Here is the main point and invitation: (a) If you and the client are both fully attending to a compelling, important, feeling-arousing center of attention, rather than attending to one another; (b) if you are situated so that the client’s words come from inside you, truly as if from some part of you, rather than from a separate person who is over there; and (c) if you are “aligned” in these two ways throughout most of the session, then (d) you can have virtually direct access to the most private, personal, sensitive world in which the person is living and being, both on the surface and more deeply and (e) you can probably be in direct touch with the feelings and experiencings occurring in the person, both at the surface level and much more deeply. Here is a way of being empathic by going “beyond empathy” and into therapist–client “alignment” (Mahrer, 1996; Mahrer, Boulet, & Fairweather, 1994).

What are the Aims and Goals of More or Less Traditional Empathy and of Empathy as Therapist–Client Alignment?

Empathy is generally acknowledged as brought into psychology and psychiatry by Theodore Lipps in 1897 and as probably first used in the diagnosis of mental disease by Southard in 1918 (Schilder, 1953; Schroeder, 1925). Since then, it has been acknowledged as playing a central role in many therapies (Brenner, 1982; Cox, 1988; Fox & Goldin, 1984; Freud,
Empathy is generally understood as having two aims and goals. First, it is to enable the therapist to get inside the client's frame of reference, to see the client's world through the client's eyes, and to see the client's world the way the client does (Carkhuff, 1972; Egan, 1986; Havens, 1974; Mearns & Thorne, 1988; Rogers, 1951). Second, it is to enable the therapist to know, have, grasp, understand, sense, and share what the client is feeling, thinking, and experiencing both at a more surface level and at a deeper level (Berger, 1987; Jaffe, 1986; Kohut, 1978, 1984; Langs, 1982; Margulies, 1984; Schafer, 1959). In general, empathy or being empathic includes both of these components (Berger, 1984; Brammer & Shostrom, 1982; Brenner, 1982; Dymond, 1949; Fliess, 1942; Gladstein, 1977, 1983; Korchin, 1976).

The aims and goals of therapist-client alignment are essentially the same, and it is fair to say that being aligned is another way of being empathic.

What is a Definition of Empathy as Therapist-Client Alignment?

The therapist is aligned when (a) both therapist and person are mainly attending out there, onto something that is important, that is the center of their attention; and (b) the person's words seem to be coming from inside the therapist, from some part of the therapist, from in and through the therapist.

When the therapist and the person are doing these two things rather well, then there usually are two consequences, and these two consequences help define empathy as therapist-client alignment. The therapist lives, exists, in the immediately ongoing world of the person. The therapist can live in this world as much as, or even more than, the person. The therapist actually has, undergoes, the feelings and experiencings that are occurring in the patient, both at the more or less surface level and at a much deeper level.

This is the state the therapist is in throughout most of the session. It is not some state that the therapist dips in to and out of.

When therapists began writing about this state, they described it as merging or fusing with the patient. Although alignment shares much of the spirit of these two terms, what the therapist actually does and the defining consequences may be a little different than the pictures that might go with more poetic terms such as merging and fusing into the patient, although the spirit is similar.

WHAT DO YOU DO TO ACHIEVE EMPATHY AS THERAPIST-CLIENT ALIGNMENT?

There are explicit things you can do to get into and remain in this aligned state throughout the session.
How Can the Seating Arrangements Help Therapist and Client to Attend Mainly Out There and Help the Therapist to Live and Be in the Client’s Personal World?

I like to use big, comfortable chairs, with high headrests and ample arm rests, where we can lean back and put our feet on large foot stools. Both chairs are quite close to each other, perhaps 1 or 2 feet apart, and facing in the same direction. I want the chairs close because I would like to be almost united with the person. I want the chairs facing the same direction because we will both be attending out there, at whatever it is, at the young fellow in the elevator, or her mother’s frowning face, or the cancer in her lung.

To help me see what is out there, and to feel and experience what the person is feeling or experiencing, and to minimize all the interferences and problems of two people looking directly at each other, I close my eyes throughout the whole session. I also invite the person to do the same, for precisely the same reasons.

These seating arrangements are fine for most patients. However, many therapists have a hard time. To make it easier for these therapists, it usually helps if you sit at the usual angle with the person. Explain that it helps you to listen carefully if most of the time you are looking off, or away, or down, or out there, rather than directly face to face and that you may even close your eyes at times, to concentrate more on what the person is saying. Invite the person to do the same thing if he or she wishes. After all, this is what two people often do when they are both looking at the baby or the tennis racket or the faucet, when one is concentrating on what her mother actually said, or when both are recollecting the high-school teacher. Looking away, and even closing your eyes, are rather natural under these conditions, even though this does not happen much in most therapies.

Give Opening Instructions to Enable the Client to Attend Out There and to See Strong-Feelinged Scenes

In the beginning of each session, your opening instructions aim at enabling the person to look out there; to put most of his or her attention out there, and to see things, objects, times, or scenes of relatively strong feeling. You are candid in showing the person what he or she is to do and why.

You say something along these lines.

Put all your attention out there. Be ready to see something, maybe one or two things. Just see the things that come to your mind, whether or not they have anything to do with what I say. You may see anything, or all sorts of things. It may be from recently or maybe from some time...
ago. . . . Ready? Are you all set? . . . Think of the thing that bothers you, that really troubles you, that makes you feel rotten, awful, worried, terrible, the thing that drives you crazy, worries you more than anything. . . . Think of the times when you have strong feelings. You know that the strong feeling is in you, even if it came and went in a flash. A time when the feeling in you is very bad, awful, rotten, or maybe just wonderful, feels great. . . . Think of the kind of strong feeling that you have, one you like, feels wonderful. Or one that feels terrible, bad, awful. Now think of some time when you have this feeling. . . . All right, what did you see, whatever it was?

You may get a little more specific by naming particular topics that help the person see a scene of strong feeling. You say,

Think of when you had one of the worst feelings you ever had. . . . Think of one of the worst things about you, that thing about you, since you were little, the thing about you that you just can’t get away from, and it makes you feel bad, and it’s always been the kind of person you are. . . . When is it that you felt so scared or troubled or just awful? . . . What is on your mind now, and when you think of it you feel rotten, depressed, torn apart? . . . What is the thing that bothers you so much, worries you? . . . When is it that you feel good, great, just wonderful . . . or awful, terrible, the worst? . . . There, so what comes to mind? No matter what it was, what did you see?

When you give the opening instructions well, and when the person is ready and willing, she will be looking mainly out there, she will be seeing scenes of at least moderate feeling, and she will be having at least moderate feelings.

Both Therapist and Person are Fully and Continuously Attending Out There Rather Than Mainly to Each Other

From the moment you start the session, as you give the opening instructions, and throughout the entire session, your attention is mainly directed out there. The patient’s attention should likewise be mainly out there. Showing him or her how to do this is one of the purposes of the opening instructions. Accordingly, throughout the whole session, both of you are attending predominantly out there, onto whatever it is, and not mainly at each other, as is the usual posture (Havens, 1986; Mahrer, 1978, 1982, 1986, 1989a, 1989c, 1996; Major & Miller, 1984; May, 1989; Rothenberg, 1987).

Both of you are looking at some scene, some incident, or some particular thing such as the flower or the toy truck or the bird, or something inside such as the cancer or the headache. Even when you address the person, your attention is always and continuously directed out there. In this stance,
you rarely attend mainly to the patient. This model has essentially no place for the two of you to be face to face, mainly attending to each other.

What the Patient Says and Does Come From Inside the Therapist

With your attention mainly out there, and with your eyes closed, posture yourself so that the patient's words are coming from inside you. It is as if the person is a part of you, and what is being said, including how it is being said, is coming from within you. It is as if your outer boundary has stretched to include the patient, or as if the patient is an enlivened, speaking part of you, or as if the two of you are within an encompassing, larger personality. With the two of you sitting so close, with both of you attending out there, with your eyes closed, it is easy to receive what the patient says and does as if it is originating from within you and occurring in and through you. Quite literally, you are both saying these words, and in this way. Beyond your “talking along with the patient” (Rothenberg, 1987, p. 451), the patient’s words are almost literally your words, literally coming from you (Mahrer, 1986, 1989a, 1989c).

Put your attention out there, and let the person’s words be as if they are coming from inside you, coming in and through you, said by you: “I love my mother. I would do anything for her . . . I never show my feelings, and I think that’s the way the whole family is.” Practice until the patient’s words are your words.

What Are the Necessary and Just-About-Sufficient Conditions for You to Be Aligned With the Person?

Three of these conditions have already been mentioned. You have to give opening instructions so that the person and you direct most of your attention out there, on some scene that is accompanied with relatively strong feeling. Second, both you and the person are to be attending mainly out there. Third, you are positioned so that what the person says and does comes from inside you.

Fourth, you must be sufficiently competent and skilled to give the instructions, to attend out there, and to let the person be inside you. Just knowing what to do is not enough; you have to be competent and skilled. Fifth, both you and the person must be quite ready and willing to attend mainly out there. If either of you is not fully ready and willing, you cannot be aligned. Usually, it is much harder for therapists than for clients to put most of their attention out there and to stay in this posture throughout the session. The willingness to throw oneself fully into attending out there usually represents the turning point between a therapist who can’t quite be aligned and one who is good at being aligned. Finally, it is necessary that the aligned posture makes sense and seems to fit with your picture of psycho-
therapy. When these conditions all seem to be nicely present, then it is almost certain that you are being aligned.

Can You Be Aligned With Just About Any Person, or Are There Particular Clients and Client Qualities That Make Alignment Difficult?

If you are competent and skilled, and if the client is quite ready and willing, you can be aligned with just about any client. None of the categorizations by which most therapists describe patients seem to make any difference. It makes little or no difference if therapists describe the person as psychotic, having this or that mental disorder, being autistic, emotionally labile, character disordered, resistant, unmotivated, controlling, borderline, acting out, paranoid, or a paragon of abhorrent qualities. When you are skilled at letting yourself be aligned, you can be aligned with just about any person; there are essentially no limits.

Nor does the likelihood of being aligned have much to do with the relative goodness of fit between your characteristics and the patient's. You may be Black, young, female, slender, short, upper class, and beautiful. You still can be aligned with a patient who is White, old, fat, tall, lower class, and ugly. Although there may be some extreme examples, you can be aligned even if you have not been through the history, background, or experiences the person has been through. Most of the usual restrictions make little or no difference when the person is ready and willing and you are skilled and competent at being aligned.

There are mainly two ways that clients can make alignment almost impossible, at least in this session. One is that the person is neither ready nor willing to follow the instructions and to put most of his or her attention out there, on whatever is accompanied with relatively strong feelings. The other is when the person is insistent on attending mainly to you and not to whatever is out there. When patients are either of these two ways, alignment is almost certainly difficult, at least in that particular session.

Can Just About Any Therapist Be Aligned, or Does Alignment Seem to Call for Certain Therapist Qualities and Characteristics?

I have been wrong so often that I don't even try to predict which therapists will be able to learn the skills of attending out there and letting the patient's words come from inside the therapist. To learn the skills of being aligned, the therapist needs to be able to learn the skills of being aligned.

What does seem to be important is that the very notion of being aligned with patients makes psychotherapeutic sense. If it does make sense, you can learn the skills. If, alternatively, what seems much more sensible is for you and the patient to be face to face, attending almost exclusively to each other, then it could be very hard to be aligned. The very idea
would grate, especially because you would be sacrificing all the supposed advantages, role relationships, and personal experiencings that go with attending mainly to each other in a face-to-face posture (Mahrer, 1978, 1989a, 1995).

Being able to be aligned seems to have little or nothing to do with the kind of person that you are. You would think that being able to be aligned would depend on the degree you can have many different feelings or you have been through the kinds of experiences the patient has been through. Although there may be some extreme exceptions, I find that when you are truly skilled, you can be aligned, even though, in contrast to this client, you have not been pregnant, tried to kill yourself, been beaten up by a violent stranger, been truly alone, felt absolutely crazy, been with a friend who died in your arms, or grew up as the only boy with four older sisters. When you are truly skilled, the range of who and what you can be is about as great as when you become something or someone in a dream.

Except for being skilled and having alignment make sense, I know of few if any personal qualities or characteristics that mean a therapist probably can or cannot be aligned with this patient.

The Consequence is That You Live in the Patient’s Immediate World

The consequence of being aligned is that you will see all sorts of things. You will live and be in scenes and situations that are from the person’s immediate and conscious world or from farther in and deeper (Havens, 1978, 1986; Mahrer, 1978, 1989a, 1996; May, 1989). What you see may be fleeting or more lasting, real or unreal, vivid and detailed or softly diffused and cloudy, immediate or remote, mundane or dramatic or big whole situations or tiny objects.

You are a little girl, walking with grandmother in the park, with your right hand raised, rhythmically squeezing her hand as the two of you walk along. You are seeing your neighbors huddled together and eying you with evil intentions. You are lying in bed lightly kissing the neck of your lover. You are seeing the cancer in all its fatal glory. You are witnessing the “depression” attacking you whenever it chooses. You are seeing your self, walking along the street, bloated with fluids of all kinds.

The payoff is seeing, living, and being in this scene, in the patient’s immediate world.

The Consequence is That You Have the Feeling and the Experiencing Occurring Inside the Person

When you are living and being in the person’s world, and when the person’s words come from inside you, the consequence is that something happens inside you. You have a feeling or experiencing (Buie, 1981; Furer,
1967; Havens, 1972, 1973, 1978, 1986; May, 1989; Mearns & Thorne, 1988; Vanaerschot, 1990). You may be having this feeling or experiencing just a little bit or fairly fully and intensely. But you can undergo, sense, share, resonate with, and have whatever feeling or experiencing goes with your saying these words in this way and in living and being in this scene. You will feel aroused, critical, silly, or cruel, like you had better get out of here, or like bathing in the glory of his or her looking at you that way.

There is a special added bonus when you and the person have discovered the precise moment of strong feeling, when both of you are living and being in this moment of strong feeling and when you are quite fully aligned with the person. The bonus is that you can go beyond the more or less surface feeling or experiencing. You can sense, receive, and have experiencings that are deeper within the person. Finding and being in these precious moments of quite strong feeling seem to be a royal road into what lies deeper inside the person (Mahrer, 1982, 1986, 1989a, 1989b, 1996: cf. Major & Miller, 1984; May, 1989; Mearns & Thorne, 1988; Vanaerschot, 1990).

How can you be reasonably confident that this is indeed the surface experiencing or perhaps even the inner, deeper experiencing? What makes you believe that the inner, deeper experiencing is of winning, beating, being the best? The experiencing may be held in reasonable confidence provided that you are well and truly aligned. Once you have fully allowed the person's words to come from inside you, and once you are fully living and being in the evoked scene, then you may confidently trust the experiencings you get.

The Consequence is That You Virtually Let Go of Your “Self,” Your Stream of Private Thoughts, and the Face-to-Face Relationship With the Patient

When you are thoroughly aligned, you have essentially stepped outside your own continuing sense of self, your identity, the continuing person who you are. You are mostly disengaged from your own troubles and worries, your own sense of who and what you are, your own way of thinking about things, and your own personal world. Instead of being a therapist with this patient, you have disengaged from that you, and you no longer have that continuing ordinary sense of self.

Being aligned means that you have essentially let go of the usual stream of private thoughts. There is virtually no removed stream of inferences, no executive monitoring of what is going on, and no private observations. There are essentially no private thoughts about how to phrase what you intend to say, whether to deal with this particular matter now or a bit later, what topic to pursue next, and how what the patient is saying is similar to what he said in previous sessions. You are no longer in a position to have this stream of private thoughts.
When you are aligned, almost all your attention is out there, and almost all of the patient's attention is out there. This means that there is little if any of the two of you attending mainly to each other. The vaunted therapist–patient “relationship” is all but washed away. You have stepped away from helping alliances, transferences, and relationships in which each party is attending mainly to the other. Even when you address the patient, it is generally with most of your attention out there, on something other than mainly that person. When you are aligned, the two of you have departed from the mutual attending to and relating to each other.

These are the ways to achieve empathy as therapist–client alignment. We now turn to how to use this state of alignment, how to use the scenes of your living in the person's world, and how to use the feelings and experiencing that you have.

**HOW DO YOU USE EMPATHY AS THERAPIST–CLIENT ALIGNMENT?**

Once you are in a state of alignment, how do you use that state? Suppose that you are living and being in the person’s world, how do you use that? Suppose that you have the person’s feeling and experiencing, how do you use that?

**You Can Stay in This Aligned State Throughout the Entire Session**

You can use the state of therapist–client alignment by remaining in this state. Throughout virtually the whole session, most of your attention is out there, and you are positioned so that the person is inside you, talking from in and through you. This is your normal, ordinary, continuing position from the very beginning to the end of the session. You do not dip into and out of this posture, this state.

**You Can Be the Voice of the Person’s Experiencing**

One of the most useful consequences of being aligned is that you sense, you undergo, and you are the very experiencing that is occurring in the person. You speak as this experiencing, you are the embodiment of this experiencing, and you are the live expression of this experiencing. You think, feel, and behave as this experiencing. This experiencing is the kind of person that you are.

Typically, you are on much better terms with the experiencing than the person is. You can be more welcoming, more appreciating, and more loving of it. You relate to it much more wholesomely. It feels good being this experiencing. Whether it is an experiencing that is more on the surface
or deeper, you probably can like the experiencing more than the person does. You can be better friends with it. You can also be the inner experiencing more openly, fully, easily, and spontaneously. Quite often, the person draws back from it as something awful, twisted, and dangerous and sees it as appropriately awful, twisted, and dangerous. In contrast, the experiencing that you are is softer, nicer, more fun, gentler, friendlier, more gracious, good-feelinged, and different.

You are the voice and the being of the person's caring, nurturing, and loving; you are the person's sensuality, sexuality, and eroticism; you speak as the person's being superior, accomplished, and better than. If the experiencing shifts about, especially in the first step of each session, you shift the experiencing to which you give voice. Whatever the nature of the experiencing, you are its voice. Essentially, empathy as therapist–client alignment defines and tells you who you are throughout the session.

You Can Enable the Person to Live and Be in Feelinged Scenes, Rather Than Attending Mainly to You

Throughout the whole session, your attention is mainly out there, and you are living and being in scenes of relatively strong feeling. This means that the person can also be attending mainly out there and, likewise, can live and be in scenes of relatively strong feeling. If you can do this, so can the person. When you are ready and able to do this, the chances are good that the person can also do this. When the person is attending out there, living and being in feelinged scenes, the person is thereby not attending mainly to you. In this aligned state, the person is able to go through the steps of experiential change, and the person can avoid the traps of attending mainly to you.

You Can Get the Information You Need for Experiential Change

For the person to go through experiential change, you mainly need to discover the deeper experiencing that is inside, and you need to know the scene or situation that is out there, the one in which the person is living. This is the main information you need to proceed with your work. The aligned posture is explicitly designed to enable you to get this kind of information. If you are mainly face to face with the patient, attending mainly to each other, it will probably be much harder to get this information.

The common face-to-face way of being with clients can provide all sorts of other information and is probably better if you want to get such information as how the client does on hundreds of tests, what kind of mental disorder the client has, what the client's demographic information is, what the client's medical histories is, how far the client went in school, what
previous treatments entailed, what jobs the client has had, how often the client has sex and with whom, which parts of the country the client lives in, and lots of other information. However, if you want to get the kinds of information you need for experiential change, the face-to-face way of being with a client is probably much less useful than the aligned posture.

You Can Use the Therapist–Client Alignment to Help in Finding the Deeper Potential for Experiencing

Finding the deeper potential means that both of you must first find a scene of strong feeling. Then you both are to enter into this scene, to live and be in this scene, and to try to find the precise moment of strong feeling in this scene. Once you are living and being in this precise moment of strong feeling, you can be in a position to access, to receive, the deeper potential. There are various methods of accessing and receiving the deeper potential, once you are in the moment of strong feeling, but all of these methods depend on your being aligned with the person. Indeed, just about everything that you do to find the deeper potential for experiencing requires that you be in this state of alignment.

Once You Find the Deeper Potential, You Can Use the Therapist–Client Alignment

Once you discover the deeper potential, your being aligned with the person enables you to accomplish some valuable kinds of therapeutic changes.

In Enabling the Person to Welcome and Appreciate the Deeper Potential

Once the deeper potential is accessed and discovered, it is possible for the person to achieve a radical change in the way the person relates to this particular deeper potential. Instead of fearing it; hating it; running from it; and keeping it hidden, distant and barricaded, there can be a magnificent change so that the person welcomes and appreciates the deeper potential, enjoys it, feels good about it, and relates more integratively toward it.

There are lots of specific methods both the therapist and the person can use to help enable this kind of change. The aligned state is just about essential in using the methods for enabling the person to welcome and appreciate the deeper potential.

In Enabling the Person to Be the Deeper Potential in the Context of Earlier Life Scenes

Once the person welcomes and appreciates the deeper potential, the person is in a position to undergo a radical change of disengaging from
the ordinary, continuing person and entering into or “being” the deeper potential. This is accomplished when the person can be the deeper potential within the context of earlier life scenes. These scenes may be relatively recent or from some time ago. The methods for accomplishing this qualitative change virtually require that the therapist be aligned with the person, that the therapist live and be in these earlier scenes right along with the person, and that the therapist likewise make the momentous shift into being the deeper potential. The therapist is to take on the identity of the deeper potential, is to be the voice of the deeper potential, and is to join with the person in being the deeper potential in these earlier life scenes.

In Enabling the Person to Be the New Person in the Present

The final step in each session gives the person a chance to be a whole new person right now, in the present, after the session, in the extratherapy world. The person ends the session and, I hope, goes into the extratherapy world as this new person and as someone who is now relatively free of the bad-feelinged scenes from the beginning of the session.

Accomplishing this fourth step calls for particular methods that depend on the therapist and person being aligned. Being aligned, by itself, does not accomplish this fourth step. But just about all of the methods rely on the therapist being aligned.

How do you use empathy as therapist–client alignment? Being aligned with the person, both attending out there, with the words of the person coming from inside you—these are essential ingredients for you to enable the person to access the deeper potential, to have a good relationship with the deeper potential, to actually be the deeper potential in the context of past scenes, and to become the new person in the present.

HOW DOES EMPATHY AS THERAPIST-CLIENT ALIGNMENT RELATE TO SOME OTHER MEANINGS AND METHODS OF EMPATHY IN OTHER APPROACHES?

Answering this question enables us to take a closer look at this meaning of empathy. At the same time, we can get a more careful picture of how this meaning of empathy may differ from some other meanings in some quite explicit ways.

Therapist and Client Both Attend Mainly to the Focal Center of Attention Versus They Attend Mainly to Each Other

In the aligned model, both therapist and client spend almost the whole session attending out there, both concentrating on the scene, the thing,
the focal center of attention. The actual content of this third thing, this focal center of attention, generally shifts quite a bit throughout the session, but they both are attending mainly out there, onto the focal center of attention.

In most other approaches, therapist and client spend just about the whole session with most of their attention on each other. Even when most therapists are being empathic, their attention is mainly on the client. Of course there are some exceptions. Therapists may not be attending mainly to the client when the client is free associating or looking over a symptom checklist, but almost always most therapists studiously attend to the client even when therapists are being empathic. This is why it is understandable that so much is made of the relationship and the interaction. From moment to moment throughout most sessions, most therapists and most clients are attending mainly to each other. The two models differ immensely on this point.

The Methods of the Aligned Model are Generally Outside the Methods of the Face-to-Face Models

In the aligned model, the therapist attends mainly out there, seeing what is out there, living and being in those scenes, and doing so along with the client. In the aligned model, the therapist allows the words of the client to come from inside the therapist. These two methods, and the specific techniques and procedures for doing these two things, are generally outside the methods of face-to-face approaches. A list of the empathic methods, in the face-to-face models, would seldom include our two methods. In teaching students the methods of empathy, our two methods are not standard fare. They are almost certainly outside the boundaries of most face-to-face therapists.

Which Model Is More Useful for Enabling the Therapist to Let Go of One's Self, Therapist Identity, Private Thoughts, Inferences, and Preconceptions About the Client?

Some therapists talk about a state of being so naive, so open to what comes from the person, and so sensitively receptive to the person that this state earned its own name of recipathy (Murray, 1938). Other therapists talk about the empathic state as one in which the therapist is relatively free of the sense of self, of personal identity, and of having few if any private thoughts or inferences and virtually no preconceived ideas about the client. Some refer to this as a state of Husserlian “phenomenological reduction” in which you are free of what is you and you are almost wholly open to the phenomenon itself. In this general state, you are essentially free of your own self-awareness, your identity, and your preconceived notions of the
person's history, personality, your feelings about this person, and the treatment program for this session. In general, many therapists see this as an essential ingredient in being empathic (Buie, 1981; Chessick, 1992; Freud, 1912/1953; Greenson, 1967; Margulies, 1984; Margulies & Havens, 1981).

The aligned model places high premium on this state. Its methods enable you to achieve this state. You achieve this state when you attend fully to what the person's words put out there for you to focus on and to live and be in. You achieve this state when the person's words are your words, when how and what the person says are how and what is coming from inside you.

The Aligned Therapist Has and Is the Experiencing Occurring in the Person Versus the Therapist Retains One's Own Identity or Self

The aligned therapist is almost fully undergoing the experiencing that is occurring in the person. Rather than having this experiencing just a little bit and being keenly aware of your being a therapist who is having this experiencing, you are the self or identity who is this particular experiencing. You are literally being the experiencing of defiance, refusal, and standing one's ground. You are much less a therapist who says, "I, the therapist, sense an experiencing of defiance, refusal, standing one's ground. How interesting this is! This explains why he is treating me like this." There is little or no conscious awareness of being you, a therapist, with your own identity and self, and that you are being with a patient who is over there. There is, in other words, a washing away of the self–other distinction (Vanaerschot, 1990). It is as if the two of you now occupy the same physical space (Rothenberg, 1987), and you literally take on the experiencing identity or self that is the other person (cf. Buie, 1981; Corcoran, 1982; Havens, 1978; Major & Miller, 1984; May, 1989; Olden, 1953).

In contrast, in most face-to-face therapies, the empathic therapist is to keep a firm grip on one's own sense of identity or self. Tiptoe out a bit, venture toward the client's self or identity, but do this "as if" you are being the patient. Do not go too far, do not become the client too much, and beware against losing your own stable identity or self (Airing, 1958; Beres & Arlow, 1974; Blackman, Smith, Brokman, & Stern, 1958; Cooper, 1970; Lichtenberg, 1984; Mearns & Thorne, 1988; Rogers, 1959; Schafer, 1968; Schroeder, 1925; Stewart, 1956).

In the same way, most face-to-face empathic therapists want to know the feelings and experiencings going on in the patient, but there are plenty of warnings against actually undergoing the patient's feeling and experiencings, and certainly against having them "too much" (Beres & Arlow, 1974; Cooper, 1970; Rogers, 1959; Rogers & Truax, 1967; Rowe & Isaac, 1991; Schafer, 1959; Szalita, 1976; Truax, 1967). Havens (1973) is clear in describing Freud as being penetratingly drawn toward knowing what is going
on inside the patient, the feelings and experiencings, but as clearly not wanting to undergo them.

The Aligned Therapist Lives in the World of the Patient Versus the Face-to-Face Therapist Remains Safely Outside the World of the Patient

The aligned therapist actually lives in the scenes created by the words of the patient. So much of the therapist's attention is directed out there, and so ready is the therapist to live and be in these scenes, that the therapist is typically living in the patient's world at least as much or more than the patient. The therapist is wholly living in a scene in which she and her mother are having coffee together, or he is writhing in sexual feelings on the bed, or he is slapping the other guy on his shoulder and laughing in camaraderie, or she is holding the infant on your lap and feeling her right index finger pushing your lower lip down.

In contrast, most face-to-face therapists are warned against living in the patient's world "too much" or entering in "too far," or becoming caught or lost in the patient's world (Airing, 1958; Blackman et al., 1958; Cooper, 1970; Mearns & Thorne, 1988; Rogers, 1959, 1975; Schafer, 1959; Stewart, 1956; Vanaerschot, 1990). The face-to-face model's emphasis on generally retaining one's self and identity is not especially useful to allow the aligned therapist to live and be in the patient's immediately ongoing world.

The Aligned Therapist Joins With the Patient in Going Through the Steps of Therapeutic Change Versus the Empathic Face-to-Face Therapist Is Unlikely to Join With the Patient in Going Through the Steps of Therapeutic Change

The aligned therapist shows the patient what to do and how to do it, in going through the actual steps of therapeutic change. More important, the aligned therapist is exceedingly ready, willing, and able to accompany the patient so that both go through therapeutic changes, therapist and patient together.

In contrast, most empathic, face-to-face therapists apply interventions. They engage in relationships with their clients. They use methods and techniques that are either part of being empathic or deemed helpful in accomplishing what the face-to-face therapist seeks to accomplish. However, these interventions, methods, and techniques, these therapist-client relationships, generally do not include joining with the person in going through the actual steps of therapeutic change. Being empathic does not typically mean going through the changes right along with the patient, in the face-to-face model of empathy.
The Aligned Therapist Loses Most of What Is Provided by the Relationship, Therapist Roles, and Personal Experiencings

The aligned therapist tries to be fully aligned throughout most of the session. This means that the therapist sacrifices a great deal of what this model sees as fueling most empathic, face-to-face therapists, namely, the relationship in which the therapist attends mainly to the client and the client attends mainly to the therapist; this occurs before, during, and after those times when the face-to-face therapist is being empathic. To a very large extent, the aligned therapist loses this therapist–patient relationship, and this is a loss of what may be regarded as crucial, or at least almost essential, in most face-to-face therapies.

In addition, the aligned therapist loses the whole array of therapist roles and personal experiencings that may be a major feature in most face-to-face therapies. The aligned therapist generally loses the opportunity of being the patient’s best friend, someone the patient looks up to, someone who provides valuable insights and understandings, a trusted confidante, someone with wisdom about life, an exemplar of mental health, a solid rock of reality, someone who values and treasures the patient’s preciousness, the rescuer from catastrophic psychopathology, the expert in behavior change (Mahrer, 1996).

The aligned therapist tends to sacrifice a great deal that is provided by the therapist–patient relationship and by many therapist roles and highly personal experiencings.

Will the Aligned Model and the Traditional Empathic Model Yield Similar or Different Feelings and Experiencings and Worlds, Scenes, and Situations?

In one sense, this is a payoff question. If both the aligned model and the face-to-face model of empathy are designed to get at what the person is feeling and experiencing, and the world, scene, or situation in which the person is living, then it makes a big difference if both models come up with similar or different things. It seems to me that the two models will typically come up with quite different things.

The Aligned Model and the Face-to-Face Model Would Probably Select and Use Altogether Different Patient Statements

In the aligned model, the therapist is aligned throughout the session, from beginning to end. This means that the therapist uses just about every patient statement to grasp the feeling or experiencing and to know the world or scene that is present. In the face-to-face model, there may be some approaches that select and use a high proportion of patient statements,
notably an orthodox client-centered approach. However, it is my impression that most face-to-face therapists do not select and use most of the patient’s statements for purposes of empathy. Instead, I believe that only a relatively small proportion of particular kinds of patient statements are so selected and used, perhaps closer to 5%. If these impressions are even somewhat accurate, then it seems that the aligned model and the face-to-face model would likely come up with quite different empathic payoffs because they select and use altogether different patient statements for explicitly empathic purposes.

What the Patient Says and Does Would Almost Certainly Be Quite Different in the Aligned Model as Compared With the Face-to-Face Model

To be able to see if the aligned therapist and the face-to-face therapist get similar empathic payoffs, it would probably help if the comparison were done on just about the same patient statements. The trouble is that what the patient says and does in the aligned model would almost certainly differ from what the patient says and does in the face-to-face model. In the aligned model, the patient is mainly attending out there, living and being in some scene as he says, “Why are you doing this?” “I think it’s changing!” “What am I going to do about you?” It may occur, but it is not so very common, that in the face-to-face model the patient is attending mainly to the cancer, to her sister, and that she is living and being in some scene, rather than talking mainly to the therapist about this or that. Symmetrically, what the patient ordinarily says and does in attending mainly to the face-to-face therapist is generally not what a patient says and does in the aligned model.

If this difference is exaggerated, it is like comparing one way of being empathic, when the patient is actually undergoing sexual intercourse, with another way of being empathic, when the patient is attending mainly to a therapist and merely telling about having had intercourse. The aligned model and the face-to-face model would probably come up with different empathic payoffs, if only because the patient is likely saying and doing different things in the two models.

The Altogether Different Positions and Locations of the Aligned and Face-to-Face Therapists Would Likely Provide Altogether Different Empathic Payoffs

Even when listening to ostensibly the same words, said in ostensibly the same way, it is almost certain that the empathic payoffs would be quite different because the two therapists are located in such different positions. The aligned therapist is positioned so that he is saying these words right along with the person and is living and being in the scene created by the words. In contrast, the face-to-face therapist might typically be external to and separated from the patient, attending to and observing the patient.
The patient says, “That depression won’t go away! I can’t get rid of it. It’s too strong!” The face-to-face therapist reasons that the patient is depressed, is perhaps overwrought about her depression. In contrast, the aligned therapist says these words right along with the person, sees a form or shape that is the depression, a thing that is strong and defiant enough to refuse to go away, and the therapist experiences a sense of pride, admiration, approval of that objectified depression.

The patient says, “Sarah is only a week old, and she knows that I made a mistake in telling my mother to stay with me and help. Sarah knows everything that is best for me. She’s divine. She’ll show me what to do.” The external, face-to-face therapist may have trouble trying to be empathic because she is impelled by thoughts about the patient’s psychopathology, paranoid thinking, and mentally disordered condition. In contrast, the aligned therapist is attending to the newborn baby Sarah and is experiencing a sense of secure trust, being taken care of, and entrusting oneself.

The exaggerated extreme is if the patient were to say, “Uh, I don’t quite know if I should say this, but, your fly is open.” The face-to-face therapist is entitled to be the object or brunt or target of what the patient is saying, and any attempt to be empathic may be set aside as the therapist checks his fly. In contrast, if the therapist is aligned, he is saying these words right along with the patient, talking to the waiter in the posh restaurant, and the experiencing might be a risked nastiness, devilishness, and wickedness.

In general, both the aligned and the face-to-face therapists may get empathic payoffs, but the chances are that the payoffs would be somewhat different because of the altogether different positions and locations of the therapists.

When the Person Refers to Feelings and Emotions, It is Likely That the Aligned and Traditionally Empathic Therapists Will Arrive at Different Feelings, Experiencings, and Scenes

Ordinarily, when a patient says he is having a feeling or emotion, the traditionally empathic therapist concludes that he is having that feeling or emotion. If the patient says, “I feel irritated,” the therapist may well conclude that the patient is feeling irritated. When the patient says, “I really feel proud of my son,” it is easy to conclude that he is feeling a sense of pride. It seems generally true that the therapist will accept that the person is having the feeling he or she says he has. There are exceptions, such as when the patient is in the throes of hilarious laughter as she blurts out the words, “I feel irritated,” or he may be conspicuously fearful and scared as he is breathing hard and saying, “I am relaxed, not worried. Yes, I feel relaxed.” But most empathic therapists accept that when the patient says she is feeling relaxed or irritated she is truly feeling relaxed or irritated.

It is even easier when the patient says something about the justifying circumstances. So she says, “I feel irritated when I get home and there is
a big mess in the kitchen. Everything’s all over!” When the person adds words such as these, it is easier to conclude that she is having the feeling she says she is having, especially because the circumstances seem to justify that feeling.

In rather sharp contrast, the aligned therapist will get some idea of the feeling or experiencing by seeing what is occurring as the words come in and through him, and as the aligned therapist sees whatever scenes are put there by the words. Accordingly, if the person says, “I feel irritated,” with the words coming through him in a particular way, and in the context of a particular scene, the therapist just might have a feeling or experiencing of moderate surprise and delight, or perhaps a feeling or experiencing of tightly bound coldness and control, or maybe a feeling or experiencing of being irritated. There is usually a big difference between the feeling or experiencing that is talked about or referred to, and the feeling or experiencing in the person who is talking about or referring to the feeling or experiencing.

In the same way, when patients “talk about” feelings, there is almost certainly a big difference in the scenes that the therapist gets, depending on whether the therapist is face-to-face or aligned. Patients often talk about feelings. “I feel irritated, and I don’t like that feeling. I have tried to put a lid on that feeling.” As these words come in and through the aligned therapist, she may see the feeling of irritation. Perhaps the therapist sees the feeling looking demurely innocent, unfairly accused, unjustifiably disliked, not deserving a lid put on it. Aligned therapists can easily see such things as feelings, especially when the person refers to it, attends to it, has feelings about it, and thereby paints it as a seeable thing, an object that can be looked at.

The net result is that when the person refers to feelings and emotions, it seems quite likely that the aligned and traditionally empathic therapists will arrive at substantially different feelings, experiencings, and scenes.

What the Aligned Therapist Gets is Actually and Immediately Felt, Undergone, Experienced, Rather Than Something Different, Arrived at by Figuring Out, Inferring, Using a Private Stream of Thoughts

He is attending to the expression on his aunt’s face as they are sitting in her living room, talking about her deceased husband. “She closes her eyes for a few seconds, and she’s gonna cry. Her lower lip’s quivering like, and I just look her over, watch her, just look her over. We’re all alone. She really trusts me. She can tell me anything and I understand.”

What the face-to-face therapist gets is usually from combining, or going back and forth between, an empathic stance and a private stream of thoughts or clinical inferences. The face-to-face therapist may thereby arrive at a conclusion that the patient is really talking about his or her therapist
and is thereby communicating a wish to have a trusting relationship with the therapist who is to understand and accept everything that the patient says. Or the therapist reasons that the aunt is mother’s younger sister, that the patient does not feel close with his mother, and is displacing this wished-for relationship onto his aunt. Or the therapist has clinical inferences that the patient rarely cries and is coming closer to regarding crying as acceptable.

What the face-to-face therapist gets is substantially through use of a stream of private thoughts. The therapist is not actually feeling any of these things. Instead, the therapist arrives at things that are figured out, inferred, and reached by means of a private stream of thoughts.

What the aligned therapist gets is not through figuring it out, or inferring, or using a private stream of thoughts. The aligned therapists gets what is present as the therapist is actually feeling something and actually undergoing or experiencing something. Living in this immediate situation with the aunt, saying these words, something happens inside the therapist. She may undergo a sense of incredible caring, being concerned about, nurturing. She senses herself holding the aunt’s hands and being so very caring and concerned. Or the therapist may, perhaps unaccountably, be undergoing strong sexual feelings, feelings of being aroused, being filled with the experiencing of being sensual. These feelings or experiencings are present. They are occurring. The face-to-face therapist probably did not get these kinds of feelings or experiencings any more than the aligned therapist got what the face-to-face therapist got.

The chances are pretty good that what the therapist gets is quite different if one therapist gets it through its being immediately felt, undergone, and experienced and the other therapist gets it by figuring out, by inferring, and by using a private stream of thoughts.

Will the aligned and the traditional empathic models yield similar or different feelings and experiencings and worlds, scenes, and situations? Each of these considerations suggests that the two models will almost certainly yield altogether different feelings and experiencings and altogether different worlds, scenes, and situations.

This conclusion is important, and it makes for very different practical consequences. What the face-to-face, traditionally empathic therapist gets can be crucial for what he tries to accomplish with this patient, how he describes the patient, and what he does in the course of this and subsequent sessions. Much of the basic data and information about the patient may be provided by what you get from being empathic. If what you get varies considerably with whether you are aligned or face to face, then the significant differences can make for even more significant differences. It is perhaps inviting to believe that each way of being empathic gives you essentially similar payoff data and information. It is a whole different ball game when you accept that the aligned model and the traditional empathic, face-to-
face model will almost certainly yield altogether different feelings and experiences and altogether different worlds, scenes, and situations.

**Which Empathic Model Will Yield Feelings, Experiences, and Scenes That Are More Objective, Trustworthy, and Accurate?**

Both the aligned and the traditionally empathic models seek to get at the feelings and experiences that are going on in the person, and both try to get at the kinds of worlds, situations, and scenes in which the person is living and being. Is one model more objective, trustworthy, and accurate than the other? This question is especially important if the two models do provide different kinds of supposed feelings and experiences and different kinds of worlds, scenes, and situations.

**What Each Model Gets May Be Equally Objective, Trustworthy, and Accurate, Yet Different**

One position you can take is that there is only one answer that is objective, trustworthy, and accurate. Compare traditional models and the aligned model, and then see which one is closest to the right answer. See which one gets at the objective, trustworthy, and accurate feeling or experiencing or the scene in which the person is living, being, or talking about. One answer must be better, more objective, trustworthy, and accurate. You may accept this position, but I do not. I prefer a position that recognizes different possible answers from different perspectives. A skilled and competent therapist, using a traditional model of empathy, may come up with one notion of what the person is feeling and experiencing and the world in which the person is living. An equally skilled and competent therapist, using the aligned model, may come up with a different answer. I accept that there can be several answers, each quite different from the other, and each quite objective, trustworthy, and accurate. Accordingly, my conclusion is that both the traditional and the aligned models can be objective, trustworthy, and accurate, even though their answers are quite different.

**It is Hard to Find a Single Criterion Against Which Both Models Can Be Tested**

There may be a criterion answer that is objective, trustworthy, and accurate when you are using the aligned model and a different criterion answer using the traditional empathic model. But I find it very hard to find some single criterion against which both models could be tested. Whether we ask some empathic experts, a group of judges, the patient, or a group of researchers to serve as criterion, they would almost certainly have to use some model. Whatever they come up with is what is yielded by some particular model rather than a criterion against which both may be compared. I
know of no scale, inventory, or instrument that can be the criterion for all models. Even if there were some, they would almost certainly have to favor one of the models rather than being a separate criterion against which all the models may be compared. In general, I cannot picture some single criterion against which all the models may be compared in any useful, practical way.

The Challenge is That What the Aligned Model Gets is More Objective and Trustworthy Because the Therapist Actually Undergoes It

I believe that the aligned model is better than traditional empathic models in providing data that are real, objective, and trustworthy. The aligned model produces evidence that is real, objective, and trustworthy, whereas the traditional models produce evidence that is loose, vague, diffuse, much softer and unscientifically unreal, unobjective, and untrustworthy (cf. Havens, 1973; Mahrer, 1996; Mahrer et al., 1994; May, 1989; Mearns & Thorne, 1988; Vanaerschot, 1990).

When the aligned therapist gets a feeling or experiencing, the hard evidence is in the form of real, objective, and trustworthy bodily sensations. The therapist actually has shivers down her back, actually has perspiration on her forehead, and actually has a clutching up sensation in the belly. He actually has an erection, is actually dizzy in the head, and actually has an electrical tingling in the skin across his chest. When the aligned therapist sees the world out there, she actually sees a little baby, actually sees the elevator doors that are locked, and actually sees the knife with blood on it. The aligned model's evidence is relatively real, objective, and trustworthy.

In contrast, what the traditional empathic model yields is far more hypothetical, inferential, conceptual-bound, and cognitive. The face-to-face therapist may infer a sense of the patient's feeling sexual toward the child, but it is much less likely that the therapist is having bodily sensations of sexual excitement, is having an erection or warm oozing sensations in the genitals, is literally being here with the child, and is seeing the child. Compared to the face-to-face, empathic therapist, the challenge is that what the aligned model gets is more objective and trustworthy because the aligned therapist actually undergoes it.

Which Model Is More Useful, Objective, Trustworthy, and Accurate in Getting at Inner Deeper Experiencings?

It is very hard to answer this question because of at least two considerations. One is that you would have to value the identifying of inner, deeper material and specifically material that consists of experiencings. Not every approach values material that is held to be deep inside the person, well beyond the person's awareness. Nor would all approaches accept that what is deeper inside consists of inner experiencings. Second, even with ap-
proaches that valued identifying inner, deeper experiencings, the aligned model is expressly designed to yield this material, and the face-to-face model is not especially designed to get at what may be described as the person's inner deeper experiencings. Accordingly, it seems difficult to examine which model is more useful, objective, trustworthy, and accurate in getting at this particular kind of empathic yield.

*How Can Research Contribute to Empathy as Therapist-Client Alignment?*

I know of no research on empathy as therapist-client alignment. If there is to be research on this way of being empathic, perhaps an easy question for researchers is to see which model is more effective. Both the face-to-face model and the aligned model want to get inside the client's frame of reference; to see the client's world through the client's eyes; and to know, grasp, understand, sense, share, and have what the client is feeling, thinking, and experiencing, both at a more surface level and at a deeper level. Why not see which is better?

There are several answers as to why such research is hardly doable in a constructively useful way. One reason is that there is no criterion of the real or true or accurate or objective goals of empathy. There is no single criterion of what the client is seeing or feeling, especially at the deeper level. A second reason is that each model is almost certainly going to adopt its own criterion of exactly what it is trying to attain and of its success in attaining it. A third reason is that the two models would almost certainly not agree on precisely which client statements the contest should be held. It seems hard to decide who wins. Even if a researcher declares one the winner, it is unlikely that many proponents of the losing side would switch models.

My preference is for research that contributes to the increasing effectiveness of each model. If the model is made better, more further developed, and more carefully used, I find such research more helpful than trying to see which model wins out over the other. If researchers are drawn toward contributing to empathy as therapist-client alignment, research may focus on improving the nuts and bolts of the method. What can therapists do to put most of their attention out there on whatever the client is attending to or creating out there? How can clients put most of their attention on scenes and focal centers that are accompanied with strong feeling? How can therapists join with or align with the client so as to maximize the extent to which the client's words can seem to come from a part of the therapist? How can therapists be taught how to align fully and completely, quickly and efficiently, regardless of who and what kinds of people the client and therapist are? My preference is for research that makes each model better, rather than trying to have a contest between the various models of empathy.
CONCLUSIONS

1. There are several models or ways of trying to know (a) what the person is feeling and experiencing, both more or less on the surface and at the inner, deeper level; and (b) the scenes, situations, and focal centers that the person is attending to, living and being in. In other words there are several models of what is called empathy. One of these models or ways may be called being “aligned” with the person.

2. There are two relatively explicit methods and procedures to enable the therapist to be aligned with the person: (a) Both client and therapist attend mainly to a third focal center, rather than mainly to one another. The therapist’s attention is fully and consistently out there, on the third focal center of attention. (b) The therapist is postured so that the words of the client come in and through the therapist, with the therapist and client as two parts of a larger single person. When the person is talking, it is also a part of the therapist who is talking.

3. The aligned therapist is able to attain the aims of empathy, namely to know what the person is feeling and experiencing, and to know the world in which the person is being. In addition, the aligned therapist is in a sensitive and powerful position to discover and to access inner, deeper experiencings in the person, to enable the person to welcome and appreciate this accessed inner, deeper potential, to enable the person literally to disengage from the continuing person, and to be a qualitatively new person who is free of the bad-feelinged scenes that were front and center in the session. These are the in-session aims and goals of experiential psychotherapy (Mahrer, 1996).

4. The aligned model is a powerful, sensitive method of achieving the above aims and goals. Practitioners seeking to achieve these aims and goals are invited to adopt the aligned model.

5. The aligned model seems to differ from most face-to-face models of empathy in some ways that may be considered significant, basic, and fundamental. It is a rather radical departure from and alternative to most face-to-face models. The aligned model seems to differ from the face-to-face models in such fundamental dimensions as (a) the role, posture, and self or identity of the therapist; (b) the nature of the relationship between therapist and person; (c) the concrete working methods of empathy; (d) the specific working aims and purposes of empathy; and (e) the actual nature and content of the empathic feelings, experiencings, scenes and worlds, especially at the inner, deeper level of personality.

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