Contribution to the Panel on

THE ROLE OF EMPATHY IN THE PSYCHOANALYTIC PROCESS

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Most of what I have to say about the subject of empathy appeared in an article I wrote in collaboration with Dr. David Beres in 1974. In this opening presentation, I shall restrict myself to those issues that pertain specifically to the interests of this panel, that is, the role of empathy in the psychoanalytic process. Nonetheless, it would be impossible for me to avoid some reflections on the general subject of empathy.

Empathy has moved into a central position in recent psychoanalytic contributions. For many contributors it represents _the_ major developmental vicissitude that shapes the infant's psychological potential. The empathic interaction between mother and child during the first two years of life, in the view of many analysts, transcends in significance practically all later influences. Accordingly, empathy and empathic sensitivity have become for them the touchstones for understanding both pathogenesis and psychotherapy. This trend ultimately eventuates in special emphasis on the role of the nurturing diadic relationship with the mothering figure, as it applies to the psychoanalytic situation, the transference and the psychoanalytic process. Inevitably, such an approach must influence the technical, therapeutic procedures employed by those who subscribe to this point of view.

We should begin with some attempt to agree on the nature of the subject we are discussing. Empathy has been defined or described as a special form or mode of knowing another person's thoughts and feelings. What is special about the process is that this perceiving and knowing take place by way of experiencing another person's feelings one's self. That is why some dictionaries define empathy as "the projection of one's own personality into the personality of another in order to understand him better."

Thus, from the very beginning, empathy has to be distinguished from identification. Clinical observation of the mother-child interaction bears this out. The mother who is immobilized by her own panic when her child is in acute distress and who cannot respond appropriately to relieve the child's anxiety stops at the stage of feeling with the child. She shares his helplessness to the point where she becomes helpless herself. The empathic mother experiences anxiety when she recognizes that her child is in distress. The identification she effects with the child is only transient. She then passes over into a helpful object relationship. The distress communicated to her by observing the child serves as a signal alerting the mother to the need to perform some helpful act which would alleviate the child's distress. For example, an empathic mother may understand how threatening it is for an 18-month-old child to see its stool swept away by the waters in the toilet bowl. In various ways she may be able to help the child overcome this primitive anxiety. She passes over from

feeling the child's needs to understanding the child's needs. However, when the need to train the child reactivates this primitive form of anxiety in the mother, her identification with the child may prove so threatening that she may not be able to flush away the child's stool for hours or days. Such a mother no longer knows what the child is experiencing. She is fixed at a moment of identification with the child; she responds to her own anxiety rather than to the child's confusion and distress.

Thus, while identification is an essential component of empathy, it is only part of the process. Empathy involves both subject and object. At some point identification must break off and give way to an object relationship. In the therapeutic situation, identification with the patient must give way to thinking <u>about</u> the patient. Identification in empathy is only transient, and it is not necessarily accompanied by a fantasy or wish to merge with the object. The identification with the object is not complete or total. It may be, and usually is, specific and discrete, involving a particular memory, mood or fantasy. In the psychoanalytic situation, derivatives of the patient's fantasies are so organized as to stimulate the empathic process in the therapist. This process operates at an unconscious level and results in the evocation of a corresponding unconscious fantasy on the analyst's part. An identification between patient and analyst is effected through this shared unconscious wish that may lead to almost identical or similar fantasies appearing in the minds of both. What

happens next, however, is a rupture of the sense of momentary identification of the analyst with the analysand and a sudden awareness on his part that this inner experience, which seemed so personal and idiosyncratic, is in effect a commentary on the patient's material. Through the process of introspection he is aware of the form in which the correct interpretation came into his mind. What is required next is a set of cognitive operations by which the analyst translates and transforms the awareness of his inner experience into an interpretation. At this point identification breaks off and is replaced by an object relationship. Thinking and feeling with the patient is replaced, as Brierley (1943) and Beres (1968a) put it, by thinking about the patient.

We still have much to learn about how the capacity for empathy develops. In recent years several phenomena have been suggested as representing the precursors of empathy. Much has been said about the phenomenon of "mirroring" as representing mutual empathy between mother and child. It would seem, however, that before the process of separation-individuation is complete, that is, before the concept of an independent object has developed, only the mother can be empathic. We infer that the child has a pleasurable affective experience triggered by the perception of a familiar and gratifying set of sensory impressions. The responses of the child in the first few months of life are biologically determined, representing inherent manifestations of pleasure or pain as well as imitative responses.

These responses serve as signals. The child's behavior is not yet communication in the sense of a reciprocal or reciprocating transmission of information or meaning. At a later date, however, after the object concept has been formed, mirroring, imitative babbling and mimicry serve as forms of motor memories out of which identification with the object may evolve. It would be an interesting study to follow how the transformation of these functions affects the ultimate capacity for empathy.

The capacity for empathy requires such functions as memory, thought, comprehension and conceptualization. Only when these functions have developed to a sufficient degree can the perceptual cues afforded by experience lead to empathy. Empathy consists of more than emotional contagion. It is more than the immediate affective response. It requires considerable ego development. Accordingly, the capacity for empathy increases with age and experience.

Settlage (1978) states, "The adequacy of the developmental interaction (between mother and child) hinges importantly on the mother's capacity for empathy with the infant's drive and development-determined needs and on her emotional or libidinal availability. The mother's empathy enables her affective participation in the regulation of the infant through providing appropriate need satisfaction so as to keep tensions, urges and affects within bounds and prevent the developing ego from being overwhelmed. At the same time she must gauge the infant's need for challenge and frustration so as to evoke the developing capacities and foster self-coping experiences in furthering

the development of independence and autonomy. Such conditions favor healthy identification with maternal auxiliary regulative functions as opposed to attempts at coping, which employ the pathological use of defences. In short, optimal developmental process depends upon interaction with an empathically perceptive, developmentally attuned and, therefore, safe object."

This burden of responsibility for empathic receptiveness on the part of the mother is a recurrent theme in much of the writing of a particular school of child analysts. To me it represents an ideal that in reality can never be attained. The very nature of the exigencies of raising, nurturing and protecting a child inevitably introduce conflicts and misunderstandings that, from certain points of view, may be viewed as representing a lack of empathy on the part of the mother. Consider, for example, this clinical vignette from the analysis of a 35-year-old male professional with a lifelong distrust of women and a feeling that he was unlovable because he was inferior as a man. In the course of the examination of the roots of these attitudes, he reported the following incident. When he was about four years old, he recalled, he admired his father who seemed so tall, so capable and so powerful. He remembered his father climbing to the top of a ladder, reaching up to the ceiling, and changing a light bulb in the electrical fixture. His mother was standing by the ladder which was rickety and unstable and precariously perched at the head of the stairwell. He felt that she was impressed with his father just as much as he was. For some reason the father had to leave the house promptly, and the

ladder was left where it had been standing at the head of the stairwell. Thinking to imitate his father and so impress his mother, our young patient began a slow, laborious and dangerous climb to the very top of the ladder, trying to see if he could touch the ceiling by stretching as hard as he could. At this moment, his mother came upon the scene. Overcome by concern for her son's safety, she lunged towards the ladder, forcefully snatched the would-be Prometheus from his lofty perch and scolded him angrily with an accompanying sharp blow to his buttocks. He felt not only hurt but also humiliated, and interpreted his mother's energetic reaction to the situation as a warning and reproach. He had no right to dare to emulate his father or to aspire to occupy his role. The incident became an organizing experience about which clustered all the slights and frustrations, real or imaginary, in his competitive struggle with the father for the mother's love. One could say that the mother, frightened by the potential danger to her child, had overreacted. Clearly, however, the situation was not such that the mother could respond as "an empathically perceptive, developmentally attuned and, therefore, safe object." Crises of this sort recur regularly in the course of development. An empathic response is not always possible, especially when the experience that the child and the mother share has such divergent meanings for each of the participants.

Most discussions of the therapist's empathy emphasize the element of affect. The emotional side of the therapist's experience is only part of the process. The reaction of the empathizing therapist

is a mixture of both affect and cognition. Either component, or both, may serve as signals emerging from a momentary identification with the patient and leading to an awareness of the process that is taking place. The capacity for the analyst to identify with his patient's moods and thoughts springs from a number of important elements. First is the basic biological matrix of experience which all human beings share, the early period of helplessness, the evolution of object relations, and psychosexual development in the context of the pleasure-unpleasure continuum. Beyond these are the similarities of experience which come from a common background and cultural tradition. But perhaps most significant to the analyst in the analytic experience is the shared confidences and the piecemeal identification of the analyst with his patient over weeks and months of listening to his patient's experiences, transforming and comprehending them in terms of the events of his own life. It is on the basis of these common elements, in the shared intimacy and confidence of the analytic situation, that the tendency for identification is enhanced and intensified. By the process of empathy, the verbal and non-verbal communications of the patient, consciously or unconsciously intended and representing derivatives of his unconscious fantasy, can be perceived and responded to by the therapist as clues supplied by the patient. By the process of intuition, organized by cognitive elaboration, the data is conceptualized and elaborated into insight leading to interpretation. How the patient expresses himself in his verbal presentations is most significant in this regard. All the mechanisms and figures of speech that convey and transmit affect in

poetic and artistic creations intensify empathic communication in the psychoanalytic situation. The most significant of these is the use of metaphor. Sensitivity to metaphoric expression is one of the most significant hallmarks of the empathic person. The metaphoric language of the patient influences the analyst without the latter being aware of it. It is possible through training and experience to sharpen one's empathic capacity by paying special attention to the metaphoric language, motor activity and behavior of the patient.

Individuals who have a basic defect in their capacity to empathize hardly ever become therapists. Variations in the functioning of empathy are, of course, usually observable in the supervision of candidates. When a candidate is completely without empathic understanding of his patient, it is impossible for the supervisor really to know what is going on. In the usual course, where the candidate is having difficulty understanding the patient, he can be assisted by the supervisor because the candidate has unconsciously and selectively organized the material in keeping with his empathic apprehension of the patient's thought processes. The functioning of the candidate's empathic grasp has to be distinguished from his intuitive organization of the data. Counter-transference problems seem to intervene primarily at the level of the latter, i.e., the intuitive integration of the data made possible by empathy. This becomes apparent in many ways. If one observes closely the nature and timing of the therapeutic interventions made by the candidate who is having counter-transference problems, one can observe how these interventions are motivated by a

need to ward off the anxiety that the unconscious fantasy inherent in the patient's material threatens to provoke in the candidate. In other words, at an unconscious level, the candidate has perceived empathically enough of his patient's unconscious fantasies to become aware of the danger of some threatening, emerging impulse. The candidate has indeed identified with the patient and has come to understand him. However, for reasons of his own, the candidate in such instances understands the patient only too well. The anxiety generated by the threatened emergence of the unconscious fantasy the candidate shares with the patient mobilizes a counter-transference need for defence. Under such circumstances the next step in the process of interpretation is impeded. The candidate does not permit the patient to remind him through his material of the very same elements of his own conflicts, conflicts that the candidate would like to keep repressed. At the other end of the spectrum are those situations in which the background and essential unconscious psychology of the patient differ so markedly from the therapist that it takes a longer time for the therapist to be able to empathize with the patient, if he can do so at all. This may be one of the reasons why it is difficult for many therapists to treat perverse, psychopathic or severely narcissistic personalities.

The identification involved in empathy has to be positively tinged. A therapist whose own narcissism is vulnerable may find it extremely difficult to empathize with a narcissistic patient.

When the self-esteem of the latter is injured, the resulting withdrawal and covert hostility towards the therapist may undermine the necessary positive component which makes empathic identification with the patient possible. Thus it seems to me that the skill the therapist develops over many years represents more than accumulated knowledge. It is enhanced by the capacity to maintain an objective, positively tinged identification with the patient. Unless he is able to do so, the pursuit of psychoanalytic therapy becomes an onerous burden.