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PSYCHOANALYTIC ISSUES IN THE THEORY OF EMPATHY

City University of New York PH.D. 1986

PSYCHOANALYTIC ISSUES IN THE THEORY OF EMPATHY

by

GEORGE H. NORTHRUP

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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Abstract

PSYCHOANALYTIC ISSUES IN THE THEORY OF EMPATHY

by

George H. Northrup

Advisor: Professor I. H. Paul

The empathy of the psychotherapist is the focus of this theoretical dissertation, which critically reviews a variety of psychoanalytic formulations. An attempt is made to identify the reasons why 75 years of clinical reflection have yet to compose themselves into a cohesive theory of empathy and why empathy remains, to a great extent, an estranged concept in psychoanalysis. In this regard, attention is given to the historical origins of empathy in 19th-century aesthetics, problems in defining its phenomenological nature and mechanisms of operation, epistemological issues concerning the credibility of empathic knowledge as contrasted with natural science knowledge, and heuristic arguments for and against the development of a clinical theory of empathy as the paradigm of psychoanalytic technique. Examination of these topics suggests that the reasons for the chronically ambiguous and disputed status of empathy are essentially twofold: (a) fears associated with

the nonrational, emotional, unscientific, and (perhaps) "feminine" nature of empathizing, and (b) the relative failure to construct comprehensive definitions of empathy using existing psychoanalytic terms.

The first issue appears to have sparked a defensive idealization of psychoanalytic technique as rational, objective, and scientific. This wishful representation is inconsistent with the required use of the therapist's own personality to understand the patient and unrealistic in the clinical situation. Nor is empathy, despite its subjective nature, inferior as a means of obtaining knowledge about the mind of another insofar as it involves an adaptive integration of emotion, perception, and cognition under the auspices of secondary process. Understood in this way, empathy offers some hope of organizing and clarifying the principles of classical psychoanalytic technique.

As a step toward overcoming the second problem, empathy is described in relation to other psychoanalytic terms, including regression, evenly hovering attention, counter-transference, object representation, the economic point of view, and (especially) projection and introjection.

Particular attention is given to the theories of Robert Fliess, Theodor Reik, and Heinz Kohut, and clinical material is included to illustrate the mental operations characteristic of various aspects of empathizing.

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Chapter 1

Introduction: Perspectives on Empathy

> It is not facetious to say that often we ourselves do not know what we mean, and therefore it is not surprising that we cannot precisely communicate our ideas with others. (Alexander, 1958, p. 293)

Accolade and Cacophony

Empathy has been called "the very core of psychologic understanding" (Maddaloni, 1961, p. 21), "an absolute prerequisite for psychoanalytic practice" (Greenson, 1966, p. 271), "the foundation stone of all psychotherapies" (Beres, 1968, p. 368), "perhaps the most important characteristic of the good therapist" (Wolberg, 1977, p. 345), one of the "preconditions for any appropriate psychotherapeutic work" (Kernberg, 1978, p. 91), "the basis of psychoanalytic knowledge" (Modell, 1979, p. 70), "*the psychoanalyst's basic tool of observation, listening, and communication*" (Ornstein, 1979, p. 97; emphasis in original), and "the operation that defines the field of psychoanalysis" (Kohut, 1984, p. 174).

Behind these ringing endorsements of empathy stands a psychoanalytic literature stretching back at least to Kovacs (1912), whose volume has accelerated sharply in recent years (cf. Shapiro, 1981, p. 424). Unfortunately, the results of all this scholarly reflection are fragmentary, often

contradictory, and have yet to compose themselves into a cohesive theory. For every assertion made about empathy, there is sure to be an opposite claim somewhere in the literature.[1] Despite all the attention empathy has received, the theoretical status of the term remains about as elusive and ambiguous as it was at the time of Lipps (the turn of the century German psychologist credited with popularizing the concept of empathy in the field of aesthetics), when Kovacs lamented the "vague and amorphous"[2] nature of aesthetic empathy (1912, p. 321). Twenty-five years later, Reik complained that "the conception of empathy has become so rich in meanings that it is beginning to mean nothing at all" (1937, p. 192), and, almost 25 years after that, Ferreira considered empathy "an estranged concept that never quite became integrated in the main body of psychoanalytic theory" (1961, p. 91). Even taking into account all that has been published since then, Clark (1980, p. 187), Reed (1984), and Levy (1985, p. 362) reached essentially the same conclusion. As Reed put it, "an unusual degree of conflict and confusion surrounds the word and is matched by an equally unusual amount of inconsistency and contradiction characterizing its use" (pp. 7-8). So little progress has been made in reaching a consensus about empathy that Basch could provide a rather long list of disputed issues:

> Is empathy rational or irrational? Is it regressive or mature? Does it involve only affect, affect and cognition, cognition alone, or

> is the differentiation between affect and cognition false? Is empathy a form of projection or a mode of observation? Is it imitative or creative? Is empathy to be equated with intuition or are these two different processes? Can empathy be dealt with scientifically or is it a purely private matter? Does the analyst's empathy aid the analysis by recreating what the analysand is experiencing or is it a form of countertransference and, therefore, an interference with the analysis? Does empathy take place through identification and a permanent or temporary loss of self or identity, or is there no such identification with the object of empathy and, therefore, no loss of self? Is empathy an end result, a tool, a skill, a kind of communication, a listening stance, a type of introspection, a capacity, a power, a form of perception or observation, a disposition, an activity or a feeling? Is empathy to be equated with love, understanding, sympathy? Does empathy involve gratification? Does it or does it not undermine the rule of abstinence? (1983, p. 102)

For psychoanalytically-oriented therapists,[3] decisions about the nature and role of empathy would need to take into account the views of Freud, and, predictably, interpretations of Freud vary widely.[4] Kohut (1959, p. 464), Karush (1979, p. 62), Ornstein (1979, p. 97), Stone (1981, p. 108), and Post and Miller (1984, pp. 217-220) all regarded Freud as very much concerned with empathy, and Szalita considered that "Freud's [1914a] essay on Michelangelo's statue of Moses...provides a good illustration of the use of empathy as conceived by Lipps" (1976, p. 145). Schafer (1959, p. 342) and Shapiro (1981, p. 423), on the other hand, attributed to Freud a quite modest interest in empathy. Muslin went even further: "like Moses, Freud could not enter the promised land. He could not enter into the mental life of his patients as an

empathic observer" (paraphrase by Chattah in Panel, 1983, p. 695; cf. Muslin, 1984).

In fact, Freud's references to empathy were relatively few and brief, but in his essay on group psychology, he did seem to place a far greater emphasis on empathy than could be imagined from the infrequency with which the term appeared in his writings:

> 'empathy'...plays the largest part in our understanding of what is inherently foreign to our ego in other people (p. 108)....A path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude at all towards another mental life. (1921, p. 110n)[5]

Agosta has helped to resolve the controversy about Freud's attitude toward empathy by suggesting that Freud avoided using the term in relation to psychoanalysis because it was so completely identified with Lipps' theories of aesthetics (1984, p. 44), much as analysts today tend to shun words like *conditioning* or *modeling* that immediately bring alternative psychological theories to mind.[6]

Freud's views have not been the only ones subject to conflicting interpretation. A passage in which Ferenczi discussed the importance of the analyst's "oscillation between the free play of phantasy and critical scrutiny" (1919, p. 189) has been cited both as an apparent early description of analytic empathy (Fox and Goldin, 1964, p. 323; Stone, 1981, p. 108) and as evidence that empathy was *not* a concern of early analysts (Shapiro, 1981,

p. 423).

For so central a psychoanalytic concept to remain so controversial and so poorly understood after almost 75 years is remarkable. Even Kohut's approach to psychotherapeutic treatment, which ranks with Carl Rogers' in the explicit importance it places on empathy, contains no theoretical formulations about the nature of empathy comparable to those made about narcissism, the self, or transference paradigms. Indeed, detailed discussion of empathy in any respect is actually rather limited in Kohut's writings, occupying no more than five or ten consecutive pages in any of his major works (1959, 1971, 1977, 1982, 1984), and avoiding the large and troubled literature on the topic. Kohut's comments about empathy were frequently confined to stressing the importance of phrasing interventions in experience-near terms; when he referred to the inner empathic state of the analyst at all, it was generally in language not specific to psychoanalysis, such as "vicarious introspection" (1959, p. 459), "a mode of cognition which is specifically attuned to the perception of complex psychological configurations" (1971, p. 300), or "the capacity to think and feel oneself into the inner life of another person" (1984, p. 82). Inasmuch as Kohut was hardly averse to theorizing or technical terminology, his apparent lack of interest in developing a psychoanalytic model of empathy is striking.[7]

The picture of empathy that emerges from the psychoanalytic literature is one that is often highly

regarded, much debated, and poorly understood. The rest of this chapter attempts to identify some of the sources of disagreement and confusion, while subsequent chapters develop these themes and propose a more integrated understanding of empathy.

Historical Perspective: Origins in Aesthetics

The English word *empathy* was coined by Titchener in 1909 as a translation of the German term *Einfuehlung* (literally, "feeling into"), which, as mentioned above, played an important role in Lipps' theory of aesthetics.[8] Considering the wide attention that empathy has received, both in aesthetics and in psychoanalysis, it is surprising that, for the most part, Lipps' writings have not been translated into English; in this country his work is known primarily through secondary sources.[9]

Briefly, Lipps' concept of *Einfuehlung* referred to a subjective involvement with an object, in which a variety of psychological responses were induced by the object, leading to an integrated apperception of it. These subjective responses to the object were experienced as belonging neither to the subject nor to the object as such, but to the object only insofar as it existed in relationship to the subject--akin to what might now be called a transitional phenomenon (Winnicott, 1953), or a narcissistic or selfobject relationship. The inner responses originally

(Lipps, 1897) included a motor imitation of the object, so that, for example, the contemplation of a Doric column was thought to be associated with a muted physical effort to draw oneself into an upright position.[10] Lipps later abandoned this position in favor of a more strictly *mental* activity and became quite critical of others who held views similar to his original ideas. He also expanded his theory of *Einfuehlung* beyond aesthetics, describing it as a way of understanding the inner life of another person by way of "feeling into" what is observed through the senses (Hunsdahl, 1967, p. 184; cf. Winterstein, 1931, p. 305).

If there is any single term that comes close to explaining how *Einfuehlung* takes place, that term is probably *projection*. Summaries of Lipps' ideas about empathy often characterize it as "'projecting' one's own animation into the inanimate object" (Schroeder, 1925, p. 157), "projecting one's self into what is seen" (Pillsbury, 1971, p. 88), or words to that effect (Strunk, 1957, p. 47; Szalita, 1976, p. 145; Agosta, 1984, p. 44; Noy, 1984, p. 190; Olinick, 1984, p. 151). This attribution of subjective experience to the object accurately explains Lipps' theory as far as it goes, but omits mention of how the subjective experience was induced by the object in the first place.

How successful Lipps was in developing a comprehensive theory of empathy is open to question. Robinson, for example, considered Lipps' later ideas about empathy to be "highly abstract, obscure, and metaphysical" and, on the

whole, "rather a hindrance than a help in understanding empathy" (1963, p. 54). Lipps himself was far from satisfied with the concept of *Einfuehlung* and often criticized it, but could find no more appropriate term (Hunsdahl, 1967, p. 184).

From this short summary, it is apparent that Lipps' work anticipated many of the issues important in understanding the psychoanalytic concept of empathy. Projection and imitation are the most obvious, but there are also points of correspondence with psychoanalytic terms such as introjection and identification. Sadly, the obscurity and complexity of Lipps' thinking also anticipated the chronically confused status of empathy in psychoanalytic theory.

More subtle, but equally important in the legacy of empathy received from Lipps is the curious, almost oedipal attitude of many analysts. If psychoanalysis has not wished to marry empathy, it has at least entered into a variety of ambivalent relationships with her: it has flirted with her, idealized her, doubted her, and, now and then, rejected her. And if it has not murdered Lipps, psychoanalysis has, at times, in claiming the superiority of its own theory of empathy, sought a kind of oedipal triumph over him. While psychoanalytic theories have often been applied to the study of aesthetics, aesthetic theories of empathy have not as often been seen as relevant to understanding clinical work.[11] Schroeder, for example, in an important but nearly

forgotten early attempt to formulate the psychoanalytic method in terms of empathy and introspection, considered his ideas to be "a development of the concept of 'Einfuehlung'" (1925, p. 159), but apparently could not resist denigrating its aesthetic origins:

> In Lipps' sense, "Einfuehlung" involved what Wm. James called the "psychological fallacy" of reading into an object qualities which may exist only in ourselves.[12] My concept of the psychoanalytic method, as I am about to describe it, is believed to provide safeguards against this psychological fallacy (p. 158)....Thus, "Einfuehlung" may be considered to have been first used as a vague general term, implying in some very inadequate sense all the processes I am about to describe. (p. 159)

The "safeguards" or "checks and correctives" to which Schroeder often referred in his article consisted mainly of the contributions of the genetic point of view, which enriches understanding of a current experience; the corroborative value of the patient's introspections and associations; and the ability of the analyst to obtain a second opinion by consulting with his peers. But these advantages of psychoanalytic empathy offer nothing not already available to the art critic in his own endeavors. He, too, uses a kind of genetic point of view by virtue of his access to the work of art historians, on the basis of which he is able to place a given work of art in temporal perspective, noting the earlier developments of which it is derivative or against which it is a reaction. Corresponding to the corroborative value of the patient's associations are the artist's other productions and any comments he may have

made about his aesthetic intentions. And, of course, the art critic, like the analyst, can consult with other experts in his field.

It may be objected that the kind of understanding arrived at through psychoanalytic empathy is deeper and more meaningful than that obtained by way of aesthetic empathy (cf. Beres and Arlow, 1974, p. 46). Given the different aims of the two kinds of understanding, how this question might be settled is unclear. In any case, the specific theories that help structure the contents of an empathic experience are a separate matter from the psychological operations involved, which may well be identical in psychoanalytic empathy and aesthetic empathy.

With as little justification as Schroeder, Kohut sought to claim an elevated status for psychoanalytic empathy as contrasted with aesthetic empathy: "it is one of the specific contributions of psychoanalysis to have transformed the intuitive empathy of artists and poets into the observational tool of a trained scientific investigator" (1971, p. 303). And, disregarding Lipps' later work, Noy asserted "there is nothing in the concept [of *Einfuehlung*] that refers to a better understanding of other people" (1984, p. 171). Noy considered the perception of art to be "'animism'" or "'anthropomorphism'" and maintained that "empathic capacity" can only take place in relation to a human object (p. 178).

Why have some psychoanalytic writers sought to dissociate

clinical empathy from its origins in aesthetics? Surely part of the answer is their understandable pride in the unique contributions of psychoanalysis. But, as the quotation from Kohut suggests, the need to regard psychoanalysis as a science may also be playing a significant role. In part, this reflects the difficulties psychoanalysis has and must have complying with traditional scientific standards. These might have settled the issue long ago but for the fact that the nature of science is no longer as clear as it once was, when the distinction between the observer and the observed phenomenon seemed so much more complete and obvious than it does today. The developments in particle physics that are responsible for this change provide (for some) an attractive new scientific paradigm that just might encompass psychoanalysis, although this hope may prove as illusory as earlier rationales based on the presumed biological origins of the drives (cf. Loewald, 1978, p. 10; Brenner, 1982, pp. 11-17). Then, too, perhaps a definition of science broad enough to include clinical psychoanalysis[13] also includes aesthetics, and for the same reasons. However these issues sort themselves out, it is worth asking whether the analytic attitude is really closer in spirit to the investigation of subatomic particles than it is to the informed contemplation of a work of art.

Semantic Perspectives

The question of what the term empathy *means* in psychoanalysis is partly a semantic one. Few would go so far as Shapiro in speculating whether it means anything at all: "perhaps empathy is a creative fiction of the German language which has a propensity to agglutinate stems, prefixes and suffixes into new creations that are then falsely reified" (1981, p. 430). Of course, much of psychoanalytic theory was also written in German.

If it can be assumed that empathy means *something*, that meaning should be easiest to apprehend in those aspects of empathizing that are closest to experience, that is, in the phenomenology of empathy. Empathy is most often understood as a vicarious experience of the intrapsychic state of another, but opinions are divided on the nature and scope of that experience. Does it concern itself with the vicarious experience of another's *feelings* (Olden, 1953, pp. 112-113; Greenson, 1960, p. 418; Ferreira, 1961, p. 92; Chessick, 1965, p. 218), or of both his affective and cognitive state (Schafer, 1959, pp. 346-348; Arlow, 1979, pp. 67-68; Ornstein, 1979, p. 100; Lichtenberg, 1981, p. 334; Noy, 1984, p. 177; Spencer and Balter, 1984, p. 302)? The *vicarious* nature of the experience would seem to require that empathy involve a reproduction of what the patient is actually experiencing, but this view must be reconciled with other descriptions of empathy as transcending the object's

subjective experience by including phenomena that are not part of that experience, such as unconscious fantasies and conflicts (Olden, 1953, p. 115; Karush, 1979, p. 63; Noy, 1984, p. 177; Levy, 1985, p. 374). The same problem arises when empathy is described as an integrated understanding (as opposed to a simple sharing) of the patient's state of mind (Schafer, 1959, p. 345; Post, 1980, pp. 280, 286; Kligerman, 1984, pp. 318-319; Kohut, 1984, p. 186). Discussions of empathy as a way of perceiving or recognizing the other's experience, increasingly common in the literature since Kohut's initial reference to empathy and introspection as forms of *observation* (1959, p. 460), may easily give the impression that vicarious experience is scarcely involved at all; indeed, Demos has explicitly considered "affective resonance," though prominent, to be optional in empathizing (1984, p. 17). It is also unclear if empathy requires a positive, altruistic, or nurturant interest in the other (Racker, 1957, p. 313; Reich, 1960, p. 390; Gitelson, 1962, p. 198; Arlow, 1979, p. 69; Grotstein, 1984, p. 213) or if it is experienced neutrally, with no particular positive or negative implications (Olden, 1953, pp. 117-118; Ornstein, 1979, p. 99; Kohut, 1982, pp. 83, 84; Basch, 1983, pp. 119-120, 122; Poland, 1984, p. 336). The literature disagrees, too, about whether empathy includes a feeling of merger with the object (Sandler and Rosenblatt, 1962, p. 137), a feeling of separateness (Broussard, 1984, p. 81), or both (Schafer, 1968, p. 153; Beres and Arlow, 1974,

p. 34; Poland, 1984, p. 337).

In a general way, the various points of view just mentioned can be divided into two groups, one weighted in the direction of feelings (vicarious affect, closeness to subjective experience, libidinal interest, and merger), and the other emphasizing cognitive operations (observation, experience-distant understanding, neutrality, and detachment. The relative place of affect and intellect in a theory of empathy is one of the great issues to be resolved.

In part, the different positions taken in the literature are the result of semantics. For example, the view that empathizing involves only an affective state is usually presented in conjunction with a discussion of how a parallel process, such as intuition, grasps the unexpressed *thoughts* of the patient. On the other hand, those who define the phenomenology of empathy more broadly seldom refer to intuition, incorporating it into empathy.

As to the related issue of how vicarious the therapist's empathy must be, the semantic problems posed by empathizing with the patient's unconscious and by understanding on a deeper level than does the patient himself can be overcome if the phenomenology of empathy is defined the way Schafer did, as "*sharing in and comprehending* the momentary psychological state of another person" (1959, p. 345; emphasis added). In his definition, Schafer made clear that the other's "psychological state" is not limited to what he

is consciously experiencing at that moment, but is, in effect, a creation of the empathizer, using appropriate psychoanalytic constructs to represent the entire personality. The contrast between empathy as a mode of experience and empathy as a mode of observation can likewise be reduced by acknowledging that however "perceptive" the therapist's empathy may be, it is not a matter of seeing or hearing the patient's feelings and thoughts, and by distinguishing more carefully between empathy, which has to do with the experiencing and integrative functions of the ego, and introspection, the observing function of the ego. Empathy, then, always refers to a synthesis of the contents of experience (including unconscious experience), not to the observation of them per se, and certainly not to observation of the patient's mind. The phrase *empathic observation* should refer to observations that give rise to empathy or to the observation of one's empathy, not to what empathy "observes."

Finally, questions of merging and separateness, nurturing and neutrality, as well as others, may best be addressed by recognizing that different instances of empathizing may call for or call forth different psychological patterns, with no single paradigm capable of covering all conditions.

These semantic problems encountered at the experiential level are multiplied many times over when the nature of empathy as a psychological *process* is considered. Often the effort to clarify its dynamics or mechanisms has relied on

terms not specific to psychoanalysis, with the result that, so far, empathy has been defined largely by its connotations. To achieve a more secure theoretical standing, empathy would have to be integrated into the larger body of psychoanalytic propositions. At the least, the term would have to be defined in relation to others, such as projection, introjection, identification, neutrality, tact, countertransference, rapport, evenly hovering attention, timing, and intuition--some of which themselves lack agreed-upon meanings, at least in clinical theory. The failure to accomplish this task has left empathy as a second class term in clinical theory, without the conceptual underpinnings of first order concepts such as transference or resistance, and sometimes regarded as separate from psychoanalytic training and technique (Fliess, 1942, p. 212; Beres and Arlow, 1974, p. 27).

A still more comprehensive picture could be obtained by formulating a metapsychology of empathy--empathy as understood from the genetic, dynamic, structural, economic, and adaptive points of view. This approach would need to concern itself with empathizing as an activity involving an internalized object relationship, describing how the empathic object comes to be represented and what its function is in the psychic economy of the therapist.[14]

Epistemological Perspectives: Empathic and Scientific Knowledge

To ask what empathy means is ultimately to inquire into the basis for our knowledge of the mental life of others; a theory of empathy is, in its deepest sense, an epistemological theory. Unfortunately, knowledge of other personalities rests on rather less secure epistemological assumptions than the philosophically more familiar knowledge of material reality or knowledge of one's own mind, both of which also play essential roles in empathizing.

In the psychoanalytic literature, empathic knowledge has often been referred to as "inside" knowledge of the patient, as contrasted with the kind of knowledge acquired by "outside," "objective," or "scientific" methods (Fliess, 1942, p. 212; Greenson, 1960, p. 421; 1967, p. 367; Maddaloni, 1961, p. 27; Kohut, 1971, p. 219n; Ornstein, 1979, pp. 98-100; 1981, p. 373; Lichtenberg, 1981, pp. 340-348; Schwaber, 1981, pp. 364, 389; Noy, 1984, pp. 176-177). Although psychoanalytic practice has usually been described as requiring both approaches, far reaching assumptions for the epistemological value of one or the other have sometimes been made. For example, Gedo wrote that

> we cannot discover the analysand's failure to renounce mutually exclusive goals through exercising our empathic processes; we must infer the presence of deficits in self-regulation, which underlie the symbiotic strivings that fill the psychological field in such cases, through the

> detached observational methods of the natural scientist. (1984, p. 140)

Noy asserted very nearly the opposite: "only the empathic individual...will be able to grasp the motives, contrary intentions, hesitations, and conflicts behind the observed behavioral response" (1984, p. 177; cf. Levine, 1952, p. 209; Katz, 1963, p. 14; Kohut, 1973b, p. 700; Karush, 1979, p. 63; Ornstein, 1979, p. 99; Ornstein and Ornstein, 1985, p. 50).

Preliminary to resolving such competing claims, psychoanalysis should begin to identify and clarify the epistemological issues involved in empathic (or inside) and scientific (or outside) knowledge. An initial effort, such as this one, must largely defer ultimate questions about the credibility or truth value of either form of knowledge, including even the important matters of whether either approach can produce anything entitled to be called knowledge and, if so, what conditions must be fulfilled to reach it.[15] Excluding these questions, however, still leaves a great deal to explore about the nature and relative merits of empathic and scientific knowledge as guides to the inner life of the patient. For the purposes of this analysis, "knowledge" is assumed to be nothing more than a vision of reality, true or not as far as it goes, but not, certainly not, the whole truth or the only vision of reality possible. This apparently modest assumption may be, nonetheless, as applicable to material reality as it is to psychic reality (Wallerstein, 1973, pp. 17-18; 1985,

pp. 566-568).

Despite Freud's reminder that knowledge of other minds is a matter of inference rather than direct observation (1915b, p. 169), it is all too common in the literature to find empathy referred to as a method that provides direct access to the patient's mind. Ornstein, for example, wrote that "empathic immersion aims at a *direct comprehension*" of feelings, thoughts, and total constellations of inner experience (1979, p. 100; emphasis added), contrasting this approach with the inferential method of the natural sciences. On the other hand, those who have discussed the scientific approach are not always as careful as Gedo was (see above) to distinguish between observation and inference, implying that the thoughts and feelings of others are directly observable scientifically. In fact, both empathy and science must infer the contents of the patient's mind from what they are able to observe. Two modes of observation are important in this connection.

Fundamental to both empathic and scientific knowledge of the patient is the information the therapist obtains through sensory channels, in particular what he hears and sees of the patient's associations and behavior as these exist in material reality. This kind of *extrospective observation,* as Ornstein (1979, p. 98) and Kohut (1984, p. 32) have called it, does not presuppose that the stimuli originated by the patient are identical to what is observed by the therapist; that would be impossible, given individual

differences in the way sensation is selected and organized perceptually, coded linguistically, and, in general, processed in relation to pre-existing categories and memories considered, rightly or not, to be relevant.[16] An incoming sensation, then, evokes a variety of coordinated mental operations intended to make sense of it. Psychologically, it is doubtful that these operations could be restricted to a neutral registration and processing of the sensation that avoided mental interpretations about its meaning in the broadest sense (cf. Arlow, 1985, p. 529; Wallerstein, 1985, p. 566). To preserve the distinction just drawn between observation and inference, and for knowledge of the patient to be in any sense subject to correction and improvement, it must be assumed that the extrospective observer can, at least partially, know the extent to which he has transformed his sensory impressions of the patient, that he can tell the difference between the inevitable, presumably minimal, and ordinarily tolerable transformations, on the one hand, and others, more tentative, arising from theoretical preconceptions and clinical experience, which are, epistemologically, no longer just a matter of observation, but which approximate the inferred psychic reality underlying the patient's associations and behavior. Because the mind is all too ready to attach meanings to sensory input, even highly experienced therapists must struggle to keep their "data" about the patient (e.g., the late payment of a bill)

separate from the inferences they make about it (e.g., a feeling that therapy is worth nothing, a wish for the therapist's freely-given interest, an anal-stage reluctance to let go of something precious on demand).

These considerations indicate that knowledge of the patient's expressed material reality is both limited and difficult to separate from the psychic reality as constructed by the therapist. Nonetheless, a credible epistemological status for the therapist's extrospective observations presupposes a persistent effort to perceive and maintain that separation.

Such secondary process inferences about the meaning of extrospective observations are not, however, the only form of response the extrospective observer will have. His reactions will also include a broad spectrum of narcissistic, object-libidinal, and aggressive responses. How these reactions are employed intrapsychically differs depending on whether the extrospections are to be used scientifically or empathically and will be discussed below.

Corresponding to extrospective observation of the patient is the kind of observation known as *introspection,* the observing function of the ego. What is observed in this manner is, in principle, everything in the psychic life of the therapist, conscious and unconscious, thoughts, feelings, memories, bodily sensations, fantasies, and so forth. Whereas extrospection takes as its object the patient in the world of material reality, the object of

introspection is the psychic reality of the therapist. As with extrospection, and for similar reasons, this form of observation cannot be assumed to provide a complete or accurate impression of the reality it observes.

This analysis has treated extrospection and introspection as if they were discrete operations, and in many contexts such a view would be appropriate for practical purposes. The physician taking a patient's temperature, for example, ordinarily need not concern himself with his own internal world, but matters are not so easy for the psychotherapist trying to measure the emotional temperature of the patient. His own psychological state will directly influence the nature of his observations and how they are interpreted. Whatever role he may assign to his subjective responses--whether he seeks to exclude them as contaminants or to incorporate them as potentially valuable routes to understanding--he must first have some awareness of them, and this, of course, implies that introspection is a necessary companion to his observation of the object.[17]

By the same token, the self-reflective thoughts of a person falling asleep in a dark room may have little or nothing to do with external stimuli, but the introspections of the therapist are obviously influenced by the patient and, indeed, only relevant insofar as they are influenced by what he hears the patient say and sees him do. Sorting out the relevant from the irrelevant naturally presupposes paying attention to the patient, that is, extrospection.

The distinction between extrospection and introspection as observational approaches, therefore, does not mean that one or the other can be used exclusively. It is clear, though, that the scientific approach looks inward for the purpose of identifying, isolating, and excluding subjective influences as far as possible, whereas the empathic method uses extrospection in order to integrate observable behavior of the patient as far as possible with the contents of the therapist's mind. From one perspective, the therapist might first ask himself, "What am I feeling that makes the patient look this way?", and from the other, "What is the patient doing to make me feel this way?"

Both extrospection and introspection, like mental activity in general, must be assumed to operate at all levels of awareness; it is not absolutely necessary, therefore, for the therapist to be conscious of what he has observed about the patient or about himself. Although this paradox raises a unique set of epistemological problems, psychoanalysis cannot pretend to base its methods on conscious observation alone. According to Freud,

> It is essential to abandon the overvaluation of the property of being conscious before it becomes possible to form any correct view of the origin of what is mental. In Lipps's words...the unconscious must be assumed to be the general basis of psychical life. (1900, p. 612)

This, of course, is as true of psychotherapists as of anyone else, and equally true of extrospection and introspection:

> Excitatory material flows into the *Cs.* sense-organ from two directions: from the *Pcpt.*

> system, whose excitation, determined by qualities, is probably submitted to a fresh revision before it becomes a conscious sensation, and from the interior of the apparatus itself, whose quantitative processes are felt qualitatively in the pleasure-unpleasure series when, subject to certain modifications, they make their way to consciousness. (p. 616)

The role of the unconscious helps to explain the smooth and seemingly automatic way in which observations are made and interpreted, but it may also make it difficult for the therapist to know which kind of observations he is relying on in any given instance. Like a physician conducting a physical examination, the scientific observer may arrive at a "diagnosis" or inference so quickly that one may be tempted to attribute it to intuitive genius or guesswork instead of to an overlearned set of associations or to a rapid unconscious but entirely logical sequence of operations. At the same time, an apparently scientific conclusion that a patient is thought disordered may well be based in part on a characteristic feeling of confusion or mental strain in the observer. Attributions made after the fact may well have more to do with which observations can more readily be made conscious or with the method the therapist prefers to imagine himself using than they do with the actual contribution of either form of observation. Chances are excellent that the "scientific" approach favored by some analysts involves more empathy than they realize, and that the "empathic" approach advocated by others presupposes unacknowledged inference from extrospection and theory.[18]

Extrospection and introspection provide the lowest order and, therefore, most secure form of knowledge available to the therapist. They offer the most direct knowledge possible of the material reality of the patient and of the psychic reality of the therapist. Unfortunately, this also means that they offer no direct information about the inner life of the patient. That limitation is easier to see in the case of introspection, which is obviously limited to *self* knowledge, but it is also true of extrospection, and not just when the patient is avoiding self disclosure. To examine the limiting case, imagine the patient who says, "I am angry." Surely this statement reveals the patient's inner life to the therapist (cf. Agosta, 1984, p. 47)? Strictly speaking, it does not: it provides only knowledge of what the patient has said about himself. If it seems absurd not to accept the statement as "true," consider the epistemologically equivalent expression, "I am not angry," which most therapists would hesitate to accept at face value. The issue is only partly whether the therapist believes the patient is deceived about his actual emotional state. There may also, for example, be a semantic aspect, in which "I am angry" is more accurately understood as "I feel threatened" or "I am trying my best to assert myself." Above all, however, the issue is what criteria to use in making an inference about the patient's inner life from an extrospective observation; the observation itself cannot be the criterion (cf. Schafer, 1985, p. 545).

What, then, is the nature of the inferential process by which the personality of the patient comes to be known? No complete answer can be given, but a synthetic operation of some kind is always called for, in which the inference results from the mind's formal contribution to the observations, the way they are organized in relation to each other, integrated with previous observations and inferences, and found (or made) to fit with clinical experience and psychoanalytic theory. The general outlines of this synthetic process appear to be identical for both empathic and scientific knowledge, with the major difference arising in relation to the kinds of observations considered relevant. In principle, the scientific approach applies its synthesis *only to extrospective observations,*[19] and the synthesis is ideally a secondary process activity. As far as the scientific observer is concerned, any primary process responses are, at best, irrelevant, and, often enough, obstacles to the necessary detached focus on the object. He must, therefore, strive to become aware of, minimize, and isolate from his observations all responses of this kind. This approach, of course, is consistent with the once-widespread understanding of countertransference as simply an interference with psychoanalytic work and ideally to be avoided, although direct support for that view is difficult to locate in the literature (cf. Heimann, 1950, p. 81). If scientific inference in psychoanalysis were entirely conscious and verbal, a simple example might sound

like this:

> The patient describes himself as restless and uncomfortable, and his facial expression, syntax, and manner of speech are consistent with the idea that he is anxious. He drifts from topic to topic, none of which seems conflictual enough to be anxiety-arousing in itself. He was anxious like this yesterday, though, when he began to discuss the latest argument he and his wife had. Their relationship is a frequent theme in his sessions, but he hasn't mentioned it today. He may be trying unsuccessfully to minimize his anxiety by avoiding that topic.

More often, of course, such a synthesis would be arrived at unconsciously or preconsciously, with perhaps only the memory of the previous session reaching consciousness.

While extrospective observation is the only form of observation considered relevant for outside or natural science knowledge of the patient, introspective observations, as mentioned above, are relevant only in conjunction with extrospective observations. Empathic knowledge, therefore, requires both, for it would otherwise be reduced to solipsism: there can be no empathy without an external object, and there can be no object without extrospection. In this connection, Kohut's distinction between extrospection as the essential ingredient for the investigation of physical phenomena and empathy and

introspection as the essential ingredients for the investigation of psychological phenomena (1959, p. 460; cf. 1984, p. 32) risks oversimplifying the epistemological issue. Understandably, critics of Kohut have sometimes also implied that empathy operates independently of perception (cf. Blum, 1982, pp. 968-969). In fact, Kohut was aware of the role of extrospection in empathy, although he scarcely mentioned it. As early as 1959, he noted that empathy and introspection "are often linked and amalgamated with other methods of observation" (p. 463), and in 1973 he acknowledged that reliance on sensory impressions is not limited to the investigation of physical phenomena (1973b, p. 700). Other authors who have noted the importance of perception in empathy include Rapaport (1951, p. 727), Beres (1968, p. 368), Olinick (1980, p. 87), Buie (1981, p. 284), and Demos (1984, pp. 9, 10).

The empathic approach, then, makes its inferences about the patient's mind from both extrospective and introspective observation. Instead of being ideally a secondary process operation, empathic synthesis involves the integrated deployment of primary and secondary process. In the example given above, the therapist might have noticed himself feeling uncharacteristically bored and distracted, anxious and out of touch with the patient--"holding" the threat of a ruptured relationship while the patient sought safety in quotidian matters. These introspective data, combined with observation of the object, would probably have led to the

same sort of inference as did the natural science approach, but for somewhat different reasons, and with a difference in the psychological state of the therapist that involved vicariously experiencing as well as simply knowing what was important in the patient's mind at the moment. Strictly speaking, the distinction between scientific and empathic inference is not between intellectual and emotional knowing or between rational and nonrational knowing, but between a purely intellectual or rational knowing on the one hand and one integrated with emotional and nonrational phenomena on the other. The extent to which the therapist feels this vicarious experience is obviously variable; the relative weight carried by primary and secondary process is subject to change from moment to moment. At one extreme, the therapist's introspective contribution might be no more than a thought, fantasy, or memory more or less free of affect--as, for instance, the therapist above found himself thinking in some neutral fashion about his own wife. In such cases, it can be difficult indeed to distinguish empathic from scientific inference.

Both empathic and scientific inferences vary widely in their epistemological credibility. The lowest level of inference is limited to the subjective contents of the patient's conscious and preconscious mind and to the "here and now" meaning of his associations. One step above these are genetic inferences about the relationship between something in the present and something in the patient's

past, a relationship usually characterized as transference, repetition compulsion, regression, or fixation. At the highest level of inference are formulations about the structure and motives characteristic of the patient's personality. In general, the degree of certainty decreases with the level of inference. For example, there would ordinarily be more confidence attached to an inference that the patient is depressed than to one characterizing the depression as an anniversary reaction or a re-experiencing of an early separation or loss. The latter, however, would be more meaningful in psychoanalytic therapy. By the same token, formulations about narcissistic identification, aggression turned against the self, or the unconscious compulsion to seek out rejecting or unattainable objects would tend to be the furthest removed from observation and, epistemologically, the most tenuous, but they might be the most meaningful inferences to make because of the amount of information they integrate about the patient's clinical condition and because they can be generalized to other dynamics of the patient's personality not specifically related to depression.

These levels of inference are not psychologically or epistemologically discrete; higher levels ideally integrate, rather than supercede, inferences from lower levels. Also, the level of inference is probably not related to the method used to make the inference. That is, both empathic and scientific inferences occur at all levels; for example, the

therapist's felt sense of the patient's anxiety can form the basis of inferences about ego weakness, intrapsychic conflict, or regression as readily as can observed hesitations or pressures in the patient's speech. In practice, however, the subjective involvement of the empathic therapist may breathe more life into abstract formulations than is otherwise possible, and, although the level of inference refers to the level at which the patient is conceptualized, not necessarily to the way the therapist formulates an interpretation, the weight of primary process might well influence the extent to which an interpretation can evoke in the patient something deeper than an intellectual response. Therapists will differ in their use of empathy, too, depending on idiosyncratic assumptions about how much intellectual control is needed to keep affective arousal within tolerable limits.

With the above analysis in mind, it is now possible to ask which approach, the empathic or the scientific, carries the more convincing epistemological credentials. Despite the long-acknowledged value of the natural science approach as the most credible way of knowing external reality, no automatic decision in its favor is warranted, for the value of the natural science approach plummets sharply when applied to knowing the mental life of another (Arlow, 1985, p. 524). An argument could be made that natural science inferences about the patient's intrapsychic forces are no different in principle from the physicist's inferences about

gravitational forces. But the astrologer and the paranoid schizophrenic might say the same about their own inferences. For psychoanalytic work to be comparable to science, it would have to meet established, rigorous standards of systematic recording and hypothesis-testing. The psychoanalytic setting, however, does not provide anything like the methodological controls of the physical scientist's laboratory or the social scientist's experiment. Psychoanalysis, after all, is a method in which mathematics plays no role whatsoever and controlled replication is usually out of the question. Moreover, the technical obligation that the analyst listen with evenly hovering attention mitigates against the systematic observation of the patient. As Freud put it, the analyst "should simply listen and not bother about whether he is keeping anything in mind" (1912b, p. 112); nor should he take notes during the session (pp. 113-114). And the psychoanalytic necessity of postulating unconscious extrospection poses problems unknown to the established sciences. But if there is nothing truly scientific about the way data is gathered from the outside vantage point, then what epistemological advantage could it have over empathy, which also relies, though only in part, on more or less informal observation of the same data? The only possible advantage would be the exclusion of primary process by the scientific approach on the grounds that it constitutes an epistemological liability. This judgment

could be based either on the inherently subjective contents of introspection or on the partly subjective way empathic inferences are drawn from the combined data of extrospection and introspection. As to the first point, is it safe to assume that introspective knowledge is less certain than extrospective knowledge, that the observing function of the ego is more often subject to interference and distortion than is perception? Interestingly, this was not Freud's conclusion. In 1900 (p. 613), he implied that external reality and the unconscious were about equally unknowable, and in 1915 went even further:

> Like the physical, the psychical is not necessarily in reality what it appears to be. We shall be glad to learn, however, that the correction of internal perception will not turn out to offer such great difficulties as the correction of external perception--that internal objects are less unknowable than the external world. (1915b, p. 171; cf. Basch, 1983, p. 115f)

The second point concerns the relative difference in epistemological credibility between empathic and scientific inference, whether, so to speak, the leap from the patient's observed behavior to the patient's mind is any less perilous than the leap from the therapist's mind to the patient's mind, or, more precisely, whether an inference about the patient's mind based solely on observation of material reality is more trustworthy than one based on both extrospection and introspection. If the scientific inferences are regarded as more trustworthy because they are based on more objective data, it is also the case that the

empathizer has a larger "data base" from which to infer, and that an approach which seeks to exclude or minimize the subjective state of the therapist may be less than ideal when it comes to knowing subjective or unconscious states of the patient (cf. Loewald, 1978, p. 35).

For example, assume that a patient's references to his parents are uniformly free of any trace of hostility, but are often followed by an expression of resentment toward his therapist or employer. There is little reason to doubt the accuracy of this observation, but it is nearly useless without some inference as to the meaning of the phenomenon, for instance, that the patient is trying to preserve an idealized image of his parents by displacing his aggressive feelings about them onto substitute authority figures. Suppose that the therapist arrives at this inference using established theoretical principles about the degree of fear and guilt associated with aggressive feelings toward loved objects, the ease with which objects of drive discharge can be substituted for one another, the role of transference, and so forth. What grounds are there for saying that this inference is any more securely founded than an empathic inference based on the same behavioral observation, the same theoretical principles, and, in addition, some personal reaction, such as a feeling of being unfairly picked on, for which the inference provides a plausible explanation? In practice, it is doubtful that most experienced therapists would postulate the meaning of the patient's behavior by way

of a conscious, deliberative application of theory to observed behavior, although their knowledge of theory might help in focusing, validating, and organizing the understanding they would likely arrive at by empathy.

One final area of comparison concerns verification. Here, the scientific approach would have the advantage if its inferences were subject to more disciplined validation. But, as mentioned above, ordinary psychoanalytic practice is not conducive to such discipline, and psychoanalytic propositions are not easily put to the test, especially in the clinical setting: given the role of multiple meanings, symbols, and defense in psychoanalysis, almost any response by the patient can be construed as consistent with clinical prediction, making disconfirmation of a hypothesis a highly uncertain event. As a rule, both scientific and empathic inferences rely on the same methods of verification, namely on repeated observations of similar phenomena, increasingly refined inference, and rather informal and subjective prediction, often by comparing the results of one approach with the other (Agosta, 1984, p. 47; Gedo, 1984, p. 139).

In general, the epistemological value of either approach depends on the accuracy of the observations, the applicability of prior experience, the relatively conflict-free operation of the synthetic function, and the ability of the inferences to be verified--all variables whose condition at any given moment is a matter of the therapist's judgment. In that respect, because there is

only a single observer, the interaction of the method and the skill of the therapist must always be taken into account in drawing conclusions about the credibility of either method.

Although the empathic and the scientific approaches seem equivalent in terms of the truth value of their inferences, it is not the case that they arrive at the same truths. Differences in epistemological assumptions associated with the two approaches, therefore, lead to differences in the way reality is defined and understood. From the outside vantage point, for example, reality is constructed without benefit of the patient's point of view; in empathy, reality tends to be seen as more relative. Where one therapist may speak of a patient's resistance, another may talk of his fear; where one may describe the patient's distortions of reality, another may note how the same phenomena *are* this patient's reality (cf. Schwaber, 1981, pp. 358-374; Kohut, 1982, pp. 90-91; Gill, 1984, pp. 174-176).

Heuristic Perspectives: Empathy as Paradigm of Psychoanalytic Technique

Psychoanalytic disputes about empathy frequently reflect underlying differences about the role of empathy in theories of technique, that is, the extent to which empathy can clarify and explain the psychoanalytic approach. Although this heuristic issue ought to be decided on its merits, there has been little reasoned discussion in comparison with

the role played by other factors. If empathy is as important as those cited at the beginning of this chapter have indicated, then surely it needs to be integrated into the clinical theory of psychoanalysis. In a variety of ways, however, empathy has been portrayed as a threat to psychoanalysis.

One major problem is that empathy has become deeply embroiled in the controversy stirred up by some of the proposals of Kohut's school of self psychology. To the extent that he and his followers have parted company with classical psychoanalysis, empathy runs the risk of being regarded as an alien term by those closer to the Freudian tradition; psychoanalysts critical of Kohutian ideas have sometimes lumped empathy together with the innovations and revisions that are unique to self psychology, throwing empathy out with the bath water. Many traditional psychoanalysts appreciated the value of empathy long before the work of Kohut, but it is not clear how long their appreciation will survive it. There is a real danger that they will come to identify an interest in empathy with the Kohutian school exclusively, and, in criticizing that school, forfeit an understanding of the role empathy has always played in their own work. Some Freudian analysts now seem to regard the concept of empathy as a Trojan horse that, once inside the gates, will spring its tricks and leave in ruins the classical approach.[20]

This mistrust of empathy arising from disagreements with

other Kohutian views falls in an important historical context. The attention given to empathy in the last 25 years has been described as a reaction to the emphasis on "classical" technique during the 1950's, itself partly a reaction to the work of Alexander and French (1946), who, like Kohut, were regarded as dangerously unorthodox (cf. Post and Miller, 1984, pp. 220-221; Levy, 1985, p. 362). As Kohut is consciously or unconsciously identified with an older current of nonstandard approaches to treatment, the term empathy becomes identified with revisions to the practice of psychoanalytic therapy.

Shapiro, for one, held Kohut partly responsible for what he regarded as an excessive interest in empathy that was dangerous to psychoanalysis, making the puzzling assertion that empathy "is a phenomenon that can only lead to a new metapsychology of the self rather than a metapsychology of a mental apparatus" (1981, p. 430).[21] In taking Kohut to task for conceiving of empathy as a "new organ of perception" (p. 430), he sought to contrast this view with the approach of Freud:

> Freud's assertion [about the problems of knowing another's consciousness (Freud, 1915b, p. 169)] places us in a position as mental scientists to be concerned with *perception* of and *judgment* about the feelings and thoughts of others, but does not propose the need to construct a new organ with which to see within. In that sense, Freud keeps us well within a natural science frame. (p. 432; emphasis in original)

Kohut's metaphor may have been unfortunate, but no more regrettable than Freud's references to consciousness as a

sense organ (e.g., 1900, p. 615; 1926b, p. 201) or to the analyst's unconscious as "like a receptive organ [turned] towards the transmitting unconscious of the patient" (1912b, p. 115). Freud's choice of words in these contexts was almost identical to Kohut's and, indeed, Freud and Kohut may both have been grappling with the same issue, especially in light of Freud's later reference to empathy as the basis for any understanding of another's mental life (1921, p. 110n; cf. Ornstein, 1979, p. 99). The dissociation of Kohut's ideas about empathy from traditional psychoanalytic thinking even where the two coincide makes empathy appear as revisionist as any of Kohut's other beliefs.

Whatever reservations classical analysts may have about the separate line of development for narcissism, the concept of Tragic Man, the deficit versus the conflict model, the reformulation of the oedipus complex, or the view of drives as breakdown products, therefore, they should evaluate Kohut's view of empathy on its own terms and not in relation to the larger body of his work (cf. Stone, 1981, p. 108). Historically, Kohut's belief that empathy and introspection are the essential investigative tools in psychoanalysis was stated as early as 1959 (p. 460), long before the development of his later, more controversial ideas, and it encountered no opposition until his critics began to link them. In his last published work, Kohut specifically considered the potential for conflict between empathy and the traditional analytic approach, concluding that the

empathic aspects of self psychology did not differ in principle from the classical model, were not "more empathic" (1984, p. 82), and did not constitute a new kind of empathy, but merely "expanded the potential range of application of this instrument of observation" by virtue of self psychology's theoretical grasp of narcissistic personality disorders (p. 84).[22]

Despite such reassurances, Kohut's position regarding the central role of empathy has, at times, been criticized as involving an "overemphasis" on empathy (e.g., Treurniet, 1980, p. 326), losing the "rhythmical balance between observing and experiencing" by restricting his approach to "only one of its constituents, the empathic-immersion" (p. 327).[23] Treurniet made these statements even though he himself believed that "psychoanalysis is to a large extent based on empathy and introspection" and while protesting that "I would be the last person to deny a creative scientist his right to temporary one-sidedness" (p. 327). The implication is that the Kohutians are so immersed in their empathic experiences that, if their theories reflect how they actually work, they cannot tell their own point of view from that of the patient (p. 328). In a moment, it will be possible to examine the element of truth in Treurniet's criticism, but first it is necessary to dispense with his view of the Kohutians as imprisoned by their own empathy.

Here is what Kohut has actually written about this issue:

> The scientific psychologist, in general, and the psychoanalyst in particular, not only must have

> free access to empathic understanding; they must also be able to relinquish the empathic attitude. If they cannot be empathic, they cannot observe and collect the data which they need; if they cannot step beyond empathy, they cannot set up hypotheses and theories, and thus, ultimately, cannot achieve explanations. (1971, p. 303)

He made essentially the same point six years later:

> Among the sciences that inquire into the nature of man, psychoanalysis, I believe, is the only one that, in its essential activities, *combines empathy,* employed with scientific rigor in order to gather the data of human experience, *with experience-near and experience-distant theorizing, employed with equal scientific rigor* in order to fit the observed data into a context of broader meaning and significance. (1977, pp. 302-303; emphasis added)

From these passages as well as others (e.g., Kohut, 1973b, p. 711n), it should be clear that Kohut's style of therapy is not restricted to the experiential pole, nor lacking in disciplined cognition. Although Treurniet erred in suspecting the Kohutians of a one-sided immersion in empathy, he was correct in another sense. In the paragraphs just quoted, the Kohutian analyst steps beyond empathy apparently only to formulate what he has empathically observed, not in order to collect different kinds of observations that could be the basis of independent formulations. Thus, in theory at least, Kohut excluded the natural science or outside point of view from psychoanalytic technique, but did not exclude detached cognition and self-reflective observation altogether, and, therefore, did not forfeit the "rhythmical balance between observing and experiencing."[24] In this regard, Shapiro faulted the self psychologists for believing that "the *only* way to plumb

complex mental states...is via 'vicarious introspection' or empathy" (1981, p. 428; emphasis in original), an epistemological position now common in the literature (Kohut, 1973b, p. 700; Karush, 1979, p. 63; Ornstein, 1979, p. 99; Noy, 1984, p. 177; Ornstein and Ornstein, 1985, p. 50). To know one's patient from the outside vantage point (for example, the behavioral/descriptive psychiatric diagnosis), however, can be essential for good treatment and even for good empathizing. It should not, therefore, be the ideal of psychoanalysis to rely entirely on empathy to understand the patient, even if this were psychologically possible.

Both in and beyond discussions of Kohut's work, the heuristic challenge posed by conceptualizing analytic technique in terms of empathy has elicited the same kind of reactions just described. Empathy has been portrayed both as a threat to the psychoanalytic tradition and as an emotionally volatile process that neglects reason, reflection, and extrospective observation.

Exemplifying the first reaction, Spencer wrote that some of the meanings of empathy mentioned by Reed (1984) "are inherent not in the *empathic experience* as traditionally conceived, but rather in the process of doing psychoanalysis as traditionally conceived" (Spencer, 1984, p. 40; emphasis in original).[25]

It is true that psychoanalysis involves the same attributes Reed mentioned, but it does not follow that they

are, therefore, not inherent in empathizing. Indeed, the obvious possibility is that empathy and psychoanalysis as traditionally conceived have a great deal in common. Spencer's statement makes the issue sound more like a territorial one than a heuristic one, more a matter of loyalty to tradition than finding the best way to describe how psychoanalytic therapists work. Shapiro, too, turned the heuristic issue into a struggle between old and new, cautioning against "throw[ing] the whole show over with an ill-conceived definition of empathy as a new guide to knowledge" (1981, p. 437), even though psychological theories of empathy are as old as psychoanalysis itself and relatively senior within psychoanalysis.

Spencer was specifically concerned that placing empathy in the center of the psychoanalytic method would relegate other aspects of clinical practice to a secondary place, as if empathy could only displace or obscure, rather than integrate, existing concepts. However, he saw no such threat from other, more traditional superordinate terms such as transference or resistance, which he regarded as "terms of a different order" (p. 39).

Those aspects of clinical practice that Spencer sought to shield from a superordinate definition of empathy consisted of the following, which he regarded as the

> lowest order defining characteristics that make psychoanalysis unique: 1. *Free association*....2. *The analyst's evenly hovering attention*....3. *The atmosphere*...created by the analyst's actions and responses [that] encourages patients to say what comes into their minds without fear of criticism,

> attack, or seduction....[and] 4. *The analyst's interventions*. (p. 39; emphasis in original)

As Spencer noted, it is difficult to imagine psychoanalysis without these characteristics, but it is not difficult to imagine them co-existing peacefully within a clinical theory of empathy, in which empathy helps to illuminate the way the analyst's evenly hovering attention is poised to receive the patient's free associations, provides an understanding, receptive emotional climate that encourages patients to say what comes into their minds, and informs and makes palatable the analyst's interventions (cf. Stone, 1981, p. 108). Rather than slighting traditional concepts, empathy offers some hope of integrating them by acting as a kind of common denominator. Certainly those who advocate a superordinate role for empathy in clinical theory have an obligation to specify that role in some detail. Relatively little of this conceptual work has been completed, although calls for empathy as a unifying clinical term are beginning to emerge in the literature. Addressing the kind of concern voiced by Spencer, Levy acknowledged that inadequately defined general terms can lead to confusion and controversy, but noted that

> psychoanalysis can tolerate superordinate terms and be enriched by them so long as their shared meaning is maintained and clarified by careful study and increased understanding of their component parts or different applications in varied contexts. Neutrality, narcissism, character, and countertransference are other examples of such psychoanalytic terms. (1985, p. 375)

By contrast, Spencer's solution was to regard empathy as an "important *adjunct*" rather than "the central defining characteristic" of psychoanalysis (1984, p. 38; emphasis in

original).

The question of what is central to psychoanalysis involves a variety of prospective candidates of both high and low order, including the four Spencer mentioned as well as transference (along with the unobjectionable positive transference that Freud called "the vehicle of success in psycho-analysis" [1912a, p. 105]), countertransference, resistance, neutrality, insight by the patient, working through, and others.

Fortunately, one relatively simple distinction greatly reduces the scope of the problem. If empathy is central to psychoanalysis, it is clearly in relation to the technique and personality of the *analyst*, not to the behavior and personality of the patient. Empathy need not, therefore, encompass or subordinate some of the features mentioned above--free association, transference, resistance, insight by the patient, and working through. Analysts who regard a central role for empathy as ill-advised sometimes forget this distinction. Thus immediately after citing Ornstein's description of empathy as "*the psychoanalyst's basic tool of observation, listening, and communication*" (1979, p. 97; emphasis in original) and a statement by Karush that "empathy alone can help us grasp that part of [the person's] mental content, his feelings and needs which are largely unconscious" (1979, p. 63), Spencer continued, "I believe that this use of the word 'empathy'--as if it denoted *the necessary and sufficient characteristics of psychoanalytic*

method--has led to most of the confusion and ambiguity" (pp. 38-39; emphasis added). But this was not at all what Ornstein and Karush were saying. Their comments clearly indicate that empathy is necessary, but hardly suggest that it is sufficient.

Psychoanalysts have reason to be proud of their tradition, but the continuing development of that tradition presupposes that other formulations be examined with an open mind. A clinical theory of empathy should be evaluated as an alternative description of psychoanalytic technique, not as an alternative *to* psychoanalytic technique.

In addition to regarding empathy as a threat to the psychoanalytic tradition, critics have also portrayed it as wild and dangerous, easily carried beyond its proper limits, and less trustworthy than other sources of information about the patient. In this view, the implicit heuristic issue is whether psychoanalysis should be regarded primarily as a rational, objective enterprise. Of course, it is essential to recognize the fallibility of empathic hunches and insights, and authors who undertake a critical examination of empathy are under no obligation to mention the shortcomings of other approaches. But the often one-sided remarks easily leave the impression that empathy leads to error, while other psychological attitudes--usually intellectual or scientific--do not. As extreme examples, a purported failure to recognize the limitations of empathy has been implicated in a number of suicides (Buie, 1981,

p. 281) and in the high incidence of drug addiction among war veterans (Treurniet, 1980, p. 326).

More generally, Shevrin has taken the position that "the psychoanalyst does better if he maintains an abstract, thoughtful posture than if he engages in an overly responsive effort to 'feel with' the patient or literally to feel what the patient feels" (1978, p. 279). It would be just as true to say that the psychoanalyst does better if he engages in a responsive effort to "feel with" the patient than if he maintains an overly abstract, thoughtful posture, but in criticisms such as Shevrin's, analysts tend to see the Charybdis of too much feeling more clearly than the Scylla of too much thinking (cf. Fenichel, 1941, pp. 99-100).

Gedo reported about a patient who temporarily bolted from treatment after an intervention of his that he considered to be an "error in empathy" (1981, p. 179). His remark to the patient took place during a "seeming emergency" (p. 182) with a patient of the type "not traditionally considered 'analyzable'" (p. 169n), for whom "analytic inactivity had been too difficult...to bear" (p. 183), and in the context of a highly instinctualized and conflictual transference in which "the patient seemed progressively less able to maintain the realization that her experience of the analyst did not correspond to any objective reality" (p. 180)--a rather severe test of empathy, in other words. Because his intervention caused the patient to take flight, Gedo

concluded that "the less we have to rely on empathy in psychoanalytic work, the fewer therapeutic errors will follow" (p. 184).

Inasmuch as he considered empathy one of the "vital tools in the performance of psychoanalysis" (p. 176) and the "only instrument available" (p. 182) at the time of his intervention, Gedo's conclusion is a little like saying that the less we have to rely on our feet for locomotion, the fewer times we will stumble.

Three years later, Gedo wrote that Lichtenberg (1981) "gives proper weight to potential abuse of" the outside vantage point, but felt that "he pays less attention to analogous dangers in the overuse of the empathic one" (1984, p. 138). Actually, Lichtenberg had devoted approximately equal attention (about two paragraphs) to the hazards associated with each of the two vantage points (Lichtenberg, 1981, pp. 344-345, 346-347). It would be difficult to escape the conclusion that Gedo regarded empathy as more dangerous and error-prone than other paths to the mind of the patient.

As contrasted with what he saw as the primarily rational character of psychoanalysis, Shapiro painted a picture of empathy as if it might be equivalent to "uncritically [taking] every state of the analyst as being induced by the patient" (1981, p. 438), responding to the patient out of one's own needs (p. 439), pitying the patient's inhibition and nursing his grandiosity (p. 443), providing "Aunt Fanny"

interpretations too general to be of help (p. 444), and yielding to unmediated intuition (p. 446).

A similar rationalist bias is apparent in the following comment by Stein:

> It is a mistake...to place too great an emphasis on an introspective-empathic response at the expense of thoughtful questioning and evaluation of all types of data obtained by observation of the analytic situation. One of the risks of the former approach is that patient and analyst may find themselves existing in a state of mutual narcissistic regression, a kind of near-erotic mutual sleep. (1981, pp. 888-889)

This point of view is unobjectionable as far as it goes, but implies that questioning and data evaluation are risk free enterprises in psychoanalysis. Surely there are equivalents to the "near-erotic mutual sleep" of the overly empathic therapist in the hostile relationship created by the relentlessly skeptical analyst interested only in hidden meanings, or in the sterile intellectual relationship that results from too great a preoccupation with the evaluation of data. In other words, any technical device breaks down with overuse.

A more balanced view was offered by Blum, who considered empathy worthy of "special emphasis," but who placed equal stress on "natural-science observation as the parallel, interrelated mode of observation." Though he acknowledged that both approaches have their pitfalls, he nonetheless decided to "limit my remarks to empathic observation and knowledge" (1982, p. 967), asserting that "we cannot rely mainly upon empathy and introspection because the data on

free association over the last 80 years show us, repeatedly, that it is subject to falsification and to self-deception, to disguise" (p. 968). The hazards Blum mentioned are quite real, but it would have been welcome to read an acknowledgement that natural science observation also has its problems with the falsifications, deceptions, and disguises of free association.

It has long been recognized that successful analytic work requires a therapeutic balance between the rational or objective and the nonrational and subjective, as in Ferenczi's call for "constant oscillation between the free play of phantasy and critical scrutiny" (1919, p. 189). The authors quoted above have clearly identified empathy with the subjective, primary process aspects of the therapist's work; although this narrow view allows empathy to become a convenient repository for countertransference excesses, it is not the only possible view. In general, the detached, disciplined intellectual effort of the therapist falls into one or more of three modes in relation to empathy:

1. as a *sequential* operation, in which the therapist first has an emotional experience of some kind and then applies cognitive operations to it (Brierley, 1943, p. 120; Greenson, 1960, p. 423; Katz, 1963, p. 143; Fox and Goldin, 1964, p. 324; Kohut, 1971, p. 300; Kligerman, 1984, p. 318), for example, feeling sadness and then becoming aware of a muted depressive theme in the patient's associations. This is the kind of empathy critics fault as unstable,

unreliable, and dangerous, although the implied split between primary and secondary process is probably not typical of the way empathy takes place, and no one describing it has failed to mention the importance of the cognitive step. The reverse sequence also occurs rather commonly; that is, the therapist's cognitive understanding is followed by an emotional knowing.

2. as an *integrated* part of the empathic process itself, which is then defined not solely as subjective or irrational (Schafer, 1959, p. 345; Kernberg, 1979, pp. 76, 79; Lichtenberg, 1981, pp. 332, 334; Basch, 1983, pp. 111-112; Agosta, 1984, p. 46), for example, the patient whose glib announcement that he has feels "fine" after separating from his wife induces the therapist to recall with sadness how the patient, as a child, was encouraged not to cry when his parents divorced. This variety of empathy, probably more typical, involves the kind of integration described in the preceding section on epistemology.

3. as an essentially *discrete* operation, independent of empathy, or a separate means of validating empathy, utilizing different sources of information (Blum, 1981, p. 53; Spruiell, 1981, p. 335; Agosta, 1984, p. 47; Noy, 1984, pp. 176-177), such as noticing the patient's eyes welling up with tears and inferring the state of mind usually associated with this behavior.

If the cognitive aspect is understood as sequential or as integrated, its value consists of translating into words a

nonverbal experience, fitting it into a set of existing mental representations about the patient, or otherwise providing a secondary process structure for the primary process elements. It can hardly be described, however, as a more reliable source of knowledge about the patient than empathy or even, perhaps, as an alternative source at all.[26]

If the rational/observing activity of the analyst is understood in the third sense, as a discrete source of information in principle unrelated to empathy, it is, indeed, an alternative--the natural science approach. To a large extent, contrasts between empathy and intellectual objectivity can be attributed to a preference for this alternative paradigm of psychoanalytic technique. Among the critics of empathy mentioned above, Blum was not alone in seeking to contrast the methods of empathy with those of natural science; Treurniet (1980, pp. 329, 330), Buie (1981, p. 283), and Gedo (1981, p. 174; 1984, pp. 137, 140) all seemed to take for granted the scientific status of psychoanalysis, an issue surely as arguable (and as old) as the role of empathy.[27] It would be one thing if the critics of empathy simply had the goal of maintaining a balance of empathy and science in clinical work. At times, however, it is clear that matters go far beyond appeals to seek the golden mean, especially when empathy is portrayed as antagonistic or threatening to science or when every virtue is attributed to science and every vice to empathy.

Shapiro, for example, acknowledged the relative failure of psychoanalysis to achieve a secure scientific standing, but drew the sharpest dichotomy between science and empathy by attributing some of the increasing emphasis on empathy over the past 25 years to a "romantic vision" (1981, p. 427) or "defensive conceit" (p. 429) arising from that failure and by warning that the acceptance of empathy as its tool would remove psychoanalysis from the sciences altogether (pp. 429, 437).

If disappointment in psychoanalysis as a science has moved some analysts toward empathy, has not the same disappointment moved others away from it, while wrapping the mantle of science ever more tightly about them? Is there not, in the criticism reviewed above, a reflection of the uneasiness therapists feel about relying in part upon their emotional reactions and intuition to understand the patient, as contrasted with the presumed security of their intellectual productions and relatively more objective observations? It is the rare analyst who emphasizes the potential for error in supposing that the *patient's* associations have some relationship to each other, but, as above, it is common to find cautions against the idea that the *analyst's* associations and emotional reactions, which Freud called "a counterpart" to free association (1912b, p. 115), have some relation to the patient's state of mind. The effort to devalue empathizing by contrasting it with more rational or scientific attitudes may well reflect a

"cultural taboo" about subjective methods, especially among those practitioners whose pre-analytic training was mainly in the natural sciences (Katz, 1963, p. 23; cf. Sullivan, 1953, p. 41; Kohut, 1959, p. 465; 1973a, p. 678; Loewald, 1978, p. 35).[28] For male therapists, at least, there is the additional question of to what extent they "have come to peace with their motherly component" (Greenson, 1960, p. 423).[29]

The danger for psychoanalysis is probably not so much in the use of empathy as actually practiced, but in heuristic formulations that artificially split the rational and nonrational aspects of the psychoanalytic approach. Science then comes to stand for an ideal of certainty and objectivity, but only by stripping the empathic process of all reason, reflection, or sense. This, of course, makes a caricature of empathy, as if it were the primary means of acting out countertransference, as if it required the therapist to accept as vicarious every thought or feeling he has about the patient, or as if empathy obliged him to respond to the patient with gushing sentimentality. It would be more appropriate to stress that habitual reliance on any single analytic tool leads to error, that it is always best to check one's hunches against any other available information, as well as to listen to one's facts with the third ear. But such a truism by now should not need repeating.

Nor will repeating it likely have much effect. There will

probably not be much progress in assessing the heuristic value of a theory of empathy without simultaneously struggling to clear away the other issues that confuse the debate.

Underlying much current criticism, including that reviewed above, is a wish to define (confine?) empathy as narrowly as possible. While proponents usually have in mind a relatively broad-based conception of empathizing, the critics prefer to express their reservations about a belittled model of empathy consisting essentially of "gut feelings," simple intuitions, and unchecked associations. To take one final example, consider Hartman's discussion of Hamilton, who had outlined a definition of empathy based on extrospection, introspection, and a search for parallels among the observations (1981, p. 217). Hartman correctly pointed out that Hamilton's brief, mainly anecdotal article had omitted mentioning the role of clinical experience, theories of psychopathology, and cognition in general, which Hartman assumed were alternatives to empathy. But he included other "alternatives" as well that clearly fell within Hamilton's extrospective categories: "knowledge gained from...the patient's history, the course of treatment...[and] free associations" (1984, p. 224); indeed, Hamilton had specifically included among empathy's "sources of information" the same observation "as that used in any medical history-taking" and the same techniques of naturalistic observation used by ethologists (1981,

p. 221). Having thus cut away a significant portion of Hamilton's definition, Hartman was free to express concern about the "idealization of empathy," the "implication" that empathy is the only way to understand other people, and the possibility that "emphasizing his own affective experiences" led Hamilton "to use them as evidence of the correctness of his insights" (1984, p. 224).

Fearing, perhaps, that proponents of empathy are seeking too large a place for it in clinical theory, many critics have tried to make it too small. Instead of beginning with the actual definitions and descriptions, their criticism starts with the idea that empathy is a purely emotional phenomenon and proceeds to demonstrate why this conception of empathy should not be substituted for the whole of clinical theory. It follows naturally from this line of reasoning that "empathy" threatens the psychoanalytic tradition and invites impulses and fantasies to run riot in the consulting room.

Despite such criticism, there is a growing awareness of the variety of mental attitudes encompassed by the term empathy and the necessity of avoiding a polarization of meanings (Reed, 1984). These trends may make it possible to forge a more comprehensive theory of clinical empathy, even if it falls short of a truly integrated set of concepts. It is possible that empathy would function as an umbrella concept in psychoanalysis, covering a variety of related phenomena (much as it did for Lipps), each of which

contributes in some fashion to the intricate process by which one person acquires access to the mental life of another.[30]

As an umbrella term, empathy would differ little in its status from other psychoanalytic terms, such as *ego*, which encompasses such widely varying operations as mental representation, perception and reality testing, drive gratification and defense, consciousness, narcissism, anxiety, observing, experiencing, and synthetic functions, and secondary process. The possibility that empathy is not a unitary concept means that it varies from situation to situation in its dynamics, degree of consciousness, type and extent of affective coloring, and balance of rational and nonrational elements.

Would such a superordinate theory of empathy be entitled to claim center stage in clinical technique, or should that role be assigned to some other candidate, such as natural science observation and inference? Kohut, of course, left no doubt where he stood on this question; for him, the extrospective data of natural science were decidedly secondary:

> We see a person who is unusually tall. It is not to be disputed that this person's unusual size is an important fact for our psychological assessment--without introspection and empathy, however, his size remains simply a physical attribute. Only when we think ourselves into his place, only when we, by vicarious introspection, begin to feel his unusual size as if it were our own and thus revive inner experiences in which we had been unusual or conspicuous, only then begins there for us an appreciation of the meaning that the unusual size may have for this person and only

> then have we observed a psychological fact. (Kohut, 1959, p. 461)

Kohut's distinction was a useful one, although, given his neglect of the outside vantage point, it needs some amplification. The choice is not simply between an unelaborated perception of a physical attribute and the kind of vicarious knowing arrived at by empathy. It is possible (and often helpful) to make more or less purely intellectual inferences from extrospective data, typically by seeking a connection between the observation and *a priori* theoretical conceptions or clinical experience, for example, the way a patient's lateness for a session triggers the idea of resistance. At times, this process can be rather elaborate, as when the severity of a patient's depression is estimated from information about sleep, appetite, psychomotor retardation, individual and family history, precipitating factors, suicidal ideation, and reported mood. An assessment of this sort certainly can be made without an ounce of emotional investment by the therapist. But, as a preferred method, such detached, intellectual understanding belongs more to clinical psychiatry than it does to psychoanalysis because the natural science approach to observing the patient excludes the traditional psychoanalytic use of the analyst's own personality as the means of gaining access to the patient's unconscious (Brierley, 1943, p. 120).

The more that psychoanalysts insist upon natural science observation or detached cognitive formulations as

alternatives to empathy, then, the more they retreat from the essential character of psychoanalytic work. They trade the vicarious experience of being tall for a detached inference about the meaning of unusual size. They trade the emotional knowing of a psychological phenomenon for intellectual insight. They trade, in effect, psychoanalysis for science.

It is not that psychoanalytic therapists are forbidden from using the methods of behavioral psychiatry or natural science observation, only that it is alarming to see analysts contrast such methods favorably with the empathic approach that more nearly captures the essence of the psychoanalytic method.

It could well be that the champions of "empathy" or "science" differ less in practice than they do in theory, preferring for a variety of reasons to characterize their work differently.[31] Or, to the extent that real differences exist, therapeutic successes and failures may have pushed one group closer to the detached, observing, rational pole and the other closer to the subjective, intuitive, nonrational pole. At any rate, because "good" or "bad" technique is in part a function of the idiosyncratic strengths and weaknesses of a given therapist, there is probably some tendency for each group to idealize its favorite approach and to devalue those methods that, in its own experience, have proven less effective or characterologically less congenial.

Of course, without agreed upon definitions, criticisms of or testimonials to "empathy" are simply reflections of whatever the particular author understands empathy to mean. Given its ambiguity, empathy has functioned in the psychoanalytic literature like a Rorschach card, taking whatever form the motives of the observer might dictate.

Summary and Concluding Remarks

After three-quarters of a century, the psychoanalytic meaning of empathy has yet to emerge with sufficient clarity and consensus. As the epigraph for this chapter suggests, the creation of a clinical theory of empathy begins with efforts to understand our own ideas and intentions. There is no single best way of identifying and organizing the sources of confusion in our own minds, but they certainly include a kind of repression-about the historical origins of empathy in aesthetics, a set of semantic issues generally reflecting conflicts between feeling and thinking, unquestioned epistemological assumptions about the nature of reality and how best to apprehend it, and doubts about the servicibility of empathy as a technical vehicle.

Uncovering and clarifying these issues has required a variety of methods, including excursions into related fields and topics, detailed textual analysis of material all too frequently characterized by global, piecemeal or contradictory conceptions, and an attempt to find rational explanations for stated differences as well as to propose

rational solutions. If the literature were less divided, these methods might have been sufficient. But the state of the literature is so symptomatic that it has required more drastic treatment in addition. In the same passage from which the epigraph was taken, Alexander sought reassurance in the idea that the "heated arguments and occasional schisms" characteristic of psychoanalysis can mainly be attributed to semantics or differences in emphasis (1958, p. 293). If only this were true! At least in the case of empathy, there is something more that contributes to the ongoing, high level of dispute. As Schwaber so aptly expressed it, "if ambiguity persists despite repeated efforts to arrive at clarity, then there is something affectively at stake, warranting further reflection" (1984, p. 26; cf. Post and Miller, 1984, p. 232). Judging by the literature, empathy is a psychoanalytic symptom severe enough that it can neither be ignored, wished away, nor ameliorated by the power of suggestion. In a sense, the analytic literature has had to be put on the couch, with selected portions treated as a set of free associations about empathy. As in any psychoanalysis, this one has been interested in latent conflicts, defenses, unconscious fantasies, early history, narcissistic issues, parapraxes, and so forth.

As viewed through the lens of this chapter, empathy is a concept borrowed ambivalently from aesthetics that has often remained identified with the subjective, emotional side of

human understanding, especially as contrasted with ideals of objectivity and scientific detachment. Remarkable in a profession that values so highly the historical origins of current ideas and fantasies in its patients is the relative neglect of empathy's early childhood in aesthetics, along with a presumption that the "scientific" empathy of psychoanalysis outdoes its ancestor. In a more general sense, the genetic issue is applicable to the history of empathy even within psychoanalysis. Many articles on the topic show little acquaintance with previous work, and psychoanalysis cannot benefit much from the latest thinking without also taking a fresh look at some of the old thoughts.

In the realm of semantics, it is clear that there are many empathies, and equally clear that discussions of them have foundered because authors have assumed an understanding of the issues that was far from complete. We ourselves do not know what we mean. It is crucial, therefore, to recognize that empathy is not just an emotional knowing of the patient. It is also, more cognitively, the ability to make sense of things the way the patient does, and, on a deeper level, to understand the way his mind works. In this last respect, at least, empathy is not simply a vicarious reproduction of the patient's mind; in part, it is a creation of the therapist, though hardly a random one. Urgently needed, in addition, is a specifically psychoanalytic definition of empathy, using terms that have

some agreed-upon meaning already. These would include evenly hovering attention, countertransference, projection, introjection, identification, neutrality, interpretation, and others. They would probably *not* include "intersubjectivity" (Agosta, 1984), "mutual entrainment" (Restak, 1984) or "interactional entrainment" (Condon, 1984), "sensitivity" (Noy, 1984), and "affective resonance" (Demos, 1984), terms that might very well lead to good theories, but which are too distantly related to psychoanalysis to offer much hope of integrating empathy into its adoptive family. Whether or not one agrees with Spencer's and Balter's idea that it is better to define "empathy in terms of psychoanalytic concepts" than to use the term empathy "to define psychoanalysis" (1984, p. 291), the former is certainly a priority.

As an epistemological approach to knowing the patient's psychic reality, empathy is often contrasted with the detached observational and inferential method of natural science. Analysis of this dichotomy reveals that what is called science is, instead, just an honest effort to think clearly about the patient's mind. Empathy, on the other hand, is shown to be less of an alternative to this outside vantage point than it is a more inclusive mental operation drawing on the same extrospective data as well as on the therapist's nonrational reactions to the patient. Empathy, too, involves an inference, this one reached through an integrative primary and secondary process operation that

attempts a convergence of inner and outer reflections of reality. Neither approach "observes" the patient's mind directly, and, if differences in their epistemological credibility exist, they are not easy to discern.

These epistemological considerations have important heuristic implications. In particular, they rule out blind loyalty to science and micropsic visions of empathy. Nor should empathy, like self psychology, be seen as a threat to the traditional psychoanalytic approach. Clearing away these obstacles allows the heuristic issues to be faced directly and leads almost inevitably to the conclusion that empathy, properly understood, encompasses the fundamentals of psychoanalytic technique more adequately than does any other single term.

Discussion of these historical, semantic, epistemological, and heuristic perspectives has brought into sharp relief the pervasive psychoanalytic conflict about its status as an objective or scientific discipline. While the subjective aspects of psychoanalysis do not disqualify it as a respectable body of propositions about human nature, development, psychopathology, and treatment, they do seem to have worried analysts enough so that they sought to represent clinical psychoanalysis as a science. This defensive idealization may have been essential psychologically to buttress the credibility of an originally medical discipline which hoped to find its way back to neurology, but which meanwhile was often received with

skepticism by the scientific community. A defensive *ideal* of science, however, cannot provide a real epistemological rationale or heuristic paradigm for psychoanalytic technique, and the persistence of this ideal is part of the reason why more realistic conceptions, such as those based on empathy, are regarded with ambivalence and remain misunderstood and undeveloped.

In the daily lives of most psychoanalytic practitioners, as opposed to the posture sometimes adopted in the literature, science is probably of only passing interest. Despite the fact that psychoanalytic propositions can be made the focus of genuine scientific research outside the consulting room, such attempts are rare and even more rarely reported in the "scientific" meetings of psychoanalytic societies and in the most prestigious psychoanalytic journals. Psychoanalysis may want to be *seen* as science, but it has never much wanted to actually do the things that science does.

Because of the central and potentially organizing role of empathy in clinical practice, it becomes necessary to pursue as exact and comprehensive an understanding as possible. This dissertation does not attempt to develop a complete psychoanalytic theory of empathy, which is still premature, but to pave the way for such an undertaking by identifying the psychoanalytic issues that have traditionally been associated with building a theory of empathy, introducing a few new ones, and discussing each in ways intended to arrive

at appropriate definitions. The point of view offered here can be summarized by saying that it merely seeks to formalize the long-ambiguous status of empathy in traditional psychoanalytic technique.

Notes

1. Analysts even dispute whether there really are differences of opinion, with Basch proposing that "an examination of the seeming disagreement between the various authors who have investigated the nature of empathy will show that these differences are more apparent than real" (1983, p. 103). And Kernberg wrote that "the review of the pertinent literature shows a gradual, quite harmonious development of the understanding of empathy, and of its relations to the boundary concepts of psychoanalytic technique, namely, intuition, countertransference, and interpretation" (1979, p. 75). At the other extreme, Pine took the position that the special form of "knowing" attributed to empathy in contradistinction to other forms of "knowing" is "bound to be the subject of endless and *ultimately unresolvable dispute*" (1985, p. 169; emphasis added).

2. In German, "vag und konturlos."

3. This dissertation generally ignores differences in empathy that may occur in psychoanalysis as opposed to psychoanalytic psychotherapy. Rather than simply employ the more general terms *therapy* and *therapist*, however, the terms *analysis* and *analyst* are sometimes used in order to avoid making an unintended extension of the views of authors under discussion.

4. The wish to be safely on the side of the Freudian tradition is evidently a strong motivator in the claims and counter-claims made regarding empathy--so strong, in fact, that it has led to some scholarly parapraxes. Lichtenberg, for example, quoted Freud to the effect that the analyst gives "empathic attention to everything that there is to observe" (Lichtenberg, 1981, p. 329), although Freud had actually referred to "*impartial* attention" (1909, p. 23; emphasis added). On the opposite side of the issue, Shapiro inadvertently expanded Anna Freud's dictum regarding the analyst's equidistance from the id, the ego, and the superego (1936, p. 28)--a formulation that places the analyst, so to speak, *inside* the patient--by indicating instead that she endorsed a vantage point "equidistant from drives, superego, *reality*, and the defending ego" (Shapiro, 1981, p. 438; emphasis added), a position closer to the natural science approach of the *outside* observer that Shapiro favored

5. For interpretation of the phrase "any attitude at all," see Basch (1983, p. 103n) and Post and Miller (1984, p. 217).

6. Strachey has written that Lipps was an influence "of some importance" on Freud in the late 1890's (1960, p. 4), but only in relation to Lipps' theories of the unconscious. Instead of empathy, Freud may sometimes have relied on similar terms, such as sympathy (Freud, 1928, p. 190).

7. For an exception to this rule, consider Kohut's psychoanalytic but cryptic reference to "empathy--i.e., cognition via the narcissistic investment of the other" (1973b, p. 701).

8. Lipps was not, however, the first to use the term. An 1873 book on aesthetics by Robert Vischer is usually cited as the earliest published occurrence of *Einfuehlung* (Robinson, 1963, p. 53; Hunsdahl, 1967, p. 181; Wind, 1969, p. 150). Lee (nee Violet Paget) maintained that the word "was in current use even before...Vischer applied it to aesthetics" (1913, p. 66), and Munro wrote that Friedrich Theodor Vischer (father of Robert and, like him, a professor of aesthetics) had formulated a theory of *Einfuehlung* in 1846 (1971, p. 222). Robinson also provides historical references to the *concept* of empathy or *Einfuehlung* before either term was available (1963, pp. 52-53). If Lipps was not the first, he was also not the last to develop a theory of empathy outside of psychoanalysis--see Hunsdahl (1967) for a review through 1925.

Schroeder (1925, p. 158), Maddaloni (1961, p. 22), Katz (1963, p. 2), and Olinick (1980, p. 83) all credit Titchener with the first translation of *Einfuehlung* as *empathy*. Hunsdahl (1967, pp. 180-181) supplied 1909 as the year of Titchener's translation, apparently relying on the Earl of Listowel (1934, p. 59) for this information. According to Post (1980, p. 277) Lee had made the same translation in 1904, but Post was unable to provide the reference. Lee had, in fact, made an early translation of *Einfuehlung* as "sympathy" in an 1895 lecture (Reed, 1984, p. 7), but as late as 1909 (p. 239) she was still translating *Einfuehlung* as "sympathy" or "with-feeling," *not* as empathy. Lee herself gave Titchener the honors (1913, pp. 59, 66). His translation was by way of the Greek roots for "feel into," and, it turns out, the word *empathein* appears in Aristotle's *Rhetoric*, in the sense of animating the inanimate (Hunsdahl, 1967, p. 180). Although some of the traditional meanings of sympathy are synonymous with empathy, others such as pity, commiseration, and approval anticipate important questions about the relationship between empathy and psychoanalytic neutrality.

9. The following account relies heavily on Lee and Anstruther-Thomson (1912), Robinson (1963, pp. 54-56),

and Hunsdahl (1967, pp. 181-186).

10. Similar ideas had been developed independently by others in the field of aesthetics. See Robinson (1963, pp. 53, 56).

11. If, as mentioned above, Agosta (1984) was correct about Freud's reasons for avoiding use of the term empathy, this problem stretches back to the very origins of psychoanalysis. Some analysts, of course, have acknowledged the debt of psychoanalysis to aesthetics and stressed the similarity or continuity of the two kinds of empathy. See, for example, Schafer (1959, p. 348), Beres and Arlow (1974, p. 45), Muslin (1984, pp. 301, 307-308), Oremland (1984, pp. 255-262), and Poland (1984, pp. 339, 345).

12. This seems a little unfair to Lipps, whose knowledge of philosophy would have made him unlikely to fall into so obvious a trap. At any rate, "it is not a case of Lipps in a strict sense carrying on the Kant[ian] distinction between a world 'an sich' and 'fuer mich'" (Hunsdahl, 1967, p. 182). And, according to Munro, Lipps showed "how the process of empathy is not purely subjective but dependent for its satisfaction on the nature of the work of art" (1971, p. 222). Even Worringer, who criticized Lipps for the incompleteness of his theory, wrote of it that "this apperception is therefore not random and arbitrary, but necessarily bound up with the object" (1908, p. 7).

13. These comments apply only to the *practice* of psychoanalysis. The discipline does have a claim to scientific status insofar as its clinically derived postulates and predictions can be tested by accepted scientific methods, but this would almost certainly have to take place outside the clinical setting. Something similar is true in aesthetics, where the analysis of brush strokes or the chemical composition of paint might provide scientific grounds for assigning authorship to a given painting, but not in the course of an aesthetic experience.

14. This dissertation is not so ambitious as to attempt all these integrative tasks. The structural, dynamic, and economic points of view are best represented, the genetic point of view is largely slighted, and the adaptive point of view is included at most in the narrow sense of how empathy is adaptive for the psychotherapeutic process. Broader adaptive issues are now widely mentioned in relation to infant care, and not only by Kohutians (e.g., Winnicott, 1960, p. 40; Bergman and Wilson, 1984; Broussard, 1984; Demos, 1984) and as a basic element in all human interaction (Beres and Arlow, 1974, p. 47; Loewald, 1978, p. 35; Agosta,

1984, p. 43; Noy, 1984, p. 191).

15. The use of the term *science* is likewise not intended as an endorsement of psychoanalytic claims to scientific standing. It has been adopted here because of the frequency with which it appears in the psychoanalytic literature in relation to the kind of mental operations associated with the outside vantage point. Contrasting the terms science and empathy will doubtless displease some who regard empathy as scientific; see note 28.

16. See, in this regard, Arlow's discussion of neurophysiological evidence that incoming visual sensations are subject to alteration and control en route from the retina to the visual cortex (1985, p. 530). Wallerstein mentioned "a reality 'out there' that is truly influenced as well by the selective perspective, framework, theory, or world view with which we apprehend or, I would rather even say, construct it" (1985, p. 566).

17. In another sense, the extrospective observer requires introspection to locate memories, for example, from previous sessions; these will, however, only be relevant insofar as they are memories *about the patient*. Although they are, strictly speaking, accessible only by introspection, it is a different and more limited introspection from that which is applied to self-reflective observation in the usual sense.

18. See note 31.

19. As Chessick noted, the only alternative to empathy and introspection in psychotherapy is behavioral description (1977, p. 264).

20. Although this impression of Kohut's views is largely unwarranted, some of his followers have paraded under the banner of empathy as if they had exclusive claim to it. Schwaber, for example, wrote of empathy as if it applied *only* to selfobject phenomena (1979, pp. 469, 472, 475, 477--but see Schwaber, 1981, p. 373), and Gedo, without citing specific instances, has complained that "in recent psychoanalytic discourse, disagreement with Kohut's viewpoint has sometimes been equated with being unempathic!" (1984, p. 139). The Kohutian schism, then, has clouded an understanding of empathy on both sides of the dispute.

21. The remark is puzzling not only because it takes for granted the superiority of a metapsychology based on a conception of the personality as an apparatus, but also becuase it implies some inherent incompatibility between that theoretical model and empathy. While some

of those drawn to self psychology are motivated by a distaste for the mechanistic model (Noy, 1984, p. 187), there is nothing inherent in the nature of empathizing that prevents its use in relation to mechanical models of personality. The pre-Kohutian literature on empathy in which the inherited metapsychology went unquestioned should be proof enough of that; see, however, the following note.

22. Not all of his followers agree with Kohut on this point. Somewhat paradoxically, Ornstein argued both that psychoanalysis always implicitly recognized the fundamental importance of empathy (1979, pp. 95, 97, 99), and, at the same time, that Kohut's view of empathy marks a "shift in the mode of listening" whose "direct result" is the "new paradigm" of self psychology (p. 102). Contrary to the view presented above that some of Kohut's more controversial ideas are wrongly associated with his views about empathy, Ornstein wrote of a "direct linkage between empathy and self-psychology" (p. 102). It seems unwarranted to suggest that empathy is any more closely related to the theories of self psychology than it is to the theories of classical psychoanalysis.

23. Compare this view with Worringer's criticism of aesthetic empathy as one sided, neglecting man's urge to abstraction (1908, p. 4).

24. The balance between observing and experiencing is a concept whose ultimate forebear in psychoanalysis can be found in Ferenczi's famous passage about the "oscillation between the free play of phantasy and critical scrutiny" (1919, p. 189). This "scrutiny" or observation involved applying the analyst's cognition to the "material submitted by himself *and* the patient" (p. 189, emphasis added).

25. For Spencer's conception of the traditional view of empathy, see Spencer and Balter (1984, p. 291), who equated the traditional view with Beres' and Arlow's statement that empathy is an "adjunct to our technical procedure" (1974, p. 27). It is not clear why that statement is any more traditional than Beres' and Arlow's other comments that empathy is "of focal significance in our work" (p. 26) and "central to the psychotherapeutic relationship between patient and therapist" (p. 47).

26. The same reasoning applies even to instances of "empathy" that are subsequently understood to be the result of irrelevant emotional reactions of the therapist. For example, a therapist notices in himself an erotic interest in the patient, suspects that this reflects some as yet unnoticed aspect of the

transference, but then, after some introspection, concludes that it can better be ascribed to instinctual pressure arising solely from his own needs. Here too, his second thoughts about the meaning of the erotic impulse do not constitute an alternative source of information *about the patient;* they merely rule out his first hunch. Naturally, this type of rational selection among competing hypotheses is itself subject to error, and every therapist can cite instances of a delayed understanding when, as a result of his own or the patient's defenses, important insights were wrongly attributed to the interference of countertransference.

27. See Burnham (1967, pp. 99-108) for a review of some of the earliest debates about the scientific standing of psychoanalysis.

28. If the tendency to downplay the role of empathy is associated with unsubstantiated assertions that clinical practice is scientific, the equal and opposite error involves characterizing empathy itself as a scientific tool (e.g., Kohut, 1959, p. 464; Waelder, 1962, p. 628; Schwaber, 1981, p. 379; Ornstein and Ornstein, 1985, p. 43). Reed was probably correct to think of such efforts as a reaction formation against the mystical and irrational connotations of empathy (1984, p. 16); even the proponents of empathy, it seems, have their qualms about its subjective properties. The view of empathy as science can be compared to Titchener's similar idea that his application of scientific methods to mental processes would be "the boldest and farthest thrust of the scientific movement" (Heidbreder, 1933, p. 121). His work, however, probably had a stronger claim to scientific status than does psychoanalytic empathy, given his method of repeated observations of a constant stimulus, his restriction of introspection to the conscious mind, his rigorous effort to exclude inferences about meaning, and his avoidance of *vicarious* introspection.

29. The issue of subjectivity prompts some speculations about the unconscious perception of empathy as a feminine characteristic (cf. Fenichel, 1926, p. 104). Certainly there are suggestions of such a view in models of empathy derived genetically from the sensitivity of mother to infant. Like woman in society at large, who has been subject to idealizing and devaluing by men, empathy in psychoanalysis is seen by some as its Muse and by others as the fickle, instinctualized source of all errors in technique. Empathy has, over the years, acquired the same reputation of being hard to understand that men have given to women. And, like patriarchal societies, some psychoanalysts have relegated empathy to the role of

helpmate in technique, often with the rationale that its hysterical excesses require subjugation to some (more masculine?) principle of science or intellect. Then, too, all of the severest critics of empathy are males. Consider, in this connection, the following comment by Shapiro: "I would go so far as to suggest that the solace that we may take in our own empathic success is related to the distortion afforded by identification with a longed-for good mother who knows and understands everything" (1981, p. 446). If it is a "distortion" to identify with a maternal ideal in cases of empathic success, is there an equivalent distortion in identifying with a masculine ideal upon success in some more rugged pursuit? Is it a distortion for an analyst to identify with his ego ideal of Freud when his imitation of Freud's technique produces comparable discoveries?

30. The umbrella of empathy should probably not be so broad, however, as to shelter a concept such as *empathy for oneself* (Katz, 1963, p. 130; Kohut, 1971, p. 305; Ornstein, 1979, p. 103; Grotstein, 1984, pp. 202, 203; Skolnikoff and Horowitz, 1984, p. 212), which is apparently intended to refer to a "vicarious," tolerant, and understanding attitude toward one's own disapproved of motives or self representations.

31. Despite all his emphasis on rationalism and natural science, for example, Shapiro (1981, pp. 436-437) regarded with favor the idea that the free floating attention of the analyst be directed toward his own associations; he also stretched the scientific attitude so far as to include intuitively grasping the expressions of the patient's unconscious (p. 423). It may be that some analysts uncomfortable with the concept of empathy as a psychoanalytic term refer to natural science observation not so much as an alternative mode of understanding the patient, but as an alternative *term* for the cognitive aspects of empathy.

Chapter 2

Regression, Evenly Hovering Attention, Countertransference, and Empathy

> The special talent and the pathologic are usually just two sides of the same; a slight shift in cathexis may transform an unconscious mechanism of the analyst from a living out of his own conflicts into a valuable sublimation. (Reich, 1951, p. 29)

Regression

The term regression is commonly used to refer both to pathologically deteriorated states of mind and to phenomena within the realm of normal experience, such as daydreaming, fatigue, creative thinking, and play. These two types of regression can be distinguished in principle by their depth, duration, and reversibility, and by the extent to which higher level cognitive functions and defenses are preserved or remain resilient. In short, whether there occurs a lapse or a collapse of secondary process activity is crucial.

Over the years, the work of the analytic psychotherapist has also come to be described as involving a regression, usually in terms of (a) a partial and temporary decrease in defensive, rational, and reality-oriented mental activity; (b) a decreased differentiation of self and object representations; and (c) a corresponding increase in the availability of primary process material and genetically

prior phenomena of all kinds, including earlier self representations, object relationships, memories, and in general the whole of unconscious contents and activities. Under these conditions, nonverbal and nonrational modes of experience, such as fantasy, symbolic imagery, feelings, and sensorimotor representations, assume a greater prominence than is otherwise the case.[1]

The main purpose of this regression is to augment the therapist's ability to understand the patient by removing barriers to the desired intimate, affective relationship. Regression thus becomes one of the prerequisites for empathic understanding. The therapist finds himself receptive to the patient's transference (up to a point) in a way that allows him to appreciate its psychological meanings. In this connection, Olinick referred to a "partial, controlled suspension of disbelief in the patient's transference operations" (1980, p. 9). Reik described this same cooperative attitude in his typically colorful, less technical fashion:

> To approach the unconscious processes in the spirit of cold, rational disavowal would be as stupid as it would be to protest "There are no ghosts!" when the ghost of the king appears in *Hamlet*. One must first accept and acknowledge the psychological reality of the apparition, otherwise it is not possible to understand what goes on in Hamlet's mind. In this recognition the audience follows the advice of the prince himself. When the ghost speaks, Horatio cries, "O day and night, but this is wondrous strange!" And Hamlet answers, "And therefore as a stranger give it welcome." It is in this spirit of preliminary acceptance that analysts listen to the voice of unconscious processes. (1948, p. 112)

Though the effect of the regression *by itself* is not to make what is unconscious and nonrational in the therapist more active--only more accessible to awareness--the fact that it takes place in a dyadic setting means that its dynamic course is influenced by the patient.

The capacity for such regression obviously presupposes that the therapist or analyst not maintain an essentially phobic, paranoid (Little, 1951, p. 38) or resistant (Kohut, 1971, p. 148) attitude toward his unconscious and that his sense of identity be secure enough to permit the required de-integration and de-differentiation without undue anxiety.

To say that this regression is partial does not imply that the therapist goes only so far back down the developmental path--in selective respects the depth of his regression may well match or exceed that of his patient--but rather that only a limited sector of his personality participates in it, with circumscribed effects that are continually supervised by secondary process, like a subsystem of the ego as described by Gill and Brenman (1961).

Evenly Hovering Attention

This particular form of regression is the psychological state associated with what Freud called "evenly hovering" or "evenly suspended" attention, which requires the analyst to "give himself over completely to his 'unconscious memory'"

(1912b, p. 112) and "surrender himself to his own unconscious mental activity," thereby "to catch the drift of the patient's unconscious with his own unconscious" (1923a, p. 239). The importance of this approach may be inferred from Freud's description of it as "the necessary corollary to the demand on the patient to communicate everything that occurs to him without criticism or selection" and from his observation that "if the doctor behaves otherwise, he is throwing away most of the advantage which results from the patient's obeying the 'fundamental rule of psychoanalysis'" (1912b, p. 112). In the first of many descriptions of the analyst's use of his own unconscious as a specialized mode of listening, Freud also wrote that the analyst

> must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound-waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations. (1912b, pp. 115-116)

The concept of evenly hovering attention has remained a popular way of describing the analytic attitude, although reformulations of that attitude have been attempted almost from the beginning. Ferenczi's endorsement of a "constant oscillation" between unconscious fantasy and "logical scrutiny" (1919, p. 189; cf. 1928, p. 98) has already been mentioned. Later reformulations of evenly hovering

attention were made by Reik. In 1937, he described how a patient's unconscious impulse communicated itself to the analyst by a verbal or gestural expression that stimulated or induced a like process in the latter's unconscious, which subsequently emerged into his awareness as an insight into the patient's personality. This he referred to as "the instinctive basis of psychological comprehension"(p. 193). By 1948, Reik had introduced Nietzsche's concept of the "third ear" to psychoanalysis and employed this term (as well as others) to explain the special way of listening employed by the psychoanalyst:

> One of the peculiarities of the third ear is that it works two ways. It can catch what other people do not say, but only feel and think; and it can also be turned inward. It can hear voices from within the self that are otherwise not audible because they are drowned out by the noise of our conscious thought-processes. (1948, pp. 146-147)

Reik's 1948 book furnished many examples of the tension between the analyst's experiencing and observing functions that has such a stormy history in the theory of psychoanalytic technique. Despite his frequent references to experientially-derived "conjecture" as an "initial phase" to be followed by a more rational and conscious "comprehension," the former is his nearly exclusive focus, and his comments on comprehension carry much less conviction. For the most part, Reik seems to have seen himself as a lonely advocate of the use of one's personal fantasies and associations in treatment:

> The worship of the bitch-goddess objectivity, of pseudo precision, of facts and figures, explains why this is the only book that deals with this subject matter, or which insists that the subject matters. (pp. 147-148)

He was often tempted to mock or caricature those (especially Fenichel) whom he saw as neglecting the experiential mode, and there was probably not a single analyst who recognized himself as "an interpreting automaton, a robot of understanding" (p. 271), for whom psychoanalysis was a "drawer full of formulas and terms" (p. 270). Even if Reik's one-sided approach can be understood as an effort to correct real or imagined excesses by those of opposite temperament, it drove him to make extravagant claims about the analyst's emotional reactions and associations: "their symptomatic value cannot be overappreciated. The psychological implications to which they lead cannot be overrated" (p. 314). But of course they *can*.

A more balanced view does appear now and then in Reik's work, as in this comment that seems to echo Ferenczi:

> During the analytic session the analyst shares with the patient this realm between fantasy and reality. He vicariously lives with his patient's experiences and at the same time looks upon them with the factual regard of the investigator. He dives with the patient into the life of old and new experiences, but at every moment he is ready to regain the safe shore of psychological observation. It is his task to keep intact this character between reality and fantasy that is the essence of the analytic situation. (1948, pp. 111-112)

Some years after Reik, Isakower developed his own conception of evenly hovering attention, which he described as the "analyzing instrument." This involved "1) the

concentration of attention upon the analysand's communications; 2) the concentration of attention upon the analyst's own internal perceptions; and 3) the suspension of critical activity regarding these two objects of the analyst's attention" (Balter, Lothane, and Spencer, 1980, p. 485).

The regressive nature of these clinical concepts of evenly hovering attention, the third ear, and the analyzing instrument was only implicit. Perhaps the idea of regression, like countertransference, implied a kind of personal pathology, ideally to be expunged.[2] But by 1935, Kris had introduced the idea of "regression in the service of the ego" and thus improved the chances of finding an accommodation, in theory at least, between the nonrational, unconscious, and experiential mode of listening and the cognitive, conscious, and observational operations that supervise its therapeutic use. Like empathy itself, regression in the service of the ego originated in the broader context of aesthetics.[3] Similar operations, such as Hartmann's "regressive adaptation" (1939, p. 36), Loewald's "regression...in the service of higher organization" (1960, p. 25), or Olinick's "regression in the service of the other" (1980, p. 9) all describe a regression that involves no major loss of psychic equilibrium nor the liberation and gratification of impulses in their original form, but rather denotes a creative, therapeutic partnership between primary and secondary process.[4]

All of them also appear to be close conceptual relatives of empathy, a relationship that is easiest to see in connection with evenly hovering attention, of those discussed above, the term in widest use. Despite some occasional views to the contrary (Gedo, 1981, pp. 162, 172; Lichtenberg, 1981, p. 340; Spencer, 1984, p. 41), empathy and evenly hovering attention are often linked in the literature. Sometimes they are simply mentioned in the same breath, as concepts that somehow belong together, but without a defined relationship (Levine, 1952, pp. 208, 209; Greenson, 1966, p. 271; Reich, 1966, p. 346; Poland, 1974, p. 285; Chessick, 1977, p. 264; Modell, 1979, p. 70). At other times, an attempt is made to specify a relationship, not always with clear results. Harris, for example, regarded empathy as the more inclusive term, writing that "a sequence of events" including evenly hovering attention was "the basis of empathy" (1960, p. 125) Gitelson, by contrast, considered empathy a relatively minor part of evenly hovering attention (1962, p. 198). Evenly hovering attention has also been called "one of the substrates of empathy in the analytic setting" (Levy, 1985, p. 355), as well as something that "encourage[s] empathic comprehension" (Kohut, 1966, p. 263) or "activates the empathic process" (Ornstein, 1979, p. 97). And, for some authors, the two concepts are virtually synonymous (Kohut, 1977, p. 251; Olinick, 1984, p. 145; Skolnikoff and Horowitz, 1984, p. 213).

Countertransference

In some respects, the kind of regression the therapist experiences, however it is formulated, resembles the therapeutic regression of a patient in a well-proceeding analysis or analytic therapy (Spencer and Balter, 1984, p. 296), chiefly in its collaborative use of observing and experiencing functions. And just as controlled regression by the patient contributes to mastery, adaptation, and development of personality structure, the therapist's careful immersion in the deep water of his own psyche (and, vicariously, that of the patient) can bring similar benefits to himself. But it must be acknowledged that the therapist, like his patient, is subject while in this state of regression to a variety of irrational forces, including all those that fall under the general heading of countertransference. Certain of these appear to be intrinsic to the therapeutic setting, in particular those instinctual pressures of the seductive, voyeuristic (Low, 1935, p. 1; Reich, 1951, p. 29; Greenson, 1966, p. 276), and retaliatory (Winnicott, 1949) kind, and, of course, the reparative urges (Little, 1951, p. 34), undoing, and reaction formation that hasten to follow them. Beyond these, the therapist must also contend with the idiosyncratic forces in his own personality that are brought into play. As Kernberg noted,

> through the mechanism of empathic regression in the analyst, certain conflicts of the patient may reactivate similar conflicts of the analyst's past; this regression may also reactivate previously abandoned, old character defenses of the analyst. (1965, p. 42)

How, then, can the therapist be of help to the patient under these circumstances? In recent times, a number of analytic theorists have begun to question the traditional concept of countertransference as something the therapist ideally does without, and to speak instead of a broader definition that encompasses the whole of the therapist's conscious and unconscious reactions to the patient, many of which are potentially useful in gaining access to the patient's own feelings and motivations by entertaining the possibility that he has contributed in some fashion to their emergence in the therapist (Heimann, 1950; Racker, 1957; Kernberg, 1965). To the extent that these possibilities bear therapeutic fruit, it becomes appropriate to speak of a *sublimated countertransference* that contributes positively to the therapeutic process (Reich, 1951, pp. 30, 31; Gitelson, 1952; Weigert, 1954, p. 242; Spitz, 1956, p. 259; Racker, 1957, p. 313). Little went so far as to say that with certain psychotic patients,

> the counter-transference has to do the whole of the work, and in order to find something in the patient with which to make contact the therapist has to allow his ideas and the libidinal gratifications derived from his work to regress to a quite extraordinary degree. (1951, p. 36)

The greater the role assigned to countertransference and the more it is understood as a reaction to the patient, the more

the therapist's empathy becomes a process initiated and orchestrated by the patient. An extreme but intriguing version of this view was proposed by Heimann, who wrote of countertransference as the patient's creation and part of the *patient's* personality (1950, p. 83).

According to this line of reasoning, Freud's discovery that the patient's transferences were both the greatest obstacle to and the best vehicle for therapeutic work has an analogous application when it comes to countertransference. In particular, the sublimated countertransference corresponds to the "unobjectionable" transference Freud (1912a) described (cf. Weigert, 1954, p. 242; Racker, 1957, p. 314).

Naturally, a broadened conception of countertransference cannot be permitted to obscure those idiosyncratic and countertherapeutic reactions which are not in practice capable of sublimation or which are not induced by the patient, such as a chronic intolerance of obsessional traits in all patients or irritation with a patient whose appointment falls at the end of an already too long and frustrating day. For these, a term like unsublimated or pathological countertransference provides an apt description. They represent the greatest risk in the context of the therapist's regression, though one which is partially controlled by introspection and by the weight of moral prohibition against any regressive responses whose therapeutic potential has given way to primarily

self-gratifying aims.

By contrast, the sublimated countertransference of the therapist proceeds in a less problematic way for two related reasons. First, some of what falls under the broad definition of countertransference consists of mainly cognitive reactions, such as fantasies, memories, and so forth, whose relation to drive state is strong enough to push them into awareness, but not strong enough to disrupt the therapeutic process. These are analogous to what Racker called "countertransference thoughts" (1957, p. 321). Reik (1948) provided many examples of this phenomenon (e.g., pp. 176-180). More importantly, because many countertransference reactions--Racker (1957, p. 355) would say *all*--are vicarious or induced by the patient, they are less subject to internal conflict and defense, especially in relation to the superego. That is, the therapist's attempt to remain regressively in touch with the patient's intrapsychic state is less hampered by the obstacles the patient himself faces in this regard (cf. Ferenczi, 1928, p. 89; Greenson, 1960, p. 422).

Thus, the therapist who becomes conscious within himself of a particular erotic or aggressive impulse, infantile danger situation, guilty reaction, or other response of some relevance to the patient's own state of affairs has a better opportunity than does the patient to use the response adaptively. The patient's uneasy compromise formation is, transposed to the therapist, more a matter of sublimation

(cf. Little, 1951).[5] In Reik's words,

> and these...impulses really are roused in embryo, but they are immediately intercepted when they arise, unconsciously or preconsciously. Their instinctive energy is not used for motor activity, but is placed at the service of psychological cognition. (1937, p. 243)

More recent analytic writers might modify this description somewhat, speaking instead, as Schafer (1983, p. 37) did, of how the therapist's raw and primitive emotional reactions are not so much replaced by as subordinated to others of a more neutralized sort.

That the separate regressive experiences of patient and therapist are of a different economic order is important for the generative aspects of the treatment (cf. Schafer, 1959). Were they the same, the therapist would be in no better position to help than the patient would be to help himself. Though generativity in the therapist is not solely to be derived from this economic disparity, it permits the therapist a more tranquil and insightful integration of his experience that can serve a generative aim.

The affects induced in the therapist by the patient are, therefore, mostly abbreviated ones, but sufficient to permit recognition of the emotional milieu--as Reik put it, the way the opening bars of a familiar melody permit one to identify the piece (1937, p. 239; see also Berman, 1949, p. 162; Heimann, 1950, p. 82; Fliess, 1953, p. 280; Greenson, 1960, p. 418; Buie, 1981, pp. 295-296). In some respects this brief or muted affective experience can be conceptualized

along the lines of Freud's theory of signal anxiety, a connection already suggested by a number of authors (Schafer, 1959, p. 347; Reich, 1966, p. 352; Kohut, 1971, p. 278; Beres and Arlow, 1974, p. 35; Kernberg, 1979, p. 76; Schlesinger, 1981, p. 409; Kligerman, 1984, p. 319). As Freud described this economic process,

> the ego subjects itself to anxiety as a sort of inoculation, submitting to a slight attack of the illness in order to escape its full strength. It vividly imagines the danger-situation, as it were, with the unmistakable purpose of restricting that distressing experience to a mere indication, a signal. (Freud, 1926a, p. 162)[6]

If we assume with Freud (1915b, p. 181) that the psychic energy made available by depriving an idea of its preconscious cathexis may then be used in countercathexis as defense, it follows that the same energy, when no longer employed for defense, is available to create or amplify affect signals that may be used to "catch the drift of the patient's unconscious." This view is consistent with Freud's statement (again, in relation to signal anxiety) that "there is nothing to be said against the idea that it is precisely the energy that has been liberated by being withdrawn through repression which is used by the ego to arouse the affect" (1926a, p. 140).

The role of affect signals (along with the associated fantasies, memories, representations, and other expressions of the unconscious) helps explain how countertransference can alert the therapist to empathic possibilities.

When the signal is intense enough to strike the analyst's

awareness but faint enough not to disrupt it, the process nears the ideal. In practice, a characterological need to limit the quantity of emotion aroused will choke off many important signals, just as too great a susceptibility to strong feeling will cause the therapeutic posture to lean dangerously in the direction of primary process. As so often in psychotherapy, the ideal can only be approximated, and often feelings run rather more forcefully or more subtly than one would like. This unruly quality of the therapist's emotional reactions is due not only to his own unresolved conflicts, but also to the difficulty of adapting his internal economy to the emotional states the patient induces in him.

To summarize and integrate this discussion, conducting psychotherapy involves a partial regression on the part of the therapist, in some ways analogous to the patient's free association, which gives relatively greater play to the irrational and ordinarily unconscious parts of his personality for the primary purpose of grasping and remaining in touch with the corresponding regressed, undeveloped, and unintegrated aspects of the patient's personality. Though this process carries risks as well as benefits, for the most part it remains a useful therapeutic endeavor by virtue of its mainly sublimated character. In economic terms, the therapist's regression can be described as a withdrawal of cathexis from defensive, reality-oriented, and logical operations, which is then

available to draw into awareness the various feelings, representations, and ideas of relevance during the session, and to make *psycho*logical connections among them. This energy will, of course, also be readily available for secondary process and defense as the therapeutic situation or the therapist's psychic equilibrium requires. Until Kris (1935) showed the way with his concept of regression in the service of the ego, clinical theory had no rationale for describing this dimension of the analytic attitude by its proper name, and countertransference was seen more as an obstacle than a vehicle for understanding the patient.

Since the time of Freud, a variety of terms have been suggested to describe the required relationship of primary and secondary process activity on the part of the analyst, including (especially) evenly hovering attention, but also oscillating cathexes, listening with the third ear, and the analytic instrument. With the growing interest in empathy over the last 25 years, that concept has been increasingly recognized as related to evenly hovering attention in ways that, so far, have escaped exact definition.

Evenly hovering *attention* appears to refer almost precisely to the psychological mode in which the analyst "observes"--in the language of chapter 1, it refers to extrospection and introspection, with the necessary partial suspension of defenses, logic, and self/other differentiation. What the analyst observes with evenly hovering attention are both the sensory impressions he has

of the patient and the contents of his own subjective experience--that is, countertransference as it has come to be understood, ideally in signal form. As a superordinate clinical concept, empathy thus incorporates and integrates the more basic concepts of evenly hovering attention, regression in the service of the ego, and (sublimated) countertransference.

Clinical Illustration

A male psychotherapist was conducting a session during the opening phase of treatment with a young male patient who had a history of severe alcohol and drug abuse, several suicide attempts, homosexuality, the occasional use of a female name, and a desire for a sex change operation that had proceeded as far as hormone injections a few years earlier. The patient began the session complaining of feeling "upset" about a suspected theft of his welfare check by his roommate, a male transvestite. Feeling an awkward distance from the patient that he at first attributed to the global character of the word "upset," the therapist asked what he meant by it. The patient then explained that he felt "anxious, depressed, frustrated"--notably *not* angry--and the therapist continued to feel an emotional gulf between himself and the patient. Thinking that this involved some disavowed hostility, the therapist

remarked simply that he was surprised the patient had not also said that he was angry. This intervention elicited an unexpectedly strong reaction in the form of a threat to kill the roommate. The therapist almost immediately fell into a series of at first seemingly irrelevant and distracting memories about the patient's father, a large, burly truck driver who had beaten his son often and rejected him altogether when his homosexual preference had become evident at age eleven. Accompanying these memories was a strong feeling of resentment and bitterness toward the patient's father, who in the therapist's fantasy was a giant towering over a small, frightened boy. After a few moments, the therapist was able to bring into awareness a rough outline of the following insights about his experience:

1. As a child, the patient had harbored unusually rageful feelings toward his father, which, out of fear, he had had to repress. Instead, he felt "anxious, depressed, frustrated."

2. This state of affairs interfered with identifications with his father and helped set the patient on an unconscious campaign to become exactly the opposite of the father he detested: sensitive, compassionate, masochistic, and (most strikingly) female instead of male.

3. He continued to seek to avenge himself on his

father (who, in fantasy he had already executed: "I don't think about him very much. It's as if he was never there.") His method of doing so, however, was indirect; in his persistent drug abuse, suicide attempts, and pursuit of transsexual surgery, he sought to destroy the son his father had created.

4. The roommate was a contemporary stand-in for the father, who had also deprived the patient of money by refusing to support him. The patient may also have regarded his roommate as a sadistic, persecuting object, like his father.

5. The therapist was suspect in the patient's eyes by virtue of sharing the same gender and role of authority with his father, and this was what accounted for the therapist's odd feeling of being kept at a distance. As the patient had often hidden from his father to avoid a beating, he now sought to conceal himself and his hostility while in the presence of his therapist. By the same token, the patient still longed for his father's love and masculinity, which he hoped to receive instead from other men. This helped to explain why he had not followed through with the intended surgery or successfully engineered his own death, and why a working alliance could be approximated in spite of an often negative transference.

Needless to say, the therapist did not then grasp these complex issues in as orderly a manner as they are

presented here. Rather he experienced a series of thoughts, feelings, and representations all in an integrated but essentially nonverbal gestalt, and all, apparently, following from a sense that some unacknowledged aggression was getting in the way of a closer relationship between two men.

This vignette illustrates a number of the issues discussed in this chapter. To begin with, it demonstrates the nature of the partial regression of the psychoanalytic therapist. This was a patient whose symptoms and recent history would elicit anxiety, moral condemnation, and a heightened level of defense in most observers; to mention only one factor, the patient's pursuit of sex-change surgery could hardly be more evocative of castration issues. But the therapist was able to avoid a defensive emotional distancing from the patient and to keep open a network of fantasy, affect, and memory in which the castration wish/fear played an organizing role. The reality-based matter of the missing welfare check was noted, but was not a major focus of the therapist's attention, nor did the therapist attempt to dispel from his own mind seemingly illogical associations to the patient's narrative. The feeling tone of that session also included a sense of oneness with the patient that lingered for some hours in the therapist's mind--it was, fortunately, his last appointment of the day--and he could only account for

this in terms of a deep regressive identification with the patient in relation to his father. In spite of this probably excessive relaxation of self/other differentiation, the therapist's regression remained adaptive for therapeutic purposes and remained subordinated to synthesizing secondary process operations.

As an example of countertransference, the vignette shows how the subjective experience of the therapist during the session can be sublimated into deeper understanding of the patient.

Although this was a session of psychotherapy and not psychoanalysis, it does indicate the way an evenly hovering attention to external and internal stimuli allows the therapist to arrive without effort at insights that no amount of concentrated thinking could duplicate.

Finally, and more generally, the session demonstrates how regression, countertransference, and evenly hovering attention enter into the therapist's empathy. His identification with the patient as an approximately oedipal-age child allowed a vicarious experience of the patient's fear and anger toward his father that put into perspective other oedipal dimensions of the patient's personality having to do with castration and consolidation of gender identification. It is characteristic that the emotional core of empathy does

not exist in isolation, but becomes a psychological glue with which more intellectual insights are bonded together.

Notes

1. There are obvious parallels to other experiences from everyday life, such as dreaming. For an analysis of the regressive aspects of the aesthetic experience, see Robinson, who spoke of a "weakening of the critical faculty" (1963, p. 68) and a "drop in the level of integration" (p. 73).

2. Writing from this earlier period, Low detected a reluctance of analysts working with adults to follow the lead of child analysts in permitting themselves an extensive therapeutic use of their emotions and fantasies:

> For the child-analyst must perforce be deeply and instinctively in touch with the phantasy-life of the child if he is to succeed at all: he cannot damn[sic] up phantasy behind the screen of words in the same way as can the analyst of the adult. (1935, p. 7)

It is tempting to speculate that the typographical parapraxis betrays the same inhibition toward regression just postulated. Perhaps, too, the analyst's partial regression seemed, at the time, difficult to reconcile with the desired scientific character of psychoanalysis.

3. Schafer (1959, p. 346), and Greenson (1960, p. 423) were among the first explicitly to relate regression in the service of the ego to empathy.

4. See also Hartmann's description of the "'switching' operations of the ego" and their relation to regression (1955, pp. 233-234).

5. The broadly defensive value of sublimation may also be relevant to understanding why the therapist most often does not succumb to regression:

> Sublimation has often been described as a defense mechanism, and it is true that it represents one of the most efficient means to deal with "danger" threatening from the drives. Thus it can be used as defense, though it is not always and often not only defense, as it takes care, economically speaking, of the nondefensive functions of the ego too. (Hartmann, 1955, p. 234)

6. Of course, signal anxiety itself can lead to a countertherapeutic collusion in which patient and

therapist unwittingly avoid the source of the anxiety (Little, 1951, p. 39). The problem is not only how to tell the "signal" from the "noise" of idiosyncratic responses, but how to tolerate the anxiety that either may induce.

Chapter 3

Representational and Economic Aspects of Empathy

> One can neither identify with nor introject aspects of another person unless one's ego has previously constructed some sort of mental model of that person. (Sandler, 1960, p. 146)

An Intrapsychic Model of the Patient

Every instance of empathy takes place in relation to a set of mental representations[1] about the patient. This intrapsychic *model*, as it has been called, varies in the quantity and nature of its representations, in the ways these are organized and integrated, in the amounts and kinds of psychic energy with which its parts are invested, and in the extent to which it is conscious. Though there are important respects in which it is rational and realistic, the model is not a mental diagram or set of abstractions about the patient. Rather, it is best conceived of as a psychological construct drawing on both primary and secondary process modes of representation. Despite some features that distinguish the psychoanalytic therapist's model from the kinds of object representations characteristic of everyday life, it shares with these a large contribution by unconscious, nonrational, and affective elements. The creation of the model, as well as its adaptive use by the psychotherapist, depend

significantly upon the kind of controlled regression described in the last chapter. Complementing the model of the patient are representations about the social structures (Schafer, 1959, p. 355) or social context (Katz, 1963, p. 179ff.; Lide, 1966, p. 148) in which the patient lives. Important, too, are representations of his significant objects (Schlesinger, 1981, p. 397). Whether these are to be considered part of the model itself depends on the extent of psychological differentiation being represented at that moment. In psychotherapy, as in other intimate relationships occurring over extended periods of time, the model tends to be open-ended, so that it is always subject to revision.

Although it is primarily *representations* of the patient with which the therapist's empathy is concerned, there are obviously some aspects that involve the patient as an external object. Empathy is initiated and often supported in an ongoing way by verbal and visual cues from the patient (see chapter 1), and when the therapist speaks or acts in ways derived from empathy, this is directed to a flesh and blood audience, not to a ghostly imago. But the central psychological process of empathy itself has been regarded by generations of writers on the subject as essentially internal or intrapsychic (Prandtl, 1910, p. 24; Lee, 1913, pp. 80-81; Fliess, 1942, p. 214; Schafer, 1959, p. 346; Katz, 1963, pp. 97, 119; Buie, 1981, p. 282; Spencer and Balter, 1984, p. 290).[2]

A moment's reflection will confirm the correctness of this view. Anyone who has identified with the trials of Job or who has seen the Pieta of Michelangelo knows that, although empathy is set in motion by an external stimulus, it is primarily a private experience, not a public or observable one. The introduction of a *human* object as an external stimulus, as in psychotherapy, does not fundamentally alter the intrapsychic nature of this process.[3] Empathy is but one example of how relationships with other people, including quite intense ones, can be carried on for extended periods largely or even entirely in an intrapsychic fashion. Separation and grief reactions are two other examples of the same phenomenon, and have in common with empathy some important dynamic, structural, and economic characteristics (see chapter 6).

It might be supposed that the empathic model brought to life in the therapist's mind should constitute as veridical a reproduction of the patient as possible, but this is true only up to a point. Naturally, the model is realistic in its representations of the patient's age, sex, physical characteristics, and other, more or less factual information. The model must also accurately represent the patient's conscious, subjective experience: the large and small events he reports of his life, the feelings associated with these, his conscious images of himself and important figures in his life (including the therapist), his evolving understanding of his history and conflicts, and so forth.

Yet these representations form only a part of the model. To take a single but crucial example, the patient's experience of the therapist ordinarily must be represented both from the patient's point of view *and* as transference. In general, the therapist must accept and feel the patient's conscious experience, even while searching to understand it in other terms as well. If the therapist is to be more than a sympathetic listener, therefore, he must integrate into his representations of the patient's conscious experience others that seem to capture something of the patient's nature, but which the patient himself might not recognize or represent in the same fashion. Apart from the transference reactions just mentioned, these additional representations include libidinal and aggressive drives and their derivatives, reconstructions of early childhood conflicts and traumas, isolated or otherwise inaccessible affects, split off self and object representations, current unconscious conflicts and fantasies, defense mechanisms, and, in general all that is important in the unconscious life of the patient. These various aspects of the therapist's mental model of the patient correspond to the levels of epistemological inference discussed in chapter 1; the sources of these representations involve the same extrospective and introspective observations described in that chapter.

Extrospectively derived representations or inferences include the factual ones mentioned above as well as others

stemming from the therapist's theoretical knowledge and clinical experience (Greenson, 1960, p. 422; Buie, 1981, p. 295). These contributions can be conceived of as representations of large or small aspects of personality that may be useful to invoke in understanding the patient. They might include, for example, "average expectable" representations of the patient-beginning-treatment, of the haughty withdrawal that can follow narcissistic injury, of the disorganizing effect of severe anxiety, and so on.[4]

Representations derived from the therapist's experiencing ego offer limitless possibilities. The representation of a defense, for example, may arise from a physical sensation, such as a shudder that attempts to shake off associations to some material just introduced by the patient, and which may reflect the patient's own uneasiness about it. Or, a stray fantasy about the patient crawling into the therapist's lap may represent a libidinal turn in the transference or a response to a depressive shift in the patient's mood. These representations, too, like those originating in extrospection, can benefit from abstractions that help to bring into focus some important theme or integrate seemingly diverse elements of the patient's life.

In general, the therapist's representations about the patient tend to integrate what Schafer has called secondary process and primary process object representations, where secondary process is understood to refer to a regulatory or hierarchical relationship to primary process, rather than to

a necessarily dichotomous one (Schafer, 1968, p. 127). Primary process plays an increasingly important role as the model goes beyond a reproduction of the patient's conscious experience, though there are obviously elements of primary process involved in the patient's conscious experience as well, and, therefore, in the therapist's representations about it. In a sense, the model can be described as the result of compromise formation, which Boesky has indicated is characteristic of all representational structures (1983, p. 581).

Consider the interplay of primary and secondary process in the following (hypothetical) example: an overweight female patient remarks, "There's no point in dieting because every time I go on a diet I gain weight." At the simple, conscious level, the therapist would readily represent the patient's implied frustration in her efforts to improve her appearance and, perhaps, her experience of the world as a contrary, chaotic place that offers no rewards for good behavior. This might be followed by some thoughts about the dynamics and genetics of this oral issue: is this a patient who had significant early conflicts about feeding, who felt deprived of her mother's nurturance, who feels so deprived now that, when she eats less than she wants, she more than makes up for it with a later binge? The therapist might also note the kinds of defenses involved in these oral conflicts--rationalization, for example, or denial about her actual food consumption when dieting. Reality, too, would

be represented, as the therapist might find himself reflecting that, all other things being equal, decreased caloric intake must lead to weight loss. Attempting to allow for some realistic basis for the patient's belief, the therapist might remind himself that, as a woman, her weight would be subject to hormonal effects and changes in the proportion of water retained, which might temporarily offset the effects of decreased food intake. This thought, associated with the patient's reproductive function, might in turn lead to a hypothesis about an unconscious fantasy such as, "If I lose weight, men may be attracted to me, and I might get pregnant (i.e., fat) as a result of dieting."

The large group of representations that diverge from the patient's conscious experience remains "true" of the patient insofar as psychoanalytic concepts provide a true vision of the mind. But the therapist's model extends even beyond the patient "as he is," from his own vantage point or as understood psychoanalytically. For empathy to be *generative* (Schafer, 1959), the working model of the patient must also incorporate representations of the patient's unrealized development. These can be regarded as one aspect of what Schafer called a "temporally articulated internal image of the patient's world" (1959, p. 357), including not only the patient's past and present circumstances, but his future prospects as well. Along similar lines, Greenson wrote that the model includes the therapist's "expectations and anticipations of the patient's potentials" (1960, p. 422).

These generative representations derive in large part from the therapist's synthesis of the patient's idealized, negative, and realistic self representations, a synthesis made possible by the therapist's more integrated identity and which also draws upon his own ego ideal and identifications with representations of generative objects. Here, too, relevant aspects of the therapist's clinical and theoretical knowledge play a role. Generative representations of the patient tend to rely more heavily on secondary process (Schafer, 1968, p. 129).

A clinical example may help to clarify the nature of these generative representations. A young narcissistic patient's grandiose fantasies of stardom in the entertainment field alternated with feelings of utter impotence and dejection as he repeatedly failed the academic coursework that would have prepared him for employment in that field. Although both of these extremes of self valuation were richly represented in the therapist's mind, there was in addition a more integrated version that reflected realistic potential for success and realistic limitations. To a significant extent, this generative integration drew upon the therapist's own prior experience reconciling his ambitions and disappointments to his abilities. To place this process in context, it needs to be added that all three sets of representations--the grandiose, the dejected, and the generative--had to be organized preconsciously in relation to their libidinal (e.g., exhibitionistic) and aggressive

aims, adaptive and defensive functions, structural and economic implications, resistive and transferential properties, and so forth.

In addition to these generative representations that differentiate between the patient "as he is" and the therapist's model, there are important economic differences, notably in the intensity with which affect is represented (Reik, 1937, p. 239; Berman, 1949, p. 162; Heimann, 1950, p. 82; Fliess, 1953, p. 280; Greenson, 1960, p. 418; Buie, 1981, pp. 295-296), in the degree of resistance and defense (Greenson, 1960, p. 422), and in the resultant anxiety and conflict. For the model to be integrated and workable, it is usually necessary that the amount of psychic energy associated with it be neutralized enough so as not to disrupt the therapist's adaptive use of it while empathizing. Momentary countertransference responses obviously impose a different set of economic and representational circumstances, but for the purposes of *representing* the patient, no particular instinctual prohibitions need be invoked. The need for neutralization applies more strictly to the therapist's empathic use of the model, though even then a depth of understanding sometimes requires a depth of feeling impossible without a temporary instinctualization of the model, for example, when the very point of the patient's experience is its intensity.

This brief review of the ideal nature of a therapist's mental representations about a patient may give the

impression that the construction of a psychic model is overly complex and unwieldy. In practice, of course, there are only approximations of the ideal. But anyone--not just a psychotherapist--who embarks on a long and intimate relationship with another develops an elaborate set of object representations whose complexity is largely obscured by the fact that most of them are unconscious most of the time. In a similar way, the therapist tends to work with a core set of representations that includes symptoms; major images of self and other; basic drive derivatives, defenses, and conflicts; guiding unconscious fantasies; and repetitive behavioral and transferential phenomena that are maintained consciously or preconsciously. Viewed from another perspective, the scope and complexity of the model imposes no greater burden on the therapist than--and to a great extent corresponds to--the familiar dictum that each aspect of the patient's personality must be analyzed.

Although the construction of a mental model of the patient is, therefore, a realistic psychological undertaking, it has already been noted that the model is and needs to be not wholly realistic as a replica of the patient, both for epistemological and for specifically psychotherapeutic reasons. The epistemological limitations of the analyst in representing the patient have been summarized by Schafer (1983). In his view, no analyst ever makes a complete mental model of the patient; at best, one can make a model of the patient-in-analysis, which is necessarily somewhat less

complete than the person himself. Second, there is no single best mental model of the patient, for there is no way to represent the patient without having a point of view and, therefore, a bias. Analysts within and between different schools construct different models "*all* more or less justified by 'data'" (1983, p. 40, emphasis in original). Finally, it is only through this idiosyncratic set of representations that the analysand can in any sense be "known" (cf. Restak, 1984, p. 66; Kohut, 1982, pp. 90, 91).

In addition to the epistemological problems, Schafer has addressed himself to the analytic transformations that take place in constructing a model of the patient, that is, to the ways in which analytic empathizing transcends efforts merely to imitate or reproduce the patient's experience. He mentioned in this regard Picasso's reply to the objection that his portrait of Gertrude Stein did not resemble her at all: "It will," said the master (1983, p. 56). The therapist's model, on the other hand, both does and does not resemble the patient, and for good reasons. The balanced use of representations that are close to and distant from the patient's own experience makes it possible to supervise the therapeutic process without being unduly aloof or confrontative, and to remain immersed vicariously in the patient's experience of himself and his world without feeling to the same degree the patient's sense of inertia or helplessness.

It is necessary to ask, however, how trustworthy the

therapist's portrait of the patient can be expected to be, or, conversely, how much relativism and fallibility are acceptable. Unfortunately, there does not seem to be a satisfactory answer to this question. Over the long run, a therapist may take some consolation in having been vigilant about countertransference and in evidence of therapeutic results, but he must recognize that his efforts to represent the patient are prone to error. Whether he describes his attitude as a cautious, investigative, scientific frame of mind or as ordinary uncertainty, he will need to keep his model of the patient within adaptive bounds, revising it where necessary. If he smugly assumes the acuteness of his empathy or seeks to adorn his work with a halo of science, these defensive, narcissistic attitudes will pose greater problems than the epistemological limitations. Instead of Picasso's "It will," the therapist must be content with a much more humble level of confidence.

To summarize: empathy in psychotherapy is an intrapsychic process that takes place in relation to a set of mental representations about the patient. The therapist integratively attempts to reproduce the patient's own phenomenological experience, to characterize the contents of the patient's unconscious, and to envision a more adaptive state. In its temporal dimension, the model includes the patient's past, present, and future. Some aspects of the model are derived largely from secondary process, for example, perception, theory, clinical experience, and a

generative interest. Other representational components, such as drives, conflicts, fantasies, and affects, are more strictly the product of primary process, and these are ordinarily represented with less intensity than they are in the patient. The model is mostly preconscious at any given time, and is subject to the limits of what any person can know of another's life.

Economic Aspects of Object Representation

This chapter began with a statement that the therapist's empathic model of the patient varies in the amounts and kinds of psychic energy with which its parts are invested. It could be added that empathy also requires the therapist to cathect his own self representations in a variety of ways. Inasmuch as subsequent chapters depend on these psychic investments to account for various aspects of empathy, it is necessary to prepare the way for such descriptions. The economic aspects of empathy are of particular concern because Schafer, to whom the theory of empathy owes a large debt, has been among those who in recent years have sought to redefine the economic point of view.

In a departure from more familiar usage, Schafer (1968) has taken the position that it is inappropriate to speak of representations being cathected. Indeed, this marked a shift from the view he had expressed in 1959, when he

referred to the "introjective component" of empathic understanding, which "amounts to carrying on a relationship with another person internally, and with a relatively high degree of cathexis" (1959, p. 348). In 1968, however, he took the following position: "I propose that a representation is an idea, and an idea is neither a dynamo generating its own power, nor a surface or container that attracts, captures, and retains energy or is invested with forces" (p. 60). He contrasted this view of a representation as an idea with the more traditional approach that implicitly treats a representation as a kind of psychic structure:

> A consistent application of this [structural] viewpoint would require that every representation be called a structure in that it would have to have enough organization and durability to be identifiable in the first place...And if all representations are structures, of what use is the term *structure*? (p. 61, emphasis in original)

An obvious disadvantage of the prevailing structural view, then, is that it tends to encourage a conception of a representation as a "microsystem--one that is modeled after the systems id, ego, and superego, or some combination of them" (p. 61). Furthermore, Schafer detected a redundancy in the idea that representations can be cathected, for it should be sufficient to speak of the cathexis of aims, of which the representations are "referents" (p. 62).

Examining Schafer's suggestion systematically, there is no reason to burden the concept of representation with the metaphor of a "dynamo generating its own power:" the origin

of psychic energy is to be found in the id and the ego. If representations appear to function with their own energy, it is clearly borrowed, not self-generated. Secondly, it is true that a representation is not a "surface or container" and theoretical formulations should not imply otherwise, but if cathexis makes a representation into a container for energy, it would presumably do the same to an aim. Thus the "container" problem, if there is one, originates in the concept of cathexis, not in the concept of representation, and cannot be solved by defining representations as merely ideas. A solution to the container problem would require a more careful and sophisticated conception of psychic energy, one which, for example, discarded the old hydraulic model, with such expressions as the *damming up of libido*.

As far as the question of proliferating structural entities and microsystems is concerned, Schafer's argument is a cogent one, but it likewise applies not only to representations. The field of psychoanalytic thinking abounds with such entities as functions, mechanisms, apparatuses, and, of course, aims. The need to define each of these microsystems in relation to the others and to superordinate structures is a continuing problem in psychoanalysis, but, again, not one that can be solved by divorcing representations from cathexis.[5] Moreover, Schafer soon modified his position that representations are nonstructural ideas when he described "primary process presences"--ideas, in his view--as "structured, that is,

they are enduring organizations whose rates of change are slow or negligible," even while maintaining that they are not "structures in the sense that id, ego, and superego are structures" (pp. 130-131). This rare lapse in the logic of Schafer's thought highlights the difficulty even the best analytic theorists have in adopting a consistent position about the status of mental representations, which of all the psychic entities have the least clearly defined relationship to the structures of the tripartite model (see Jacobson, 1983a, 1983b; Boesky, 1983). "Ego strength" and "identity integration" are often used interchangeably, for example, and "ego boundaries" is a term often employed to mark the limits of what is represented as self.

So far, this critique of Schafer's position applies mainly to his proposed solution to the problems he cited. The problems themselves--the treatment of postulated mental phenomena as quasi-physical structures and the hydraulic concept of psychic energy--largely remain, and it is easy to see how Schafer's line of thought, carried forward systematically, would lead to radically different formulations of existing psychoanalytic concepts, such as the kind he presented in terms of action language in 1976.

In the development of Schafer's thought, it is interesting to observe that by 1983 he was discussing an empathically constructed "model" of the patient (pp. 39-43) and its interaction with the "second self" of the analyst (pp. 43-51). Although Schafer attempted to reconcile these

concepts with action language (pp. 52-53), they are perhaps more plausibly represented as psychic structures than as ideas or actions. Still, this implies nothing one way or the other about their ability to be cathected.

Yet to be considered is Schafer's argument that cathecting a representation is a redundant way of saying the representation is relevant to a cathected aim. Thinking of the situation this way, he pointed out, is much closer to the way many analysts actually speak to patients: one would never tell a patient about his deployment of anticathexis against a given idea, but would comment about his motives (i.e., cathected aims) in not allowing himself to think of something (p. 65). Unfortunately, this advantage in clinical practice does not apply to *hyper*cathexis; there would be no reason to tell a patient either that he had a hypercathected representation or that he had a motive "to know, to perceive, to be aware" (p. 63) of that representation. In another passage, Schafer wrote that

> in considering the sequellae of the normal, satisfying sex act, it is not the best way of looking at it to speak of a decreased cathexis of representations of the sexual object; it is, I propose, better theory to say that the sexual urge has decreased markedly and with it the subjective importance of certain sensual and other representations. (p. 67)

This is true as far as it goes. But how should one describe theoretically an *increase* in loving, sensual, affectionate behavior or in the esteem with which an object is held just after sexual intercourse? The standard theory allows one to

speak of the cathexis of representations independently of the cathexis of aims: in this case, an increased libidinal (probably, in part, narcissistic) cathexis of representations of the object and a decathexis of the genital aim. To the latter Schafer would have to add an increased cathexis of object libidinal and narcissistic aims in order to account for this phenomenon. To stay with Schafer's example, what metapsychological circumstances reflect the choice of a particular sexual partner? What binds a particular representation to the sexual aim? A greater libidinal cathexis of that representation provides one answer, but if this option is rejected, it may be necessary to invoke yet another set of aims or to fall back upon some notion of a stable or steady motivational state in relation to the sexual partner. Schafer's own attempts to find a psychoanalytic explanation for what binds a representation to an aim were vague and colloquial: an aim and a representation are connected by virtue of the latter being "relevant, important, necessary, or useful" (p. 62) to the former.[6]

At this point, the problem of possible redundancy must be weighed against the heuristic usefulness of limiting cathexis to aims. There are no doubt instances where it would be more useful to speak of a cathexis of aims, rather than representations. In an erotic transference, for example, to say that the patient's representations of the analyst are libidinally cathected is less informative than

to talk about a seductive or exhibitionistic motive. Still, no clarity is lost by permitting both forms of expression. In other cases, neither approach offers a distinct advantage: is it an improvement in psychoanalytic theory, for example, to discard hypercathexis of an idea in favor of a "motive to know" it? In still other cases, forfeiting the cathexis of representations might make it much more difficult to describe some psychological phenomena. Thus, at present, one can postulate two sets of representations about the same object that are unintegrated because one set is libidinally charged and the other aggressively so, *or* one can mention opposing motives associated with each set. The former is more relevant to the structural point of view, the latter to the dynamic. With only one way to describe such phenomena, it would be impossible to refer to "good" or "bad" object representations as an indication of the type of energy involved in their cathexis, only to representations relevant to libidinal or aggressive aims.

Other familiar ways of thinking would also be affected by Schafer's proposal. Consider, for example, Hartmann's (1950, 1955) classic formulations of narcissism in terms of a libidinal cathexis of self representations. Along similar lines, the Kohutian school has defined "the weakness of the self...in terms of its underlibidinization--as a cathectic deficit" (Kohut & Wolf, 1978, p. 414). A strong identity or a stable sense of self does seem to encompass more than a set of ideas about oneself, more even than a structured set

of ideas, or ideas toward which highly cathected aims are directed. Despite such terms as "well-integrated" or "poorly-integrated," it is doubtful that conceptions of identity can be described adequately without the quantitative dimensions of the economic point of view. Indeed, the very idea of structure or integration implies a cohesiveness attributable to economic factors.

No doubt Schafer could reformulate narcissism and identity in the motivational terms he preferred, although such an approach is potentially quite cumbersome. His suggestions, however, deserve more attention than they can be given here, and a conclusive answer about them must be postponed (cf. Eisnitz, 1980). At the least, Schafer's approach emphasizes the importance of joining economic statements about changes in the cathexis of representations to others of a dynamic nature specifying the concurrent changes in the kinds of motivation involved. Perhaps the possible redundancy went unnoticed for so long precisely because, as the object relations approach has competed with the tripartite model to describe the same phenomena, representations have been mentioned too frequently in isolation from the motivational context in which they arise.[7]

Economic Aspects of Aggression and Empathy

A particular economic issue in need of clarification is

the role of aggression in empathy. Many analytic theorists have stressed the role of sublimated *libidinal* interest in the patient as an essential element of empathy or, more generally, of good technique (Low, 1935, p. 7; Racker, 1957, p. 313; Reich, 1960, p. 390; Gitelson, 1962, p. 198; Nacht, 1962, p. 210; Greenson, 1966, p. 272; Katz, 1963, pp. 153, 154; Arlow, 1979, p. 69; Kohut, 198', p. 190). Rogers' concept of *unconditional positive regard* (e.g., 1957, p. 96) seems to reflect a similar attitude. The withdrawal of this sublimated libidinal cathexis invariably produces a bored or inattentive therapist. For the most part, however, the relationship of aggression to empathy has been overlooked. In this regard, the Kohutian school, with its special emphasis on the role of empathy in development and in treatment, has been sharply criticized over its neglect of aggression, particularly in view of the strong negative countertransference its narcissistic patient population tends to evoke (e.g., Searles, 1979).

To approach this problem, a distinction must first be made between instinctual and neutralized aggression. An instinctual aggressive cathexis of the therapist's object representations (or an aggressive aim directed at them) is nearly always counterproductive of empathy (Olden, 1953, p. 119; Noy, 1984, p. 195) or of good technique in general (Reich, 1951, 1960). Exceptions to this rule are rarely reported. Searles, for example, has written that "one of the turning points in the treatment of one chronically

schizophrenic woman with whom I had been working for a number of years was our coming to vent really venemous hate upon one another" (1979, p. 51). But, in general, the urge to hurt and the urge to heal are not easily reconciled.[8] Is there, then, a role in the therapist's empathy for *neutralized* aggression comparable to the more generally acknowledged role of sublimated libidinal interest? At least one analytic theorist has offered some speculations relevant to this question. In Reik's view, "psychological interest [in other people] is derived from a tendency to gain mastery," which has both libidinal and aggressive roots (1937, p. 244).[9] The urge to gain mastery is one example of where it may be more useful to speak of the cathexis of an aim (Schafer, 1968; see above) rather than of the representational model itself: like the suitor who "aggressively" pursues a love object, the aggression is deployed in the service of an ego aim, not with the goal of satisfying itself upon the object. On the other hand, an aggressive cathexis of the model might be necessary adequately to represent certain structural aspects of the patient's personality--a punitive superego, for example, or a set of dissociated, "bad" self representations.

When the model is used empathically, however--instead of merely for the purpose of representation--this economic picture changes, and it is probably never the case that empathizing calls for an aggressive cathexis of the model. Instead, in every instance of empathizing with the patient's

aggressive drive derivatives, what occurs is an aggressive cathexis either of the therapist's own self representations or of an object representation, not of the model. A few examples will illustrate why this must be so.

The first possibility is the situation in which the patient is experiencing some form of aggression turned against the self. The prototype of this circumstance is guilt, and this can be formulated as an aggressive cathexis of self representations by the patient's superego. Empathizing with a patient's guilt obviously could not be a matter of the therapist's superego investing the model with aggressive energy, for such a state of affairs would represent a kind of moralizing disapproval of the patient, not empathy at all. Rather, an empathic appreciation of a patient's guilt requires an aggressive cathexis of the therapist's self representations by his superego, together with a temporary identification in which those representations are momentarily altered to resemble the model.

A second possibility concerns the case where the patient aggressively cathects an object representation, for example, that of a parent, sibling, or spouse. Empathizing with such a patient's anger can be understood economically as a neutralized aggressive cathexis by the therapist of a representation of the patient's object (usually a representation fashioned in large part after a significant object in the therapist's own life), and, again, an

identification with the model.

A third possibility is really a variation of the second: it is the situation where the patient's "bad" object is the therapist himself as a transference object. In this case, the patient can be said to cathect aggressively his representation of the therapist and, often, of a significant other object as well. In empathizing, the therapist cathects with neutralized aggressive energy his representation of the other object and, by way of identification, his representation of himself as the patient's object.

As these examples indicate, empathizing with the patient is inconsistent even with a neutralized aggressive cathexis of the model. This does not mean, however, that an otherwise empathic therapist will never feel irritation or anger toward a patient. Such feelings obviously do occur, and, when treated as the kind of affect signals mentioned in chapter 2, allow afterwards for a better empathic view of the patient's emotional landscape. By that point, though, an economic change has taken place, involving the neutralization of the aggressive energy and a shift in its cathexis from the model to the therapist's self representations or to another object representation. Needless to say, this describes the ideal situation; a degree of empathy is compatible with some failure in neutralization or with a cathexis of the model that includes some antipathy.

Consider, by way of illustration, the following exchange between a therapist and a young, male paranoid schizophrenic patient:

Patient: I called my sister today.

Therapist: Oh, how is she?

Patient: What's it to you?

The therapist was thrown off balance by the unexpected aggression in the patient's last comment and immediately felt a strong wariness and irritation, resentful that his innocent inquiry had evoked a hostile response. So far, nothing had happened beyond a talionic response: the patient's aggression toward the therapist aroused the therapist's aggressive feelings toward the patient. He recognized, and, in a sense, shared the patient's hostility, but there was no question of empathy at this point. The therapist then remembered the patient's description in a previous session of how, as a child, he had been beaten often by his mother with a baseball bat and by his father with an electrical extension cord. Fragments of other conversations were also recalled, in which the therapist had noted the presence of aggressive material every time the patient spoke of friendship, sex, or love. By this time, the therapist's anger had been largely neutralized. Instead of seeing the patient's hostility as unprovoked, he now recognized it as an

understandable reaction in view of a history in which intimacy and hostility were inextricably linked. What the therapist had regarded as a friendly question, the patient had seen as a danger situation with potentially aggressive consequences. The therapist's inquiry ("Oh, how is she?") had evoked just the same wary response in the patient as the patient's question ("What's it to you?") did in the therapist. But this identity of feelings had no empathic character until the therapist's aggression could be neutralized and until he was capable, in identifying with the patient, of representing himself and the rest of the patient's object world as dangerous.

Somewhat later, the therapist reflected further on this brief interaction and discovered that his apparently casual question carried an important history of its own. There had, in fact, been several other instances in which relatively neutral statements by the therapist had drawn sarcastic or otherwise hostile comments by the patient. Without yet understanding it, the therapist was concerned about this problem and had unconsciously sought to be especially careful in his remarks to the patient--too careful, perhaps, in the present instance, in which he unwittingly made the interchange more friendly and casual than necessary. He questioned, too, whether there was some insincerity or feigned interest in his tone as he inquired about

the patient's sister, a quality that might have been added to conceal some lingering resentment over the patient's prior hostility toward him. Thus, the suspiciousness and aggression that were the chief characteristics of their immediate encounter had not been entirely the patient's initiative, and the way for the therapist's empathic identification had in part been prepared by the therapist's own developing sense of danger in the relationship.

The incompatibility of empathy and aggression toward the patient is not mentioned in a prescriptive way, such that if one wants to be empathic, one should avoid feeling hostile toward the object. Instead, the point is that the dynamics and economics of empathizing turn the path of aggression from the empathic object to another one, or to the empathizer himself.[10] Two facilitating factors should be mentioned in this connection. First, the therapist's stable libidinal investment in the model makes it easier to neutralize an aggressive impulse. Given the already sublimated nature of the therapist's libidinal investment, there is less potential for conflict or other pathological outcomes and less difficulty neutralizing the aggression than if the libidinal cathexis were more instinctualized or absent altogether.[11] The second, and related, factor concerns the universal tendency to deflect aggression from a loved object, even at the cost of directing it toward oneself. Empathy, then, is not so far removed from the fear

of object loss which accounts for this displacement (see chapter 6). Although empathy is defined here in terms of sublimated, essentially nondefensive activity, the practice of psychotherapy provides many examples of empathy shading into a less fully sublimated desire to become the patient's "good" object, a situation in which aggression is also less than optimally neutralized, and is, instead, countered by repression, reaction formation, or splitting.

Greenson has noted that "people with a tendency to depression make the best empathizers" (1960, p. 424), and it is likely that empathic therapists tend to have more inhibitions about object-directed aggression than do other types of therapists (cf. Olinick, 1984, p. 154n). By the same token, a more detached or confrontative style will yield its own particular problems with aggression. Kohut was at least partly correct when he wrote that "'resistances'...are most frequently the result of actions from the side of the analyst (especially, of course, interpretations) that the patient experiences as empathy failures" (1977, pp. 114-115; cf. Brandchaft and Stolorow, 1984, p. 342).

But this is not the place to argue for the superiority of one or another style within the psychoanalytic approach to treatment. If one cannot separate the dancer from the dance, it is not possible to separate a treatment approach from the particular personality dynamics of the therapist who employs it. At worst, there is a tendency to

rationalize one's own bias as the ideal form of treatment, and at best, that bias can elevate one's work to a very high level indeed. See, for example, Reich's genetic reconstructions about Dr. X, an unusually talented analyst (1951, pp. 29-31), and Herold's views on the personality of the "trapper" and the "hunter" in analytic practice (1939, p. 229).

Notes

1. Boesky has rightly pointed out that the term *mental representation,* like so many psychoanalytic terms, is used in different ways by authors who tend to suppose they are all referring to the same thing. Mental representation, he suggested, is a "concept broader than the sum of self- and object representations" (1983, p. 566), and it should be noted that the representational model of the patient described in this chapter is likewise broader than the sum of the therapist's object representations about the patient.

2. Incidentally, this characteristic of empathy helps answer the charge that empathy involves an attempt to "cure through love:" on the whole, the therapist's empathy is a private matter, whose adaptive aim is a better understanding of the patient. That understanding, interpreted to the patient, forms the largest part of the therapist's contribution to the ameliorative effects of psychotherapy. If it were possible to separate empathy itself from the understanding to which it gives rise, some incidental and indirect benefits to the patient would certainly be found as a result of empathy. But empathy is rarely to be communicated to the patient for its own sake.

3. This is one of the factors that distinguishes empathy from sympathy, which involves a greater tendency to express or to wish to express one's feelings to the object, though there are also private sympathies.

4. In this sense, the therapist's representational model is constructed similarly to that of the mother's empathic model of her infant. That model would hardly exclude information such as how long it has been since the last feeding or nap (cf. Demos, 1984, p. 11) and general notions of how infants are expected to behave.

5. As applied to physical objects, structure obviously implies dimensionality or spatial extent. Psychic structure of whatever kind, however, refers to an organization of mental phenomena that need have no spatial implications, any more than do social structures that exist only to the extent that people act in harmony with intrapsychic representations of them. Psychic structures "include" other structures the way social structures include family structures or economic strata. In terms of the specific relationship of mental representation to the tripartite model, Boesky's point of view is instructive:

> [Jacobson (1964)] said that the self- and

> object representations invested with libido (or aggression) were all *in the system ego*. I think it would be more clear to say that any "representation" of the self or object is formed by the interaction of all three agencies and cannot exist *in* any one system. (1983, p. 574; emphasis in original)

Alexander (1958, p. 294) might have been one of the first to point out the problems of conceptualizing the mind in spatial terms, which he regarded as endemic to the structural approach.

6. This view, however, is substantially the same as Freud's in 1915: "the object of an instinct...is what is most variable about an instinct and is not originally connected with it, but becomes assigned to it only in consequence of being peculiarly fitted to make satisfaction possible" (1915a, p. 122).

7. See, for example, Boesky's criticisms of Kernberg:

> In his writings one hears of the reified self- and object representations undergoing all kinds of amalgamations and regroupings without much discussion of the organizing influence of unconscious fantasy in forming these self- and object subsystems. It is analogous to an orchestra of representations of self and object who seem to perform with virtuosity but without a conductor. We see them changing their seating arrangements on stage to form new and novel ensembles, we hear them, now in solo, now in complex groupings, but always performing with shadowy and mysterious autonomy, and capable of bewildering feats of coordination without a musical score. (1983, p. 577)

8. Searles did not, of course, claim this approach was empathic. As a parameter for bringing into focus disavowed hostilities that have poisoned the therapeutic atmosphere, the kind of technique he described may clear the air and prepare the way for a genuine therapeutic alliance. But it would be difficult to imagine it being used successfully at any other time, for example, in the opening or termination phases of treatment, or when there is good evidence that the therapy is going well.

9. Herold, in a commentary on Reik and Reich, interpreted the desire to gain mastery solely in terms of aggression (1939, p. 233).

10. Schafer has criticized as sentimental an empathic

approach that excludes such "bad" qualities as "avariciousness, overweaning pride, sociopathy, sadism, and the like" (1983, p. 36). Although it certainly is possible, and useful, to recognize these qualities in a patient, and even to empathize with them when, at rare moments, a patient describes himself as greedy, prideful, or sadistic, it would be a mistake to characterize as empathic a pejorative view of the patient that the patient does not share. Empathy typically comes into play in relation to these particular personality characteristics when they can be seen as the patient does, consciously or unconsciously. For example, what would be seen from the outside, objective, or scientific view as greed might be empathized with as an effort to compensate for chronically low self esteem, to incorporate the unreliable breast, to recover lost fecal products, to become more powerful than an oedipal rival, and so forth.

11. A more complete description of neutralization than this one would have to mention the role of the ego, for example, in testing the realistic basis for and the consequences of the aggression, and of the superego, in relation to the "therapeutic conscience."

Chapter 4

A Critique of Two Theories

> Much of the older descriptive psychiatry and descriptive academic psychology was written as if from the viewpoint of an onlooker, who worked as if unaware of his own contribution to the interpretation of what was observed. (Schroeder, 1925, p. 166)

Introjection and Projection

A physician conducting an examination of a physically ill patient also constructs a model of the patient as he proceeds, with the history, physical signs, symptoms, and laboratory tests each contributing information that leads to a diagnostic impression of the patient and implications for treatment. Similarly, a behavior therapist who construes a patient's phobia in terms of the controlling reinforcements and appropriate counterconditioning strategies creates a model of the patient suited to his therapeutic task. Contained in both models is a vision of the patient's ideal or future condition.

The working model of the patient that is used by the psychoanalytic therapist differs from these others in relation both to the kinds of material considered relevant and to the methods by which it is acquired and put to use. There is, of course, much overlap among these different approaches in that all rely, at least in part, on

information obtained by extrospective observation, and on clinical experience, a variety of theoretical constructs, and rational analysis to interpret that information. What makes the analytic model distinctive is the additional and special contribution of the nonrational, both in the creation and in the use of the model while empathizing.

If the medical specialist examining a patient happens to remember for a moment his hypochondriacal mother, if he senses that the patient seems almost pleased at the prospect of surgery, or if he finds himself fantasizing about her death on the operating table, these reactions will almost certainly be dismissed as irrelevant to the task at hand (though, of course, they may still unconsciously influence his actions). His mind is not apt to attend to latent issues of secondary gain, masochism, or death wishes. Not so, however, with the analytic therapist. For him, such "distractions" breathe life and meaning into his model of the patient. In large part, this nonrational process is made possible by introjection and projection. "They constitute," according to Reik, "the primary psychological conditions of the comprehension of other people's unconscious processes" (1937, p. 199; cf. Kovacs, 1912, p. 253; Schroeder, 1925, p. 162; Winterstein, 1931; Low, 1935, p. 3). These terms are used here as mental operations that, like regression, need not be pathological, that may vary widely in the degree to which they satisfy pleasurable, defensive, adaptive, or sublimated aims. In the case of

empathy, they also take place in conjunction with and under the supervision of rational and moral parts of the personality.

Fliess' Theory of Empathy

In a classic paper, Fliess (1942) presented a theory of empathy based essentially on introjection and projection. His status in the field of empathy was indicated by Schafer, who called him "the only author to have attempted a systematic metapsychological treatment of empathy as well as detailed clarification of the role of identification in it" (1959, p. 344) and by Reich (1966, p. 347) and Poland (1984, p. 347) each of whom characterized his essay as "brilliant." Early in the article, Fliess referred to empathy as a kind of psychological "trick" (p. 214), but, it turns out, the "trick" is in Fliess' description of empathy, not in empathy itself. Before entering into a detailed analysis, he began with the following summary: "a person who uses empathy on an object *introjects this object transiently, and projects the introject again onto the object*" (p. 214, emphasis in original). This formulation will be referred to as the *summary version* of Fliess' theory. He compared the analyst to "the tea taster, who introjects materially a small sample only long enough to be able to taste it" (p. 214).

A close inspection of Fliess' argument will serve to bring into relief some of the problematic issues about

introjection and projection and to point the way toward meaningful definitions. According to Fliess, there are four stages of empathy in all, the first of which is as follows:

> "(1) The analyst is the object of the [patient's] striving" (p. 215); that is, the patient experiences in the transference an infantile striving or conflict, and "an instinctual response [is] stimulated in the analyst" (p. 215), which the analyst entirely sublimates (p. 216).

Although Fliess did not discuss introjection explicitly in this stage (nor, for that matter, in any of the stages that follow), he did seem to suggest that the analyst's "instinctual response" was tantamount to an introject, for he used the terms *striving* and *introject* interchangeably: in the summary version, he wrote that the empathizer "projects the introject" (p. 214), and in stage 4 (discussed below) that he "projects the striving" (p. 215). It sounds superfluous to invoke introjection to account for the presence of an impulse in the analyst which the patient "induced" (p. 215), and, in any case, the term introjection ordinarily implies a particular kind of object relationship, not merely a state of induced arousal. In an earlier passage, Fliess had, in fact, spoken of introjecting "the patient's mind" (p. 214) or "more correctly, the patient's ego" (p. 214n); the summary version had also mentioned introjecting the "object." Why, then, in the body of the theory, did Fliess treat the induced striving as an introject? To answer this question, it is necessary first to clarify what Fliess meant by introjection. He seems to

have used the term in two ways. In the first, it means simply to take in. This certainly is the meaning applied in relation to the tea taster. Thus, to speak of a striving as an introject is to make of it something taken in from the patient, in effect, to undo the fact that the patient has stimulated in the analyst a striving of his own. Indeed, in the rest of the theory, Fliess never again mentioned the striving as induced, but invariably spoke of it as something belonging to, or at most borrowed from, the patient. In stage 3, for example, he wrote that, as a result of identification, "the patient's striving has been transformed into a narcissistic one in the analyst" (p. 216), a transformation that is unnecessary if the striving was induced in the analyst in stage 1. Similarly, in stage 4, Fliess mentioned "reprojecting the striving in question after it had been the analyst's for the brief moment of trial identification" (p. 218). Here it was again implied that the striving is acquired from the patient by identification, rather than arising from the analyst's own instinctual life in response to the patient. This small difference has large implications for the theory of empathy. These cannot be spelled out in detail at this point, but lead to a very different conception of empathy, in which the analyst's projections play a large part in representing the patient. By contrast, what Fliess meant by projection was nothing more than returning to the patient what had been "taken in" from him temporarily.

It should be apparent that impulses cannot be one's own and at the same time taken in from some one else. Nor, in fact, does it make for good theory to say that impulses can ever be "taken in" (cf. Fenichel, 1945, p. 164).[1] With one exception (discussed below), internalization in psychoanalysis is ordinarily and properly limited to the replacement of external authority with internal structure and to the development of a representational world. This process should be called a kind of "taking in" only in the most informal sense and ideally not at all, because it presupposes a spatial model of the mind, into which portions of other minds can be transported and because it blurs the distinction between objects and psychic representations.[2]

The exception referred to above is, of course, the important role of fantasy. In fantasy, the mind can take in (or expel) whatever it wishes. In this sense, introjection as a kind of "taking in" refers to a primary process wish or motive to possess an object internally, like the infant's "hallucination" of the breast. This motive to take in has much in common with what Schafer has suggested as the definition for *incorporation* (1968, pp. 20-23), and incidentally provides a way of distinguishing between two terms that have often been used interchangeably (e.g., Reik, 1937, p. 199; Knight, 1940, p. 334).[3] At some risk of oversimplifying, incorporation can be used to designate a *dynamic* or motivational process, while introjection then refers more to a *structural* process.[4] As Schafer expressed

it,

> Introjection is the fulfillment of an id wish to incorporate the object and it is a regressive change in ego organization which obscures the distinction between the idea of the object and its temporal or external referents....Introjection is an event, a change in psychic organization and in the psychic status of an object representation. (1968, p. 78)

If this distinction between incorporation and introjection is adopted, it becomes possible to incorporate tea, in fantasy or fact, but not to introject it, as Fliess (p 214) supposed.[5] And, although a striving of one's own cannot be designated as an introject, that striving is perfectly compatible with an incorporative motive to possess internally the object that induced the striving.

The second meaning of introjection in Fliess' theory is closer to the structural one just mentioned, though it is largely implicit. The introjection of the patient's "mind" or "ego" has already been mentioned, and although these references can be understood merely in the incorporative sense, they permit the notion of an introject to be expanded from an impulse wishfully "taken in" to something more like a representation of the patient. If Fliess' passing reference to introjection as capable of "convert[ing] the analyst partially into the patient" (p. 214) is also taken into account, then introjection extends even beyond the setting up of a representational model. It begins to approach the kind of structural changes mentioned by Schafer. At no point, however, did Fliess specify the nature

of these changes, and, as will be seen below, his concept of introjection (in this second sense) cannot be distinguished from identification.

Only the economic aspects of Fliess' first stage of empathy remain to be considered. He indicated that there is a complete sublimation of the analyst's "instinctual response" in order to "reinforce his sole and only purpose of intellectual penetration" (p. 216). This energic transformation "will so to speak furnish the momentum for the analyst's entry into the next phase" (p. 216). A total sublimation of instinct for the "sole and only purpose of intellectual penetration" describes a cognitive activity rather at odds with the partly emotional character of empathy and the regressive, nonrational context in which it occurs. A complete intellectual distillation of the analyst's instinctual response would leave him with at most an idea about the patient's feelings, rather than a vicarious experience of them. It is also difficult to reconcile with Fliess' later intention that the analyst "lay hold of the emotional correlate of the object of his curiosity" (p. 216) in the second stage of his theory. Fliess was hardly forced into this position by introducing sublimation into the picture, for sublimation by no means precludes affective experience.

Perhaps some of the newly sublimated energy is directed toward thinking, but it is difficult to see how this would create the momentum toward identification that Fliess

mentioned. If, by momentum, Fliess had in mind a shift in the status of the analyst's mental image of the patient from ordinary object representation to introject--and, therefore, a shift in the direction of identification--the momentum would have to lie somewhere other than the intellectual faculties. One possible explanation, though unrelated to the induced striving, was suggested by Greenson, who, in a passage that seems to refer to introjection, wrote that the "temporary de-cathexis of one's self-image" (1960, p. 423) was necessary for empathy. This could well occur in conjunction with an increased narcissistic cathexis of the object representation.[6] Perhaps the momentum toward identification, then, is not a matter of an impulse sublimated into intellectual activity, but rather of narcissistically cathecting the therapist's representational model of the patient, that is, transferring narcissistic libido from the analyst's self image to that model as the economic aspect of introjection.[7] This description is, of course, very different from Fliess' own, and reflects an expansion of the role of object relations in empathy, which Fliess largely neglected and subordinated to drive theory.

Alternatively, it is possible that a momentum toward identification is created by projecting the analyst's striving onto his model of the patient. If this is the fate of the analyst's instinctual response, and not sublimation into intellectual penetration, then it becomes possible to preserve the emotional character of empathy even as this

(nondefensive) projection creates a momentum toward identification by representing the patient to some extent "the same" as the analyst. As Schachtel put it, "A relation of kinship is established by the [empathic] projection of the subject's feeling on the object" (1950, p. 99).

To continue with the subsequent stages of Fliess' theory of empathy, after the analyst has completed the first stage,

> (2) he identifies with its subject, the patient; (3) he becomes this subject himself (p. 215)....It is expedient to review this second phase, the identification with the subject of a striving directed at the analyst, in conjunction with the next. For with this third phase the identification has been accomplished: the patient's striving has been transformed into a narcissistic one in the analyst, who by now has become its subject as well as its object. (p. 216)

Oddly and unfortunately, this was all Fliess had to say about stages 2 and 3, whose "expedient...conjunction" raises the question whether stage 3 is anything more than a restatement of stage 2. In his article, this brief passage is followed by a much lengthier discussion of how identification with the patient is a "danger situation" for the analyst that "threatens his mental health" (p. 216) and leaves him vulnerable to masochism, depression, and physical illness.

In stages 2 and 3, Fliess introduced the concept of identification, which had been absent in the summary version, but he did so without describing how identification differs from introjection. His only comment relating the two provided no basis for distinguishing them: "We know that

the nuclear process in identification is introjection. The analyst's identifying with the patient...can only mean that he introjects the patient's mind" (pp. 213-214). Fliess relied upon his readers to understand the difference between introjection and identification, but neither then (Knight, 1940, p. 334) nor at the present (Meissner, 1981, p. 2) have these terms acquired generally accepted and distinct meanings.

That Fliess had *some* difference in mind seems likely. For one thing, he disagreed with Reik's (1937; pp. 194-195) position that psychological understanding of other people involved introjection, but not identification (1942, p. 213n); if the two terms were synonymous, there would have been no basis for disagreement. One way to understand the difference between introjection and identification is to regard identification as the *result* of introjective and projective processes, that is, as an end product, rather than a mechanism or process in its own right. Some of Fliess' contemporaries held this view (Fuchs, 1937; Knight, 1940), but Fliess apparently believed that identification is both an independent mechanism and the result of introjection (p. 213n).

It is possible to infer a difference between introjection that "convert[s] the analyst partially into the patient" (p. 214) and identification, in which he "becomes" the patient (p. 215), a difference based on the degree of structural change in the analyst. But the evidence for this

distinction is not very strong (the "becoming" is presumably also partial), and sounds in any case like a difference in the degree of identification, rather than a qualititative way of distinguishing identification from introjection. Except for the restricted sense of introjection as a way of "taking in" (i.e., incorporating) the patient, therefore, Fliess' theory offers no basis for distinguishing introjection from identification, and hence, no rationale for using both terms except as synonyms.

The other feature of stages 2 and 3 is the transformation Fliess mentioned of the "patient's striving" into a "narcissistic one." But this transformation rests on the magical supposition that the original striving induced in the analyst belonged to the patient, not to the analyst. Since any striving in the analyst's mind can only be his own, no narcissistic transformation is necessary or possible.

Identification does call for some kind of narcissistic transformation, however. Following Hartmann's (1950, 1955) definition of narcissism as a libidinal cathexis of the self representations, it must be the analyst's self representations, not the patient's impulses, that are transformed in identification. Depending on the scope of the identification, it would be necessary also to speak of changes in ideals and moral values, in cognition and defense, and in the role of instinctual derivatives. All of these transformations are fashioned after the model or

introject of the patient, and presumably involve a redistribution of cathexes in line with the momentum discussed above, that is, a greater investment in those qualities of the analyst that resemble the patient. For the transformation to take place at all, it presupposes both that the identification draws on some pre-existing, evocable configuration of the therapist's own self representations, drives, and defenses, and that the empathizer has no strong conflicts about making such an identification, which typically embodies a conflict, danger situation, or the like.

What is the fate of the induced striving in this identification? Neither of the two conflicting alternatives proposed by Fliess can be accepted, for the reasons already given. The striving is neither diverted entirely into intellectual penetration, nor is it acquired from the patient by introjection or identification. If, instead, it is assumed that the analyst's striving is projected onto his model of the patient, then his identification includes a relationship with that striving, not in its original form, but as it now appears in identification, that is, more from the patient's point of view. In the clinical example mentioned in the last chapter--the patient who had telephoned his sister--this sequence could be illustrated as follows: the therapist projected his aggressive reaction to the patient onto his representational model, where it was readily integrated with representations of the patient's

experience of intimate relationships as full of hostility. It was then not difficult for the therapist to comprehend the psychological meaning of the patient's aggression by identifying with the patient as thus represented in his mind. The therapist's identification involved a change in the way the aggression was represented; instead of "unprovoked hostility," it was seen as a retaliation for past suffering and a self-protective attempt not to be deluded by an object's untrustworthy displays of benevolent interest. It would be wise here to recall that this identification occurs under conditions of only partial regression, with the preservation of observing and other functions of the ego and superego alike.

In the fourth and final stage of empathy, the analyst

> projects the striving, after he has "tasted" it, back onto the patient and so finds himself in the possession of the inside knowledge of its nature, having thereby acquired the emotional basis for his interpretation. (p. 215)

This statement must be read in context. The "and so" and "thereby" apparently refer to results of the entire four-stage process, in particular stages 2 and 3; the analyst cannot come into possession of something by giving it back to the patient.[8] Indeed, Fliess seemingly invoked projection as a device for the analyst to rid himself of something, rather than to retain it. There does not appear to be any necessity for projection in Fliess' theory beyond that of terminating the trial identification: Fliess evidently felt he needed this step to rid the analyst of the

striving once and for all. Note that the striving was said to be projected onto the *patient*, as if, like tea, it were capable of being expelled from the body. Projection is better conceptualized as a way of representing an element of the psyche as "other;" in this sense, stage 4 completes the empathic cycle by restoring to the status of "other" a striving that had been represented temporarily as the analyst's own. But if the striving was the analyst's all along, a projection of it at this point (*after* identifying with the patient) neither restores it to its proper owner nor serves any other useful purpose. Just as it was necessary in stages 2 and 3 to substitute an object relations perspective for the more strictly instinctual view of Fliess--to apply a narcissistic transformation to the analyst's self representations, not to his striving--a similar substitution is now called for. In terminating his trial identification, the analyst's self representations revert to something resembling their previous state, and the representational model or introject becomes more differentiated from these. Whether this psychic reorganization can be termed projection, however, is open to question, and ultimately depends on how flexible a definition of projection is adopted. It may be more appropriate in the earliest months of development, when representations of self and other are inherently unstable because of the constant interaction of projective and introjective mechanisms. Just as Fliess tended to use the

term introjection in an incorporative way, his theory seems to allow at most for a dynamic meaning of projection, for example, an orally derived wish to expel something "bad" that accompanies the redifferentiation of the analyst's representational world at the close of a trial identification.

In concluding his remarks on projection, Fliess opened the way for an exploration of why he constructed his theory in the often contradictory way that he did: "The fourth phase, that of reprojecting the striving in question after it had been the analyst's for a brief moment, presupposes its having been kept free from admixtures" (p. 218). There follows in his text an analogy to "bacteriology, where we may transfer a bacterium from an animal onto a medium and back again, and where we have to be sure that it has remained uncontaminated by anything that the medium might carry" (pp. 218-219). Fliess then warned about the dangers of similarly contaminating the image of the patient with "instinctual additions of our own" (p. 219). His concern about "admixtures" was developed in a footnote critical of Low's efforts to compare the analyst to the artist, who "obtains his material, moulds and illuminates it by fusion with his own unconscious, and presents it again, thus re-shaped" (Low, 1935, p. 8). Low's description would probably go unchallenged today, but to Fliess it represented a serious contamination of the supposedly pure introject by elements of the analyst's personality, in other words, by

projection. In his view, the introject affected the analyst temporarily (by identification), but not vice versa. According to Fliess,

> The sober metaphor of the tea taster was chosen not because we deny the existence at certain points of an analogy between the artistic and therapeutic "creation," but because the point in question seems to us precisely one wherein they differ. (p. 219n)

This strong stand goes beyond a simple and legitimate concern that countertransference can distort the analyst's understanding; it is, instead, a blanket rejection of any use of the analyst's own personality to represent the patient. Low had, after all, not been advocating the unregulated use of countertransference.

At bottom, Fliess' theory suffers from distortions introduced because of a phobic view of the regressive aspects of empathy. Recall that besides the concern with contamination just mentioned, Fliess had earlier described identification only briefly, then immediately launched a discussion of the threat that the analyst's work poses to his mental and physical health. With this nearly hypochondriacal tone, it is impossible not to wonder about some anxiety associated with the relaxation of boundaries and exposure to instinctual processes required by empathy. It is apparently not only the patient who needs to be protected from contamination, but the analyst as well: this is the latent meaning of Fliess' theory. It may explain why he was so enamoured of the tea taster metaphor, with its

genteel overtones and its rapid in-and-out process.

If this suspicion of a phobic attitude is justified, it makes many of Fliess' other comments take on a new light. He had begun his essay, for example, by drawing a distinction between the patient, who progresses toward health during treatment, and a view of the analyst as curiously untouched by the analytic process, remaining "from beginning to end what he always is while at work: essentially a 'categorical person'" (p. 211). In a later passage, he rejected as inadequate Ferenczi's (1919) concept of an oscillation between unconscious fantasy and more rational, realistic activity, maintaining that the "uninterrupted use" (p. 221) of both was necessary. His explanation of how the analyst achieves this psychological feat began with the following description of the analyst as superhuman, or very nearly so: "The answer is that the analyst must make possible what rightly seems impossible, because it is actually impossible for the average person, and must do so by becoming a very exceptional person during his work with the patient" (p. 221). Thus, while the instinctual life of the patient brought to Fliess' mind the image of bacteria present in animals, his view of the analyst came close to an idealization.

Consistent with this exceptional ability of the analyst was Fliess' contention that any instinctual response be used only for the purpose of intellectual penetration. The exact wording was "sole and only" purpose, a tautology that

perhaps conveys just how essential it was to Fliess that matters be kept intellectual. Similarly, the word *penetration,* which occurs three times in his essay, and always with the analyst as the active party, presents only one side of a process whose more important aspect is a willingness *to be penetrated* by the latent meaning of the patient's associations.[9]

Despite the phobic and defensive character of Fliess' theory, there were unwitting hints here and there of how empathy must, after all, "contaminate" the patient with the analyst's own psyche. The concern with admixtures cited above seems to have vanished entirely in a later section of the same article, when Fliess shifted his attention to the "topographical redifferentiation" associated with "conditioned daydreaming" (p. 220), his term for evenly hovering attention. There he wrote:

> By availing ourselves of our preconscious psychic content and of the help of primary process in elaborating, by means of conditioned daydreaming, upon our analytic perceptions, i.e., the patient's material, we supplement most efficiently our rational elaboration upon this material, both in the transference and elsewhere. (p. 220)

In this artificial distinction, a "striving" should have no "admixture," but "elaborating...the patient's material" with "the help of primary process" was regarded as standard technique, much as Low had described it. Nor can the avoidance of admixture (i.e., projection) be squared with Fliess' preliminary comment (before presenting the theory)

that "the material out of which I erect the other person in me cannot but be my own" (p. 213n).

It seems fair to conclude that the theory of empathy proposed by Fliess cannot be accepted without modifications so extensive as to change it beyond recognition. Almost every point he made would be affected. His conception of introjection lacked any meaning because it was confused, dynamically, with incorporation, and structurally, with identification; he employed the concept of projection not in the sense that would seem to be required--as a way of using one's own personality to understand the other better--but only as a vehicle for concluding a temporary identification; he almost entirely neglected the role of object relations; he tried to confine within the limits of sublimation and secondary process what must be a more instinctual and emotional process; and, finally, he seems to have taken many of these positions in reaction to a phobic view of the de-differentiation and openness to the unconscious that empathy requires.

A Comparison of Fliess and Reik

There are many points of similarity between Fliess' theory of empathy and a 1937 book by Reik, to which Fliess referred in a footnote on the subject of identification, but of which he otherwise made no mention. Reik, too, presented a theory loosely organized into stages, but he insisted it was only

"near to" empathy (1937, p. 196), and he preferred to think of it as a theory of "psychological conjecture," unique to the in-depth methods of psychoanalysis. Like Fliess, however, he wrote of a process whose essential elements were introjection and projection.

Reik's first stage was called the stage of observation. It included some conscious observation of the patient, but chiefly involved the unconscious perception of latent impulses in the patient, which stimulated similar impulses in the analyst by a process of "induction" (p. 193). This stage corresponds closely to the first stage of Fliess' theory, wherein a striving on the part of the patient "induced" (Fliess, 1942, p. 215) an instinctual response in the analyst. Reik's account of the accompanying sublimatory process is similar to that of Fliess, but with a less strictly intellectual emphasis. Reik indicated that the impulse stimulated in the analyst was transformed into "psychological interest" or "psychological cognition," with a "substitution of one form of psychical energy [i.e., instinctual] by another," adding that this energic transformation of the impulse occurred "very early, immediately after its emergence" (p. 243).

Along with the induction and sublimation of an impulse in stage 1, Reik wrote that a "temporary introjection" also began to take place, by which "the ego is transformed" (p. 199). As Fliess was later to do, Reik left ambiguous the relationship of the induced impulse to the introject. At

different points, both induction and introjection were made responsible for what appear to be the same set of psychic transformations leading to "a reproduction of what goes on in the other person's mind" (p. 198). Thus, at one point he suggested that

> through the process of induction by the unconscious impulses, the psychical possibilities in the observer's ego are realized for a moment. In other words, by means of the repressed content in the manifestations of the other person, a latent possibility in the observer's ego becomes actual for an instant. (p. 198)

Only a page later, however, Reik attributed these changes in the ego not to induction, but to a seemingly independent and essentially incorporative kind of introjection: "The special form in which the ego is transformed by taking another person into itself for a moment can only be called an introjection" (p. 199).

Though Reik, like Fliess, used introjection to mean the taking in of an external object, his many references to the resulting transformations of the ego gave it a somewhat greater structural emphasis than it had in Fliess' theory.

The second stage of Reik's theory is the stage of unconscious assimilation: "the stage of observation passes into another, governed by the unconscious assimilation of the psychical data we have taken in" (p. 204). Reik's account of assimilation relied on a series of analogies to convey the nature of the process. All of these suggest a responsiveness on the part of the analyst both to the patient and to the analyst's own unconscious, so that under

the influence of the internalized patient a corresponding psychological state is created or, rather, recreated. In one of these analogies, he compared the analyst to an actor who, rather than simply imagining and attempting to imitate the way his character might have felt or behaved, draws on his own experience to create the role. "The greatest and most convincing actors," he wrote, "...are not resonance chambers for alien experience; but the resonance comes from the unconscious memory and revival of their own experience" (p. 195). A later comment makes the same point: "We have, I believe, seen that it is not the other person's impulse as such, but its *unconscious echo in the ego,* that is the determining factor in psychological conjecture" (p. 242; emphasis in original).

In one sense, the term assimilation somewhat inexactly describes a process whose most important feature is not so much absorption of the patient into the analyst's psyche as a synthesis of the analyst's own personality, for which the induced impulse acts as catalyst. And yet, assimilation better conveys the intrapsychic character of empathy than the corresponding digestive treatment accorded the patient in Fliess' theory. For Fliess, the patient was more of a foreign object, "*passing through* what might be called the psychic 'working metabolism' of the analyst" (1942, p. 215, emphasis added).

During the stage of assimilation, the "most important part" of introjection takes place (p. 204). As mentioned

above, Reik maintained that this was not a matter of identification, while Fliess (p. 213n) demonstrated, on the basis of Reik's own language, that identification was the proper term for it after all.[10] In any case, the two theories used remarkably similar language: Fliess wrote that in stage 3 the analyst "*becomes this subject* [i.e., the patient] himself" (p. 215, emphasis added), and Reik that "in order to comprehend the unconscious of another person, we must, at least for a moment, change ourselves into and *become that person*" (p. 198, emphasis added). Thus, the two theories coincided as to the psychological operation required, though differing in how to label it.

Following the introjection or identification in Reik's second stage, a projection occurs, which brings the operation for the first time to consciousness. At times, Reik's references to the projective aspect of psychological conjecture sound much like those of Fliess, for example, when he spoke of "the detachment of the object taken into the ego, and the projection of that part of the ego" (p. 204). This is no more than a projection used to reverse an introjection. But Reik also mentioned projection in other ways, consistent with the use of the therapist's own personality to represent the patient. In referring to the "latent possibilities in the observer's ego" brought about by induction--these "possibilities" being, presumably, self representations--he wrote that "this image of the ego, turned to psychical reality, is projected into the external

world and perceived as an object" (p. 198). More explicitly, he considered that "projection enables us to become conscious of *our own impulses*, displaced onto the other person" (p. 244, emphasis added).

Reik was on very safe ground in mentioning these examples of the analyst projecting self representations or impulses of his own in order to comprehend the patient better, because he had earlier specified that images or impulses induced in the analyst were "of a like tendency," "of a similar kind" (p. 193), "kindred," or even "the same" (p. 194) as the patient's. In effect, he had defined all possible error out of his theory by constructing it in such a way that nothing could be projected by the analyst that was not characteristic of the patient in the first place. With regard to introjection, Reik even maintained that "there are no psychological errors on that plane of the unconscious" (p. 199) where introjection takes place. Obviously, this is much too narrow and ideal a view of things. In practice, a therapist can hardly assume the infallibility of his unconscious. Even if induction reproduces unerringly some aspect of the patient's psychological state, and even if possible defensive distortions are ignored, other responses may also be induced,[11] such as complementary or idiosyncratic responses of the therapist. It is necessary, therefore, to make empathic projections in a tentative way.

The crucial point, however, and the one that distinguishes

Reik from Fliess, is that Reik was prepared to acknowledge how the psychological comprehension of another--empathy, one would call it now--includes as an essential element the representation of the other by means of one's own personality, a projective process that Fliess ruled out as an admixture or contamination.

Reik's description of projection was also significant for its topographical quality: projection was the means by which a hitherto unconscious process of observation and assimilation was brought to awareness as a conscious, vicarious experience. Indeed, it is open to question whether Reik believed the process could become conscious in any other fashion. There is no doubt that empathy often operates in just this way, that a therapist becomes aware of and can empathize with a state of affairs in the patient because it corresponds to a psychological state of his own of which he was unconscious until that moment. But Reik's theory did not include two other possible outcomes, one in which the therapist attributes a feeling to the patient only *after* becoming aware of it in himself, and the other--more fraught with the risks of countertransference--in which the projection occurs without bringing any aspect of it into awareness. This last could still qualify as empathy so long as the reasons for its absence from consciousness were not mainly defensive.

Reik's third and final stage, that of conscious assimilation, has no equivalent in Fliess' theory, which

left the topographical situation unspecified throughout. But Fliess' interest in intellectual penetration and his concern that the analyst not be lured "into overstepping his role of observer" (1942, p. 217) suggest an orientation more toward conscious operations than was Reik's. The difference in emphasis between the two theories could not be drawn more sharply than in the following statement by Reik:

> the rigid assertion that a psychologist maintains an attitude of aloofness towards the mental processes of his subject, and merely observes them, can be upheld at most only for the conscious part of his mind. The assertion of the *impassibilite* of the analyst is a fairy-tale, and not even a pretty fairy-tale." (p. 242)

By now, the problematic issues in these early theories of empathy have doubtless become clear. Though Fliess' work is more often cited in relation to empathy, it is Reik's theory that more closely approximates the nature of empathy as it has since come to be understood. An updated psychoanalytic theory of empathy will need to expand the object relations perspective, develop structural alternatives to the incorporative usage of introjection, clarify the role of projection, and elaborate the nature of the identification involved in empathy.

Notes

1. It is true that Freud mentioned the introjection of aggressive impulses (1930, p. 123), but it was clearly the subject's own impulses that were "introjected," that is, turned against himself.

2. Fliess' use of introjection to mean "taking in" comes very close to the Kleinian meaning of introjection. In some comments that he said were "based on Fliess's remarks," Grinberg wrote, "the analyst selectively introjects the different aspects of the patient's verbal and nonverbal material, together with their corresponding emotional charges" (1962, p. 436). If "emotional charges" approximates what Fliess called "strivings," Grinberg likewise attributed to impulses a capacity to travel between persons. Grinberg's article contained several examples of how, in the Kleinian view, the symptoms, anxiety, and even drowsiness of one person are "placed" or "pushed" into another person. See criticisms of Klein by Jacobson (1964, p. 46) and Novick and Kelly (1970, pp. 73-74).

3. Schafer's distinction is not universally accepted. For example, Meissner insisted that incorporation be regarded as a "mechanism" (1981, p. 17), that is, as a structural term. Yet he frequently employed the phrase "incorporative *fantasies*" (emphasis added), while using more consistently structural terms for other kinds of internalizations, such as "introjective configurations" or "introjective organizations" (p. 37). At the least, incorporation would have to be used both dynamically and structurally. The conceptual difficulty involved in treating a fantasy operation structurally is apparent in his comment that "we shall interpret incorporation as referring to a specific psychic process that is conceived as somehow analogous to the physical process of ingestion" (p. 15). Just how analogous can be seen in a later description of incorporation, in which "the external object is completely taken into the inner world of the subject" (p. 18). This, obviously, can only be an oral fantasy, not a structural process. Meissner intended incorporation to be used structurally to refer to

> the most primitive, the least differentiated form of secondary internalization, in which the object loses its distinction as object and becomes totally taken into the inner world....As a result, boundaries between the inner and outer world are decathected and dedifferentiated. (p. 18)

He had, however, already described secondary internalization as requiring "the establishment of self-object differentiation and the capacity to distinguish and recognize what is internal from what is external" (p. 11). He was, therefore, obliged to describe incorporation as requiring some differentiation, but at the same time expressing a regressive wish to do away with it and re-establish primary identification or internalization. So far, the terminology is consistent; incorporation refers to a regressively re-established primary identification. But Meissner himself did not follow this usage consistently. In a later passage, he mentioned incorporation in relation to phenomena that, while archaic, involved no regression from a higher level of differentiation:

> Through incorporation the object representation becomes wholly and indistinguishably merged into the organization of the self. This rather global and undifferentiated taking in...may also play a role in the course of early infant development, *before any realized differentiation between self and object.* (p. 51, emphasis added)

And, before long, he seemed to be designating incorporation as occurring *only* before self and object are differentiated: "Incorporation must thus be regarded as the most primitive and rudimentary form of internalization and is to be distinguished from more autonomous identificatory processes" (p. 52). Of course, Meissner's lack of clarity and consistency is not by itself reason to reject his proposed definition. What may actually be more significant is that, in his usage, incorporation continues to refer also to fantasies of taking in, moreover, to such fantasies at all levels of corresponding structural organization, for example, in identifications that are not regressions to symbiotic phenomena.

By 1976, Schafer himself had changed his mind about introjection and incorporation, and wrote that "introjection can only be a synonym of incorporation, which is to say that it must refer to the fantasy of taking something into one's body" (p. 160). From the context in which he drew this conclusion, it appears that Schafer was motivated by concern with the way psychoanalytic concepts involving internalization, if taken literally, represent psychological processes that have to do with regulatory structures, functions, and relationships as if they occurred in some kind of psychological or other "space," a space that has no theoretical standing except in fantasy. There is no reason to be so literal, however, and, unless the idea

of intrapsychic structure is rejected altogether, it remains possible to distinguish incorporation as a dynamic term from introjection as a structural one. In fact, such a distinction helps ensure that structure is not confused with dynamic motives to take in or expel, which do require some notion of psychological space.

4. In fact, Fliess even characterized his summary version as "merely dynamic" (p. 214).

5. Fliess was not alone in this view: "'ocular introjection'...takes its place with oral, anal, epidermal, and respiratory introjection" (Fenichel, 1935, p. 378); "in olfactory perception the introjection of minute particles of the objects is actually *real*" (p. 381; emphasis in original).

6. See also Freud's statement, in another context, about the hypercathexis of a loved object "at the ego's expense" (1921, p. 114). Kohut may have had a similar economic picture in mind in the following passage:

> Foremost among the obstacles which interfere with the use of empathy (especially for prolonged periods) are those which stem from conflicts about relating to another person in a narcissistic mode. Since training in empathy is an important aspect of psychoanalytic education, the loosening of narcissistic positions constitutes a specific task of the training analysis, and the candidate's increasing ability to employ the transformed narcissistic cathexes in empathic observation is a sign that this goal is being reached. (1966, p. 263)

7. This is a better way of describing the economics of introjection than, for example, the way Meissner did:

> Introjection effects a modification of the self by the institution of an internal object; it takes in a libidinally cathected object and redirects the flow of libido toward the self. (1981, p. 67) In introjection, for instance, object libido is redirected to the self so that self modification is directly effected. (p. 64)

Meissner, then, conceived of introjection as involving an absorption of object libido by the "self," rather than the cathexis of an object representation with narcissistic libido. Leaving aside the problems associated with the term *self*, Meissner's description of the economics of introjection depends on the ability of

an object representation to be "taken into" the self, along with its object libido: if only the libido is taken in, then the object representation has lost, rather than gained status in the psyche, and this could hardly be what is meant by introjection. But, as already indicated, "taking in" is better understood as a dynamic or motivational term, and not, by itself, a change in psychic structure. The problem of metapsychological space (see note 2) plagues Meissner's description, but disappears if the object representation is, so to speak, left where it is, but narcissistically cathected. See also chapter 6.

8. See also Fliess' other reference to "inside knowledge," which is explicitly the result of trial identification (pp. 212-213).

9. This language invites some speculations about the differences in empathizing between women, on the one hand, and men, who not only lack an incorporative libidinal zone organized at the genital level, but who are also apt to have more conflicts about oral incorporation (e.g., more counterdependency, more rigid differentiation from maternal object representations) and anal penetration. This last is probably not an important somatic contributor to later psychological attitudes of receptiveness in either sex, but in males the stimulation of unresolved elements of the negative oedipus complex seems to elicit defensive measures against passive incorporation in any form. For Fliess, it appears that an orally-derived wish to "take in" the patient was tolerable so long as the patient could immediately be expectorated and fears associated with being contaminated or damaged by the patient could be turned into phallic urges to penetrate.

10. Herold had earlier come to the same conclusion (1939, p. 238).

11. Reik began to consider this objection to his thesis that *only* like impulses are stimulated in the analyst and even indicated that "the original impulse speedily made way for another, or several others," but then abruptly dropped the subject (p. 241).

Chapter 5

Projection and Empathy

> Without any special reflection we attribute to everyone else our own constitution and therefore our consciousness as well, and...this identification is a *sine qua non* of our understanding. (Freud, 1915b, p. 169)

The Validity of Projection as an Empathic Mechanism

In their respective theories, both Fliess (1942) and Reik (1937) considered projection an essential part of empathizing--or, in Reik's case, "psychological conjecture" about other people--but they had rather different definitions in mind. Fliess saw projection as merely a mechanism for terminating a trial identification (a kind of "putting out" of what had been "taken in" from the patient), while Reik regarded it as the use of the therapist's own personality to represent the patient. Other analysts have doubted that projection is involved in empathy at all, objected that it renders empathy altogether unreliable, or, most commonly, ignored the term projection altogether in discussions of empathy.[1] This chapter will begin with a more extended review of the issue, present a definition and a clinical illustration, and close with a discussion of the limitations of projection as an empathic tool.

In a brief but important paper published at about the same time as the theories of Fliess and Reik, Knight drew a

distinction between "identifying one's self with an object and identifying the object with one's self" (1940, p. 336). The former refers to a process he compared to empathy, in which "I identify myself with the object mainly by projection of my feelings onto him, so that I imagine him to be experiencing emotions that I am experiencing. It may be that I also then introject this object" (p. 336).[2] This view places Knight somewhat closer to Reik than to Fliess. For Fliess, the projection by the analyst of his own feelings would cause a contamination of his analytic observation, while such projection was, for Reik, an important mechanism, and, for Knight, the *major* mechanism in empathy. Both Fliess and Reik put projection after introjection in their theories, however, while Knight believed that "introjection...seems always to involve *previous projections* onto the object of the subject's own unconscious tendencies" (p. 334, emphasis added), thus locating projection earlier in the empathic process.

It may not matter which occurs first, introjection or projection, nor is it likely that a single paradigm could cover all instances of empathy. The important thing is that the role of projection in empathy need not be limited to a mechanism for terminating a trial identification. As indicated in the last chapter, the impulse aroused in the analyst during stage 1 of Fliess' theory is better viewed not as synonymous with introjection, nor as entirely sublimated into intellectual activity, but as the basis for

a projection onto the analyst's object representation of the patient in order to improve his understanding. Epistemologically speaking, projection is the means by which the therapist arrives at an empathic inference.

Other analysts have presented views broadly similar to those of Reik and Knight, emphasizing that the psychological grasp of another's mental life depends in part on projection. According to Schachtel, "projection plays a role in every act of *empathic understanding* since the subject cannot have an inner understanding of another person's feeling except in terms of his own experience of that or a similar feeling" (1950, p. 98; emphasis in original). Along the same lines, Schafer wrote that the shared affective experience characteristic of empathy stems from the tentative projection by the analyst of feelings he experienced under circumstances similar to the patient's (1959, p. 347; cf. Kovacs, 1912, p. 253; Schroeder, 1925, pp. 162, 163; Winterstein, 1931; Schafer, 1954, p. 280; Klein, 1955, p. 143; Noy, 1984, p. 177ff.).[3] As noted above, however, these views do not represent a consensus about the role of projection in empathy.

The earliest dissent was offered by Fenichel. In a brief discussion of its projective aspects, he complained that empathy "does not guarantee the objective correctness of its results. Obviously, the tendency to perceive all reality as being like the self subserves the pleasure principle" (cf. Schilder, 1923, p. 215). He considered empathy "a

regression to the period of pure pleasure principle, to psychotic thinking; but such thinking cannot attain a knowledge of reality" (1923, p. 11). He apparently considered the projective aspects of empathy to be entirely indiscriminate, never subject to reality testing, and never informative about the object except by chance. Although empathic projection admittedly lacks the guarantee Fenichel mentioned, this criticism is useful only if alternative approaches to the mental life of others do offer such a guarantee.[4] Fenichel's view of empathic projection ultimately rests on a presupposition that primary process cannot operate in conjunction with and under the regulation of secondary process. It reflects a strongly biased and polarized view of mental operations, in which the pathological potential of unconscious or irrational activity is emphasized, but the limitations of secondary process go unremarked. If, as Fenichel believed, "the tendency to perceive all reality as being like the self subserves the pleasure principle," it is also true that the tendency to perceive all reality in factual, rational terms leads to a very constricted understanding of human experience. Ornstein has made a similar observation:

> We have appropriately recognized that the use of the empathic approach to the study of external reality will inevitably lead us (as it often has) to animistically and anthropomorphically distorted perceptions. But we have not recognized equally clearly that the use of the extrospective-inferential approach to the study of psychological reality would inevitably lead us (as it often has) to a mechanistic and physico-biologistic view,

> expressed in experience-distant metapsychologic theories. (1979, pp. 99-100)

As a heuristic paradigm, then, empathic projection, like any alternative, may or may not be vulnerable to distortion, depending on the balance of factors that dictate the relationship of primary process to secondary process at the moment.[5]

In more recent years, others have explicitly ruled out projection as an aspect of empathy, on the grounds that projection is a "defense mechanism" (Katz, 1963, p. 42) or is "defensive and unconscious" (Basch, 1983, p. 113). This view rests on a semantic preference for a narrow definition of projection (much narrower, for example, than Freud's), and raises the question of what psychoanalytic term to use for empathic inferences that derive from the therapist's own personality. Basch preferred the term *generalization* (cf. Shantz, 1975, p. 19), which had been suggested in 1970 by Novick and Kelly as a way to describe primitive attributions or assumptions people make about the world based on their own nature, that are conscious and free of defensive properties. This kind of attribution is sometimes referred to as animistic thinking or egocentric thinking. Projection, they proposed, should refer only to the unconscious, defensive allocation of a drive to the external world.

Novick and Kelly, it should be stressed, did not themselves apply the concept of generalization to empathy. But there are grounds for evaluating this possible

application, given that the kind of projection useful in empathy is not always unconscious, nor used primarily for defense.

But to replace empathic projection with empathic generalization would require that this aspect of empathy always attain conscious awareness, which is not regularly the case. Rather, empathic projection occurs at all levels of awareness, and often alternates, for example, between the preconscious and the conscious mind. In fact, projection has little intrinsic relation to any given topographic level. When projection occurs unconsciously, this is a result of repression, not projection per se. The familiar instance of the patient who says, "I know this must be my projection, but I can't help feeling you dislike me," the fact that projection is typically invoked as a defense mechanism when repression begins to falter, and Reik's idea that in understanding other people, "projection enables us to become conscious of our own impulses, displaced onto the other person" (1937, p. 244), all point to the conclusion that projection is not used so much to keep something out of awareness as it is to represent it as external. When projection is unconscious, the associated repression may have a specific defensive aim, or it may merely reflect an adaptive selection among the hierarchy of material competing for consciousness. This is often what happens in empathizing, which the concept of generalization would unduly restrict to attributions the therapist consciously

made. As Reik stressed, empathy as a conscious endeavor is not a satisfactory approach to psychoanalytic understanding (1937, pp. 191-193).

To regard projection exclusively as a defense mechanism, as Novick and Kelly also suggested, is to part company with a long tradition in psychoanalysis that began with Freud, who took a broader view: "projection was not created for the purpose of defence; it also occurs where there is no conflict" (1913, p. 64). Since then, A. Freud (1936, p. 123), Glover (1943, p. 9), Fenichel (1945, pp. 109-110), Schachtel (1950, p. 75), and Harris (1960, p. 127) have all mentioned nonpathological uses of projection, Shapiro has indicated that projection in empathy does not presuppose a disavowal of that which was projected (1974, p. 12), and Noy even maintained that an excessively restricted use of projection in empathy should be considered pathological (1984, p. 188). Moreover, there is a growing trend in psychoanalysis to recognize the versatility of "defense mechanisms" of all kinds in normal, adaptive living. For example, one implication of Kris' (1935) concept of regression in the service of the ego is that processes previously thought of as essentially defensive or pathological can be re-examined usefully for their adaptive aspects. The same can be said of countertransference (see chapter 2). Given this tradition, the advantages of introducing a new term appear limited.

A Definition of Empathic Projection

With these objections to the role of projection in empathy now answered, it is possible to describe that role in more detail. To be clear about the term under discussion, the following definition is suggested: *empathic projection is an intrapsychic process occurring during a state of adaptive regression in which a conscious or unconscious idea, affect, motive, fantasy, or self representation of the therapist is represented as the patient's.*[6] The rationale for this approach rests on the assumption that the projected material was first induced in the therapist by the drift of the patient's associations or by some nonverbal behavior of the patient and is, therefore, of relevance to the patient's state of mind. Naturally, this assumption is not always correct. Thus, the therapist's projection is represented in his mental model of the patient in a temporary and tentative way, with little or no denial of alternative information about the patient. The words "temporary and tentative" refer to projections that are largely neutralized and only provisionally integrated into the model. In addition, this process occurs with the anticathexis employed in repression low enough so that the origin of the projected material and the projective process itself are, either immediately or upon reflection, recognizable to the therapist.

This definition does not require that the defensive aspects of projection be entirely absent, though they are

largely suspended, mainly because of the reduced role of the superego in initiating defense. This, in turn, results from the therapist's interest in sublimating any impulses aroused and from his moral purpose in conducting his work for the benefit of the patient. Obviously, there are relatively greater defensive contributions when the projected material remains unconscious, when it involves unresolved conflicts of the therapist, when it does not "fit" the patient, or when alternative possibilities are ignored.

In cases where the therapist is not conscious of the projection until afterwards (Reik, [1937, p. 244] believed projection always operated this way in "psychological conjecture"), the process is defensive inasmuch as displacement interferes with the most direct route to awareness. Clearly, *some* anticathexis is still applied to the particular impulse or idea, so that it is often not, at least at first, recognized as one's own. But this defensive function, which makes the process risky, is also a major element in the phenomenological essence of empathy, namely that one feels one is having an experience that belongs to some one else. To an extent, the broadly defensive properties of sublimation (Hartmann, 1955, p. 234) are always at work in empathic projection; when the therapist is aware of the projection and the derivations in his own personality, sublimation is the only defensive function remaining.

The relatively nondefensive use of projection--that is, in

relation to psychic contents that are not in any important sense "unwanted"--is familiar from everyday experiences. Imagine the child who says of the willow tree, "See how tired it feels--it's all bent over," or the adult who characterizes the weather as "gloomy." These usages draw upon projection to animate our experience of the world around us. In a similar way, the therapist's use of projection is, ideally, a creative, enriching one.[7]

Working to the therapist's advantage in this respect is the fact that many developmental experiences and personality dynamics are universal and, thus, part of the common heritage of all mankind (Deutsch, 1926, p. 137; Schachtel, 1950, p. 99; Levine, 1952, p. 209; Reich, 1960, p. 391; Katz, 1963, pp. 45, 148; Kohut, 1966, p. 262; Sawyier, 1975, pp. 43-44; Arlow, 1979, p. 68). Assuming the therapist has more or less freely available to him enough of these experiential universals, they play an essential and generally reliable role, especially under conditions of partial, adaptive regression. Envy, abandonment, anger, anxiety, guilt, the sense of being helpless or a victim, the yearning for love and approval, and countless other experiences common to all people form a phenomenological pool in which the therapist often can glimpse the patient's reflection.

What he has not experienced directly, the therapist may locate in his introjects and object representations (Buie, 1981, p. 289; Gedo, 1981, p. 161), which are also a source

of material for projection, or, more strictly, for displacement (Jacobson, 1964, p. 47). For example, if the therapist can find little in his own life that is psychopathic or manic, he has known others with these traits, on whom he can draw in order to represent the patient before him. Expanding on the concept of *complementarity* (Deutsch, 1926, p. 137; Racker, 1957, p. 311) concept, it would also be possible to speak of complementary projections, or projections onto the therapist's representations of the patient's objects.

Attributing to the patient such mental operations as repression, splitting, and so forth may also qualify as a kind of projection, or occur as secondary process activities in conjunction with projection. It tends to be the emotional elements, however, that are most important in projection, and *everything that involves the therapist's vicarious affective experience of the patient is necessarily projective because, economically speaking, the source of the energy required to feel anything can only be in one's own psyche and, therefore, supplied to the model by way of projection* (cf. Noy, 1984, p. 178). Naturally, this is not to say that all emotional reactions the therapist feels are vicarious or that all are projected onto the patient. Projection is not needed to account for why a therapist finds obnoxious a patient who is often late for sessions, does not pay his bills on time, and spends his hour complaining about the therapist's inadequacies (cf.

Winnicott, 1949). Reik's concept of induction (1937, p. 193) would be sufficient to account for the therapist's irritation. But if the therapist experienced his reactions of narcissistic injury and annoyance *vicariously*, this would ordinarily rule out representations of the patient as "provocative," "acting out," "resistive," or "unfair" in favor of others, empathic projections, that represented him as, like the therapist, having good reasons to be offended and annoyed. This shift ordinarily involves a partial sublimation of the therapist's instinctual response, and includes a change in his self representation as well, from being the aggrieved victim of another's aggression to becoming the (transferentially) guilty party. In turn, this opening into the patient's emotional life tends to provide immediate hints about the patient's motivation, for example, that he seeks to withhold from a therapist experienced as ungiving or coercive, or that his devaluation of the therapist proceeds from a position of envy or a perception of the therapist as condescending. The genetic determinants of the patient's present state of mind may also become evident in sorting out its meaning in the transference.

Aside from determining the therapist's vicarious affective experience, the economic factor plays a key role in estimating the intensity of the patient's emotion. Consciously and preconsciously, the therapist makes comparative, quantitative adjustments in a tentative way until he can judge that what he attributes to the patient is

now "close enough." In any given instance, it is not sufficient for the therapist to project anger, grandiosity, or a suicidal wish; the projection needs to approximate *how* angry, *how* grandiose, or *how* suicidal. As applied to interpretation, this aspect of projection has much to do with timing and tact.

Clinical Illustration

The interplay of these economic aspects in the projective dimension of empathy is demonstrated in the following clinical example.

> A young man was ordered by a local court to undergo up to ninety days of psychiatric observation as an inpatient after being found mentally incompetent to stand trial on an assault charge. He had struck his mother in the course of what appeared to be a drug-induced psychosis, although a schizophreniform disorder had not been ruled out. Once in the hospital, the young man was quite cooperative and mild-mannered, but eager to be discharged. Near the end of the ninety days, his discharge was delayed for several weeks because the head of the hospital's Forensic Committee misplaced some essential documents. After his therapist informed him of the delay, the patient appeared calm and acquiescent. Though intelligent, however, he seemed to have some difficulties grasping

the implications of what had happened. Several times he asked (and was told) what the new discharge date would be, as if it took all his concentration to hold this information in his mind.

The therapist, meanwhile, had been outraged upon learning of the Forensic Committee's inefficiency, and from the time he sat down with the patient felt frustrated, bitter, and demoralized. At first, he assumed these feelings reflected the patient's own state of mind, but then was obliged to doubt this inference as he observed the patient's continuing placid demeanor, and as he realized that his own preconscious was seething with memories of how he himself had been subject to similar bureaucratic cruelties at the hands of the same hospital. A few weeks earlier, he had nearly been laid off in a temporary budget crisis and, at about the same time, the head of the Forensic Committee had, more out of his own obsessive needs than any legal or clinical consideration, required that he prepare additional reports and obtain various signatures attesting to the patient's present lack of dangerousness. Complying with the latter request had taken a week's time, stirring the therapist's resentment and guilt over being a cause of the patient's continued, probably needless, confinement. The therapist's revised assessment of his feelings was that they represented a

much stronger version of anything the patient was consciously experiencing at the time. That they were still relevant to the patient, however, seemed likely in view of the following: (a) the patient's strained preoccupation with the date of discharge could be understood in terms of his efforts to organize intellectual defenses against aggressive feelings; (b) the patient had a sound, realistic motive for avoiding displays of aggression, given the reason he was hospitalized and the overly cautious, unreliable behavior of the Forensic Committee; (c) the therapist's motives for anger closely approximated the patient's own experience: besides the close psychological connections between being discharged and being "let go," the pair had in common a history of "victimization" by the Forensic Committee; and (d) the therapist realized that his own anger at the hospital rarely surfaced during his sessions, except at those times when his patients complained about the realistic shortcomings of the institution.

It may be argued that no particular empathy is required to suspect that this patient in these circumstances might be angry and upset about the delay in his discharge. Common sense, or a knowledge of the frustration-aggression hypothesis, would suggest as much. But either of these might well have led to different conclusions about the patient once the expected anger failed to emerge, for

example, that the patient was actually not so eager to leave the hospital, or that his capacity for robust affective response was blunted in the manner often characteristic of schizophrenia. Of course, common sense might also suggest that this patient would want to inhibit any resentment he did feel, but the therapist's projection of his own feelings provided a broader basis for associations leading to understanding than could have been attained from a more strictly rational, observational approach. In this case, the associations alerted the therapist to the patient's efforts to swallow his anger and shift his attention to the new discharge date. In a more general sense, the advantages of "true" insight over intellectual insight apply as much to the therapist as to the patient.

Though it is difficult to factor out projection from other elements that played a role, his grasp of the patient's defensive approach may also have been based to some extent on projection, inasmuch as his frustrations with the hospital had been handled in a similar, if less inhibited, fashion.

The Limits of Empathic Projection

This vignette is also useful for the issues it raises about the limits of projection in empathy. The actual experiences of the patient and therapist in the hospital overlapped to an unusual extent, one that makes for

considerable confidence in the accuracy of the therapist's projections. Still, the plausibility of this projection by itself provides insufficient evidence of its validity, which would have to be established by subsequent confirming material.[8] But what about cases in which the experiences of therapist and patient widely diverge? That empathy is less reliable in such circumstances has often been pointed out (Fenichel, 1923, p. 11; Kohut, 1959, p. 467; Shantz, 1975, p. 19; Treurniet, 1980, pp. 325-326; Gedo, 1981, pp. 174, 177; Agosta, 1984, p. 56; Muslin, 1984, p. 314; see also Freud, 1915b, p. 169), and this is surely due to the scarcity of material available for projection by the therapist: if projection were not a major dynamic in empathy, there would be no reason why empathy is less reliable in relation to those who are "different."

At issue are not so much the superficial similarities, such as those of the patient and therapist in the illustration above--these are useful, but not usually crucial. It is in the latent and basic aspects of an experience where similarity is most important and where human reactions are less diverse. Katz (1963) cited a charming example from a book by Rebecca West to the effect that one can appreciate the gracefulness of a ballerina not because one can dance as well, but because one has the same muscular structure (West, 1928, p. 101). Yet there would be wide variation in such empathy by those whose bodily movements tend to be inhibited and stiff, those who enjoy

dancing or coordinated athletic activity, and those who have had some formal training in ballet. To the degree that the background and experience of the therapist differ from the patient's, therefore, projection can be relied upon to provide only the most basic sense of the patient. In these instances, more typical than the case of the patient whose discharge was delayed, projection must be increasingly supplemented by secondary process representations of the patient, and must be monitored even more carefully.

A hypothetical clinical illustration may help to show the limitations of projection alone, and the consequently greater need for secondary process.

> A female patient with a long and close relationship to her father one day announces in therapy that he has died suddenly of a heart attack the night before.

Any empathic therapist will easily share some of the shock and grief the patient may be assumed to be experiencing, that is, the more or less normal reactions to such a loss. This is accomplished by projecting the feelings aroused in oneself by deeply personal losses in one's own life. But a good therapist will also be listening for the unexpected, idiosyncratic, and pathological elements of the patient's mourning, for instance, the unresolved oedipal issues. How successfully these conflictual elements can be represented will depend to some extent on the gender of the therapist, for at the bedrock level of primary process, what a female

therapist experiences mainly as an oedipal defeat, a male therapist will experience to a greater degree as the loss of a rival. Naturally, he would be able to draw upon his libidinal attachment to his father to some extent, to supplement this with fantasied or remembered reactions to his mother's death, and, to the degree that his patient is also, ambivalently, glad to be rid of her father, to employ empathically his oedipal death wishes toward his father. All of this would be available for projection, but would probably make for a rather anemic empathy with this area of the patient's life, and would call for a correspondingly greater reliance on more rational modes of representation. At issue is not just the important question of gender differences, but how and to what degree significant differences in experience, personality development, and psychic structure of all kinds can be overcome by empathy.

Freud himself illustrated in a poignant way his awareness of how individual differences may interfere with empathy, while holding out hope that essential experience held in common can compensate for them. In a special preface written for the Hebrew translation of *Totem and Taboo*, he wrote,

> No reader of [the Hebrew version of] this book will find it easy to put himself in the emotional position of an author who is ignorant of the language of holy writ, who is completely estranged from the religion of his fathers--as well as from every other religion--and who cannot take a share in nationalistic ideals, but who has yet never repudiated his people, who feels that he is in his essential nature a Jew and who has no desire to

alter that nature. (1934, p. xv)

Notes

1. Kohut is a striking example of this last phenomenon, but by no means alone. Lichtenberg, Bornstein, and Silver (1984a, 1984b) edited a two-volume collection of essays on empathy totalling more than 700 pages; in the indexes there are but three references to projection, all in the same article. In general, projection is mentioned less often by contemporary writers than it was in the past.

2. "Identifying the object with one's self," on the other hand, takes place mainly by way of introjection. See chapter 6.

3. Each of those cited (Knight, Schachtel, and Schafer) referred specifically to the projection of feelings, but did not necessarily limit empathic projection to the range of phenomena covered by that term: affects, impulses, drives, and sensations. Reik (1937, p. 198) had indicated that self representations were projected in psychological cognition. Later in this chapter, a still more inclusive definition will be described.

4. Hartmann (1927, p. 379) and Treurniet (1980, p. 328) have also faulted empathy for lacking a guarantee. Eagle, too, concluded that empathy was not a reliable criterion for the systematic determination of the validity of psychoanalytic formulations, but maintained that nothing else in the clinical situation was, either. The only way psychoanalytic formulations can be confirmed, he suggested, is by rigorous experimentation outside the clinical situation (1984, p. 174). Even this, of course, would not determine the truth of general propositions in any particular case, at any particular moment, of psychotherapy.

5. Fenichel's critique was not limited to empathy between persons. In discussing "'empathy' with animals, plants, and inorganic matter," he objected that it involves "a falsification of them" because "instead of the requisite introjection a projection takes place" (1923, p. 11). Would Fenichel have applied such a view of projection to the important subset of "inorganic matter" that is the focus of aesthetics? In that field, at least since Lipps (1897), the aesthetic experience has often been explained in terms of attributing and transferring qualities or activities of the subject to the perceived object (e.g., Worringer, 1908, p. 14; Lee, 1913, p. 64; Maddaloni, 1961, p. 21; Katz, 1963, p. 92). But the pleasure derived from such activity in no way places the aesthetic experience entirely under the sway of primary

process.

Lee (the pseudonym of Violet Paget) had called it a misinterpretation of *Einfuehlung* to define it as a "*projection of the ego*" because empathy

> depends upon a comparitive or momentary abeyance of all thought of an ego; if we became aware that it is *we* who are thinking the rising, we who are *feeling* the rising, we should not think or feel that the mountain did the rising. (1913, p. 67; emphasis in original)

But it is unclear whether Lee was using the terms *projection* or *ego* in anything like the psychoanalytic sense. Her argument in this passage seems to be directed against a *conscious* projection, rather than against projection per se. See also p. 68 of her book, where she referred to empathy as "that inference from our own experience which has shaped all our conceptions of the outer world."

6. Some qualifying remarks in relation to the representation of an object along the lines of the superego will be presented in the next chapter.

7. "Empathy," said Lee, "is what explains why we employ figures of speech at all" (1913, p. 62).

8. This is as close as a therapist comes to the kind of guarantee sought by Fenichel, Hartmann, and Treurniet. See note 4.

Chapter 6

Introjection and Empathy

> We may not, as Freud told us, take the role of prophet, saviour, or consoler to the patient, but may we not--indeed, must we not--become the lover of the material projected by the patient and make it our introjected "good object"? (Low, 1935, p. 7)

A Structural Definition of Introjection

In chapter 4, the use of the term introjection to mean *take in* by a mental process analogous to physical ingestion was rejected, and that meaning was referred to incorporation, a dynamic motive or wish to possess another internally. Introjection was described as best referring to a structural process of some kind, which was left unspecified.

As a structural term, introjection needs to be distinguished from identification; in the theories of empathy reviewed so far, this has not been the case. As Fliess understood it, introjection would "convert the analyst partially into the patient" (1942, p. 214); however, this was found to be indistinguishable from a partial identification. Reik mentioned that "the ego is transformed" (1937, p. 199) by introjection, but he gave no detailed account of this transformation, which would also be characteristic of identification. Similarly, Greenson

referred to the therapist's mental model of the patient as "an introject of sorts," but also said that cathecting the model "approaches the identificatory processes" (1960, p. 423), apparently regarding introjection as an early form of identification. Such attempts at differentiating introjection from identification leave much unexplained.

Introjection also needs to be distinguished from ordinary object representation, and here, too, past efforts have had limited success. The most common approach has been to treat introjection as the structural counterpart to a fantasy of incorporation. In this manner, introjection has been described as the taking of an object[1] into the ego (e.g., Ferenczi, 1909, p. 47; Reik, 1937, p. 199, Knight, 1940, p. 334). Simmel described an introjected object as "wholly merged in the ego" (1926, p. 475), whereas Malin and Grotstein considered it to be within the ego, but unassimilated (1966, p. 27n).

No matter what the status of the introjected object "in the ego," this translation of incorporative language into structural language is probably too literal to convey the desired meaning. In particular, it increases the risk of understanding mental phenomena in a quasi-physical manner that may obscure other, more fruitful formulations. To say that an object representation has moved into the ego is about like saying that a person has moved into the middle class: it is more an attempt at classification according to certain specified qualities than it is a way of representing

the location of something.

Even if the term *in the ego* were a satisfactory way of classifying introjects, it would raise conceptual problems in the related areas of object representation and structural theory. If an introject is to be distinguished from other object representations by virtue of its being within the ego, for example, where and in what sort of metapsychological space are those other object representations located? And, as indicated in chapter 3, despite the problematic theoretical relationship of representations to the id, ego, and superego, there are pitfalls associated with conceptualizing any psychic structure as a container. According to Boesky,

> I think it would be more clear to say that any "representation" of the self or object is formed by the interaction of all three agencies and cannot exist *in* any one system....It can be misleading to believe that any part of the representational model and the id-ego-superego model are reciprocally "containable." (1983, p. 574, emphasis in original)

It may be better to discard altogether the idea of *taking in* as an aspect of introjection, reserving it exclusively for incorporation. In any event, introjects cannot be distinguished from other kinds of object representations by some general quality of being "inside," for all representations are "inside," that is, intrapsychic. Nor is introjection unique by virtue of an accompanying motive to incorporate, because incorporation can be a motive for identification or object representation in general. An

alternative formulation of introjection is needed, one that does not depend on a concept of taking in or being inside, and whose structural aspects allow it to be distinguished both from identification and from ordinary object representation. Moreover, that formulation would need to be meaningful specifically in relation to empathy, as well as consistent with more general usage.

For Ferenczi, who introduced the term, introjection was a neurotic[2] attempt to mitigate anxiety associated with "free-floating, unsatisfied, and unsatisfiable unconscious wish-impulses" (1909, p. 47) that had become dissociated from their original parental object. This was to be achieved by attaching them to objects newly internalized for this purpose. He seems to have regarded introjection as a kind of indiscriminate object hunger, as in the following passage: "The neurotic is constantly seeking for objects with whom he can identify himself, to whom he can transfer feelings, whom he can thus draw into his circle of interest, *i.e.*, introject" (pp. 47-48). Ferenczi also described introjection as identical to transference, preserving the latter term only because of its particular clinical context. "The designation 'introjection'," he wrote, "would be applicable for all other cases of the same psychical mechanism" (p. 53n).

In the space of a few pages, Ferenczi articulated a global concept of introjection that seems synonymous with incorporation, identification, transference, and even the as

yet unnamed repetition compulsion. The confusion surrounding the meaning of the term was, therefore, present from the beginning.

For the most part, Ferenczi's concept of introjection was dynamic in nature, relying on a motive to incorporate objects for the purpose of displacing and discharging free-floating affects. But the corresponding structural operations were indicated to some extent. According to Ferenczi, "whereas the paranoiac expels from his ego the impulses that have become unpleasant, the neurotic [i.e., hysteric] helps himself by taking into the ego as large as possible a part of the outer world" (p. 47). Consequently, "the psychoneurotic suffers from a widening, the paranoi[a]c from a shrinking of his ego" (p. 48). This "widening" or "shrinking" of the ego does not determine how populous the object world has become, for "we see the paranoiac on a similar search for objects who might be suitable for the projection of 'sexual hunger' that is creating unpleasant feeling" (p. 48); while the hysteric may seek to love or hate the whole world, the paranoid thinks he is loved or hated by the whole world (p. 48). The difference, then, must be that the hysteric's large object world is "in the ego," while the paranoid's is not.

The problematic nature of the phrase "in the ego" as a structural definition of introjection has been considered above. But Ferenczi's contrasting of the hysteric and the paranoid points the way to a possible reinterpretation of

introjection in more legitimately structural terms. The defensive aim of the paranoid is to maintain a sharp differentiation of self and object representations, while the aim of the hysteric is to minimize such differentiations. This suggests that "in the ego" refers to object representations less differentiated from self representations than are ordinary object representations.

Ferenczi's assertion that introjection is the same as transference opens the door to some additional structural considerations. It is customary to think of transference in terms of the displacement of mental products from the patient's early object representations to his representation of the therapist, as more of an expressive than a receptive process. This view is difficult to reconcile with Ferenczi's explanation of introjection. But Ferenczi was proceeding with the following definition of transference in mind, which Freud had developed a few years earlier:

> What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity which is characteristic of their species, that they *replace some earlier person by the person of the physician.* (Freud, 1905a, p. 116, emphasis added)

The interpretation of this passage depends on how the following question is answered: does transference refer to the *displacement* of an impulse or to the *replacement* of an object by introjecting a new one?[3] These are not simply different ways of saying the same thing, but two aspects of

a process that involves both instincts and object relations.

Displacement is relatively well understood, but what is the nature of the "replacement" or introjection that occurs in transference? To say that a new object replaces an old one surely cannot mean that mental representations move about in the mind, exchanging positions with one another. Rather, this expression can only mean that the new object is represented in important ways as similar to the old one and that the subject attempts to carry on in some fashion with this new object aspects of the prior relationship. In other words, the new object is, in some respects, not very well differentiated from the old one. Instead of referring to a process of taking in or substitution, therefore, introjection is better understood as a particular way of representing an object.

To take this idea one step further, the "new" object need not be new at all, except for the way it is represented, which is, in fact, an *old* or archaic form of representation. Sandler has gone so far as to state that introjection can only take place in relation to a "*previously constructed*" mental representation of the object (1960, p. 146; emphasis added).

This interpretation of Ferenczi suggests that an introject is a mental representation of a special kind, one which, by virtue of being "in the ego," is not very sharply differentiated from self representations, and which, because

it involves the "replacement" of an old object with a new one, is also not very sharply differentiated from early object representations.

Ferenczi's formulation did not allow for parental object representations to be characterized as introjects, any more than they could be transference objects. Nonetheless, over the years, parental object representations have come to be regarded as the earliest introjects, and it is possible to formulate a definition that takes this common usage into account. *An introject, then, can be described as a mental representation of a transitional kind, that is, one which is represented neither fully as self nor fully as object and which, in its capacity as object, features archaic representations of the earliest objects (primary introject) or archaic representations of later objects modeled after the former (secondary introject). Introjection, in turn, refers to the creating or maintaining of this particular kind of mental representation.*[4] Introjection is, therefore, at once a change in the way an object is represented and a change in the way self is represented in relation to that object. It is more than object representation and less than identification.

This is not altogether a new way of referring to introjects and introjection.[5] In 1962, Hartmann and Loewenstein began to move away from the idea of *taking in* and toward the structural concept of a partially integrated mental representation:

> For many the distinction between identification and introjection has come to refer to differences in the degree to which this "taking in," this integration, has been accomplished. We would also consider the relation between the degree of integration and the degree to which self-representation has been substituted for object representation. These two factors vary partly independently. (p. 153)

Meissner has adopted an even more explicitly transitional view: "introjective configurations hold an intermediate position in the psychic scheme of things--intermediate between the objectified realm of object representations and the ultimate subjectively experienced ego core" (1981, p. 49).

The introject can thus be conceived as occupying a psychic status somewhat like the transplanted kidney or heart in the body. Whose is it--the donor's or the recipient's? A good argument could be made for either side, on biological or psychological grounds. Introject-like phenomena are also recognizable in terms such as auxilliary ego, imaginary playmate, transitional object, holding environment, and selfobject, but especially and most familiarly, the superego. Indeed, the superego is itself a transitional structure and is the mental agency most closely associated with introjection.

The Superego as Transitional Structure

When the activity of the superego becomes apparent subjectively, it tends to be as a transitional experience

that feels both alien and familiar. The rebukes of conscience are a kind of *self* criticism, and yet they also have the character of punishment by an "other." The ego ideal, too, functions in this transitional way, holding out an ideal version of the self, yet holding it far enough away so that there is a "feeling of triumph when something in the ego coincides with the ego ideal" (Freud, 1921, p. 131).

Similarly, the classic formulations in "The Ego and the Id" presented the superego in what can be described as transitional structural terms. On the one hand, the superego was called "a grade in the ego" (Freud, 1923b, p. 28) or "a precipitate in the ego" (p. 34) and, as such, was omitted from the title of that essay and from the diagram of the mind that accompanied it (p. 24). On the other hand, the superego was characterized as capable of confronting "the other contents of the ego as an ego ideal or super-ego" (p. 34), as having "the capacity to stand apart from the ego and to master it" (p. 48), and as constituting one of the *three* agencies of the mind (p. 40). In one of his last works, Freud wrote of the superego explicitly in terms of the degree of its differentiation from the ego: "*in so far as* this super-ego is differentiated from the ego or is opposed to it, it constitutes a third power which the ego must take into account" (1940, p. 146; emphasis added).

It is exactly this capacity to be both a part of the ego and apart from it that gives the superego its transitional

status in the mind. According to Fenichel, "the superego is in a sense half ego and half outer world" (1945, p. 431). In somewhat more formal terms, Loewald has made the same point: "the superego is conceived as an enduring structure pattern whose elements may change and move either in the direction of the ego core or in the outer direction toward object representation" (1962, p. 503). Specifically in relation to the ego ideal, Jacobson has referred to the "double face of the ego ideal, which is forged from ideal concepts of the self and from idealized features of the love objects" (1964, p. 96). She also took up the question of whether the ego ideal should be considered part of the ego or of the superego, concluding that the mature ego ideal "gradually bridges the two systems and may ultimately be claimed by both" (p. 187).

Just as introjection has often been confused with identification, the origin of the superego has often been accounted for structurally by the mechanism of identification. For example, Freud generally preferred to characterize the creation of the superego as the product of identification, though he sometimes used introjection and identification in the same breath while discussing this topic (1923b, p. 29; 1924b, p. 176) and sometimes mentioned only introjection (1924a, p. 167).

Later analysts have occasionally singled out introjection as the structural term appropriate in discussions of the superego. Only a few years after "The Ego and the Id," Rado

conceptualized the formation of the superego in terms of introjection (1927, pp. 51, 59). In 1934, Strachey reviewed several articles calling attention to the temporary introjection of the analyst by the patient, describing this as a superego activity (pp. 134ff.). He also equated the superego with the "introjected object" in several places (pp. 137ff.), and indicated that the superego is composed of "introjected imagos" (p. 140). Consistent with this view, Sandler and Rosenblatt (1962, p. 132n) have advised restricting the term introjection to processes involved in the formation of the superego.[6] See also Heimann (1966, p. 254) and Eagle (1984, pp. 79-80).

Still, the superego continues to be discussed in relation both to introjection and identification (Schafer, 1960, 1968; Meissner, 1981), raising the question of under what circumstances it is appropriate to speak of identification in relation to the superego.

Identification seems to be the proper term to use when conflict between the ego and superego is avoided or resolved by modifying the ego in the direction of the superego. Identification, therefore, refers to a condition in which ego-superego conflict is absent[7] and the existence of the superego as a partly differentiated mental structure would have to be considered latent. It describes situations where the superego has lost its transitional character and become "a grade in the ego" by virtue of the ego taking over its functions. Identification is, therefore, an ego, not a

superego activity. The ability of the ego to make such an identification naturally depends on many factors, such as current instinctual pressures and realistic opportunities for gratification, which make many identifications partial, temporary and situation-specific. Genetically, the origin of the superego is a matter of introjection, while the broader developmental task of internalizing moral standards involves both the ego (identification) and the superego (introjection), depending, as Hartmann and Loewenstein expressed it above, on the degree of integration and the degree to which object representation has given way to self representation (cf. Sandler, 1960, p. 150).

Parenthetically, the earliest superego introjections provide the first more or less autonomous experiences of taking another's point of view into account. In that sense, the existence of the superego becomes a genetic prerequisite for empathy.

The Object as Ego Ideal

In general, introjects appear in two forms, as representatives of the conscience or of the ego ideal. Aggressive introjects are by far the more widely noted in the literature, perhaps in part because of Freud's greater attention to the aggressive as opposed to libidinal aspects of ego-superego relations (Schafer, 1960, p. 164). It is possible, however, to derive an understanding of libidinal

introjects from Freud's comments about the role of the ego ideal in object relations. Describing certain cases of sexually frustrated object choice in which the ego displays a "'devotion'...to the object, which is no longer to be distinguished from a sublimated devotion to an abstract ideal," he summarized the situation by saying, *"the object has been put in the place of the ego ideal"* (1921, p. 113; emphasis in original). A little later in the same monograph, he explained a group's relation to its leader as a second example of "putting the object in the place of the ego ideal" (p. 130). Such an operation, Freud noted, was to be distinguished from identification (pp. 113-114, 130, 134). In line with the remarks above, the idea of putting the object in the place of the ego ideal should be understood not as a literal substitution, but as a new way of representing the object, taking the ego ideal as a standard.

Putting the object in the place of the ego ideal was explicitly linked to introjection by Knight, who wrote that introjection was the main mechanism in "identifying the object with one's self," in which "the attributes and standards of the object become part of my ego ideal and as such tend to govern my behavior" (1940, p. 336).

For Freudian analysts, there is probably no better illustration of putting the object in the place of the ego ideal than their own behavior in relation to their "father" Freud (cf. Kanzer, 1972, p. 260; Kohut, 1984, p. 203). In

the analytic literature, appeals to Freud's writings tend to have the same status as quotations from scripture do for the devout, reflecting a widespread idealization and deference derived from Freud's place in the analytic ego ideal. To paraphrase the passage cited above, analysts experience a "feeling of triumph" when something in their own work coincides with the work of Freud. The introjected Freud often exerts his influence in clinical and theoretical discussions, in which authors take pains to demonstrate the continuity of their own thought with that of Freud.[8] In extreme cases, a fragment of correspondence or an obscure passage from the *Standard Edition* is held up as proof of Freud's "discovery" of some clinical or theoretical point since found important or useful all out of proportion to its place in Freud's own writings. These phenomena are not to be explained as *identifications* with Freud, for if they were, the highly cathected relationship to the introjected Freud would not be so prominent, nor would analysts find it necessary to please, appease, or demonstrate obedience to the Freud that they carry in their heads. This view of Freud as an introject helps explain why some analysts write and practice in a more "orthodox" way than Freud himself: they behave the way "Freud" wants them to, instead of the way Freud himself did (cf. Katz, 1963, pp. 177-183).

Of course, analysts also form partial identifications with Freud. But, given the special regard that is attached to his person and his work, Freud is most often an ego ideal, that

original "other" that invites identification by serving as the object of one's personal aspirations.

It requires only a short step to apply these observations to empathy. Specifically, *empathic introjection refers to a temporary restructuralization of the therapist's representational model of the patient along the lines of his superego, particularly the ego ideal.*[9] In empathic introjection, the model changes its structural status from object representation to ego ideal. To regard the patient as an ego ideal is a new and unfamiliar way of conceptualizing the relation of therapist to patient, one that obviously requires careful explanation of the many points of correspondence between empathic introjection and the ego ideal.

The Ego Ideal as an Object for Identification

As a special case of putting the object in the place of the ego ideal, empathic introjection presupposes a wish to be like the patient, that is, it takes a motivational and structural step in the direction of trial identification. This is merely a particular instance of the general rule that the ego ideal is what the ego seeks to become. Excluding identifications motivated by conflict, such as identification with the aggressor, identification typically follows a representation of the object as possessing some valued attribute that one would ideally like to have. In

other words, identification is usually preceded by a representation of the object along the lines of the ego ideal. Empathic identifications differ from many others in that the therapist seeks only a partial or temporary semblence and does so always with the adaptive aim of employing the identification in the service of better understanding the patient. These differences in motives mean that the therapist does not take the patient as an ideal for his life in general, but takes as his ideal a vicarious understanding of the patient, which he hopes to achieve by way of identification. Like the lover Freud mentioned above, the therapist shows a "'devotion'...to the object, which is no longer to be distinguished from a sublimated devotion to an abstract ideal" (1921, p. 113).

Economic Aspects of Empathic Introjection

Conceiving of the introjected patient as an auxilliary ego ideal is also consistent with the economic aspects of empathy mentioned in previous chapters. For one thing, it helps clarify why, in empathizing, the patient is never the object of the therapist's aggressive drives: the empathically introjected patient, like the superego, can never be the object of the id's aggressive urges. As Rado described this aspect of the superego, "the ego *loves* the internalized parents just as it loves its 'good parents' in reality, but it must not allow itself to *hate* them like its

'bad parents,' even if they behave like 'bad parents'" (1927, p. 59; emphasis in original). In empathy, as in clinical depression and in the formation of the superego (all linked by introjection), aggressive urges toward the object are transformed or redirected, often turned back against the self.

The libidinal cathexis in empathic introjection is patterned after the formation of the ego ideal, as in Freud's formulations that "this ego ideal is now the target of the self-love which was enjoyed in childhood by the actual ego" (1914b, p. 94) or that the ego ideal "is the heir to the original narcissism in which the childish ego enjoyed self-sufficiency" (1921, p. 110).

These considerations obviously require that the patient as ego ideal be subject to an idealization by the therapist, a conclusion that, at first glance, appears inconsistent with the idea of psychotherapy as a means for the exploration and resolution of psychopathology. But the term idealization is a legitimate way to describe the narcissistic shift in moral perspective that goes with empathic introjection. In minimizing reliance on a realistic, external view of the patient and in renouncing any interest in finding fault with him, the therapist grants the patient a psychic status equivalent to the "presumption of innocence" or "benefit of the doubt" that is reserved for an idealized object. He suspends the more or less normal narcissistic assumption that regards one's own point of view as self-evident and the

point of view of others as alien. This is an idealization in the same sense that normal self love is often unearned and objectively unwarranted. It is almost as if, to understand the patient on his own terms, the therapist must look at him through the rose-colored lens of the ego ideal, allowing a libidinal cast to obscure a more realistic, external point of view. Perhaps this is why psychotherapists tend to be regarded by others, although not by their patients, as *too* understanding or sympathetic.

The idealization characteristic of empathic introjection does not, as a rule, lead to so distorted a perception as to make unavailable more objective assessments of the patient, nor does it involve rationalizing the patient's motives or behavior. But it is one of the elements of empathy that make it possible to practice psychotherapy with child abusers, murderers, and the like--in short, people who, except for empathic introjection, would move a person to recoil in horror. On a more commonplace level, idealization permits the therapist to accept in a patient a variety of lesser antisocial tendencies and to understand these in something other then a simple moral sense. It may not be an exaggeration, though it is certainly a paradox, to say that idealization is one of the economic sources of analytic neutrality, a concept whose energic correlates cannot be adequately defined by an absolute neutrality of cathexis.

Aside from these adaptive aspects, empathic introjection permits the therapist an opportunity to identify with ideal

representations of himself as an understanding and helpful listener. The narcissistic satisfaction or "feeling of triumph" when these ideals are approximated is the chief emotional reward of working as a psychotherapist and probably has its roots in infantile experiences of blissful perfection in fantasied union with idealized, omnipotent parental figures (cf. Loewald, 1962, p. 495). In a sense, then, the transitional nature of empathic introjection yields a narcissistic dividend to both patient and therapist.

The Empathic Introject as Regulatory Authority

Like the superego, introjects in general are characterized by a regulatory role (after the example of the parent), serving to guide or direct the way the personality functions, providing a personalized standard to which one subjectively feels accountable. In Schafer's view, "the ability of the introject to influence the subject is its outstanding experiential quality" (1968, p. 83).

Implicit in the process of introjection is the fact that objects taken as introjects have certain rights that the introjector does not. Patients, too, have certain rights that therapists do not, for example, the right to say anything at all without regard for the consequences, the right to have the undivided attention of another, or the right to a professional, confidential, and altruistic

relationship. Corresponding to these entitlements, of course, are obligations that fall upon the therapist.

As applied to the therapist's introject of the patient, the patient's entitlements and the therapist's obligated state suggest that the model of the patient becomes a moral force regulating the therapist's conduct of psychotherapy. Empathic introjection describes a state of mind in which the therapist relinquishes aims to control, direct, manipulate, or gratify himself upon the object, and instead adopts a rather ascetic, passive, accepting, uncritical, and benevolent stance. The therapist may be the technical expert, but the patient is the moral authority, to whom, as allied with his own superego, the therapist is answerable. In a sense, the analytic goal of increasing the patient's autonomy begins by giving him an exalted place in the therapist's mind. Like the ego ideal, which, in Freud's earliest formulations, watches the ego and compares it to an ideal standard (1914b, pp. 93, 95), the introjected patient functions as an internal judge of the therapist's work.

How are these formulations reflected in clinical practice? The introject, like the superego, holds the therapist to the highest standards of technique, and its influence tends to surface in the countless exchanges every therapist has with the patient-in-his-head. These are evident as ego ideal operations in the private rehearsals for and re-enactments of interpretations or other interventions, and often comprise a large part of the

therapist's motivation to seek consultations or supervision, whose goal is always to make perfect some aspect of the treatment. By way of such behavior, the therapist attempts to approximate more closely his therapeutic ideals and also reveals his subservience to the introjected patient who, in alliance with the superego, has taken on a regulatory role, and whose approval he desires, at least in relation to his technical conduct of the treatment.

Introjection brings empathy beyond the therapist's usual modes of experience and personality organization, just as the superego imposes a realignment of motivation, defense, and behavior in accordance with the standards of good and evil that it embodies. This new ordering of the personality under the orchestration of the introjected model allows the emergence of experiences that the therapist otherwise would not have. Introjection thus involves not only changes in the representation of the patient as ego ideal, but in the therapist's self representations and subjective experience under the influence of that ideal. Often these changes reflect a partial accommodation to the role of transference object, which the patient assigns to the therapist. In representing himself as transference object, the therapist adopts the patient's unconscious point of view, and does so with an understanding of how the patient is "right" to perceive him in that manner, much as, in other contexts, he automatically accepts the demands of his ego ideal as "right." In addition, introjection serves to direct the

therapist away from destructive countertransference reactions in which the patient is represented as "wrong."

For example, one young male borderline inpatient with a history of several hospitalizations over a brief period was angrily (and quite prematurely) demanding immediate discharge. His therapist at first was inclined to reiterate an explanation of the more pressing need for a workable discharge plan, complete with living arrangements, clinic appointments, vocational training, and so forth. But he hesitated, sensing that the two were not engaged in a discussion of discharge so much as autonomy. Any behavior on the therapist's part--however well-meaning and appropriate to the *management* of the case--that allowed the patient to represent him as allied with the patient's own controlling and belittling introjects would only have deepened the psychological rift between them. Nor was the patient at that moment prepared to accept an interpretation addressing this issue. So instead, the therapist quietly and sincerely asked, "Would you like to leave today?" The patient looked a little startled, paused for a moment, and answered, "Well, I don't know if I want to leave just yet."

The therapist had resisted acting out a complementary identification with the patient's introjects in favor of representing the patient (unrealistically?[10]) as

an authority capable of deciding when he wanted to be discharged. Recognizing and accepting his assigned transference role, he was then able to intervene, albeit minimally, in a way that could ultimately permit the patient to lessen the intensity of his struggle with authority figures of all kinds by fostering a realistic differentiation between his primary introjects and contemporary objects who had control, in various ways, over his life.

The objection will be raised that putting the patient in the place of the ego ideal is at odds with much of the recent literature that portrays the therapist as a psychological "parent" to the "infant" patient. Such paradigms can be highly instructive, but do not contradict the view presented here. As transference object, the therapist remains the psychological "parent" even while granting the patient the authority of his ego ideal. The tendency to equate parent and authority is a carryover from childhood, whereas, from the adult's point of view, the essence of generativity lies in the promotion of autonomy in the other and the progressive diminution of one's own influence. The goal is surely that the other should reach an ideal developmental state comparable to one's own ego ideal, though differing in its particular features. In this sense, every child is represented in its parents' minds as an ego ideal in a variety of ways that include the child as legitimate regulator of the parents' behavior, the child as

idealized object, and the child as embodiment of the parents' unrealized aspirations.

Even in the symbiotic phase, where the promotion of autonomy in the infant is far less of an issue, the infant exemplifies the immense power of the powerless and derives that power from its status as an ego ideal in the mother's mind. Throughout her pregnancy, the mother has been prepared for the symbiotic phase with innumerable reminders of the fetus as both merged and separate--a transitional state, like introjection, with significant narcissistic investment, idealized representations of the object, and an attitude of self-sacrifice and duty.

There is a passage in Freud's paper, "On Narcissism: An Introduction" (1914b, pp. 89-91), that lends support to the views just mentioned, most succinctly in its reference to "His Majesty the Baby" (p. 91). That essay, significantly, marks Freud's first mention of the ego ideal. And the language Freud used to characterize the parents' attitude toward their child is strikingly similar to the language he used to describe the ego ideal or ideal ego, as he sometimes called it: "Thus, they [the parents] are under a compulsion to ascribe every perfection to the child" (p. 91), he wrote; a few pages later, speaking more generally of his new discovery, he said, "this new ideal ego...finds itself possessed of every perfection that is of value" (p. 94).

In the broadest sense, the representation of an infant or a patient as ego ideal is no more than an extension of the

well-worn psychoanalytic insight that, no matter how much later development may add in the way of autonomous object choice, mature intimacy, and egalitarian motives, the early relationship to one's parents serves as a model for all subsequent relationships of any importance. As Freud put it in 1905, "there are thus good reasons why a child sucking at his mother's breast has become the prototype of every relation of love. The finding of an object is in fact a refinding of it" (1905b, p. 222). In the case of empathic introjection, that refinding includes a refinding of the first object's regulatory role.

It may also be objected that the regulatory functions mentioned here are those of the therapist's superego alone, not the result of an alliance of the superego with the introjected patient. Although the present formulation is a new one, similar intrapsychic structures in the *patient* have long been recognized. In their discussions of the patient's "analytic super-ego" (Ferenczi, 1928, p. 98) and "auxilliary super-ego" (Strachey, 1934, pp. 138-141), early analysts stressed the therapeutic results obtained when the patient introjects the analyst and, thereby, restructures his superego. That something similar takes place in the therapist should not be surprising, in view of the parallels noted in earlier chapters, for example, in regression and transference/countertransference. The alliance of introject and superego in the therapist is part of what terms like *work ego* or *therapeutic conscience* (Fliess, 1942, pp. 221,

222) mean, or should mean: a personalized, ad hoc mental structure appropriate to the therapeutic task with a given patient.

This kind of alliance is not unique to psychotherapy, but is actually widespread in daily life. In any institutional work setting, for example, day to day questions of right and wrong tend to be resolved by the joint involvement of the employee's own moral standards and the standards of the institution, as personified in supervisors, directors, and so forth. It would not be an exaggeration to characterize the latter as introjects. Similarly, when a husband or wife unilaterally undertakes a decision affecting both partners (a decision that is necessarily in part a moral one), he or she is apt to "consult" the spousal introject about the matter. Such decisions, especially when they support the best interests of the marriage, naturally differ from those that would have been reached had the influence of the introject not been taken into account.

Psychotherapy is a particularly striking case of such introjective superego operations, one whose effects can help explain why, as Schafer has noted, therapists tend to empathize much better with their patients than with relatives or colleagues (1983, pp. 37-38), or why a therapist who is quite tolerant of severe psychopathology in the course of a long day of clinical work may find himself perturbed by the same behavior in other contexts (cf. Freud, 1929, p. 196). In nonclinical situations, as a rule, a

therapist is seldom as accountable as he is at work.

To deny the influence of the therapist's introject of the patient, then, forces an artificial conception of the process of psychotherapy in general and empathy in particular, one isolated from the corresponding intrapsychic operations of the patient and from the psychology of everyday life.

Empathic Introjection and Object Loss

Formulations about introjection have often stressed the dynamic motive to preserve an absent or "lost" object. Clinical depression, of course, is the classic example (e.g., Freud, 1921, p. 109; Rado, 1927; Loewald, 1962). As a general rule, the loss is best understood as an intrapsychic, rather than an external one. Thus, the introjections that bring the oedipal phase to a close replace parents who have largely been given up as erotic objects, not lost altogether. Introjection can even occur in situations of *imagined* loss or separation (Schafer, 1968, p. 130). To activate a motive for introjection, it is probably sufficient that the subject feel out of touch with the object or that the object has been lost as a "good" object because of the subject's aggressive feelings toward it. Greenson characterized this motive to recover the object as follows:

> One empathizes to re-establish contact--with an elusive object. One resorts to empathy when more

> sophisticated means of contact have failed and when one *wants* to regain contact with a lost object....This is in accordance with Freud's view of the process of grief and mourning in regard to the lost object. (1960, p. 423; emphasis in original. See also Greenson, 1966, p. 272; Olinick, 1984, p. 146)

Empathic introjection can refer either to an ongoing transitional *state* or to a specific psychic *act* or mechanism in which the patient is represented along the lines of the ego ideal. Both forms of introjection are assumed to reflect attempts to master early experiences of separation and object loss (cf. Frank, 1961, pp. 364, 365; Poland, 1984, pp. 337, 346), but the act of introjection may involve somewhat stronger motives to overcome feelings of loss in relation to a current object.

Object loss, in the sense of emotional loss, can be conceptualized as a shift from transitional representation to object representation and as a corresponding state of tension between the ego and ego ideal. Introjection following object loss or loss of emotional contact serves the function of re-establishing that transitional relationship. In clinical depression, this is done in a much more intense and instinctualized fashion than is the case with empathic introjection. By contrast, the wish to regain emotional contact and rapport with the patient can usually be put to use adaptively--for example, empathic introjection makes the patient less alien and easier to understand. In terms of defense, empathic introjection serves to ward off guilt and anxiety associated with loss of

emotional contact with the patient[11] and with failure to achieve therapeutic ideals, and it helps to manage countertransference reactions that threaten the therapeutic relationship.

The idea that object loss involves a shift from transitional representation to object representation assumes that an introjective component is present in every relationship whose rupture would be experienced as object loss. That is, the term object loss is often a misnomer to the extent that the experience of loss reflects the loss of a transitional, idealized relationship, not necessarily the loss of the object per se. Intrapsychically, the situation does not involve the "loss" of an object representation, but rather the transformation of a transitional mental representation into separate self and object representations. This narcissistic aspect has long been applied to *pathological* reactions to object loss. Freud, for example, suspected that "the disposition to fall ill of melancholia (or some part of that disposition) lies in the predominance of the narcissistic type of object-choice" (1917, p. 250).[12] But given Freud's earlier emphasis on the role of narcissism in maintaining self esteem (1914b, pp. 98-100), it follows that the drop in self esteem characteristic of object loss is *always* a narcissistic issue.

With the growing interest in normal narcissism in recent years has come a willingness to appreciate that intimate

relationships of all kinds have a narcissistic component, that they lack a rigid differentiation between self and other. For his part, Ferenczi considered "*every sort of object love*...both in normal and in neurotic people...as an extension of the ego, that is, as introjection" (1912, p. 316; emphasis in original). In purely economic terms, Freud put the matter this way: "a real happy love corresponds to the primal condition in which object-libido and ego-libido cannot be distinguished" (1914b, p. 100). Kohut, whose term *selfobject* approximates the meaning of introject, has expressed this point of view as follows:

> Self psychology holds that self-selfobject relationships form the essence of psychological life from birth to death....The developments that characterize normal psychological life must, in our view, be seen in the changing nature of the relationship between the self and its selfobjects, but not in the self's relinquishment of selfobjects. (1984, p. 47; see also Schafer, 1968, pp. 157-158)

Empathic introjection is one of the normal relationships to which Kohut referred. It can be understood as the optimal ongoing relationship of therapist to patient, and also as a specific way of "holding on to" or "getting hold of" the patient emotionally when empathy is threatened by an unwanted change from a "selfobject" relationship to an object relationship. One implication of this view is that, where object relations are concerned, the "depersonalized" superego (e.g., Freud, 1926a, p. 128) cannot always be regarded as the optimal outcome of superego development.

Clinical Illustration

An example of empathic introjection drawn from a psychotherapy session will serve to demonstrate the nature of introjection as described above. The patient, a female college student, had recently begun psychotherapy and was seen twice a week. Her presenting problems were fairly general--occasional anxiety and depression--and nothing she regarded as very serious; she had waited about a year after deciding to seek treatment before actually making the initial contact. At the beginning, the patient had rejected a number of suggested appointment times because they were inconvenient; after regular times were established, she was frequently late. She was in the habit of talking virtually nonstop in a somewhat pressured way, often interrupting any interventions the therapist attempted to make, but resentful about his silence if he did not speak when she wanted him to. The patient was aware of her ambivalence about being in therapy and discussed it frequently. In the session reported below, she arrived 15 minutes late after a week's absence that coincided with school holidays (she had been unwilling during that period to travel to the therapist's office, which was some distance from her home, but not far from school). The therapist, still in training, was relatively inexperienced. As part of his supervision, the session was recorded on audio tape and later transcribed.

It is partially reproduced here.

"It's freezing outside, worse than freezing. I don't know what I'm doing here--I'm so ill. New Year's was nice, Christmas was nice. I'm surprised how well things are going. I'm feeling okay, basically. Things aren't bothering me as much.

"Sometimes I spread myself too thin and get myself in little conflicts over who I want to spend time with. In school, too, I run around too much and take part in too many things. I'd like to do fewer things and focus my attention on them. I let their real value slip through my fingers. Over the holidays I would visit two or three people a day, and it felt like I was squeezing them in. I haven't decided what to do about it, except to try to concentrate my time on whomever I'm with. I think it started just before Christmas vacation. I noticed I was always talking to some one, and then some one else would come along and say hello, and people started asking, 'Does *every*body know you?' I'm confused. I don't know how to spend my time--I mean, I *know* how to spend my time--doing what I want to--but I'm afraid of spreading myself too thin. Am I confusing you? If I'm confused, then you *must* be. I don't know. I don't know if I want to talk about anything. I'm really looking forward to the end of finals and not being in school for awhile. I can't

stand waking up early and the reading and the tests. I don't know why I subject myself to it. But I guess it's the thing to do. [Pause] Things are okay, basically.

"A strange thing happened. I was thinking over the holidays about how I felt about therapy, and what I *thought* I should be doing--I thought I would miss it and it would bother me that I wasn't here. I was sure I was on my way to being dependent, and to my surprise it didn't phase me. [Therapy is] supposedly good for me, so why doesn't it bother me [to miss sessions]? I almost cancelled today's session, but I didn't have time to call you. I could have done it with no guilt whatsoever, but I got out of the exam late and knew you'd be waiting, so I came. I feel like something's wrong if I can so easily miss a few sessions. Is that legitimate? Some of my friends really carry on if they miss a session. I feel guilty because it didn't phase me; in a way, I don't feel guilty. Why don't I get upset when I'm not here? Q---- and G---- are traumatized if they miss a session. They walk around like zombies. It's nice to come here, but, I don't know, it doesn't phase me. Somebody told me yesterday the therapy can't be going well if I'm not excited about going back today. Do *you* have any thoughts about it? No? I don't know. Anyway, that was just a thought. It still doesn't phase me. Maybe I haven't

become dependent yet. I just feel like I should be going through this, and I'm not. I don't care how other people do it. Most of the people we're talking about have been in therapy a much longer time. I don't know, I'm at a total loss. Maybe I haven't had time to become dependent yet. To me, they behaved in extreme ways. They made it a life and death matter. I got the impression from them that I should feel I was lacking something the week I wasn't here. I really didn't feel I was missing anything. It's not that it's not important; it's just not *that* important. I think my therapy is good for me, and I'm sort of beginning to feel comfortable with the routine of coming. But missing a session doesn't phase me. I don't mean to take anything away from the therapy, but that's how I feel."

The therapist then interrupted to note the patient's concern that she might seem ungrateful or dissatisfied.

"Oh no no no no!" she replied. "Well, maybe I'm just reminding myself [that I am satisfied], because one person said to me, 'Well, if you don't feel this way, the therapy might not be good.' And I couldn't agree with it. I don't think I've been there long enough to know if it's a good therapy or not. I guess what I'm scared of is that you would interpret my feelings the same way other people did. But [laughing]

you interpret everything the right way, which amazes me. I don't know. It's horrible to say, but it's not that I'm so preoccupied with your feelings. I just don't know. I'm at a loss. You're a great help, too: I just get blank stares. I don't know. I don't feel there's something wrong with therapy. But I don't know. This is my first time in therapy. I don't have the right to say something's lacking, because I don't have anything to compare it to. So therapy's fine, but I'm puzzled about why I don't get upset, even mildly, when I'm not here. I have no idea. But it's not so important that I've got to seek out the answers. [Pause] You don't buy that. You want *more*. I don't know. I don't know what to do. Why don't you make a little comment now [laughing], like 'Talk about that.'? I don't know what to tell you. What time is it?"

The commentary that follows is organized into rough stages, with each stage subdivided into two parts. The first part is essentially a description of the therapist's conscious, subjective experience at the time; it is followed by a metapsychological paraphrase.

The therapist's interest had initially been captured by the patient's idea of spreading herself too thin, which he empathically understood as a wish for more depth and intimacy in her relationships, including the therapeutic one. But he soon began to feel that the patient was also

hinting at something very different, namely that therapy was one of many relationships in which she felt overextended. This second interpretation seemed to belong on what the therapist came to view as the patient's list of reasons why she should not be in therapy. The list included her ill health, the cold weather, her lack of psychological distress, the anticipated trauma of future separations once she became "dependent," and (especially) her disavowed suspicion that there was something wrong with the treatment.

The therapist's overriding impression, then, was of the patient's resistance. She seemed unwilling to be a patient, frustrated that she had talked herself into appearing for the session, and more than a little inclined to take that frustration out on the therapist. Unlike the patient, he was not about to attribute her apparent lack of interest in therapy to the fact that the treatment was still young. Nor did he attach much weight to her assertions that therapy was good for her and that the therapist was amazingly skillful at interpretation. These seemed clearly to be reaction formations against her generally aggressive feelings about the therapist and the treatment he offered, as seen in such stinging comments as, "You *must* be [confused]....I almost cancelled today's session....I could have done it with no guilt whatsoever....It doesn't phase me....I really didn't feel I was missing anything....It's just not *that* important....It's not that I'm so preoccupied with your

feelings....You're a great help." The therapist's mental paraphrase of her associations went something like this: "I'm feeling okay, so I don't belong here. You mean nothing to me. People who value their time with you must be crazy. I don't know why I subject myself to this."

In reaction to this view of the patient, the therapist felt exasperated and helpless against the patient's resistance. Though attempting by conscious effort to maintain a therapeutic posture, his aggressive countertransference was dangerously close to being acted out. He felt like telling her bluntly that if she was so reluctant to be in therapy, she might as well quit instead of cancelling sessions, arriving late, and wasting his and her time obsessing about her ambivalence. And, as he later realized, his intervention, which appeared to be a defense interpretation intended to bring to consciousness the patient's guilt over her abuse of the therapist, concealed an accusation of ingratitude and a demand that she stop "misbehaving."

1. Induction. The patient had, with her own aggression, induced an aggressive response in the therapist, which at this point was not capable of being used therapeutically.

The therapist felt increasingly uneasy about his countertransference. Though the patient's hostility seemed essentially unfair, it nonetheless prompted self doubts about his ability as a therapist. Was the lack of therapeutic alliance due to his inexperience? Was she too

difficult a case for him? He felt more and more isolated from the patient, withdrawing defensively to avoid an overtly destructive reaction.

2. Object Loss. The therapist lost whatever empathic contact with the patient had existed earlier in the session. She was now represented as a "bad" object, even as he wished for the return of the "good" object with whom he could empathize. Not only had the patient lost her place in his ego ideal, but a state of tension (guilt) had developed between his ego and superego, which was blaming him for being inept and for feeling aggressive toward her. In a sense, he had lost along with the patient the loving and benevolent introjects that rewarded his good work. Instead of being joined to and taking on characteristics of his ego ideal, she took her place in his mental gallery of accusing and hard-to-please introjects. Under this moral pressure, the need to recover the "good" patient and restore the ruptured relationship became more urgent.

The impasse began to resolve itself at the end of the passage quoted above. The therapist suddenly realized how anxious the patient was, particularly at the moment she wanted to know the time, which he heard as a frightened plea: "How much more of this do I have to endure?" Until then, the anxiety that lay beneath her pressured, ambivalent narrative had been obscured by derogatory representations of her as scattered, obsessive, and controlling. Recognition of her anxiety came as a surprise to the therapist, for it

could not be readily integrated into his representation of her as only superficially involved in treatment. It did not seem, for example, that her hostility was making her fearful of retaliation, but rather, that her aggression stemmed from her fear.

At the same time that he became aware of her anxiety, the therapist noticed that some of her perceptions of him were oddly distorted. Specifically, her expectation that he wanted "more" struck him as absurd, as did her idea that his "little" interventions were apt to take the form of comments like, "Talk about that," a phrase he never used, and one which would have been of little value. Where did she get the idea that the therapist stood ready to encourage more of her verbal overproductions? Though, indeed, he would have welcomed a greater effort on her part to "seek out the answers" to her resistance, he knew that what she meant by "more" was more of the same--a frenzied, defensive monologue from which introspection was all but precluded. As she put it a few minutes later,

> "I see your position as sitting there and being a thing that's only satiated through words, words, and more words [laughs], and, no matter how much I say, I feel you could definitely sit there another five hours and listen to me talk. I feel I have to talk, even if it's garbage."

3. *An Adaptive Shift to Secondary Process. Under pressure*

from his conscience to restrain his hostility and restore a working relationship, and with a little help from the patient, the therapist was able to hold in check enough of his aggression to do the only thing that is therapeutic when empathy fails, namely, to observe in a relatively detached and rational manner. His observations brought him an immediate and unsettling awareness of her anxiety and her wish to see him as urging her to talk.

As he wondered what could be making the patient so anxious, the therapist remembered her earlier mention of the word *dependent,* a quality the patient seemed to expect of herself, but was contemptuous of in her friends. All of a sudden, the therapist understood what the patient meant by dependency: a kind of emotional subjugation in which she would be at the therapist's mercy. Far from not being "phased" by therapy, this was a patient in extreme dread of what might lie ahead. Therapy was "good for me" so long as it did not elicit such fears, but it became a "life and death" matter when she could catch a glimpse of how helpless she might feel. Now, too, the wall of words she erected and her resistance in general could be understood as attempts to ward off this feared outcome.

4. Projection. Corresponding to the more rational observations and hypotheses of the therapist in this and the previous stage was a major change in the way he represented the patient. Quite unconsciously and reflexively, he represented her as, like himself a moment before,

exasperated and helpless in reaction to the overpowering and belittling behavior of another. Similarly, her anxiety was represented along the lines of the superego anxiety the therapist had been experiencing: a reaction to the harsh, demanding, disapproving voice of conscience--a reaction she had helped to induce. As so often is the case, the feelings the patient had induced in him were a virtual mirror of her own, and the therapist's understanding was blocked until he could plausibly attribute them to her, accepting his experience as a vicarious one.

By this time, the therapist no longer felt hostility toward the patient. Instead, he became aware of a kindly, protective feeling, which grew out of his understanding of her fear and resistance. There was also an increase in his self esteem (that is, a drop in hostility toward himself) as he began to feel like a "good" therapist again. Nor did he experience the patient as hostile any longer.

Despite this change in the emotional climate of the session, the therapist's understanding was far from complete. In particular, he had as yet no clue as to why the patient was so frightened of him. Then, quite belatedly, his associations to the idea of dependency led him to the answer: he recognized that the patient was relating to him as a transference figure. Her quarrel was not with him, but with an insatiable, sadistic, and frightening object of her own, in relation to whom her fears of dependency had originally arisen.

From much other material,[13] it was clear that the patient was in part re-enacting a struggle over toilet training in which, on a symbolic level, words equalled fecal products, talking was equivalent to compliance at toileting, the therapist was an intrusive mother who could only be satisfied when the last little turd was forthcoming, and who was sadistically prepared to wait "five hours" for that event.

The therapist could now sense how genuine was her feeling of danger, how desperately she attempted to pacify him with "words, words, and more words." In contrast to the earlier paraphrase, the new one went like this: "I am afraid to let you mean anything to me because I am afraid you will be just like my mother. Fears like this poison all my relationships."

5(a). Introjection (Idealization) and Identification. The therapist had recovered the patient as a "good" object. To some extent, this involved a sublimated object-libidinal cathexis (his "kindly" feeling), but the narcissistic quality was evident, too, in the simultaneous restoration of his self esteem and his creation of a selective, idealized representation of the patient, in which he was willing to credit her with the same "realistic" basis for her transference reactions as he had earlier accorded his own countertransference.

In her reconstituted form as a "good" object or ego ideal, the patient had, so to speak, an unearned position in the

therapist's mind. She was the same resistive, unpleasant person with the same veiled contempt for her therapist, except that now she was seen as psychologically justified in her behavior because of the new interpretive frame through which the therapist was motivated to view the situation. Whereas his prior hostility can be understood as a talionic response induced by her own aggression, no such process accounted for the subsequent libidinization of his object representation: he saw her as "good," in essence, for reasons of his own, not because she, the external object, had in any way induced that change.[14]

These alterations in his representation and cathexis of the patient required a corresponding change in how he perceived himself: he needed to be some one capable of provoking such dread and resentment as the patient was experiencing. Because there was little or nothing in his overt behavior that could explain such a reaction, he had to look elsewhere for the cause. In searching unconsciously for a way of representing himself that would complement the patient's emotional state, the therapist was assisted by his earlier sense that the patient wanted to see him as demanding "more" of her, by the now dissociated representations of her as controlling and hostile, and by his earlier countertransference. From these fragments he constructed a representation of the patient's "bad" mother, formed a trial complementary identification with that representation, and thus came to understand the transference

and genetic implications of the patient's resistance. Representing himself as the patient's mother also allowed the therapist a deeper and richer understanding of the patient's emotional state and the childhood context in which it had first arisen. For brief moments, his identification shifted from the frightening and impatient mother to the toddler, cranky and squirming on the toilet seat.

In making these identifications, the therapist was relying on a split in his representations, in which all that was "good" about the patient was represented as a "good" object or ego ideal, with whom he could identify, while all that was "bad" was represented as the "bad" mother with whom she struggled internally, and with whom the therapist formed a trial complementary identification.[15] The split in the therapist's mind reflected a similar dichotomy in the patient's mind, in which, as "herself," she was the frightened, coerced child attempting to cope with the demands of an intrusive mother by complying and resisting, while in identification with her mother (identification with the aggressor) she belittled what her object (the therapist) had to offer and showed contempt for his feelings.

The therapist's introjective idealization can be attributed in part to reaction formation (as can the formation of the ego ideal; Freud, 1923, p. 56) so long as it is kept in mind that it brought the therapist a much closer appreciation of the patient's unconscious view of herself in the situation and was, therefore, appropriate to

his empathic task.

The fate of the therapist's aggression can be formulated as follows: a neutralized portion was absorbed into secondary process, where it assisted his intellectual understanding; another fraction, less fully neutralized, cathected his object representation of the patient's mother; the remainder seems to have been repressed as part of a defensive but adaptive idealization of the patient. The therapist's motivation to carry out these energic shifts stemmed from the pressures of conscience and the wish to recover the patient as a "good" object.

The therapist settled into a more or less comfortable, passive state in relation to the patient; knowing what was expected of him, he could follow along with the patient's transference script without risk of aggression or withdrawal. He obligingly accepted the patient's unconscious view of him as a demanding, controlling, and malevolent figure.

5(b). Introjection (Authority). The patient was endowed with a prescriptive right to dictate the terms of the transference relationship. Her influence as ego ideal required that the therapist relate to her passively, as her object. In particular, he was obliged to adopt the role of the patient's original sadistic object, altering his self representations to accommodate her in this respect. His behavior recalls Nunberg's observation that, "whereas the ego submits to the superego out of fear of punishment, it

submits to the ego ideal out of love" (1932, p. 146).

In the intimacy of this situation, the therapist shifted significantly from the detached, observing role he had earlier adopted. His perception of the situation changed from a relatively simple view of an obnoxious, resistive patient and a well-intentioned but frustrated therapist to a much more complicated emotional matrix in which both he and the patient were simultaneously enacting the role of the patient's mother as well as the role of the mother's victim, and in which wishes to hurt, control, ward off, appease, and preserve as "good" an ambivalently cathected object could hardly be subjectively localized in himself or the patient, but instead passed in a fluid fashion back and forth, making a relationship in which the designated roles would not remain stable.

5(c). Introjection (Transitional Representation). In this context, self and object differentiation was temporarily and partially abandoned. It was replaced with transitional mental representations in which the patient as "good" object or ego ideal was unconsciously brought into association with the archaic, idealized introjects of the therapist's first objects and with ideal representations of himself. The patient as "bad" object had ceased to exist, replaced by a transitional representation in which the patient in identification with her mother, the therapist in identification with the patient's mother, and the mother herself were represented in the therapist's mind with a

relatively limited degree of differentiation.

Of the two separate transitional representations ("good" introjects associated with the ego ideal and "bad" introjects associated with conscience), the former was more strongly cathected and felt more real, while the aggressive character of the latter functioned more as an ego-controlled fantasy structure.

The patient's transference can be conceptualized as an attempt to punish the therapist for "being" her mother, the effect of which, in the therapist's mind, would have been a shift in aggressive cathexis from his superego to his ego. From the point of view of his personal equilibrium, however, this could not be accomplished. His ideal representations of himself had been brought close to realization by his success in overcoming his hostility, by his better understanding of the transference, and by a representation of himself as her "good" mother. "Punishment" of the ego was, therefore, precluded by the lack of tension between his ego and ego ideal. In addition, the therapist's complementary identification with the patient's mother reflected not so much an active wish to become her, but more of a passive motivational state, a willingness to be identified *with her, which seems characteristic of the adaptive use of complementary identification. The net effect of these representational and motivational factors was that the therapist's superego could not be induced to act as a conduit for the patient's hostility. The*

potentially destructive consequences of experiencing her negative transference as a personal attack, of responding in kind, or of feeling attacked by his own conscience were thereby averted.

Summary and Concluding Remarks

As a structural term, introjection refers to the creation or maintenance of a transitional mental representation, one that bridges the psychological gap between self and other. From the genetic point of view, introjects are necessarily modeled after the mental representations characteristic of early life, before parental object representations were well-differentiated from self representations. As such, they partake of some of the qualities of those early object relations and are associated with the superego, which, as the part of the personality most closely tied to those early objects, is itself a transitional mental structure.

Empathic introjection places the patient in the role of the ego ideal, (a) inviting a trial identification, (b) idealizing the patient to the extent that he (like the early objects) is regarded as "right" and "good" and protected from aggressive reactions by the therapist, (c) setting up the patient as an intrapsychic authority to which the therapist is accountable, and (d) providing an adaptive route for overcoming loss of emotional contact with the patient, a situation that is genetically related to early

experiences of object loss.[16]

In a broad sense, empathic introjection can be said to characterize the usual state of the the therapist who, at the moment, is neither identifying with the patient nor in a more fully differentiated, more purely observational posture. It is also the structural state associated with evenly hovering attention while the therapist is in the role of transference object. More narrowly construed, an *act* of introjection takes place when the motive to regain emotional contact with the patient becomes paramount, typically when countertransference aggression threatens a breach in the therapeutic relationship.

Introjection involves an intrapsychic *relationship* between the subject and the introject (Schafer, 1959, p. 348; 1968, p. 16; cf. Loewald, 1970, p. 59), which helps to distinguish introjection from identification, in which the "relationship" is one of identity. In the context of empathic introjection, brief, trial identifications may also occur, either directly, with specific representations of the patient, or (more typically) as complementary identifications with representations of the patient's objects. The former, however, requires that the therapist momentarily or partially step out of the role of transference object, which permits these intermittent, direct identifications to be distinguished from introjection proper. Still, an absolute distinction between introjection and identification is not possible, even in theory, any more

than the ego and superego can be fully distinguished. But introjection in general describes a change in the superego and in the way an *object* is represented, whereas identification refers to a change in the ego and in the way *self* is represented; although changes in self representation may also occur with introjection, they are not modeled after the object, as is the case with identification.

Introjection becomes an increasingly important concept as psychoanalysts have begun to realize how few significant object relationships are with objects represented in a more or less fully differentiated fashion. On the contrary, introjective, transitional, or selfobject relationships tend to be the norm, both in pathological and in healthy, adaptive behavior.

In its old (and here discarded) meaning of *taking in*, introjection was able to occupy an exalted place in empathic understanding. Where it was necessary to comprehend something foreign to one's own experience, this could be accounted for by some structural counterpart to incorporating that experience. Carried to an extreme, it was possible to "introject" another's mind or ego by some process analogous to taking a sip of tea (Fliess, 1942). If this somewhat magical route to understanding alien experience is psychologically and theoretically unjustified, introjection must occupy a more humble place in empathic understanding than previously, restricting itself to what the therapist can accomplish within the limits of his own

experience and personality; to the extent that the patient's life is utterly foreign to the therapist, introjection can provide no special access (cf. Reik, 1937, p. 199). Paradoxically, although empathic introjection presupposes a far greater degree of narcissistic involvement by the therapist than has previously been acknowledged, it stops far short of the almost grandiose fantasy that underlies the old view of introjection, according to which the contents of the patient's mind are somehow mentally appropriated by the empathic therapist.

Notes

1. More correctly, an object *representation*, but the literature has not always made this distinction.

2. In keeping with the thesis that psychic processes such as regression, projection, and introjection should not be restricted to pathological applications, it can be noted in passing that Ferenczi shared this view: "the paranoiac projection and the neurotic introjection are merely extreme cases of psychical processes the primary forms of which are to be demonstrated in every normal being" (1909, p. 48; see also pp. 50, 52 and 1912, pp. 317, 318).

3. This question recalls the old dispute as to whether libido is primarily pleasure-seeking or object-seeking (cf. Fairbairn, 1952, p. 137).

4. With this definition, introjection cannot be equated with transference, as Ferenczi did, but secondary introjection does constitute the structural or representational (as opposed to the dynamic or instinctual) aspect of transference. In Ferenczi's definition of introjection, the dynamic and structural points of view were combined. It may be better to separate them in order to allow for the variety of different dynamics that are associated with introjection in contexts other than transference.

5. Nor is it difficult to reconcile with the kind of meaning that Reik (1937), Fliess (1942), and Greenson (1960) seem to have had in mind, as outlined at the beginning of this chapter. Consider, for example, Greenson's statement that "a working model of the patient....is an internal representation which is not merged with the self and yet is not alien to the self" (1960, p. 423).

6. Restricting introjection to the formation of the superego essentially limits it to the relationship with the earliest objects of infancy, ordinarily the parents. This, of course, is very different from what Ferenczi (1909) intended when he described introjection as, like transference, an aspect of the relationship to later, "new" objects. Both seem to be valid and useful meanings.

7. The absence of ego-superego conflict cannot, by itself, be taken as proof of the ego's having identified with the superego and taken over its functions. Many ego activities--perceptual, cognitive, and motoric--have a low enough potential for conflict with the superego so

as not to require any particular modification of the ego in identification with superego requirements (cf. Hartmann, 1939, pp. 8-9). However, when the ego more or less automatically modifies its intentions at the cost of potential gratification and in obedience to the superego, then identification by the ego with the superego has taken place.

8. The present work is, of course, no exception.

9. Why the ego ideal is more involved in empathic introjection than is conscience requires a few words of explanation. Therapists do, of course, at times represent their patients as aggressive introjects, but this tends to occur either when the therapist has failed to recognize the transferential quality of an aggressive assault by the patient and takes it as a personal attack (See the clinical example at the end of this chapter) or when the patient berates the therapist for some actual technical or other failing with no particular transference significance. The arousal of conscience under either of these conditions (or in general) makes empathy more difficult except insofar as that moral pressure induces adaptive efforts by the therapist to achieve or resume empathy, which typically involve a change in representation of the patient from aggressive introject to ego ideal. By and large, the conscience of the therapist asserts itself most vigorously when he has lost empathic contact with the patient. Though the capacity for empathy and the activity of conscience are not mutually exclusive, they do, therefore, seem inversely related.

10. It is tempting, but unwarranted, to assert that the therapist's representation of the patient *was* realistic because the patient decided to remain hospitalized. That outcome was welcome, but hardly predictable. If, as Greenson suggested, the analyst must be both gullible and skeptical (1966, p. 276), the gullibility seems more associated with the idealizing aspects of introjection, the skepticism more a matter of the empathic projection of qualities the patient needs to defend against recognizing in himself.

11. Cf. Winnicott, who considered a transitional object to be "a defence against anxiety, especially anxiety of the depressive type" (1953, p. 91).

12. Greenson's view that the best empathizers have a tendency to depression (1960, p. 424) was noted in chapter 3.

13. Some examples of the material supporting this assertion, all from the same session: "I mean, you sit

there like I still have to talk. He's not satisfied...I feel like I've got to talk. Sometimes I feel like a fool if three seconds go by and I don't say anything. I have a friend who went to her therapy session with a book and sat there reading it the whole time. I thought that was hysterical. It's like I have to take the initiative and words have to come out. It's very difficult; it's painful...I feel I *have* to talk...It's very uncomfortable to just sit here, so I feel I have to talk...Either I don't talk and feel uncomfortable, or I *do* talk and feel uncomfortable about having to continue...If I were sitting here alone, it wouldn't phase me, but there's another living thing sitting in another chair that I see as waiting for me to talk, and I get anxious about that person's patience. I feel you'll be patient with me, realistically, but there's another part, like I have to perform for you. I'm not scared that you'll scream at me to talk. I'm sure, if I was in your position, it would frustrate me to have this person not open her mouth."

14. An unconscious idealizing motive on the patient's part can, of course, be postulated, and evidence for it exists in her expressed view of the therapist's interpretations as amazing. But to say that this induced an idealizing response on the therapist's part seems unwarranted.

15. Compare this process with Rado's classic formulation of the double introjection characteristic of melancholia, a similar intrapsychic phenomenon with similar aims of resolving ambivalence about a lost object, though in a more instinctualized form:

> The "good object," whose love the ego desires, is introjected and incorporated in the super-ego. There, in accordance with the principle which...governs the formation of this institution, it is endowed with the prescriptive right...to be angry with the ego--indeed, very angry. The "bad object" has been split off from the object as a whole, to act, as it were, as "whipping boy." It is incorporated in the ego and becomes the victim of the sadistic tendency now emanating from the super-ego. (1927, p. 60)

16. These formulations are equally applicable to theories of parental or maternal empathy.

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