working in a psychiatric hospital, admits to not engaging in dialogue about her person-centered and pre-therapy practice with the psychiatric team as this misaligned with the medical treatment plan. This gave her the space to offer a small PCE oasis for her patients within the confines of the medical setting. Therefore, during this early period of her practice she was neither working integratively, building bridges with her health specialist partners, nor introducing important ideas about personhood to other specialists. In fact, she later came to a more nuanced position, learning how to hold onto to her own person-centered view of her patients while at the same time empathizing with colleagues from other disciplines. Unless we develop shared language, which can belong to everybody, then we cannot share ideas or develop a common working model of health and rehabilitation, moving along the continuum of health between 'person' to 'patient'. The practice of pre-therapy has been gaining wider acceptance for clients who are out of psychological contact and who have received a range of medicalized diagnoses, such as people with dementia (Dodds et al., 2014) and those with psychotic process (Traynor, 2014), fragile and dissociative process (Warner, 2014) and autistic process (Carrick & McKenzie, 2011; Robinson et al., 2021).

We question the dichotomy separating body and mind, widely-accepted in our western societies. In fact such a separation is impossible, since the mind is part of the body and our existence depends on the functioning of our bodies, as a range of philosophers and health scientists have pointed out. We agree with other humanistic philosophers in advocating for counseling approaches to treat mind – body holistically (e.g. Felder et al., 2014). Following Merleau-Ponty (1989), we see ourselves as embodied beings who experience the world through our embodied experiences of the world. This suggests that the person knows best what they experience and how to explain their being healthy or ill. Engel (1977), a proponent of the biopsychosocial model, argued for moving away from a reductionist model of health and including the influence of psychology and social factors as contributors to health problems, and including the person's experience of being unwell. Unfortunately in current practice the biopsychosocial model is still very much a matter of different disciplines each doing their thing without having any common philosophical ground between them. Further, Cox (2011), a psychiatrist, proposed a person-centered medical model based on empathy and the quality of the therapeutic relationship, leading to an integrative psychological medicine as opposed to the currently segregated biological, psychological and social models of health care delivery.

Thus we are arguing that the medical model needs to broaden its thinking about illness per se, accepting that non-medical forms of treatment are possible, and that psychotherapy has an important role to play with medically-ill client populations, especially those with unexplained or chronic conditions. We propose that PCE therapists can play an important role both in preventive medicine and in promoting a humanistic, phenomenological model of health where the person is not de-humanized and objectified and whose self-experience of malaise is taken into account to help treatment. We can help by accepting somatic symptoms as another form of self-expression, as opposed to reducing them exclusively to disease; in this way we can shed the dualistic residue implicit in our thinking. In our view our position is consistent with the more integrative view found in many nonwestern countries (Lago, 2011; e.g. traditional Chinese medicine, Wu, 2011). In fact, in their meta-analyses of outcome research on PCE therapies Elliott et al. (2013; 2021) have consistently found good evidence, from a total of 53 studies, for the effectiveness of these therapies with clients living with a range of chronic medical conditions, including medium to large pre-post change, medium controlled effects and statistical equivalence to other treatments, including cognitive-behavioral therapy.

We would like to return to the importance of physical empathy and its foundation in the PCA by reflecting on Rogers (1957)) definition of mental health in his propositions. In proposition 14 he writes: ' … psychological adjustment exists when the concept of self is such that all the sensory and visceral experiences of the organism are or may be assimilated on a symbolic level into a consistent relationship with the self-concept'. In proposition 15, he posits that psychological maladjustment ' … exists when the organism denies awareness of significant visceral experiences, which consequently are not symbolized and organized into the gestalt of self-structure'. Rogers (1953) recognized the importance of the body and used the terms 'sensory and visceral experiences' which focusing-oriented therapists now call the 'felt sense' or 'bodily felt sense' (Ikemi, 2005). We are advocating that PCE training could enhance therapeutic practice if therapists were trained specifically in physical empathy. First, we recommend highlighting the importance of physical symptoms as (following Rogers) sensory and visceral experiences that need to be assimilated into

the self-concept. Second, we support training therapists in physical empathy (for example by learning focusing) to open their receptivity to exploring the body memory and personal meanings encoded in physical symptoms. Third, we advocate training therapists to attend to their own bodily felt sense as a possible empathic mirroring response to their clients' physical symptoms, helping them to support their clients in unfolding body memory and meaning making. Thus, we see the practice of physical empathy as offering potential to aid symbolization of physical parts of self into the gestalt of self-structure.

We also call for research on extending our concept and practice of empathy to include physical symptoms, and the personal presenting meanings encoded in them. How therapists can best empathize with physical symptoms requires further investigation, through qualitative interviewing and observational process research. First, we need to know more about how and when therapists respond empathically to clients' physical symptoms, and what impact this has on clients. Second, it would be useful to study therapists' experiences of physical empathy, including the impact this has on them, and how awareness of physical empathy can be used as a self-reflective practice tool. Third, we recommend systematic task analytic research (e.g. Greenberg, 2007) on the process of helping clients explore and elaborate their puzzling or unexplained medical symptoms, including markers, effective ways of facilitating work on them, and what resolution looks like. In general, we want to know, 'How do clients' and therapists' bodies interact and understand each other within the process of physical empathy?'

In closing, we return to Merleau-Ponty's (1962) observation that the body is the primary way humans experience the world. As soon as we come into contact with another person, our bodies interact and understand each other, a process of pre-reflective bodily understanding, or *intercorporeality* (Merleau-Ponty, 1989). Physical empathy occurs in therapy within this pre-reflective bodily space between therapist and client. Body memory, including intercorporeal pain and traumatic memory (Fuchs, 2011), is held within the client and can be explored within the therapeutic encounter. Being able to help clients unfold current body experiences as well as body memories is of particular importance to therapists working in health and medical settings where patients are likely to present with physical symptoms. Therefore, having an awareness of body memory in its differing forms is an important skill for therapists working in such contexts. We also call for expanding PCE training to include experiential training in body-oriented therapies such as Focusing, as well as enhanced empathy training where therapists and counselors in training learn how to use their bodies to open up multiple channels of receptivity (Rutherford, 2012).

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