Exploring Therapeutic Empathic Presence through the "Now Moment": an interdisciplinary integration

G. Hiroko Taguchi

Abstract: Through an interdisciplinary focus on "now moments" in therapy, I argue that a multidimensional, developmentally-grounded framework for what I call "therapeutic empathic presence" can emerge that shows the crucial role that direct access empathy can play in the therapeutic encounter. I elaborate my framework through integrating perspectives from theories of mind, phenomenology (including neurophenomenology) and psychoanalysis and discuss intercorporeal and inter-affective elements as well as a psychoanalytic mutual recognitive concept. In all, I show that such presence involves an ethically-guided, mature empathy that involves authenticity and cultivated self- and self-other awareness. Key concepts are illustrated in a clinical vignette.

Keywords: Empathy; Presence; Now Moment; Psychotherapy; Phenomenology; Neurophenomenology; Psychoanalysis; Intercorporeality; Inter-affectivity; Recognition

I. Prologue

In this paper, I explore therapeutic empathic presence as it occurs during heightened affective "now moments" in the clinical encounter. Through integrating philosophical and psychoanalytic views on developmental forms of empathy, I argue that a differentiated framework for therapeutic empathic presence can emerge that more fully elucidates empathy's multidimensional processes that includes a foundational direct access empathy and later evolving indirect access empathy. In all, I show that such presence can be understood as an ethically-guided, mature "generative empathy" that involves authenticity and cultivated self- and self-other awareness which, when successfully taken up, can productively navigate challenges to the therapeutic alliance and facilitate therapeutic progress.

First, as introduction, I briefly outline the main debates on the concept of empathy in philosophy and psychoanalysis and demarcate the notion of empathy I focus on in therapeutic empathic presence ["TEP"] (I). I then construct a framework for TEP by discussing the phenomena of "now moments" and its relata in therapy and the operation of direct access empathy (II). Next, I elaborate on the latter through a discussion of neurophenomenological, phenomenological and psychoanalytic concepts (III). I then outline psychoanalytical conceptions of cognitively-mediated, indirect access empathy (IV). I complete my framework by sketching a mature form of empathy (V). I then illustrate key conceptions I have discussed through a clinical vignette (VI). I conclude by suggesting that an interdisciplinary approach can contribute to the elucidation of the many dimensions of therapeutic empathy, including a crucial foundational direct access empathy. I also suggest further research (VII).

II. Introduction

The concept of empathy is a contested term with currently a plethora of conceptualizations in philosophy and psychoanalysis. In the former, current controversies revolve around three main positions. First, holding dominant sway with its Cartesian orientation are cognitively-mediated, indirect access views of empathy such as “theory theory” (Baron-Cohen 1995) and, particularly “simulation theory” (Goldman 1989, 2006) and its variation “embodied simulation theory” (Gallese, Eagle, and Migone 2007). However, there are those who, through “interaction theory” (see e.g., Fuchs 2017; Fuchs and De Jaegher 2009; Gallagher 2004), argue for an acknowledgement of the significance of a direct access view of empathy that builds on ideas from the phenomenological tradition, including those of Merleau-Ponty, Scheler, Stein.

In psychoanalysis, the concept of empathy and its role in the therapeutic encounter is a matter of long-standing controversy (Aragno 2008). Sigmund Freud’s view of empathy, which was influenced by Theodor Lipps’ view of it[1], arguably continues to dominant the field in terms of an indirect access view that is broadly similar to simulation theory. However, Freud’s perspective has faced challenges including, most notably, by Heinz Kohut, whose innovation of self psychology included a notion of empathy as a “mode of observation” that includes indirect and direct access elements (1959).[2] Others have extended Kohut’s view including, relevant to present purposes, Evelyn Schwaber. In her eclectic self psychological approach, she notes that: “Empathy [...] is that mode of attunement which attempts to maximize a singular focus on the patient’s subjective reality, seeking all possible cues to ascertain it” (1981, 379). Schwaber’s elaboration includes an intriguing recognitive notion that originated in Japanese psychoanalysis, which I discuss below. In terms of the field itself, direct access views have become seriously considered since the late 1990s (Stern et al. 1998).

In the midst of the many concepts of empathy then, I focus on the notion of it that was delineated by the early phenomenologists, such as Husserl, Stein and Scheler (Zahavi 2014). For them,

> […] empathy is quite generally the term of choice for the experience of foreign consciousness. It is a distinctive form of other-directed intentionality, distinct from both self-awareness and ordinary object-intentionality, which allows foreign experiences to disclose themselves as foreign rather than as [one’s] own (Ibid., 138).

From this concept, I endeavour to construct my multidimensional framework in agreement with Zahavi’s general recommendation.[3] As he notes: “We need multiple complementary accounts in order to cover the variety of abilities, skills and strategies that we draw on and employ in order to understand and make sense of others” (Ibid., 141).

And making sense of others, particularly in the therapeutic encounter, can be challenging. Therapists commonly acknowledge that discursive descriptions of their experience with a pa-

---

1 Lipps’ view was opposed by the early phenomenologists such as Husserl, Stein and Scheler (Zahavi 2014).

2 Kohut’s account of empathy was first delineated in terms of “vicarious introspection” and “empathy” (1959). The former is often construed in terms of a simulation theory view, i.e., “putting oneself in the other’s shoes,” whilst the latter appears to include a direct access empathy. For example, Kohut notes that “it is only through [vicarious] introspection and empathy that we understand the shades of meaning of astonishment and disapproval that are contained in the raising of the eyebrow” (1959, 461). Kohut also finds that empathy occurs only when there is a psychological basis or intentionality in the “purposeful actions” of the other (1959, 462).

3 For an account of empathy that delineates it from first-, second-, and third-person perspectives, see Fuchs (2017).

tient fail at times as they struggle to put into words what it's like to be in the room with the patient. In philosophy of mind, the perception of non-conceptual aspects of empathic experiencing has been called "the subject character of experience" by Nagel (1974), that is, the enigmatic quality of the something it is like for the subject to undergo an experience in consciousness. On Nagel's view, the subject's object intentionality is considered from a traditional one-person phenomenological approach. Here I consider the therapist's intentional interaction with the patient from both a one- and two-person perspective that includes a dynamical systems perspective.

III. Empathy as Direct Access through Now Moments and Moments of Meeting

In the late 1990s, the Boston Change Process Study Group ["BCPSG"], a group of infant researchers, psychoanalysts and others who studied enactive therapeutic change processes, a neglected topic in psychoanalysis at the time. In a seminal paper, BCPSG describe the therapeutic process as generally a habituated one, composed of "present moments" that move the process along (Stern et al. 1998, 909). However, at times, they find the familiar can change to a mutually-experienced, affectively-charged "now moment" that compellingly emerges. They understand that it can perhaps feel like an impasse or an opportunity with a sense of expectancy or anxiety. They emphasise that for the therapist,

> Now moments […] demand an *intensified attention* and some kind of choice of whether or not to remain in the established habitual framework […]. They force the therapist into *some kind of 'action'*, be it an interpretation or a response *that is novel relative to the habitual framework*, or a silence (Ibid., 911, emphasis added).

In terms of the TEP, I suggest the intensified attention and what I understand to be a self-awareness that is required in having to make a choice in such a pressing moment are key factors in whether the therapist will be able to successfully take up and navigate such a distinctive moment. BCPSG note that "When a now moment is *seized*, that is, responded to with *an authentic, specific, personal response from each partner*, it becomes a 'moment of meeting'" (Ibid., 909, emphasis added). Further below, I discuss the BCPSG's problematic understanding of "authentic" and "personal response" in the clinical vignette. For now, it is important to emphasise that the successful disruption and repair interaction cycles are key components of the "shared implicit relationship" in which an altered "implicit relational knowing" can be created that frees the patient from dysfunctional habituated ways of relating (Ibid., 905). Thus, when things go well, a complex process of "fitting together"[4] occurs encompassing the implicit (procedural) processes as well as the explicit (declarative) processes between patient and therapist that are continually adjusted for (Bruschweiler-Stern et al. 2002). It should be noted that less affectively-heightened moments of meeting in disruption and repair cycles can also have positive change-making effects (Ibid.). In all, BCPSG find there is "something more"[5] (Stern et al. 1998,

4 I understand this as involving a metaphorical "container and contained" regulatory process in which the therapist "contains" the patient intolerable thoughts and feeling through her "reverie" – i.e., a receptivity to the verbal and non-verbal communications of the "contained" patient – so that meaning-making can occur within the intersubjective interaction (Bion, 1962).

5 As Monti has noted: "This 'something more' […] includes a series of different functions: empathy, containment, support of the therapeutic bond, working alliance, as well as the hopeful expectation to attribute meaning to one's psychic life vicissitudes" (2005, 1024).

903) occurring beyond traditional sole use of interpretation that can be fateful for the therapeutic process and the patient's improvement.[6]

In developmental psychology of pre-verbal infants in intersubjective interaction, the concept of implicit relational knowing is an "essential" one (Ibid., 905). Such knowing is grounded in a fundamental, direct access empathy achieved through "comprehending the affective expressions of the other" that is present at the outset of the post-natal infant-caretaker phase and is on-going through life (Ibid., 916). The capacity for cognitively-mediated, indirect access empathy evolves later.[7] Whilst BCPSG do not delineate the two complexly, interwoven domains that operate in implicit relational knowing, they do provide an encompassing formulation. They note that:

> Clinically, the most interesting aspect of the intersubjective environment between patient and analyst is the *mutual knowing of what is in the other's mind*, as it concerns the current nature and state of their relationship. It may include states of activation, affect, feeling, arousal, desire, belief, motive or content of thought, in any combination. These states can be transient or enduring, as mutual context. A prevailing intersubjective environment is shared (Ibid., 906, emphasis added)

The BCPSG also find that the mutual knowing may remain implicit and out of awareness, yet "[…] can also form a basis for much of what may later become symbolically represented" (Ibid., 905-6). I elaborate on this below.

IV. Neurophenomenological Dynamical Systems Elaboration

In a departure from traditional cognitivism, "the extended body" perspective by Froese and Fuchs (2012) provides a compatible neurophenomenological, dynamical systems account of the social cognition and direct access empathic processes discussed above. Indeed, one of the achieved aims of this enactive account was to provide a confirmation of findings of an infant research study involving mutually created, contingent intersubjective interactions (Ibid., 215).

In a nutshell, through computer modeling, the extended body model describes intersubjective dynamics from both the perspective of the individual and the shared paired interaction through time from living through lived experience (Ibid., 216-7). It shows how the pairing acts as a single, integrated system with uniquely shared elements that cannot be reduced to or attributed to a single participant, which are each a system in themselves. Through this view, it becomes possible to sort out subjective elements, whilst not losing a grasp of the global intertwined dynamics, which are my dual concerns here.

I now highlight what the model describes as an intersubjectively-shared "transient region" in which there is a "mutual entanglement" of shared participation (Ibid., 227). Though I can only outline the model here with some elaborations, I suggest key elements can be applied to the TEP and will illustrate some in the clinical vignette.

In the extended body view, participants have "[…] become parts of a dynamic sensori-motor and *inter-affective* system that connects both bodies by reciprocal movements and reactions […] in *inter-bodily resonance*" (Ibid., 213, emphasis original).[8] In this shared region, this dynamic can be self-maintaining through "each other's mutually responsive presence" (Ibid., 223) as each agent's intra-bodily dynamics, i.e., their "internal milieu" can be transformed through

---

6 For a different, though resonating perspective, see Giorgi (2011) who formulates a singular, change-making "pivotal moment" within the context of a retrospective consideration of an entire therapy from a one-person, psychological perspective.

7 The capacity for indirect access empathy generally begins around age 4 (Gallagher 2004, 199).

8 Relatedly, Fuchs (2017) finds these to be constitutive processes in the social cognition that underlies direct access "primary empathy."

the inter-bodily dynamic occurring in the interactive process (Ibid., 231). Such dynamics have an historical and epistemic dimension, i.e., an "inter-bodily or intercorporeal memory" or, referencing BCPSG, an "implicit relational knowledge" (Ibid., 213) that forms through the shared implicit relationship. I suggest that a therapeutically-significant aspect of the latter can be further elucidated through the psychoanalytic conception of "*amae*."

Takeo Doi first psychoanalytically discussed the notion of *amae,* a Japanese word with no literal English translation (1973). He described it as "what an infant feels when it seeks its mother" (Schwaber 1995; Doi 1993) or "a basic and ongoing sense of emotional connectedness" (Schwaber 2010; Doi 1973). Schwaber, referring to infant researcher Louis Sander's work, further elaborates *amae* as the "recognition" that occurs in a "moment of meeting" involving "knowing" and "being known" between infant-caretaker and similarly between patient-therapist that is a fundamental constituent of the infant's/patient's development (1995, 279). *Amae* occurs not only in the implicit pre-verbal domain of experiencing but the explicit meaning-making one as well. In the therapeutic encounter the experience of connectedness can be profound for the patient. As Schwaber notes, citing Doi (1993), *amae* can involve "the patient['s] understanding that the analyst has come to understand him in the depth of his mind" (2010, 171). Schwaber also finds that the capacity for insight within the patient can be nascently generated through such empathic attunement. She notes that "When the patient feels recognized, she or he may experience a sense of familiarity, filling in gaps, memories emerging largely spontaneously" (Ibid., 172).[9] Within an extended body view, I suggest *amae* can be understood as an inter-affective sense of connection through mutual recognition involving an intra-bodily feeling of, on the one hand, being known (patient) and, on the other, knowing (therapist's empathic presence) that can strongly reverberate within the inter-bodily dynamic. In these ways then, I include *amae* as an important concept for the TEP framework.

In exploring dimensions of implicit relational knowing, a question now arises: how might the formation of implicit relational knowing be further elaborated phenomenologically? I suggest that Thiemo Breyer's formulation of the phenomenological concept of "phantasmic self-affection" when integrated into the extended body model can help. First, Breyer finds that "phantasmic self-affection" provides the mind with "typifying affections" that automatically complement or complete the person's "perceptual mode" regarding new objects through a "sedimented connection" with previous "perceptual content" that is "of the same kind" (2020, 804-806).[10] I suggest that this accrual process can be understood on the intra-bodily dimension as reinforcing "typical" elements of previously sedimented, perceptual content and generating a generally habituated mode of perception for each individual within the intersubjective interaction, which through time helps consolidate a shared inter-bodily memory/implicit relational knowing with one another. The origins of this developmental process, as BCPSG note, go back to pre-verbal development in infancy and the creation of implicit relational knowing through interaction with primary caregivers, any one of which may be dysfunctional. Whilst more cannot be elaborated here, as previous discussed, in therapy the successful navigation of moments of meeting can result in alterations in dysfunctional implicit relational knowing.

I now turn to a psychoanalytic account of shared consciousness to elucidate a process that connects the implicit nonconscious domain with that of the explicit meaning-making domain in the TEP. In their "dyadic expansion of consciousness model," Harrison and Tronick (2007, 853) describe dynamic flows between the realms of dynamic unconscious (or what is repressed

---

9 Noting the significance of empathy, American psychologist Carl Rogers found that "a high degree of empathy in a relationship is possibly the most potent and certainly one of the most potent factors in bringing about change and learning" (1975, 3). His notion of empathy (1975) resonates with a simulationist view.

10 Breyer elaborates on indirect access empathy through a "perspective-taking" and "phantasy-consciousness" approach that also integrates direct access empathy (2019).

and representable) and the implicit nonconscious in what could be construed as the zone of mutual incorporation or mutual entanglement. They note that through implicit and explicit processes, “meaning brings the past into the present, makes sense of the individual’s place in the world, and guides future actions and sense-making […]” (Ibid., 857). I consider the implicit nonconscious processes next and will discuss the explicit meaning-making processes further below.

Regarding the implicit, nonconscious dimension, I suggest it can be elaborated in terms of what Fuchs has described as the lived body’s “implicit memory cores” that can become activated under certain conditions and become an “explication” of a present moment (2012, 19). Such explication or retrieval of memory can be a “complex of bodily sensations and implicit, only intuited recollections and meanings” (Ibid., 20). Whilst Fuchs notes that such memory cores can be helpful in somatically-oriented therapeutic work with a patient (2012, 20), I suggest that this associative, implicit process can also contribute to the therapist’s empathic self-aware understanding and connection to the patient’s experience in the TEP. I elaborate on this below in the clinical vignette.

V. Cognitively-Mediated, Indirect Access Empathy

I now briefly contextualize two psychoanalytic views of cognitively-mediated, indirect access empathy within philosophical theory of mind categories. First, in the category of theory theory, I would include the therapeutic concept of “mentalization” (Fonagy et al. 2002), which involves facilitating the patient’s ability to *consciously* theorize and understand one’s own and another’s mental states that underlie behaviour. For example, patients with certain deficits in early development that remain through adulthood may lack intersubjective and social cognitive skills and thus misinterpret others’ responses. In such cases, mentalizing interventions can facilitate understanding of others’ responses to them that would otherwise be misinterpreted.

Second, in the category of simulation theory and embodied simulation theory, the latter which claims the “as if” process of simulating or imagining another person’s perspective is unconscious rather than conscious, I suggest a novel view of Freud’s account of empathic process can further explicate the operation of TEP. Specifically, Freud finds that empathy [*Einfühlung*] “plays the largest part in our understanding of what is inherently foreign to our ego in other people” (1921, 108). Freud’s Lippsian-influenced notion of empathy rests on a “feeling into” with one’s own experience, projecting onto another person (1913, 189; Aragno, 2008, 718) and employing inference. Regarding the latter, Freud finds that “Consciousness makes each of us aware only of his own states of mind; that other people, too, possess a consciousness is an inference which we draw by analogy from their observable utterances and actions, in order to make this behaviour of theirs intelligible to us” (1915, 169). In my account of TEP then, I would reject Freud’s Cartesian, monologist view that neglects an intersubjectively-constituted, direct access understanding of empathy. However, I would then integrate Freud’s notion of “normal projection” which is not usually included in Freud’s view of empathy. In such projection, Freud finds that the one who projects can exercise self-awareness and consciously self-attribute their projection as they maintain a sense of separateness from the other person (Freud 1892, 209).[11] I also include a “working through” of impediments or “resistance” to the therapy through self-awareness and self-analytic reflection. It is this differentiating capacity employed in indirect access empathy that could be fruitfully employed in the TEP.

---

11 This key (and variable) capacity within the TEP would, for example, allow the therapist’s own sedimented connections (from their own repertoire of implicit relational knowings with significant others) that emerge within the shared implicit relationship with the patient and that might threaten to derail empathic understanding to become distantiated and made available for cognitive appraisal.

VI. A Mature Form of Empathy: Generative Empathy

I now discuss an overall guiding, integrative mature form of empathy that Roy Schafer calls "generative empathy," then add an additional element to it. I suggest Schafer's account shares several compatibilities with the neurophenomenological, interaction view discussed earlier whilst also providing an ethical elaboration of it in the context of the therapeutic encounter. First, Schafer finds that:

> Empathy requires the free availability of memories supplemented by the sensing or judging of similarities that make past personal experience relevant to the current situation (1959, 348).

Put another way, it could be understood as requiring a capacity for activation and explication of implicit memory cores within the therapist.
Second, Schafer finds that:

> [Empathy] requires perceptual attention, or vigilance, to elusive cues, difficult to conceptualize, in motility, verbalization, affective expression and *tempo* (Ibid., emphasis added.).

In other words, it requires close attentiveness to the effects of subpersonal sensori-motor and inter-affective elements of the unique inter-bodily resonance created in the pairing, which can also take on musical features (Froese and Fuchs 2012; Trevathen 2005).

And lastly, in describing the developmental arc of his conception of empathy, Schafer elaborates that:

> According to this approach we would seek to define qualitative changes undergone by empathy in the progression from infancy through childhood, adolescence, and adulthood. These qualitative changes should reflect the new problems of inner organization and object relationships posed by each advance in development […]. In this light, Fenichel's surmise about the role of expressive movements in empathy would refer to a genetically early though continuously operative component of empathy (Ibid., 345, emphasis added).

In other words, the foundational, direct access empathic processes occurring in the inter-bodily resonance of mutual entanglement and its responsive expressivity operate continuously along with later cognitively-mediated, indirect access empathic processes in an operation that involves inner subjective and outer interactive developmental dimensions.

Additionally, in Schafer's account of a mature form of empathy, he is inspired by Erik Erikson's conception of "generativity." Schafer notes that:

> Generativity is the seventh of Erikson's ‚eight stages of man' […]. It represents a new psychosocial primacy in which the earlier developmental attainments are fully represented but also transcended: '[...] (1959, 344, citing Erikson 1950, 231).

For Schafer, this highest stage of empathy is grounded in an ethical intentionality that has an intergenerational social aim. For him, "Generativity is primarily the interest in establishing and guiding the next generation or whatever in a given case may become the absorbing object of a parental kind of responsibility" (Ibid.). I understand this as including a socio-historical awareness that informs the therapeutic encounter. Whilst Schafer at one point finds this aim to be an "inner experience" (Ibid., 346), he also conceptualizes in terms of both an inner experiencing self and an observing self. He, first, notes that the process requires "[…] a necessity for a balance of affective and cognitive contributions to empathic comprehension" (Ibid., 350), then finds that it "[…] requires oscillation between the *observing and experiencing parts of the [body or*

embodied] ego […]" (Ibid., emphasis added). Here his description resonates with the conception of the intra-bodily dimension of an inter-bodily system.[12]

In these ways then, Schafer's account of generative empathy describes key capacities needed to engage in the major challenge encountered in therapeutic empathic presence. That is, the capacity to remain empathically open to spontaneous, affectively-eruptive (but potentially transformative) now moments that can involve multi-dimensional internal and interactive processes and forms of self- and self-other awareness and understanding, whilst also crucially ethically holding fast to the therapeutic frame.

Lastly, I would add a second ethical aim to the employment of a mature, generative empathy, namely, a concept of "authenticity." The latter differs from the BCPSG's, which I earlier claimed was problematic. As previously noted, the BCPSG describes an authenticity that involves an "authentic" and "personal response" that is spontaneous. Yet, we might ask: authentic and personal in relation to what exactly? It would seem the therapeutic relationship, but their formulations also hint at the "real" relationship outside of therapy, which implies the possibility of boundary crossings or violations, which they find understandably problematic (Boston Change Process Study Group, 2008).

K.A. Frank, who has noted the imprecision of BCPSG's notion, proposes another more clearly defined one, namely an authenticity that "striv[es] to avoid deception, including self-deception, in order to foster responsive and responsible participation as an individual" (2005, 39). It also involves an affectively-engaged, attuned person-to-person relating. In such relating, he finds "…being authentic with a patient involves an active effort to remain sensitive to one's own emotional experience, associations, actions, and their meanings, as well as the patient's" (Ibid., 39). When associations cause one's mind to wander, he finds it is important to understand why and to take responsibility for it (Ibid.). I would add such associative wanderings – what Thomas Ogden (1997), elaborating a Bionian concept, calls "reverie" – can help understanding of the patient.

Next, I elaborate and illustrate several, previously discussed key concepts as I give a brief sketch of the interplay of elements occurring within a TEP aiming for a mature, generative empathy.

VII. Clinical Vignette

For confidentiality reasons, I provide only the minimal relevant information about the patient needed to illustrate key concepts. I want to add that my psychotherapeutic approach is humanistic and whilst I integrate psychoanalytic understandings, I am not a psychoanalyst.

In this vignette I elaborate on several key concepts that were previous discussed regarding now moments and the activation of the lived body's implicit memory. I attempt to show how these elements can contribute to the therapist's self-aware understanding and the empathic connection to the patient.

The patient, whom I will call A, suffered from a depression that manifested in angry episodes with others that left her socially isolated, including from her family, amongst other issues. At the beginning of the treatment, I was struck at how I had a bodily experience of being very closely watched and scrutinized by A, something that went beyond my usual experience with patients. Initially, I also felt that I could not divert my gaze from her lest she possibly misinterpret it as a slight, i.e., an inattentiveness due to a lack of caring on my part. I would say now that in this initial phase this experience was part of the unique *inter-bodily resonance* in the room.

12 For a different view of intersubjectivity, see Matthias Schloßberger's Schelerian-based account of levels of "human togetherness" encompassing collective affective intentionality from a social philosophical anthropological perspective (2020).

I remember in the early days maintaining good eye contact as usual and becoming somewhat accustomed to the scrutiny, which subsided rather significantly as a therapeutic alliance was formed between us.

However, in one session that alliance was challenged. It happened as A was talking about caring for her partner, with whom she had recently reunited. He had recently undergone a serious surgical procedure involving meticulous aftercare. As my gaze and attention was focused on her telling me about his surgery and about how she carefully cleaned the area around the procedure, I was moved by (*inter-bodily resonated* with) her presence that included affectively-saturated facial expressions, prosodic tones, hand gestures, etc., until my gaze became momentarily diverted downward toward the floor as a significant and salient memory arose unbidden in my *reverie*. Such a diversion of my gaze, even if momentary, was unprecedented with A and looking back at her I saw that she appeared discernably angry at, what I believed, was being mistakenly taken as inattentiveness on my part. I felt a palpable tension suddenly arise between us as a *now moment* emerged. Understanding the implications of this event, I then made a deeply-felt comment on what she had been talking about as I had been listening to her even as my gaze had been, momentarily, diverted by an evocative memory. I said to her that she was worried about keeping the area clean since there could be serious problems with infection if it wasn't. The patient responded with a look of happy surprise, realizing, apparently, that *I had been listening* and what that meant to her. A relaxed smile came over her and she enthusiastically resumed telling me about caring for her partner. Through the *inter-bodily resonance*, I felt the tension between us ease apparently indicating a *moment of meeting* had occurred through a *cycle of disruption and repair*.

Delving into the phenomenology of the evocative memory that arose for me in that moment of reverie, I suggest it can be understood as occurring through an *inter-affective* and *inter-bodily resonance* in the *mutual entanglement* in the *extended body dimension of intersubjectivity* between the patient and myself. My embodied experiencing in the living immersive surround of being present with the patient as she related her deep concern for her partner gave rise to an activation within me of an *implicit memory core* that was an *explication*. The explication, which arose associatively through my reverie, was *a partial re-experiencing of a prior deeply-etched memory* of my mother's very serious illness years ago when she needed to have the same procedure and the deep concern I had over the level of care that was needed with it and, more generally, with her condition. As discussed in previous sections, I understand implicit direct access empathic processes were occurring.

Additionally, there were cognitively-mediated, indirect access empathic processes that took place as well. In the dynamic moment of my memory, I was pulled instantaneously into a heightened attention to my own history as I then quickly oscillated back to an intersubjective relating and attentive listening in the TEP, which allowed me to provide my comment. Then, as I listened further to the patient with the added information of my now recalled resonating history, similarities and differences were discerned through indirect access empathic processes. It was through the dual direct and indirect access empathic processes that a deepening affective and cognitively-enriched understanding of the patient and myself with the patient in the therapy occurred through the episode and developed beyond it as the patient's treatment progressed. Regarding the latter, as Schafer, citing Hans Loewald notes "[…] a mature object-relation is maintained with a given patient […][when the therapist is able to relate] to the patient in tune with the shifting levels of development manifested by the patient at different times [...]" (1959, 355).

In all, now moments and moments of meeting can involve "mid-course correcting" (Stern et al. 1998, 907) through disruption and repair cycles that can be challenging for the TEP. Yet, as I have sought to show, an empathically-mature aiming TEP can assist with navigation of them so as to facilitate therapeutic progress.

VIII. Conclusion

I argued that a multidimensional, developmentally-differentiated framework for TEP can be constructed through integrating perspectives from psychoanalysis, phenomenology (including neurophenomenology) and theories of mind. I sought to show that TEP aims for an ethically-guided, mature form of empathy that includes a cultivated self- and self-other awareness in an endeavor to experience and understand the mind of the patient and advance therapeutic aims. I argued that such therapeutically-efficacious empathic process, supported by empirical infant research and clinical psychoanalytic findings, is crucially grounded in direct access empathy prior to later developmental forms of indirect access empathy, contrary to indirect access only views of empathy. However, I was only able to begin to integratively discuss the operation of implicit relational knowing in its functional and dysfunctional dimensions. Further interdisciplinary elaboration would be needed to provide a more complete picture.

IX. Acknowledgements

I would like to thank Prof. Dr. Dr. Thomas Fuchs and Daniel Vespermann for their very helpful comments/questions made during the general discussion of this paper during the Manifold Senses of Presence Workshop. Many thanks to an anonymous reviewer for their careful reading and many constructive comments and suggestions.

Bibliography

Aragno, A. 2008. The Language of Empathy: An Analysis of its Constitution, Development, and Role in Psychoanalytic Listening. *J. Amer. Psychoanal. Assn*. 56 (3): 713-740.

Baron-Cohen, S. 1995. *Mindblindness: An Essay on Autism and Theory of Mind.* Cambridge, MA: MIT Press.

Bion, W.R. 1962. *Learning from Experience.* London: Tavistock.

Boston Change Process Study Group. 2008. Forms of Relational Meaning: Reply to Commentaries. *Psychoanal. Dial*. 18 (2): 197-202.

Breyer, T. 2020. Self-Affection and Perspective-Taking: The Role of Phantasmic and Imaginary Consciousness for Empathy. *Topoi* 39: 803-809.

Bruschweiler-Stern, N., Harrison, A.M., Lyons-Ruth, K., Morgan, A.C., Nahum, J.P., Sander, L.W., Stern, D.N. and Tronick, E.Z. 2002. Explicating the Implicit: The Local Level and the Microprocess of Change in the Analytic Situation. *Int. J. of Psycho-Anal.* 83: 1051-1062.

Doi , T. 1973. *The Anatomy of Dependence*. Tokyo: Kodansha International.

———. 1993. *Amae* and Transference-Love. In *On Freud's "Observations on Transference-Love,"* edited by E. Person, A. Hagelin, P. Fonagy, 165-171. New Haven, CT: Yale University Press.

Erikson, E. H. 1950. *Childhood and Society.* New York: W. W. Norton & Co., Inc.

Fagiano, M. (2019). Relational Empathy. *International Journal of Philosophical Studies* 27 (2): 162-179.

Fonagy, et al. 2002. *Affect Regulation, Mentalization, and the Development of the Self.* NY, New York: Other Press LLC.

Frank, K.A. 2005. Toward Conceptualizing the Personal Relationship in Therapeutic Action: Beyond the "Real" Relationship. *Psychoanal. Persp*. 3 (1): 15-56.

Freud, S. 1892. Draft H Paranoia from Extracts from The Fliess Papers. *The Standard Edition of the Complete Psychological Works of Sigmund Freud* 1: 206-212.

———. 1913. The claims of psycho-analysis to scientific interest. *The Standard Edition of the Complete Psychological Works of Sigmund Freud* 13: 165-190.

———. 1915. The Unconscious. *The Standard Edition of the Complete Psychological Works of Sigmund Freud* 14: 159-215.

———. 1921. Group Psychology and the Analysis of the Ego. *The Standard Edition of the Complete Psychological Works of Sigmund Freud* 18: 65-144.

Froese, T., and Fuchs. T. 2012. The extended body: a case study in the neurophenomenology of social interaction. *Phenom. Cogn. Sci*. 11: 205–235.

Fuchs, T. 2012. The Phenomenology of Body Memory. In *Body Memory, Metaphor and Movement*, edited by S.C. Koch, T. Fuchs, M. Summa and C. Müller, 9-22. Philadelphia: John Benjamins Publishing.

———. 2017. Levels of Empathy – Primary, Extended, and Reiterated Empathy. In *Empathy*, edited by V. Lux and S. Weigel, 27-47. London: Palgrave Macmillan.

Fuchs, T., and De Jaegher, H. 2009. Enactive intersubjectivity: Participatory sense-making and mutual incorporation. *Phenomenology and the Cognitive Sciences* 8 (4): 465–486.

Gallagher, S. 2004. Understanding Interpersonal Problems in Autism: Interaction Theory as An Alternative to Theory of Mind. *Philosophy, Psychiatry, & Psychology* 11 (3): 199-217.

Gallese, V., Eagle, M.N., and Migone, P. 2007. Intentional Attunement: Mirror Neurons and the Neural Underpinnings of Interpersonal Relations. *J. Amer. Psychoanal. Assn*. 55 (1): 131-176.

Giorgi, B. 2011. A Phenomenological Analysis of the Experience of Pivotal Moments in Therapy as Defined by Clients. *Journal of Phenomenological Psychology* 42 (1), 61–106.

Goldman, A.I. 1989. Interpretation psychologized. *Mind and Language* 4 (3): 161–85.

Harrison, A., and Tronick, E. 2007. Contributions to Understanding Therapeutic Change: Now We have a Playground. *J. Amer. Psychoanal. Assn*. 55 (3): 853-874.

Kohut, H. 1959. Introspection, Empathy, and Psychoanalysis –An Examination of the Relationship Between Mode of Observation and Theory. *Journal of the American Psychoanalytic Association* 7:459-483.

Monti, M. R. 2005. New Interpretative Styles: Progress of Contamination? Psychoanalysis and Phenomenological Psychopathology. *Int. J. of Psycho-Anal.* 86: 1011-1032.

Nagel, T. 1974. What Is It Like to Be a Bat? *The Philosophical Review* 83 (4): 435-450.

Ogden, T. 1997. Reverie and Metaphor: Some Thoughts On How I Work As A Psychoanalyst. *Int. J. of Psycho-Anal.* 78: 719-732.

Rogers, C.R. 1975. Empathic: An Unappreciated Way of Being. *The Counseling Psychologist* 5 (2): 2-10.

Schafer, R. 1959. Generative Empathy in the Treatment Situation. *Psychoanal. Q*. 28 (3): 342-373.

Schloßberger, M. 2016. The Varieties of Togetherness: Scheler on Collective Affective Intentionality. In *The Phenomenal Approach to Reality: History, Concepts, Problems,* edited by A. Salice and H.B. Schmid, 173-195. Switzerland: Springer.

Schwaber, E. A. 1981. Empathy: A Mode of Analytic Listening. *Psychoanalytic Inquiry* 1 (3): 357-392.

———. 1995. The Psychoanalyst's Mind: From Listening To Interpretation – A Clinical Report. *International Journal of Psychoanalysis* 76: 271-281.

———. 2010. Reflections on Heinz Kohut's Last Presentation, "On Empathy," 1981: Its Impact On My Own Pathway. *International Journal of Psychoanalytic Self Psychology* 5: 160-176.

Stern, D.N., Sander, L.W., Nahum, J.P., Harrison, A.M., Lyons-Ruth, K., Morgan, A.C., Bruschweiler-Stern, N., and Tronick, E.Z. 1998. Non-Interpretive Mechanisms in Psychoanalytic Therapy. The 'Something More' than Interpretation. *Int. J. Psycho-Anal*. 79: 903-921.

Trevarthen, C. 2005. First things first: infants make good use of the sympathetic rhythm of imitation, without reason or language. *Journal of Child Psychotherapy* 31 (1): 91–113.

Zahavi, D. 2014. Empathy and Other-Directed Intentionality. *Topoi* 33: 129–142.