Dimensions of Empathic Therapy

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Editors

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Fred Bemak

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severely distressed human beings can be treated in a caring milieu without resort to psychiatric medication.

Peter and Ginger Breggin

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I

The Concept of Empathy

1

Teaching and Learning Empathy: An Overview

Fred Bemak and Peter R. Breggin

Empathy is rarely taught in graduate and professional schools. Perhaps it is assumed that aspiring therapists and human service providers will absorb empathy from modeling their professors and supervisors. Needless to say, this is too often not the case. Instead, empathy may be discouraged and even stifled during the educational and professional experience.

Empathy is often learned outside of formal training. It may be experienced with loving family members, significant mentors, teachers, spiritual leaders, and other role models in their lives. Sometimes the responses of patients and clients alert young professionals to their lack of empathy or to the value of the empathy that they do express.

Based on our belief that empathy is essential to good professional practice, we have chosen to explore and present empathy from a variety of perspectives. We have brought together an interdisciplinary mix of the authors as professors, practitioners, center directors, and clinicians, some of whom are nationally and internationally recognized leaders in their fields. It

is striking that they come from a range of mental health disciplines including psychiatry, counseling, psychology, and social work.

This book addresses empathy within the scope of clinical practice with perse approaches that include working within unique therapeutic treatment milieus; treating children, adolescents, the elderly, and families; and providing empathy within the framework of established intervention models. Various themes are also explored such as the interrelationship of empathy with love, self-awareness, and self-transformation, as well as the use of specific techniques, such as writing, to foster empathy. The book further delves into empathy as a cornerstone of personal life and professional practice with stories, reflections, and personal journeys. Empathy is explored and discussed within the framework of culture and cultural differences. Finally there are examples of how empathy has been introduced to professionals within a graduate level training curriculum.

Tracing empathy back to the roots of our training can provide an interesting perspective about the continuum of our growth and development. Several graduate students in the counseling program at George Mason University were interviewed about their experiences in learning about empathy during their training. Their comments are poignant and provide insight into how the process can begin for budding professionals. One student, Kerry Pelletier, spoke about how she was inundated with theories and techniques

as a student and intern. She commented, “I truly feel that my ability to work through all of my questions and concerns is directly related to the support of fellow students, professors, and my on-site supervisors. . . . I have been encouraged, supported and validated.” Interestingly, Kerry translates this information into understanding empathy. “What I am realizing is how truly invaluable empathy is for a client.” Another student, Josephine Selepak, feels as if she has “stumbled upon empathy several times during [my] graduate education.” She portrays the value of empathy with a wonderful metaphor. “Sometimes I feel like I am out to sea on a raft by myself. Whenever someone reaches out to me in empathy, there are more people on the raft with me, the shore is much closer.” Jacqueline Naughton, another student who worked with children with emotional disabilities for 8 years, echoes the views of her peers. She comments, “I have been given the gift of numerous professors who are not just knowledgeable and experienced, but truly understanding and empathetic to the roller coaster of emotions and thoughts that accompany the field of counseling.” Jackie believes that like “teachable moments” there are “empathetic moments” that can “make or break” graduate students. Finally, Charles D. Smith, a 48- year-old graduate student with 22 years experience as a teacher, struggled with early classes that were contradictory to his teaching background, found the empathy of a professor pulled him through his frustration as a new student. He discovered how empathy from faculty and his peers helped him grow, develop, and “touched his soul and lifted his

spirit." These testimonies are merely a sample of the power of empathy early on in training and provide a foundation for future professionals.

Within the perse collection of authors and multiple perspectives, a core theme resonates throughout this book. It resounds through examinations of training, practice, treatment, culture, and one's own self journey. The theme is this: Empathy remains at the heart of therapeutic life and is important throughout one's professional life.

Professional training should incorporate a more systematic and conscious approach to promoting the students natural empathy. Students can be encouraged to trust the importance of empathy in psychotherapy and to remain aware of their own life's journey and its impact on their capacity to care for and to understand other human beings. At all levels of professional development and practice, empathy should be woven into the other important facets of psychotherapy and human services.

Unfortunately, formal mental health education usually tends to impede and even to crush the student's natural, intuitive empathy for patients and clients. When counselors, psychologists, social workers, psychiatrists and other professionals are taught to rely upon the latest edition of American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders,* they are pressured to fit everyone into these cookie-cutter labels. Forcing the

life stories of inpidual patients to conform to these abstract diagnoses tends to discourage empathy and to encourage emotional distance. The client becomes a diagnostic label rather than a struggling human being in need of empathy and guidance.

Similarly, when health professionals are taught to rely on the prescription of psychoactive drugs, they are in effect instructed in how to suppress the emotional lives of their patients and clients. Instead of welcoming intense feelings in an empathic manner, they are encouraged to view intense feelings as dangerous and or alien in need of medical suppression.

In psychiatry, for example, students are sometimes taught "You can't talk to schizophrenia." The young doctor is discouraged from even trying to understand the patient's suffering and conflicts. Manipulation of the patient as an object becomes the only approved approach.

Understanding empathy usually begins with subjective self-understanding about our own emotions and needs. Yet one of the beauties of empathy is that it is universal. Empathy transcends culture, professional disciplines, religions, environments, and chronological and developmental age. It can happen at any time in any place. It can produce treasured experiences that are valued for a lifetime and can help inpiduals break through and resolve

serious psychological difficulties that confront them during the course of their lives.

The development of empathy is a lifetime work. It is never finished; it requires renewed inspiration as we are challenged by new experiences in every aspect of our lives. We hope our book will assist you in this never-ending path of personal and professional development.

2

On the Incompatibility of the Biological and Empathic-Relational Model

Douglas C. Smith

Biological psychiatry and psychosocial psychotherapy are two distinct ways of trying to help people. I believe they are polar opposites of each other, and therefore incompatible and un-integratable. I should know because I have practiced within both models. I trained and practiced in the biological model for about 10 years. The second model, which I prefer to call the "empathic-relational model," relies on the healing power of relationships rather than on mechanical or chemical manipulations of the brain. I have been practicing within this model for about 4 years. My skills for working within this model are still developing, but already I see dramatically better results and have far more satisfaction in my work.

Actually, most psychiatrists don't see themselves as practicing within just one model. Although some consider themselves to be pure psychopharmacologists, most consider themselves to be practitioners of a blended or integrated model. For years, I saw myself as practicing a blended

model. Indeed, I was highly regarded because I spent more time with patients and took more interest in their own perspectives than most psychiatrists did, even though I relied mostly on medications. But I eventually came to see that the models don't mix. They are based on diametrically opposite assumptions. The models can no more mix than can communism and capitalism, or religion and atheism. Attempts to integrate them result in confusion, contradiction, and a marked diminution in the power of empathy. Only by porcing the medical model can one unlock the full power of the empathic healing relationship.

To make this more clear, I need to discuss each model in more detail. When typical psychiatrists listen to patients, they are listening for symptoms. In their minds, they try to match those symptoms to *DSM* diagnostic criteria and to medication effects. For example, if a patient says "I've been so depressed I can't sleep," the doctor thinks to himself, "depressed; could be depression (with psychotic features?), or just dysthymia, or possibly bipolar." He also will begin thinking of antidepressants, particularly those that are sedating since insomnia is a symptom in this case. He will likely ask the patient some questions along this line of thinking: "How long have you been depressed?" "Have you ever been manic?" "What antidepressants have you tried in the past?" This particular line of questioning may be in line with the patient's own train of thoughts, but most likely not.

In contrast, a doctor working within the empathic-relational model would not likely impose a line of thinking on the patient, but rather, would stay with the patient's own flow of thought. For example, the same patient, unimpeded, may go on to talk about a difficult conflict in a relationship. An empathic listener would be very interested, since this may well be the heart of the issue. A typical psychiatrist may never hear about the relationship conflict, or if he did, would be interested only to the degree that it may reflect further symptomatology ("Could this be manic irritability? A personality disorder? PTSD?"). Other than that, the conflict will be seen as irrelevant, or as a side product of the mental illness, or as a nonspecific stressor that tipped the (genetically?) depression-prone patient over into a full depression.

Psychiatrists usually don't state it explicitly, and may not even think about it, but they view symptoms as meaningless and purposeless. Symptoms are thought of as products of mental illness. They are best gotten rid of or suppressed as much as possible. We could say this is an anti-empathic viewpoint, since empathy involves meanings and purpose. But ironically, the patient may experience the psychiatrist as being superficially empathetic in that the patient usually doesn't understand his symptoms either, and often (unconsciously) wants to deny or conceal their meanings. The patient may be relieved to hear the implicit message that the symptoms mean nothing. But the doctor, in this case, is participating in and reinforcing a system of denial.

In contrast, the empathic listener receives and holds the patient's communications (including symptoms), assuming them to be meaningful even when the meanings are not readily apparent. The patient can then, through thoughtful dialogue and interaction, eventually come to understand these meanings and accept previously unacceptable or unthinkable aspects of himself. This process is ultimately experienced by the patient as profoundly empathic.

For example, depressed patients presenting in a psychiatrist's office, quite commonly do not know why they are depressed. The empathic listener will hold to the idea that the depression has understandable meaning, even if not understood yet. In the course of an interview, obvious sources of depression usually come to light. Sometimes a longer more intensive search is necessary. I have never yet (since reforming my practice) encountered a depressed patient whose source of depression could not be eventually found and understood. In my early years of practice, I would usually pick up the more obvious sources or "meanings" of depression, such as porce, trauma, and loss, but I would often get stumped in more complex or subtle cases. That's when I found myself wondering if the depressions were "endogenous," that is meaningless, and I would often pull out the prescription pad. Typical practitioners will see and understand the source and meaning of symptoms to a point, but beyond that point, they assume that no meaning exists. Empathic practitioners, in contrast, always see human experience as meaningful.

The patient can ironically experience the prescription of a medication as empathic since it feels like the problems are being taken very seriously and addressed with a powerful-sounding treatment. The patient may eagerly comply. If at all reluctant, the patient is told that taking medicines for depression is just like taking insulin for diabetes or wearing corrective eye-glasses. Most patients have great misgivings about surrendering their mind to a chemical, but they may be desperate for relief and understandably trusting of a medical professional. So many accept a drug. We know that the results are not good. Antidepressants leave most patients still with significant impairment (Antonuccio, Danton, DeNelsky, Greenberg & Gordon, 1999; Fawcett & Barkin, 1997). The majority of patients on antidepressants feel that their psychiatrist "doesn't really understand them" (National Depression and Manic-Depressive Association, 1999). Most patients drop out of treatment within a few weeks or months (Ramirez & Rush, 1995)—usually without discussing it with their psychiatrist. Those who go back to complain are given a higher dose or one or two more medicines to augment the first. When they try to go off the medicines, many, perhaps most patients, will relapse or have a "rebound" depression simply because of the effects of medication withdrawal (Breggin & Cohen, 1999). They complain again to the psychiatrist only to be told that lifelong medications are needed, probably in ever higher doses with ever more augmentation. The empathic rift grows. Psychiatrists do not acknowledge these facts and are unable to accept the patient's

viewpoint. Instead the patient is "educated" more and more about the need for lifelong compliance.

This is a stark contrast to an empathic healing relationship, which, although often slow and sometimes painful, will almost inevitably lead to a greater sense of feeling understood and to greater understanding of the previously split-off aspects of the self. How does this work? An exact understanding of the healing effect of human connection is a profound mystery. But there is a lot we know. Infant research is revealing more and more about how the mind develops and many of the principles hold true in adulthood. For example, it appears that the infant is very much dependent on the mother (or person in the mothering role) for not only relief and soothing, but also for the development of mental processes, or a system of meaning. The baby cries out to the mother in a chaotic, panicky state, which the mother receives and "metabolizes" into something meaningful and solvable—hunger, wet diaper, sleepiness, and so forth. The baby eventually grows to understand and internalize these meanings. I believe that empathic relationships serve much the same function throughout the life cycle.

The therapist, like a good mother, provides relief and soothing by accurately receiving the patient's mental state, and doing much of the work of "mentalizing" the patient's experience and reflecting it back to the patient. The patient grows to understand himself and accept aspects of himself that

had been unthinkable or unknowable. He also develops the ability to reflect on his own experience. The ability to be reflective and to mentalize experience appears to be what provides the capacity to endure pain and trauma (Ammaniti, 1999). Without this ability, the pain seems overwhelming and meaningless—like a black hole.

Of course, this is a very sketchy portrayal of a wonderfully complex process, but it should suffice to illustrate how antithetical it is to medical psychiatry. Psychiatry is a bit like the synthetic hands that reach into the sterile incubator to tend to hospitalized newborns' most rudimentary needs. They provide a transient relief of hunger or stomach gas, but without the healing presence of the mother—her arms, breast, warmth, voice, and gaze—the baby will eventually die. Patients given medications for their symptoms may get transient relief, but they are not helped to reflect on or mentalize their experience. In fact, they become even more alienated from themselves and more hopeless.

Mrs. B., is a 54-year-old woman referred to me by her family doctor because she was considering suicide. She reported to me that she had been recurrently suicidal throughout her life and that the wish to die was sometimes so strong that she would plan out her suicide in detail and then come within inches of carrying it out before stopping herself. Sometimes she wouldn't stop herself, but she had always survived the attempts somehow.

After a brush with death, she would experience relief and be in a good mood for several weeks or months before the cycle would start over again. She did not understand why she went through these dramatic mood cycles and found it odd that I expressed curiosity about it. “All my other psychiatrists told me I had a chemical imbalance, but you seem to be assuming there is more to it.” Several months went by in which she made small but significant gains in understanding herself vis-a-vis her relationship with me, but the suicide cycles continued. A breakthrough occurred 7 months into treatment when she uncharacteristically began quietly crying during our session.

> “I have to tell you something.” She said: I’ve been wondering to myself for a long time why you haven’t put me on medications yet, but I’ve been afraid to bring it up with you because I thought it was because you didn’t really care about me, or you didn’t get the message yet about how suicidal I am; like maybe you didn’t believe me or take me seriously. Every psychiatrist I’ve ever been to put me on medicines right away—everything from Elavil to Haldol. Some have even tried to put me in the hospital, which you also have never even mentioned. But I just now realized that you do care about me. In fact, you care more about me than I cared about myself, because you treat me like a human being. You treat me like all my craziness makes sense even though I didn’t think any of it made sense until you helped me see it. And you know, all those other psychiatrists were just scared of me I think. They were giving me pills because they didn’t know what else to do. They just wanted me to stop being suicidal so they wouldn’t have to worry about me, so they could sleep at night. But you are different. You understand me as a person. And I’ll tell you something else; I think if you had prescribed drugs for me you would have never seen me again.

Mrs. B.’s therapy has progressed over the 2 years since that time. We

have gone through many ups and downs together, but she has never been suicidal since that session. In fact, she told me recently that for the first time in her life she knows what it is like to feel happy. And she remains drug-free.

I have been using the example of depression so far, but the situation with psychotic patients is even worse. They suffer terribly in the (synthetic) hands of psychiatry. Most psychiatrists know what it is like to feel depressed since all people feel sad from time to time, but few understand what it is like to be overtly psychotic. Psychiatrists very quickly run up against the limits of their ability to understand meanings when dealing with psychotic patients. Psychotic symptoms then, are nearly always viewed as abnormal products of a defective brain. The singular goal becomes the suppression of the psychotic symptoms—and with them, the patient. A psychiatrist may have respect for a depressed patient's wish to rely on psychotherapy rather than medication, but never a psychotic patient's. Psychotic patients are cajoled and coerced into accepting not only medication, but the psychiatrist's view of their symptoms. The empathic gulf between doctor and patient is wide and deep. I believe this is why psychiatric treatments fail to improve the course of psychosis in any way (Kane & Freeman, 1994). In fact, outcomes for schizophrenia in this country are getting worse despite the advent of and possibly because of expensive new medications (Warner, 1994).

I want to say more about attempts to integrate the two opposing

models. Some readers may still think—as I used to—that we should borrow from the best of both worlds. We should provide symptomatic relief and at the same time provide an empathic relationship that promotes self-understanding and healing. Probably Mrs. B. debunks this way of thinking more eloquently than I could. I think that all patients in their heart of hearts have the same sense of things as Mrs. B. had, although they may not be aware of it any more than Mrs. B. was at the start. I received an e-mail recently from someone who said her psychiatrist would "dismiss her" by handing her a prescription at the end of their therapy sessions. She said that she eventually came to see that she "was being dismissed in more ways than one." Actions always speak louder than words. No amount of empathic listening will undo the clear message of the prescription pad.

The NIMH conducted an enormous multicenter study to compare medication, psychotherapy, and the combination for the treatment of depression. The data appeared to show psychotherapy to be at least as effective as medications or the combination, but the conclusions are frequently questioned and debated. One important finding often gets overlooked, however. Certain therapists in this study seemed to consistently get much better results than other therapists or other forms of treatment. The study was unusual in that it recorded provider variables. This allows us now to go back and determine the characteristics of those "super-therapists." It turns out that age, sex, years of practice, and theoretical orientation were all non-predictive.

Only two factors were statistically significant predictors of the super-therapists: First, they did not believe in psychiatric medications, and second, they expected therapy to work, but expected it to take longer than most therapists did. This finding supports my contention that efforts to mix medicine with therapy end up hamstringing the treatment or condemning it to superficiality or outright failure.

The right hand cannot welcome with empathy the very same aspects of the patient that the left hand is prescribing a drug to suppress. This is why I had to radically change my practice and my way of relating to patients. I invite all of psychiatry to follow my example so that it may become a healing art rather than what it is now—an industry of suppression.

REFERENCES

Ammaniti, M. (1999). How attachment theory can contribute to the understanding of affective functioning in psychoanalysis. *Psychoanalytic Inquiry*, 19, 784-796.

Antonuccio, D., Danton, W., DeNelsky, G., Greenberg, R., & Gordon, J. (1999). Raising questions about antidepressants. *Psychotherapy and Psychosomatics*, 68, 3-14.

Basco, M., & Rush, A. (1995). Compliance with pharmacotherapy in mood disorders. *Psychiatric Annals*, 25, 269-279.

Breggin, P., & Cohen, D. (1999). *Your drug may he your problem.* Reading, MA: Perseus Books.

Fawcett, J., & Barkin, R. (1997). Efficacy issues with antidepressants. *Journal of Clinical Psychiatry,* 58(suppl), 32-39.

Kane, J., & Freeman, H. (1994). Towards more effective antipsychotic treatment. *British Journal of Psychiatry,* 765(suppl. 25), 22-31.

National Depressive and Manic-Depressive Association. (1999, November 30). Most patients report troublesome side effects, modest improvement using current antidepressant treatments: New survey also shows dissatisfaction with treatment and care among people with depression. [Press release]. Chicago: Author.

Warner, R. (1994). *Recovery from schizophrenia.* London and New York: Routledge.

3

The Changing Face of the Ideal Therapist

Leslie Wolowitz

"Mirrors should reflect a little before throwing back images"

Jean Cocteau

Psychotherapy, in all its guises, has become a culturally sanctioned avenue for personal transformation. As such, the role of the psychotherapist is a relatively powerful one, both because it is invested with moral authority and because of the inherent healing potentials that psychotherapy carries. However, not all psychotherapies are created equal. A growing split is occurring as a managed care version of the medical model requires therapy to be short-term, diagnostically oriented, and manualized with prescribed techniques and goals. This form of "therapy" accommodates a technocratic bureaucracy where immediate costs are the "bottom line." It also appeals to our 'fix-it' mentality of medications, self-help books, and generic solutions to life problems. On the other side of the split, is an ever growing number of psychotherapists and counselors who believe that there is no substitute for an authentic relationship with a designated 'healer' entrusted with that

responsibility, that unfolds over time. The following discussion is devoted to those involved in the ambiguous, dynamic process of change and growth. It is important to recognize that I speak from a particular perspective. This perspective, while limited, is what I know best. I am a psychoanalytic psychotherapist first, and second, a person who teaches clinical psychology graduate students theory and practice. These experiences inform my questions: what is our most current thinking about what is transformational in psychotherapy; what is curative in the "talking cure"? A related topic to explore is how the use of empathy fits in with the 'latest edition' of the effective therapist?

The quest to identify the "therapeutic action" has continued since Freud despite numerous research efforts, perse accounts of therapies, and a wealth of theoretical ideas. Undoubtedly, this is because of the complex, multifaceted nature of healing and growth. These therapeutic factors may differ across patients and often vary within the course of any single therapy. Change is extremely difficult. As psychoanalyst Phillip Bromberg (1993) asks, why should people change, given the almost gravitational-like pull of staying the same. Change is disorganizing and unfamiliar; it involves personal will, a hope for something better, trust, and opportunities in the world that may be beyond either participant's control. In the following chapter I examine how the empathic approach or empathic position has become an overarching construct in psychotherapy; a meta-discourse. While empathy appears to be

foundational to a successful healing relationship, it is widely overused and misused. The tyranny of dogmatic empathy undermines the therapist's authenticity and spontaneity. It can serve as an avoidance of more profound contact by both the therapist and patient. Theoretical adherence to empathic constructs may stifle curiosity about relational qualities better described by other concepts. A case example is provided to illustrate some of the difficulties the therapist and client (patient) face in trying to forge an authentic, constructive relationship. Finally, I discuss how the concept of mutual recognition suggests that empathy is only *one response of many* that may catalyze a turning point in therapy.

THE CHANGING FACE OF THE IDEAL THERAPIST

One way to approach the question is to describe the changing picture of what a good enough therapist looks like over the 100 years since psychotherapy began. My account is highly selective and truncated. Within this context, we will see how empathy has been placed in a privileged position with regard to the therapist's approach. Contemporary accounts provide a balance to the emphasis on the therapist's function as an empathic mirror.

At the risk of oversimplifying Freud and the "classical" position of psychoanalysis, interpretation of unconscious conflicts and processes is seen as the work of the psychoanalyst and the basis for his authority (I will change

pronouns later in the chapter to represent the analytic couple as both genders). These interpretations help the patient to understand and control her symptoms. Ultimately, she can make mature compromises rather than employ symptoms that unconsciously express infantile wishes and the defenses against them. Furthermore, the analyst is to remain neutral and detached; a blank screen to absorb the patient's transference. The analyst is himself "well analyzed" and thus purified of potentially interfering neuroses. His neutrality is supposed to guarantee that the patient's perceptions of the analyst are uninfluenced by the analyst's behavior and personality. Here the capable analyst can spot the patient's transference and analyze it, rather like a detached surgeon would cut out the offending tissue (Freud,1912; Renik, 1993). The analyst does this by listening in a unique way to the unconscious narrative of the patient. In this way, Freud finds the passive complement to the active metaphor—he is both analyzing instrument and receptive listener. This is built around the idea of therapist as a seer of hidden meaning, like the prophet Teresias in the Greek mythology that Freud loved.

Within Freud's inner circle there were subversive challenges to this portrait. Most notably is Sandor Ferenczi's vision of the analyst's purpose. He believed that the cure came from the analyst's "love" for the patient and his ability to react in a truthful and open way. He made an effort to distinguish this from a giving in to the transference love demanded by the patient. He emphasized the tender, nurturing aspects of the analyst's love, identifying it

as “sincere sympathy” and “maternal friendliness”. Physical contact, in the form of touch, was used with some patients who had been sexually abused in the hopes of healing the trauma. (Homeke, 1999; Ferenczi, 1926). He further recognized that patients needed to analyze their therapist, as the therapist’s conflicts were inevitably not fully resolved (another radical departure from Freud). He even experimented with “mutual analysis” whereby the patient and analyst would literally trade places! Ferenczi acknowledged the failure of this experiment, as he fell prey to becoming involved in friendships and romantic liaisons with some of his patients. In this way he sacrificed the integrity of the analyst’s role for his interest in developing a more mutual relationship. However strange his technique of mutual analysis might strike us, it is only now that we acknowledge the truth of how reciprocity of healing is woven into a profound therapeutic relationship. Examples of these role reversals are found in recent popular movies about psychotherapy. We see how the insightful patient senses and attempts to heal the therapist’s conflicts and wounds. In *Good Will Hunting,* the young patient (played by Matt Damon) will not begin to trust his therapist (Robin Williams), until Williams acknowledges his patient’s observation that he is stuck in his love for his dead wife. In this way, both patient and therapist challenge one another to risk loving. This is also an aspect at play in the comedy, *Analyze This,* as the patient (Robert DeNiro) helps his analyst (Billy Crystal) confront, with comic irony, his oedipal rivalry with his successful psychiatrist father. Ferenczi’s

description of the analytic work begins to resemble the empathic approach. Ferenczi suggested that the analyst treat the patient with sympathy, genuineness, and a kind of maternal care that lay in sharp contrast to Freud's analyst-knows-best model.

Another portrait of the good-enough analyst that began to explore the value of emotional attunement and empathic resonance came from the object-relations group. Object-relations theory asserts the primacy of people's hunger for satisfying human contact over the drive for sexual and aggressive instinctual gratification proposed by Freud. The British pediatrician and psychoanalyst W.D. Winnicott, championed the "care cure" over the "remedy cure". Winnicott s theory and accounts of his therapeutic style, indicate that he believed that the analyst should adapt to the patient's needs. In many ways, Winnicott drew parallels between his idea of the "good- enough" mother and the good analyst. The analyst was to provide a facilitating environment. This holding environment could include literal hand-holding as well as containment in the form of adjunct hospitalizations (without medications) for his more regressed and fragile patients. The analyst's "job" was to facilitate the patient's "true self" to emerge through spontaneous play that would occur if the patient perceived the analyst as safe and caring. While the patient and analyst worked on an intellectual understanding of her history and the impingements that lead to falling ill; much of the work was in the patient's creative use of the analytic relationship to provide a new way of

relating with another and hence, a new of being.

Empathy, per se, becomes a cornerstone in psychoanalysis, with the work of Heinz Kohut and self-psychology. He asserted that the royal road to understanding was through empathic listening; defined as "vicarious introspection"(Kohut, 1959). Working with patients diagnosed with narcissistic disorders (alternatively called disorders of the self), Kohut became interested in representing patient's experience from their subjective point of view, rather than from a traditional "experience-distant" perspective that emphasized interpretation and diagnosis. The "experience-near" perspective, gained through empathic listening, helped patients to feel understood. Kohut demonstrated how faulty empathic responsiveness created deficits in self--structure. Analyst working from a self-psychology orientation tracked empathic failures and their impact on self-experience. Furthermore, self-structure is understood from a context of a "self-object" environment that can promote or weaken the self. Symptoms and experiences of fragmentation, emotional deadness, and weakness are all understood as resulting from assaults in the form of faulty self-object responsiveness. Kohut defined empathy, in the analytic situation, as the capacity to experience the patients inner life while remaining objective. While Kohut was ambivalent about the curative role of empathy in psychoanalysis, proponent have claimed that it is a reparative experience, leading to a sense of personality integration and cohesion. Thus empathy becomes essential, in self-psychology, as a mode of

listening to patients, and as a relational quality needed throughout life, that can, if missing, devastate the development of the self.

Outside of these developments in psychoanalysis, the role of empathy in psychotherapy was articulated in the late 50s and 60s through the work of Carl Rogers. Rogers created what amounted to a revolution with regard to making psychotherapy accessible to Americans. He took psychotherapy out of the medical model and into the realm of humanistic pursuits. His "client-centered" therapy markedly perged from psychoanalysis in rejecting the role of interpretation and focusing on the here and now experience of the patient. In some ways, Rogers gave the patient the ultimate authority in the relationship. Unlike classical psychoanalysis where the analyst had the last word, the client determined the direction of the therapy and the accuracy of the insights gained. Rogers conceptualized his role as a "trusted companion" whose benign presence would facilitate the clients 'natural' abilities to grow and heal. Key to facilitation were the therapeutic triad of "accurate empathy", genuineness, and acceptance. If the therapist committed himself to developing these attitudes, the client would evolve in constructive ways. Empathic contact was to be achieved through the painstaking work of reflecting back what the client was feeling, thinking, and experiencing. For Rogers, empathy is in and of itself a tremendous healing force. He considered this to be the easiest of the three attitudes to teach, but a sorely neglected therapist skill (Rogers, 1980; Thorne, 1992). Like Kohut, Rogers was careful

to emphasize that empathy must not turn into complete identification; the therapist must have a strong identity to not become frightened, overwhelmed, or lost in the client's subjective world.

While much has been made of the differences between Rogers's and Kohut's work, there are "striking parallels" between them (Kahn, 1985). These parallels include the therapist's ideal attitude, as well as constructs of how the therapy process works, and goals for outcome. Most salient is the emphasis on the therapist's immersion in the patient's subjective experience. The patient, through this process, feels understood, and on some level accepted and affirmed. Both theories attribute a variety of problems to a lack of empathy from significant others throughout development.

CRITIQUE OF THE "EMPATHIC APPROACH"

Due to the influence of Carl Rogers and Heinz Kohut, the empathic approach to therapy became a dominant force in clinical training, both in terms of theoretical models, and clinical techniques. The following considerations are offered in the spirit of restoring empathy to a more proportional place in psychotherapy. This is important because theoretical models intimately impact how we think and what we do as therapists. These models also influence patient's expectations. Empathy has become a catch all term that is overused and misused. This complaint has been voiced by clinicians and

researchers alike. Researchers find that the concept of empathy has so many pergent definitions that it lacks construct validity. The lack of agreement about what it is and how it works makes clinical research on the subject extremely problematic (Wispe, 1986). Even more relevant are critiques of empathy as it's used in the clinical situation. Ira Moses (1988), working from an analytic perspective, states, "Current theory and applications of empathic techniques, however, have become filled with illusions, fallacies and misapplications to the point that the concept is so overextended it lacks any special meaning and its use has become quite unconstrained." An apt illustration of how all manner of clinical interventions are called empathy can be found in an article by Jon Frederickson (1990). Frederickson presents a sensitive account of therapy with a man who becomes increasingly verbally abusive, shouting and swearing at the therapist. The therapist does his best to understand and explain the patient's outbursts. At one point he is pushed to a spontaneous reaction, when he stands up and yells at the patient to "shut up and stop yelling." Ironically the patient feels a profound sense of relief and tells him that this has been the most human contact they have ever had. Frederickson speculates that in these interactions where the patient was yelling, the patient has unconsciously, acted like his abusive father and put the analyst in the position of playing the patient as traumatized child. Thus he describes his reaction as an empathic intervention. While Frederickson's reasoning is plausible and informative, it seems that many issues get

obscured by collapsing all that happened into an "empathic position." The patient does not immediately feel empathy and understanding; he feels relieved that he is dealing with a fellow human being who is capable of having spontaneous, expressive reactions. The therapist's deviation from his usual and customary position (the understanding, reflective therapist) results in a kind of profound recognition of the patient (Hoffman, 1998). It is, perhaps, because the therapist was willing to act outside the role of empathic therapist that a more mutually authentic relationship developed. This does not exclude the ways in which the therapist's expression of hatred could be considered empathic from a context of unconscious enactment.

Empathy is often integrated into clinical work as both a position and as a technique. Rogers identified "accurate empathy" as an essential part of psychotherapy. While he emphasized that empathy should be an attitude rather than a technical intervention, client-centered therapy is learned through the use of empathic statements. These statements are constructed from reflection techniques that mirror as closely as possible the client's perceptions, feelings, and thoughts. These interventions often start out with something like "I think what you are saying is that . . .", or "I sense that you are feeling x." While some technique is useful and unavoidable, the consistent use of such reflections foreclose the therapist's creative thinking about other aspects of the experience. Not only is reflective thinking and inquiry limited, but it becomes unlikely that the therapist will act outside the role of empathic

therapist. The therapist strains to make sure that he has captured what the client is experiencing. Both therapist spontaneity and authenticity become scarce commodities in such an exchange. I have personally listened to entire transcripts with student therapists where every intervention consisted of reflection statements, in an attempt to be empathic. While it would be nice to think that this kind of distortion of empathy is unique to beginners, it is not. Psychotherapists (of all persuasions) are guilty of hiding behind technical jargon; of not speaking in a sufficiently personal way (Schafer, 1974). Are we in danger of substituting one jargon for another? The stereotype of the blank screen analyst ("Hmm-mmm, and what do you think?") has been replaced by the therapist who hides behind empathy. Neither is willing to risk a fully authentic relationship where their subjectivity is openly expressed. Patients often sense this hiding in plain sight and may come to realize that this attitude serves the therapist's needs more than the patient's needs (Slavin,1994). This defensive use of empathy is comically portrayed in the movie, *Analyze This.* In one of the opening scenes, we see the therapist treat his patients in an apparently empathic manner; asking them how they feel and reflecting back to them their point of view. We then see a fantasy sequence where the therapist, portrayed by Billy Crystal, tells them what he is really thinking. Ironically, he is more expressive, less patronizing, and perhaps, more helpful in his unedited response. Of course, Crystal's dilemma is resolved when he meets the patient/mobster who challenges him to act in a way that is

spontaneous, authentic, but disciplined. Ultimately, we see the therapist and patient involved in a dialogue. While this is directed at helping the patient, both change in the process.

The theologian Martin Buber articulated a similar concern many years ago. In a public debate with Rogers in 1957, Buber questioned the reciprocity of the relationship between therapist and client in Rogers client- centered therapy. A relationship not anchored in true reciprocity (where only the client's subjectivity is sanctioned) creates more self-centered individuals. It also creates dependency on the therapist for this kind of empathy (Thorne, 1992). While some of Buber's critique is a consideration in all forms of psychotherapy, I wish to deal with the troubling aspects that are specific to Roger's therapeutic position. The salient issue at stake is that an empathic approach that lets the client take the lead and that assumes the client will grow in constructive ways seems to privilege the patient's authority. In this empathic approach, the patient's world is explored in depth, but the therapist must subordinate her subjectivity. Her perspective is valued only for its reflection of the client's perspective; for her mirroring function. Where is the therapist's person in all of this. She is somewhat restricted in her thinking and acting. She must not confront the patient with her differences.

With regard to psychoanalysis, the empathic approach, fostered by self-psychology, has developed many of these same problems. Stefano Bolognini

(1997) objects to the way empathy is supposed to be used through force of will. He calls the degeneration of empathy "empathism." Empathism, in his view, consists of the problematic use of empathy as a forced analytic attitude and an over-identification with the client's perspective and feelings. This becomes a boundary problem, whereby the analyst does not give herself the psychological space to associate to the patient's material or to assume other positions in the countertransference. He is careful to point out that the dogmatic use of empathy is a distortion of Kohut's approach. Bolognini states that empathy should be a goal and not a technical stance. If we are lucky, we will gain some profound understanding of the patient's experience after long, hard work.

In a related critique, Hoffman (1998) discusses the damage we do by setting up empathy as an ideal therapist quality if, in fact, it is not a realistic, attainable goal. Furthermore, he argues that the therapist will do more harm than good if she is too concerned with playing the part of the "good object" and avoids doing anything that smacks of the "bad object" as construed by the patient. This is not a vote for an "anything goes" attitude. Furthermore, the therapist must not act in a way that violates the patient in any way. Thus, Hoffman conceptualizes the therapist's attitude as a dialectic between going "by the book" and a judicious throwing the book away. Empathy, in the form of empathic listening and reflecting the subjective world of the patient is part of what form the therapist took. The therapist must be able to step outside of

her approach to act, think, and participate in ways that are emotionally involved and spontaneous. It is helpful for therapists (and patients) to have a theoretical model for this dialectic. All too often the therapist feels guilty for having acted in spontaneous ways (how many times do clinicians withhold information from a critical supervisor) which can spoil a perfectly therapeutic interaction. However, it is important to recognize that all therapist ideals, and any kind of intervention can be used in a distorted way. Therapy is hard work for both parties, and it is easy to fall back on formulaic ways of engaging. However, it is particularly insidious when empathy is used in a clichéd, rote, or emotionally removed manner. After all, the true spirit of empathy is about feeling understood in a deeply meaningful and personal way. Empathy helps to ameliorate the inherent aloneness of human existence.

EMPATHY: A FORM OF RECOGNITION

Another relevant concept that is being developed in contemporary psychoanalytic literature, based on the ideas of the philosopher Hegel, is that of recognition and mutual recognition. Recognition from a valued other gives us our sense of who we are (Honneth, 1996). We see ourselves through the eyes of others. If parts of the self remain invisible through lack of acknowledgement then agency, power, and self-esteem are damaged. What is recognized is, of course, not necessarily some objective quality, but can arise out of creative and necessary illusions. When a mother sees her infant as perfect

and beautiful, she selectively ignores some factors in favor of the loving illusion she is creating. The struggle for recognition begins within the family but is also fought at the level of the wider social order. We tend to construct social orders that recognize and privilege its members based on traits like gender, age, and ethnicity—with various constructive and destructive results. A key part of recognition is that it *always* involves mutuality. Jessica Benjamin (1990; 1999) calls this the "paradox of recognition." To be recognized, we must, in turn, recognize the others subjectivity. In recognizing each other's subjectivity we struggle with the inevitable clash of wills of two different subjectivities and with the potential for indifference that can occur in the intersubjective space. From a psychoanalytic standpoint, the psychotherapist is in a unique position to negotiate mutual recognition, because of her privileged place in the mental life of the patient. The therapist's recognition *may* take the form of an empathic response, whereby the therapist's understanding of the patient's experience is critical in allowing the patient to validate his experience. This may help the patient to solidify his sense of reality and trust in his own perceptions. However, the recognition can take other meanings and forms that fall outside the realm of empathy per se. The therapist may recognize some other aspect of the patient's subjectivity and agency that may even take the form of a protest. For example, a therapist may react to some irritating behavior of a patient that actually challenges him to take responsibility for his effect on the other. In this case, the therapist

recognizes something that is hardly experienced as empathic, but yet helps the patient to register his potential to affect his therapist. In general, acts of recognition in therapy are often deviations from practice as usual (Hoffman, 1998). The patient senses that the act of recognition is in fact, important because it lies in contrast to certain conventions or "rules of the game." When a psychoanalytic psychotherapist attends a patient's wedding, it acquires all the more value because it goes against the grain of the restrictions on meeting outside the consultation room. It is commonplace for people in long-term therapy to compare notes on this subject—exploring what the therapist has said or done that helps the patient to believe he is special in the eyes of the therapist. These proofs of love are poignant given the fact that this is a relationship that is paid for; a far cry from the unconditional love of a good childhood. Clinical examples of recognition range from overt acknowledgement of some aspect of the person to acts like adjusting the room temperature, sensing the patient's discomfort even before it is expressed. Again, some of these events may best be described as empathic while others are not.

A CASE IN POINT

The following case is offered to share my own struggles with empathy in psychotherapy. This therapy struck me as interesting because of some unique features whereby empathy was critically important to the patient, and at the

same time his demand for empathy was often a way of avoiding the patient's difficulties accepting his own agency and thus, ultimately, contributing to his own disempowerment. Kevin was a 40-year-old research scientist of European heritage who began therapy with me to understand and ameliorate some extremely painful symptoms. The most prominent of these was his tendency to stare at other people or to look away. This caused him much anguish as he was constantly monitoring his eye contact. He felt that other people noticed his behavior and this made them uncomfortable. When I inquired how he knew that other people had observed this, he acknowledged that he did not receive direct feedback, he just "knew" that people noticed and felt it was odd. He seemed mildly irritated that I would question his conclusions. He revealed other bodily based symptoms. For example he sometimes felt as if his facial expression was fixed in a frown. Despite the ambiguity about the meaning of his symptoms, he was certain that they held at bay disturbing thoughts and feelings. He then went on to describe a number of significant "breakups" in his life that resulted in him losing people he had admired and loved. He appeared to want me to share his sense of outrage. These broken relationships often ended in an ugly scene where the other person abruptly terminated the relationship. One such situation, as I could reconstruct it, involved his dissertation advisor. He was supposed to be working on his advisor's project in the laboratory. Kevin kept bringing him work that was not what they had agreed upon. The professor, Dr. B., kept

asking him why he was working on it rather than the project they were being funded for. Kevin was mystified as to why Dr. B. wouldn't let him pursue his interest and thought that maybe it was caused by envy. He couldn't understand why such a kind and brilliant man would feel threatened by his discoveries. He instigated a series of discussions as to why he couldn't work the way he wanted to; that Dr. B. should see how his work was inspired by his mentoring and would be good for both of them. These discussions reached the point where Kevin was yelling at Dr. B. He refused to leave his office until they settled the matter. Dr. B. had a class to teach and ended up calling campus police asking them to escort Kevin out of his office. Kevin subsequently changed advisors and after many years, was able to finish. Similarly, relationship difficulties with his ex-wife (a school administrator), resulted in her complaining that she couldn't get any work done because Kevin was continually calling her at school wanting to talk about their problems. She also complained of being unfairly criticized. Their marriage ended, when his ex-wife moved to another state to further her education and get some "space." She also threatened to get a restraining order during their final days together. Previous therapy attempts ended in failure.

At the time Kevin came to see me he was preoccupied with his symptoms and with reviewing his losses. In every instance he felt he had humiliated himself and that they had failed to understand him correctly. He was aware that these situations were reminiscent of his relationship with his

father. He described his father as a man who had become increasingly verbally abusive and paranoid to the point where he had lost a prominent position in business. The family suffered a downward spiral in social class status. He alienated his wife (Kevin's mother) who felt only disgust and contempt for him. His father, who he had once felt extremely close to, began to accuse Kevin of behaving in ways that had no basis in reality. For example, he would attack his son for not taking out the garbage after having just done so. These false accusations resulted in emotionally abusive onslaughts. Kevin would try to defend himself by "standing up" to his father rather than acting intimidated. This eventually lead to his father openly expressing his regret that Kevin was his son.

Now, I would like to shift the focus to what happened between us in those first few sessions. After Kevin had described his symptoms and given much of the above history, he shared with me his goals for treatment and told me how he thought I could best serve him in our work together. He told me that the symptoms he had reported interfered with all aspects of his life. He had almost no social life (except for one friend who lived in another city) and had stopped dating for fear of further rejection. He felt that other people, including his chairperson at the college, where he was an assistant professor, felt uncomfortable around him. He spent an inordinate amount of energy trying to control his symptoms and his thinking about it often got in the way of his productivity. He was so afraid of appearing insubordinate to his senior

colleagues and to the Dean, that he felt he had squelched himself to the point of feeling emasculated. In this eat-or-be-eaten world, he was prey. Kevin spoke about such domination and submission rather literally, using examples from the animal kingdom.

Kevin was very rigid and explicit about what I should or should not do to help him. Whenever I tried to explore with him an alternative way of looking at an interaction, he responded on a continuum between mild annoyance and rage. These negative reactions to my offering other "spins" on events often resulted in me feeling quite devalued. Further attempts at interpreting these attacks as "transference" or as him doing to me what was done to him by his father went nowhere fast. He seemed to only want empathy or silence, his own version of 'if you can't say anything nice, don't say it at all.' My fear was that his attempts to control me and his devaluations would result in the same old story—where I would throw him out, unable to tolerate his domination, or he would leave convinced of my incompetence.

According to Kohut, such narcissistically fragile patients need a prolonged period of empathic immersion. They need to be understood from an "experience-near" perspective before they are ever confronted, challenged, or interpreted. Self-psychology theory suggests that empathic failures should be tracked within the therapeutic relationship (as well as in the patient's life outside) so that the therapist learns where the developmental arrests and

deficits exist. This is done by noting the fragmentation and dysphoria that may occur when the patient feels misunderstood or when their 'self-object' needs are not met in other contexts. Interestingly, there is another approach, set forth by Otto Kernberg, who recommends just the opposite. Kernberg is careful to set limits and to confront the patient with his rage from the onset of the treatment. However, when I thought of Kevin's situation, neither setting limits, delving into interpretations, nor immersing myself in his subjective world seemed to me to be the right atmosphere to create for our work together. I felt that I had to address my differences with him openly. To not do this would be hiding my agenda, my values, my skills; in short myself. If, on the other hand, I let him set the agenda (as he had tried with Dr. B.), I would enable him to dominate and sooner or later I would attempt to break free. However, had I immediately set limits on his behavior, in anticipation of his rage, he would have most likely felt unbearably constrained and might have left: treatment.

The problem that Kevin and I faced can be understood in light of the construct of mutual recognition. With the other's loving recognition we come to know our selves and develop a sense of agency. However, in being seen we must recognize that the other person exists as a separate but equal center (Benjamin, 1999; Honneth, 1992). The capacity for mutual recognition is thought to be hard-won; slowly developed, and never fully realized. From the original emotional interplay between mother and infant, to the battles of will

of the toddler, and the narcissism of adolescence; we strive to assert ourselves while reconciling the fact that our audience have their own wills. We hunger to be recognized for our uniqueness, for our value, and for our impact on the other. An undeveloped or uneven capacity for mutual recognition results in power struggles where assertion is exerted in such a way that attachment is lost. There are plenty of opportunities for problems in development. Mother must do her part in profoundly recognizing her infant (and later her increasingly independent child). She must also sustain a sense of her life apart from her children, despite internal, familial, and cultural pressures to be defined only in terms of her mothering role. This aids the growing child's realization that there are other subjects out there, not *just* objects of our desire or thwarters of our wishes, but separate others with their own initiatives who may or may not be indifferent to us. Kevin's clashing of wills with those around him seemed to grow out of a distortion of mutual recognition. His initial bid to "do it my way or else" reflected this lifelong problem that lay at the heart of his alienation. His symptoms expressed his ambivalence about human contact given his eat-or-be-eaten world. I needed to engage with him in a way that allowed us to both exist as equal subjects to each other (we were also objects to one another on conscious and unconscious levels).

The most authentic and empowering course of action seemed to be to share my dilemma with him. I "recognized" his power to hurt and control me

and tried to link this to what had happened to him in so many significant relationships. Sometimes these recognitions were spontaneous and revealed my anger as well. Other times my responses were modulated and premeditated. However, he was only able to accept this realization when I balanced it with empathy for his subjective experience of both our relationship and the other situations. If I had only empathized with him (as if that were possible!), I would have infantilized him and taken away his enormous contributions to the vicious circles he found himself in as he experienced himself as a passive victim. However, he needed and deserved significant and meaningful empathic connections as a backdrop to our work together. The self-psychology approach to track swings in his self-esteem based on his perception of my empathic responsivity was helpful but no substitute for sharing with him my subjective experience of our relationship.

Many months later, Kevin told me that my not imposing premature limits (as some other therapists before had done) was vital to his sense that he could be himself and trust me. He said he was surprised by my responsiveness, honesty, and insistence that I could not work in the way he had asked. We struggled and renegotiated these issues often and openly. Outside the therapy, Kevin continued to find himself in difficult impasses with others, but they were enacted on a smaller scale. He was sometimes open to my views about them and, even asked for my "advice." There were moments where our differences threatened to rock the foundation of our relationship. I

had to continually rethink my position in order to find a balance that would enable me to hold my ground while taking his perspective seriously. Much to our mutual relief, there emerged a playful quality to our efforts. We both brought with us our senses of humor. This aspect of our relationship enabled us to survive his rage and my defenses. Our work seemed fruitful. We managed to crack the ice of his "mask"—to reach more of his feelings of being alive. At times he would protest that I was not being "empathic" as I was supposed to be. I did not fit either his ideal of the analyzing, neutral therapist or the empathic therapist who mirrors back the patients experience. I strove to be more involved and collaborative (Renik,1993; Rubin, 1998). What was as important to the therapeutic process (as empathy and interpretations) was our search to be together in ways that acknowledged our mutual influence without violating the differences in our roles (as patient and therapist). Kevin framed the dilemma he was in quite simply when he said, "I wish I could do this work alone, but I can't—I need you here to do it with me." This is what Benjamin calls the "paradox" of mutual recognition: to be profoundly recognized, you must recognize the one who sees you.

CONCLUSION

Empathy is undoubtedly a cornerstone of psychotherapy; whether it is considered an entree into the patient's world, a necessary dimension of a healing relationship, or a final goal of the therapeutic process. However, when

an empathic approach becomes a dogma or an unattainable therapeutic ideal, we fail our patients. Empathy has been used as a screen to hide the therapists subjectivity. Likewise, patients may demand empathy when curiosity or confrontation is needed. Hopefully we can embrace and articulate other ways of responding that inspire transformation and healing. Jessica Benjamin (1999) has identified the central project of relational theory as the formulation of identifying what happens when empathy and interpretation fail to keep the therapeutic relationship alive at difficult impasses. We also need to be sure that we do not do what Racker so courageously warned us about over 40 years ago in his writing on countertransference (Racker, 1968; Hoffman, 2000; personal communication). In this seminal work, he suggested that even empathy is not some purified, accurate portrayal of the patients inner being, but rather a very complex response that originates out of an ambiguous sea of the therapist's own conflicts and life history, conscious and unconscious responses to the patient's views of the therapist, and multiple identifications with external and internal objects and attitudes within himself and the patient. This kind of reading of empathy leads us, as therapists, to continue to explore and question our intentions to cure in a way that opens us up to relating in a more vulnerable and authentic way.

REFERENCES

Bender, L. (Producer), & Van Sant, G. (Director). (1997). *Good Will Hunting* [Film], (Available from Miramax, Hollywood, CA).

Benjamin, J. (1990). Recognition and destruction: An outline of inter-subjectivity. *Psychoanalytic Psychology,* 7, 33-47.

Benjamin. J. (1999). Afterword for: Recognition and destruction: An outline of inter-subjectivity. In S. Mitchell, & L. Aron (Eds.), *Relational psychoanalysis: The emergence of a tradition* (pp. 181-210). New Jersey: Analytic Press.

Bollas, C. (1995). *Cracking Up.* London: Routledge Press.

Bolognini, S. (1997). Empathy and empathism. *International Journal of Psychoanalysis,* 78, 279-293.

Bromberg, P. (1993). Shadow and substance: A relational perspective on clinical process. *Psychoanalytic Psychology,* 10(2), 147-168.

Crystal, B. (Producer), & Ramis, H. (Director). (1999). *Analyze This* [Film]. (Available from Warner Brothers, Hollywood, CA).

Duan, C., & Hill, C. (1996). The current state of empathy research. *Journal of Counseling Psychology*, 43(3), 261-274.

Eisold, K. (2000). The rediscovery of the unknown: An inquiry into psychoanalytic praxis. *Contemporary Psychoanalysis,* 36(1), 57-76.

Ferenczi, S. (1926). *Further recommendations to the theory of psychoanalysis.* New York: Brunner/Mazel, 1980.

Frederickson, J. (1990). Hate in the countertransference as an empathic position. *Contemporary Psychoanalysis*, 26, 479-496.

Freud, S. (1912). Recommendations for physicians on the psychoanalytic method of treatment. In P. Reiff (Ed.) (1963c) *Freud: Therapy and technique* (pp. 117- 126). New York: Macmillan Publishing Company.

Hoemeke, E. (1999). Mutual recognition: Reconsidering the experience of love and intimacy in the psychoanalytic relationship. Unpublished dissertation, School of Professional

Psychology, Illinois.

Hoffman, I. (1998). *Ritual and spontaneity in the psychoanalytic process.* Hillsdale, NJ: The Analytic Press.

Honneth, Alex. (1996). *The struggle for recognition: The moral grammar of social conflicts.* Cambridge, MA: MIT Press.

Kahn, E. (1985). Heinz Kohut and Carl Rogers: A timely comparison. *American Psychologist*, 40, 893-904.

Kohut, H. (1959). Introspection, empathy, and psychoanalysis. *Journal of the American Psychoanalytic Association*, 7, 459-483.

Moses, I. (1988). The misuse of empathy in psychoanalysis. *Contemporary Psychoanalysis*, 24(4), 577-594.

Racker, H. (1968). *Transference and countertransference.* New York: International Universities Press.

Renik, O. (1993). Analytic interaction: Conceptualizing technique in the light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, 62, 553-571.

Rogers, C. (1980). *A way of being.* Boston: Houghton Mifflin.

Rubin, J. (1998). *The blindness of the seeing I: Perils and possibilities in psychoanalysis.* New York: New York University Press.

Schafer, R. (1974). Talking to patients in psychotherapy. *Bulletin of the Menninger Clinic*, 38, 503-515.

Slavin, J. (1994). On making rules: Toward a reformulation of the dynamics of transference in psychoanalytic treatment. *Psychoanalytic Dialogues*, 4, 253- 274.

Thorne, B. (1992). *Carl Rogers: Key figures in counselling and psychotherapy series.* London: Sage.

Wispe, L. (1986). The distinction between sympathy and empathy: To call forth a concept, a word is needed. *Journal of Personality and Social Psychology*, 50(2), 314-321.

4

Empathy is Not Enough

Jeff Rubin

Consider the following two vignettes, the first psychotherapeutic, the second spiritual.

1. Imagine that as you are taking a leisurely stroll you observe a man running into the street and crashing into a slowly moving car. It would probably seem shocking at first and at the very least self-destructive. It would appear that he was trying to hurt or destroy himself. You might ask yourself a variety of questions as you contemplated this incident. What was troubling him? Was he depressed? Angry? High on drugs? Hallucinating? Suicidal? Most people would probably agree that he was attempting to cope with a great deal of suffering.

2. A man went to a talk that Gandhi gave with the goal of killing him. Moved by the power of Gandhi's teachings, he shelved his plan. After the talk he prostrated himself in front of Gandhi and told him of his original plan and his subsequent change of heart. Gandhi's response to this man, a potential assassin, was: "How are you going to tell your boss about your failed

mission?"

It might change your reaction to the first vignette to know that many years ago in the middle of a therapy session an anxious and troubled man in his late twenties whom I shall call Roger, informed me that he felt "dead like a mannequin." Later in the session he suddenly had the fantasy of crashing through the window of my first floor office and running into the street and knocking into a car. I remember asking myself what function this might serve him in relation to his experience of himself, which aided me in wondering if he was trying to save and heal rather than destroy himself. I then asked him if knocking into the car would create sensation and if sensation (even accompanied by severe injury or pain) would make him feel alive and if aliveness (with the risk of physical endangerment), was preferable to feeling "dead like a mannequin." It is a question that the concept of empathy, by which I mean attempting to understand something from within rather than outside a person's own subjective psychological frame of reference (Kohut, 1959), enabled me to formulate. Empathically immersing myself in his experience and trying to see it from his perspective, rather than superimposing an externally-based theoretical explanation—such as his "suicidal" fantasy was caused by anger turned inward—helped me wonder if physical contact (knocking into the car) was a means for Roger of attempting to feel real and alive. His subsequent reactions to my speculations opened productive areas of investigation along these lines as he elaborated on how

and why he felt "psychologically dead."

From Carl Rogers to Heinz Kohut, empathy has enjoyed a highly valued status in western psychology. Empathy, like health or peace, seems like an unqualified virtue. When empathy is present in a human relationship, like in the story about Gandhi's response to his assassin, then bridges of emotional understanding can be built across the chasms that ordinarily separate people. Profound compassion can often then flower. When empathy is absent from a relationship, such as in an authoritarian regime or in any relationship (including a therapeutic one) in which one person relates to another without reference to that person's own sense of themselves, prejudices may play a more prominent role and the door is opened to potential misunderstanding, scapegoating, and even oppression.

Empathy has been important to me personally and professionally—opening up deeper understanding and connections with friends, family, colleagues, and patients. It is also vital, in my view, to the therapeutic process. It serves as a doorway into the differently organized and sometimes foreign psychological worlds of patient and therapist. Sustained empathetic immersion in the experience of a person in therapy facilitates the unfolding, illumination, and transformation of the person's subjective world (Atwood & Stolorow, 1984). Empathy fosters the development of a more meaningful emotional bond between the patient and the therapist. As the patient feels

emotionally understood by the analyst, s/he increasingly trusts that vulnerable emotional needs and experiences will eventually be understood in depth. This encourages the patient's sharing of formerly hidden and shameful experiences. Illuminating the meaning of the patient's experience also makes possible a different present, the analyst as an understanding presence. New ways of relating to self and others are made possible. The patient gradually internalizes the analyst's empathic stance, by which I mean, the former views his or her own experience with greater understanding and acceptance rather than miscomprehension and contempt. The capacity for empathic self-observation replaces the conditional acceptance of one's caregivers.

In this chapter I shall argue that empathy is an essential although insufficient facet of the treatment process in psychotherapy. It is essential because it fosters a safe, trusting therapeutic environment and opens up the possibility of deeper levels of understanding and compassion between patient and therapist. Empathy is insufficient because it omits certain vital facets of the therapeutic process, particularly what I term the patient's efforts at self-creation in the present (Rubin, 1998). Self-creation has two dimensions: the person's own responsibility for

1. transforming impaired self-care and restrictive ways of relating to others, and

2. fashioning a meaningful and fulfilling life based on his or her own unique values and ideals.

It is often assumed that patients in therapy will automatically grow and flourish when they are empathized with. The way empathy is often talked about can lead to an evasion of responsibility on the patient's part for both perpetuating old and restrictive ways of treating oneself and relating to others and for cultivating new ways of caring for and relating to self and others in the present. In order to change, the patient needs, that is, to transform their ongoing participation in their troubling past as well as actualize a different sort of existence in the present.

If the value of empathy emerged in my experience with Roger, its limitations became clearer in my work with a man I shall call Louie. Louie was a shy professional in his early 30s who had low self-esteem, suffered from conflicts over success and psychological independence, and had a pervasive sense of not quite fitting in. Louie treated himself badly. He was very overweight and out of touch with his feelings and needs. He was socially isolated, tended to become involved with friends who took advantage of him, and ultimately felt emotionally deprived.

Louie was an only child in a middle-class home. His parents both worked. His mother was emotionally needy and suffocating. His father was critical, domineering, and subject to rages. Louie had a distant relationship with his father, whom he experienced as critical and overbearing. His father could not sustain interest in him or anyone else. His father's harshness

resulted in Louie's never feeling understood or supported by him. It also squashed his confidence in himself. His father provided little guidance or direction except for his rebukes. Although Louie felt closer to his mother, her own emotional hunger and her fear of her husband rendered her unavailable as a source of love or validation for Louie.

His parents were sorely unresponsiveness to his inner reality and failed to encourage his uniqueness from emerging or flourishing. He felt emotionally neglected, without direction or a belief in himself.

Louie hid his personal values and ideals and attempted to fit in with his parents views of life in order to keep alive the hope of being emotionally connected to them. It is not surprising that Louie felt inconsequential in his home. He had great difficulty believing in the validity of his own interests and had great difficulty sustaining his commitment to himself. The price of conforming to and accommodating his parents' wishes was to bury his own sense of how he should live. He kept alive the tenuous hope of being accepted by his parents by banishing huge parts of his self through subverting and obscuring his own interests. This led to an excessively limited view of himself and his capabilities. What he wanted lacked significance to him and he felt that his life was not his own. His potentialities were dormant. This left him feeling self-doubtful and directionless.

He had what sounded at first like vital and interesting male friendships characterized by openness and depth. As time went on material emerged suggesting that several of these friends were either narcissistic or emotionally needy. He provided a great deal of psychological sustenance for his friends but seemed to receive little in return. Relationships with women were often characterized by a self-negating focus on their emotional needs— which left out his own needs. He denied his own needs, submitted to what he felt others wanted, and neglected his own goals. In fact, he did not even know what his goals were. This fed his sense of invisibility.

In the beginning of treatment Louie was affable and compliant. Initially he did not talk about what he truly desired. For many months the sessions were dominated by Louie's accounts of a variety of frustrations, injuries, and grievances in relationships and at work. I empathized with Louie's deprivation, suffering, and loneliness.

Through empathic immersion in Louie's experience I learned more about his deprived and miserable childhood, particularly his experience of his father's terrorizing behavior and his mother's fearful passivity. I tried to clarify his feelings of self-mistrust and unworthiness and related them to his experiences in growing up with self-absorbed, needy, and withholding parents. I conveyed to Louie my understanding of the way his spirit had been crushed and broken by his father's terrorizing presence and his mother's

inability to defend him.

As we explored his tendency in the transference to conform to me by attempting to speak my language, his fear that he would be alone and invisible if he did not accommodate to those around him, including me, emerged. As we understood two of the dangers he anticipated—that I would be like his critical father or his needy and suffocating mother—material about his own values and interests emerged.

He loved reading and bicycle riding. He read works of scientific fiction and psychology and spirituality. He was particularly interested in books that focused on how to cultivate greater self-respect and self-assertion. When he was not reading he enjoyed bicycle rides in nature and felt a peacefulness and a competence that he rarely felt at work or with people.

Empathetic immersion in Louie's experience helped him experience the texture of his inner life with greater sensitivity. Louie begin to be able to know his own reactions more easily and steadily. He became aware, for example, of formerly disavowed feelings of betrayal at the way his father crushed him and his mother did not defend him. He also became aware of the links between his parents' self-absorption, neediness, and lack of validation, support, and guidance and his own feelings of self-mistrust and un-worthiness. Through empathizing with Louie's experiences in childhood we

understand the way psychological and spiritual books provided missing guidance and direction that he did not receive from his parents.

Not only did his receptivity to internal and interpersonal life increase because of our empathic immersion in his experience, his attitude toward his experience changed. The empathic spirit of attending to experience without judgment or aversion gradually replaced the self-critical stance exemplified by his father. He was more patient with himself and less self-condemning.

EMPATHY IS NOT ENOUGH

Empathy is central to the process of therapy and personal change. It fosters a therapeutic environment of safety and understanding and establishes a deep emotional connection between the patient and the therapist. The empathic bond between Roger and me, for example, led to his gradually transforming his sense of psychic deadness into a life that was more meaningful and alive. Over the course of our work together, he left the halfway house that he had lived in after he had been released from the hospital for a schizophrenic episode, learned several computer languages, got a job working in a college admissions office, and slowly developed several relationships of meaning and substance.

But empathy is not enough for therapy and change to occur. Empathic understanding of Louie's plight did not mobilize him and lead to meaningful

change. He still struggled to take good care of himself and he still related to others with a self-depriving deferentiality. He still devoted much more attention in our sessions (and in his life outside the sessions) to how he had been wronged and why things could not/would not change, rather than what he might do to live the life that he valued. It became clear to me after a while that my empathic stance toward Louie's raw deal in childhood was necessary although insufficient to overcome the therapeutic stalemate. Seeing someone as a fragile and helpless victim in need of empathetic support can be a defensive disavowal of his or her unwitting contribution to self-imprisonment. Far from being a helpless victim, Louie was highly skilled, albeit unconsciously, at fashioning a particular life involving shabby self-care, restrictive relationships, and a great deal of personal deprivation and suffering.

The sessions were dominated by his litany of injustices and deprivations until we addressed his unconscious role in co-creating his suffering, particularly the way he perpetuated certain self-betraying modes of self-care and reenacted restrictive relational configurations of childhood (engaging in compliant and depriving relationships) which left him feeling alone and neglected. Louie treated himself like an object not a subject. The needs of others took precedence over his own. In a perversion of John F. Kennedy's famous refrain, he focused on what he did not do for others not what others might do for him. He left himself out of the equation of his own

life. He could not have enriching relationships with others as long as he focused on what he did (or did not) do for others to the exclusion of his own wishes and needs.

For Louie to have a life that might feel like his own it was not sufficient to be deeply understood. He also needed to take responsibility for living differently; for forging new ways of treating himself and relating to others in the present. Louie did not really change until old and restrictive ways of being were challenged and altered as well as understood. And this did not happen until I interpreted the way he was a complicitous co-participant in, as well as an existential victim of, his own suffering. Only then did Louie begin to mourn and work through old and constrictive ways of treating himself and relating to others and eventually pursue new ways of living. In order to do this he needed to understand more of his impact on others, including myself, especially the way he organized relationships so that others could rescue him from the degraded state that he was immersed in. Empathizing only with a patient's subjectivity can be limiting because it may eclipse the subjectivity of the therapist and those people who are important to the patient in his or her life. This may reinforce the patients self-centeredness and their sense of entitlement with others. Attending to my own feeling that Louie was presenting himself as a helpless victim and unconsciously attempting to coerce others into taking care of him, enabled me to explore with him his impact on others, especially the possibility that he was evading responsibility

for the quality of his life. He then began exploring his own role in perpetuating his suffering. He noticed, for example, how his lifelong focus on being crushed, disavowed responsibility for the way he unconsciously attempted to remain linked to his parents by treating himself in a cavalier manner. This led to an exploration of the way he was unconsciously invested in keeping alive a snapshot of his childhood emotional pain so that it might finally be witnessed and validated. He unconsciously equated living a more fulfilling life with letting go of the grievances of the past and exonerating his parents. Letting go of the past also meant giving up hope that the injuries of the past would be seen and acknowledged in the present.

As he became more interested in having a life in the present rather than commemorating his pain from the past, his life opened up in new and fulfilling ways. He joined a bicycle club that held weekly training rides. Through this group he met a woman who he began dating. Their relationship was characterized by mutuality rather than exploitation. He started taking longer bicycle rides, reading about nutrition, and losing weight. He got into excellent physical health. He began relating to his parents in a more authentic and self-respecting manner. He did not let them walk all over him and he felt comfortable asking for what he needed. He felt that his life was finally his own.

I hope it is clear that I believe empathy is central to the therapeutic

process. But I also believe that in focusing on the centrality of empathy we can neglect other crucial facets of the therapeutic process such as helping the patient confront his or her self-deceptions and enhancing his or her capacity for self-responsibility.

EMPATHY AND . . .

Cultural mores are a product of pendulum swings: from the authoritarianism of the 1950s it is not surprising that we get the permissiveness of the 1960s. From the expansiveness and gluttony of the 1980s it is not such a quantum leap to the moral poverty, hard-heartedness, and piousness of the 1990s.

In our current political climate there is a tendency to dichotomize empathy and responsibility. On the one hand, there are those who demonize people who struggle—attacking them for their difficulties in living without taking into account the formative circumstances of their lives. On the other hand, there is a pervasive tendency to justify the evildoer because of unfortunate circumstances in his or her life. The tendency among many conservatives to scapegoat those who suffer—blaming single mothers of color for the moral malaise that engulfs us—illustrates the first trend. The tendency among liberals to victimize and exculpate evildoers—taking the Menendez brothers "off the hook" because they were abused—illustrates the second trend.

Contemporary psychology has widened our empathic capacity by taking into account the context and circumstances of one's life. Psychology helps us be more empathic to a range of states of suffering and oppression from the pain of those who are neglected to those who are actively traumatized. We are now more attuned to the way historical and sociocultural circumstances of one's life deeply shape how people live. But such knowledge has often been used both within and outside therapy to weaken moral agency and responsibility. Explaining something by reference to antecedent conditions—the Menendez brothers killed their parents "because" they were abused—can supplant moral accountability. The Menendez brothers are more complex (and haunted) than law and order types acknowledge, and they are more responsible than our culture of victimology tends to appreciate.

In the past psychology was less empathic about psychological motives and the causes of behavior, but inpiduals may have had greater moral accountability. Patients were often viewed, prior to Freud, as moral malingers, whose emotional suffering was due to weakness (equal badness) of character. The challenge in our age may be to utilize the fertile resources of psychology to deepen our capacity for empathy without neglecting moral responsibility. In a world of what I think of as "compassionate accountability" (Rubin, 1998), we might develop more understanding of the victimized and oppressed while at the same time fashioning increasingly complex and nuanced accounts of moral responsibility.

REFERENCES

Atwood, G., & Stolorow, R. (1984). *Structures of subjectivity: Explorations in psychoanalytic* phenomenology. Hillsdale, NJ: Analytic Press.

Kohut, H. (1959). Introspection, empathy, and psychoanalysis, *Journal of the American Psychoanalytic Association,* 7, 459-483.

Rubin, J.B. (1998). *A psychoanalysis for our time: Exploring the blindness of the seeing* I. New York: New York University Press.

Rubin, J.B. (in press). *Psychoanalysis and the good life: Reflections on love, ethics, creativity, and spirituality.*

II

Empathic Clinical Practice

5

Empathy in Working With Adolescents and Their Families

Mary Newell

I propose that because the tasks of adolescence are to separate from the family and prepare for a life of one's own, many of the issues the adolescent struggles with are family issues; therefore, the therapist cannot work effectively with the adolescent in isolation. The therapist has to bring in the family. This chapter will explore some of the lessons I have learned about the uses and misuses of empathy in my work with adolescents, highlighting my treatment of one adolescent and his parents.

Those of us who work with adolescents know only too well that they can be quite difficult to engage. Frequently anger, hostility, verbal abuse, denial, and a refusal to reveal any information about themselves mark their initial presentation. Robert was such a client.

When his mother called me for an appointment, she recited a litany of complaints about him. He was 14, in the 9th grade and "wreaking havoc on the household . . . He's impossible to live with, he makes everyone miserable . .

. I leave home sometimes just so I won't have to deal with him." Not only was Robert verbally abusive, oppositional and defiant with his mother and stepfather, he was also disruptive in the classroom, and he was failing in school despite possessing superior intellectual abilities. Robert had taken up with a group of youngsters whom his mother described as "troubled," He often didn't come home from school until late in the evening and would not explain where he had been. When he arrived home, Robert would go directly to his room where he would lock the door and blast his music. He would neither eat with the family nor participate in any family activities except attending church with them on Sundays and going along on the occasional family visit to his maternal grandmother who lived a few towns away.

I could hear the frustration, fear, and hopelessness in Robert's mothers voice as she told me about her son. I pointed out how difficult it must be to live with Robert, and how worried she was about him. When I asked how long the behaviors had been going on, she stated that Roberts behavior had begun to change about the time she became engaged to his stepfather. She had been porced from his father, an abusive drug addict, since Robert was 6. She and her son had lived in an apartment in another area of the city until she remarried. Robert had moved to a new neighborhood, completed his last year of middle school in a new school, and begun high school during the time his difficulties first became apparent.

His mother reported that Robert's relationship with his stepfather was good until they told him that they were going to get married. Robert became hostile toward his stepfather and initially moved out to live with his father. Robert stayed with his father for about 6 weeks. During this time, the father, who lived in a rundown rooming house, was often out using drugs, leaving Robert alone. When his father was evicted for nonpayment of rent, Robert returned home. Robert's mother reported that Robert idealized his father and he would become quite upset when she talked about how "no good" his father was.

As I was gathering this information from Robert's mother, I was already starting to empathize with him. I imagined how it must feel for a boy to grow up in an abusive, drug-involved household, and how torn he must feel between his father and his mother. Further, I imagined what it was like for him to move from his old neighborhood at such a critical period in his development to live with a man whom he possibly perceived as trying to take his father's place. I was also intrigued by the fact that Robert went to church with his family and accompanied them on visits to his grandmother's home. This left me with the impression that family and family rituals were still important to Robert despite his behavior in the home.

When Robert and his parents arrived for the initial appointment, I was struck by how physically small he was. I find this happens quite often; I get

caught up in the parents' experience of the adolescent as they are enlisting my help to "make thing normal again." When parents, who often are consumed with frustration, fear, and guilt, are describing the adolescent's troublesome behaviors, they make the child seem very big because the problem is very big to them.

My custom is to have the parents and adolescent together for the initial session. I do this in part because I want to emphasize the point that it is a family problem and we will work on it together. I also see the parents with the adolescent in the first session to get a sense of how they interact, to inform them that I will see the parents and child together for some sessions, and to discuss the issue of confidentiality.

When we got into the substance of the issue, Roberts stepfather became quite angry and blaming toward Robert. Robert, in turn, was alternately sullen and withdrawn, and verbally aggressive toward his stepfather. His mother desperately took turns siding with one or the other to the satisfaction of neither.

I asked the parents to return to the waiting room while I talked to Robert in order to de-escalate the situation. As they were leaving the room, Roberts stepfather turned to me and said, "Robert is smart; he'll try to con you." Robert immediately retreated within himself and would not respond to

my comments or look at me.

Picking up on his desire to not deal with family issues at that point, I asked him what kind of music he liked because he had come into the session with his Walkman. Robert became animated as he talked about his favorite group and what he liked about them. We went on from there to talk about sports and his love for animals.

I met with Robert alone for several sessions in order to establish an alliance with him before bringing his parents back. During these sessions I began to see Robert as someone whose tough-guy facade masked a little boy who had wishes, hopes and fears that he was trying to hide.

I find this also happens a lot in my work with adolescents. While their initial presentations may be off-putting, and they can seem older than their years in terms of dress, behavior, and experience, they are little children. When one gets past that superficial bluster, what one finds is a child who wants his/her parents to love him/her—even if the child has never experienced that.

When the therapist/adolescent relationship reaches this state, it frequently happens that the therapist becomes angry with the parents. Someone has to be blamed for the adolescent's acting out and the therapist's alliance with the adolescent creates a blind spot to the adolescent's role in

his/her difficulties. In addition, the therapist may tend to minimize some pretty disturbing behaviors on the part of the adolescent including involvement with drugs, self-mutilation, sexual acting out, and thrill-seeking behaviors that are dangerous and criminal activity. This is one area where empathy becomes problematic in that it sets up an "us against them" relationship with the parents that is not helpful to the therapeutic process.

My work with Robert and his family was impeded temporarily because of my empathy for Robert. There were times when I found it difficult to sit through a session with his parents because they were so "unreasonable" and "intrusive," and they did not understand Robert the way I did. I was trying to make them empathize with Robert rather than acknowledging that he was being quite provocative.

After I became aware of my negative feelings toward the parents, I had them come in for a parent session where it became quite evident that despite their flaws, they were both genuinely concerned about Robert and were at a loss as to what to do. I began to understand that the mother felt guilty for remaining with her first husband for so long when she could see that it was affecting Robert. She also revealed that Robert reminded her so much of his father, and she feared that Robert might turn out just like him. One of the reasons that she had married her second husband was so that Robert would have a "good" father. She had also remarried because she was a lonely woman

who had suffered horrendous abuse at the hands of her first husband. Indeed, she was afraid that she would have to make a choice between her son and her husband.

Robert's stepfather was an anxious man whose father had abandoned the family when he was quite young. The stepfather had grown up without a father figure and had fantasized about the day when he had sons of his own and the kind of father he would be. Although he had reservations about fathering someone else's child, he welcomed the challenge. He had become increasingly frustrated and angry with Robert who seemed to rebuff his efforts to establish a relationship. The stepfather feared that his wife would eventually choose her son over him and he resented Robert for forcing her to make that choice.

The therapy changed direction after that session. I was able to help all three empathize with each other. This perspective allowed Robert to begin to see why he was "getting so much grief" at home and to take responsibility for his behavior. I also saw Robert with his mother and with his stepfather separately for a session so they could begin to build relationships with each other that were independent of the husband/wife relationship. In addition, I had some sessions with Robert and his father to address some of the pent-up anger Robert had toward his father that he was directing at his stepfather.

I helped the mother and stepfather understand Robert's behavior and begin to set appropriate limits with him. I also stressed the importance of them presenting limits and consequences to Robert as a couple so that he would not be able to play one against the other.

Over time Robert got back on track developmentally and successfully completed high school. He went to college, and he did quite well. The quality of his relationships with his mother and stepfather improved to the point that he and his stepfather participated in sports and would go off on camping trips together. There were some predictable upsets but the family never again reached the crisis state they were in when they initially consulted me.

In summary, this case presentation illustrates that work with adolescents provides fertile ground for uses and misuses of empathy. Specifically, empathy worked in my initial contact with Robert's mother. My ability to articulate her concern and frustration conveyed my understanding of her sense of urgency, and enabled her to entrust her son to my care.

My empathy with Robert worked in the first session in that I could feel that he didn't want to talk about himself, so I was able to engage him by asking about his musical preferences. This showed Robert that I wanted to get to know him rather than accept what his parents told me about him.

Empathy did not work when I joined Robert in blaming his parents. In

joining with Robert, I created a barrier between his parents and us; I temporarily became ineffective in working with the family. This situation was remedied when I called the parents in and listened to their stories. It was then that I was able to empathize with them and develop a treatment plan that was beneficial to the family.

To work effectively with an adolescent one has to work with the family system. This reality makes it incumbent on the therapist to try to understand each member of the family system and assume that the parents are doing the best they can. From this perspective, the therapist can appropriately use empathy to make systemic changes.

6

The Successful Use of Empathy With a Depressed Older Man

Rosemarie Ratto

Most older adults, defined as persons 65 and older, live independently and have close relationships with others, and their rates of depression are generally lower than for younger adults (APA Working Group on the Older Adult, 1998). However, significant problems among older adults can arise. This chapter focuses on the psychotherapy treatment of one particular older man who suffered from severe depression. The most significant aspect of this treatment was the struggle of someone almost 6 decades younger to understand, or successfully empathize, with the current and past life of an inpidual who was almost 90 years old. It is the hope of the author, who was also the therapist in this treatment, that examining this process will aid other novice helpers succeed in their therapeutic attempts with older adults.

THE STORY OF BEN

At the start of treatment, Ben was an 88-year-old White male living in a

skilled nursing home. He was referred to therapy by the social services worker within the facility. At that time, Ben was experiencing severe depression with continual crying, feelings of hopelessness, hallucinations, and persistent thoughts of suicide. He was unhappy with his current life situation and could find no constructive way out of his misery.

Ben had moved into the nursing home about 6 months earlier as a result of a stroke that left his left side paralyzed making it difficult for him to walk independently. He was restricted to using a wheelchair for mobility and required assistance with his everyday activities including getting in and out of bed and using the bathroom. Also prior to the referral, he experienced a fractured hip and knee after sustaining a fall when being transferred by one of the nursing staff. This added pain, in addition to his feelings of hopelessness, appeared overwhelming.

Ben's social supports were weak; his wife of over 50 years had died about 5 years earlier. His one daughter lived 200 miles away and visited him about twice a year. A stepson also lived about the same distance away and was unable to travel due to his own disability. His only grandson resided nearby and came in once a month and assisted Ben with his ongoing necessities. His old friends dropped by infrequently mostly due to their own health problems.

Ben described his childhood of growing up on a rural farm as uneventful and relatively happy, expressing that he felt like "Huckleberry Finn." He experienced his family as loving and believed he received everything he needed growing up. He left home around the age of 18 and moved to the city where he began working in a variety of factory jobs. He later developed a career as a contractor for interior design work and was also in the grocery business. He had retired from full-time employment about 23 years earlier and spent his leisure time traveling the United States and participating in a variety of social clubs. He loved his wife and was happily married for over 50 years. After his wife died very suddenly, he lived in his home with his grandson until he experienced the stroke.

An evaluation of Ben revealed that he had an average capacity to concentrate and pay attention. However due to the stroke, his memory and intellectual ability were slightly impaired, and he had some problems with his spatial skills. Even with these difficulties, Ben did not have dementia and was only considered to have mild cognitive deficits.

Upon first meeting Ben, he was very articulate and eager to express his current feelings of depression. He cried continuously as he spoke of wishing for more visits from family and better caretakers in the nursing home. He also expressed his sadness over the loss of his wife and his past life.

Ben's treatment consisted of weekly psychotherapy sessions over the course of about 19 months. The treatment approach primarily emphasized support and empathy to help Ben cope with his feelings and adjust to his current life. To add a framework to Ben's treatment, an overview of depression and psychotherapy among older adults is reviewed.

DEPRESSION AND THE "OLDEST OLD"

Psychotherapy with older adults is becoming an increasingly important topic as the number of older adults in our society rapidly increases. Ben's age group, known as the "oldest old" or those 85 and older, is increasing faster than any other age group. With the newness of this population, there is very little formal education or experience among mental health professionals. Consequently, there is a poor understanding of these inpiduals and many myths exist (APA Working Group on the Older Adult, 1998).

The rates of depression among older adults are lower than one might expect with a one-year prevalence rate of major depression at 1%. The rates of depression for those with physical problems, however, are much higher, and nursing home residents' rates for depression range from 12-25% with a 10% annual incidence of new episodes of Major Depression. In addition, older men, as opposed to women or younger men, are more likely to take their own lives, with the rates increasing throughout their life span and peaking in older

adulthood, with the highest level falling in the oldest group of 85 and over (McIntosh, Pearson, & Lebowitz, 1997). Demographics included, the highest levels are for White males. After examining these statistics, the severity of Ben's problems with depression appears to reflect the trends noted in the literature on older adults.

PSYCHOTHERAPY AND THE OLDER ADULT

Recently, much has been written concerning the psychological treatment of the older adult. Historically, however, the treatment of the older adult has been neglected, beginning with Freud (1924) who believed that, as a rule, older people (those above 50) were not amenable to treatment because too much material needed to be dealt with which he felt would prolong the treatment indefinitely. Myths and prejudice still thrive among professionals believing that older adults are too rigid in their beliefs to benefit from psychotherapy, that the investment of time for treatment would be better spent on younger patients, or that cognitive impairment would inhibit any meaningful progress. Research, on the other hand, indicates that older adults are as likely to benefit from psychotherapy as younger inpiduals and that, although appropriate treatments and competent clinicians are necessary, no particular approach to treatment is significantly better or worse than another (Knight, 1996b). In addition, those inpiduals who have experience doing therapy with older adults describe it as a valuable endeavor.

The use of empathy within the therapeutic relationship has been well established as one of the most significant factors associated with positive outcome in psychotherapy (Luborsky, 1988; Orlinsky & Howard, 1986; Patterson, 1984). Kohut (1978) defines empathy as "vicarious introspection" and describes it as the "capacity to think and feel oneself into the inner life of another person" (p. 82). Rodgers (1975) describes the empathic process as involving two fundamental components that include experiencing another person's feelings as if they were one's own, and as an attempt to communicate this experience to the other person.

Although empathy is regarded as a seminal part of psychotherapy, the ability to understand and be empathic with the issues of the older adult appears to be more difficult than with patients in other age groups, and many therapists question their ability to be empathic with older adults (Knight, 1996c). By examining Ben's treatment, the important issues facing the older adult are clearly illustrated which can help to provide a framework for understanding.

SPECIFIC THERAPEUTIC ISSUES WITH THE OLDER ADULT

For Ben, as with most older patients, loss or grief appears to be one of the most important issues that arises in treatment (Knight, 1996a). Although Ben had lost his wife over 5 years earlier, when he spoke of her, he would

immediately begin sobbing inconsolably. In addition to the loss of his wife, Ben was also experiencing the loss of his previous life. He was no longer in his home with his belongings and old friends nearby. He was confined to a nursing home with very limited physical space and rare visits from family and friends.

Ben was also coping with the loss of his physical functioning which significantly limited his ability to perform activities which he had taken for granted. Being confined to a wheelchair and requiring assistance from staff, Ben no longer felt in control of his life. He was overwhelmed with grief and sadness. In addition, the physical pain from his recent fractures compounded his inability to cope. Having to face his declining functioning also forced Ben to confront his own mortality and the conflicts and anxiety surrounding this inevitability.

Along with relying on nursing staff to help him, Ben also depended on family members to help with his care. Having always been the person who was relied on to give assistance, he was now in the reverse position and was highly dependent on others. This loss of independence and control created uneasiness for Ben and anger towards family members was a persistent problem. Ben's grandson, who was his primary source of support, never visited frequently enough, or, when asked to perform tasks, never did them quickly enough. A similar and more intense anger was felt concerning the

nursing staff who rarely provided services that would meet his personally high standard. He felt that, if he could, he would have done it better.

Another issue that arose for Ben, which is common among some older adults, is disappointment and regret concerning perceived life failures. Although Ben appeared to have lived successfully, he still had issues in his life that had not been resolved. He had hoped for more career success and wished he had made better investments so that he would have achieved greater financial security. He expressed regret concerning the early loss of a grandchild to muscular dystrophy and wished he could have done more for him. He also expressed a desire to have provided a more comfortable life for his wife and wanted to have saved her life in the end.

OBSTACLES TO EMPATHY

It was not difficult for Ben to identify or articulate these losses and conflicts to me; he was clearly aware and able to voice his feelings. As for my part, it was not as easy to listen and experience Ben's deep sadness which persisted week after week and continued for months with similar intensity. Truly understanding how difficult it was for him was a struggle. As a younger therapist, I had not begun to undergo many of his life experiences or any of the losses with which he struggled. I was unaware of the profoundness of his suffering. As I listened and tried to make helpful interventions, over time, I

began to realize their significance for him.

What were some of the causes stopping me from understanding Ben's feelings? As mentioned, being a younger therapist created difficulty empathizing with his problems because of my lack of identification with his experience. Also, being with a much older client ultimately brings up feelings concerning one's own parents or grandparents which have rarely been completely resolved. On the other hand, by being younger and female, Ben often saw me as a substitute for his grandson or daughter, the two most significant people in his life, and would project onto me the anger and disappointment he felt toward them. Most importantly, being with older patients who are chronically ill forces the therapist to confront very difficult issues concerning illness and death. Especially difficult for the therapist is confronting one's own mortality.

The slower pace at which the sessions proceeded made it difficult to sustain attention to what was being said, and the older adult's propensity to repeat stories created problems being patient with the process. The setting for the treatment also created obstacles. The lack of a private, quiet space and the constant intrusion of staff and other residents added to the difficulty in focusing and concentrating on the issues which arose within the sessions.

TERMINATION

Within my growing understanding of Ben's experiences, his crying spells slowly lessened in duration. He no longer had active thoughts of suicide, and he became more involved in the activities in the nursing home. Being sensitive to Ben's significant issues with loss, I gradually tapered my visits to every other week and then to once a month. At that time it was clear that sufficient progress had been made and treatment could stop. Although Ben was reluctant to see our meetings end, termination was seen as a success; he was able to cope and be independent of help from me.

Reports from staff and observations from several post-termination visits covering more than a year revealed that Ben continued to improve, although, he still cried on occasion and became frustrated with staff and family. He kept up his involvement in activities; his favorite was the pizza and a movie outing to the mall. He made several new friends and purchased an electric wheelchair which helped him feel more independent. He also enjoyed visits from his first great-grandchild who was born a few months before his 90th birthday. His coping abilities also appeared to improve as demonstrated by successfully undergoing and withstanding surgery for both skin cancer and replacement of a hip with no decline in his psychological functioning. Although he continued to experience conflict and wished for the ability to do more himself, he was able to state that he felt "fortunate in many ways."

When I met Ben, I did not believe he would attain much improvement,

especially considering how slow his initial progress seemed. By listening to Ben and learning from him, I was able to slowly understand the cause of his pain and helped him to understand it in return. Ben's progress indicates that, as Abraham (1919/1953) suggested, it is not the age of the patient but the age of the neurosis that matters. In conclusion, as others who have done this work have found, allowing oneself to openly experience the older adult's world can provide a rewarding experience for personal growth.

REFERENCES

Abraham, K. (1919/1953). The application of psychoanalytic treatment to patients at an advanced age. In S. Steury, & M. L. Blank (Eds.), *Readings in psychotherapy with older people* (pp. 18-20). Washington DC: Department of Health, Education and Welfare.

American Psychological Association (APA) Working Group on the Older Adult. (1998). What practitioners should know about working with older adults. *Professional Psychology: Research & Practice*, 29, 413-427.

Freud, S. (1924). On psychotherapy. In *Collected papers,* Vol. 1 (pp. 249-263) London: Hogarth Press.

Knight, B. (1996a). Overview of psychotherapy with the elderly: The contextual, cohort-based, maturity-specific-challenge model. In S. H. Zarit, & B. G. Knight (Eds.), *A guide to psychotherapy and aging* (pp. 1-34). Washington DC: APA.

Knight, B. (1996b). Psychodynamic therapy with older adults: Lessons from scientific gerontology. In R. T. Woods (Ed.), *Handbook of the clinical psychology of aging* (pp. 545-560). West Sussex, England: John Wiley & Sons.

Knight, B. (1996c). *Psychotherapy with older adults.* Thousand Oaks, CA: Sage Publications.

Kohut, H. (1978). *The search for the self* Vols. 1 and 2. P. Orenstein (Ed.). New York: International University Press.

Kohut, H. (1984). *How does analysis cure?* A. Goldberg (Ed.). Chicago: The University of Chicago Press.

Luborsky, L. (1988). *Who will benefit from psychotherapy?: Predicting therapeutic outcomes*. New York: Basic Books.

McIntosh, J. L., Pearson, J. L., & Lebowitz, B. D. (1997). Mental disorders of elderly men. In J. I. Kosberg, & L. W. Kaye (Eds.), *Elderly men: Special problems and professional challenges* (pp. 193-215). New York: Springer Publishing.

Orlinsky, D. E., & Howard, M .1. (1986). Process and outcome in psychotherapy. In A. E. Bergin, & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 311-381). New York: Wiley.

Patterson, C. H. (1984). Empathy, warmth and genuineness: A review of reviews. *Psychotherapy*, 21, 431-438.

Rodgers, C. (1975). Empathic: An unappreciated way at being. *Counseling Psychologist*, 5, 2-10.

7

Empathy as the Medicine of Life

Richard A. Goodman

Genuine feelings of empathy successfully communicated from one human being to another can heal emotional wounds, stimulate growth, and support life. For instance, a parents empathic connection to his or her child during the first years of life creates a oneness that is the kernel from which that child's full potential can blossom. The only way a child can develop the strength and resilience for life is from an empathic parenting relationship.

Parents who instinctively resonate positive feelings to their infants create the first experiences of love. This empathic emotional experience is the basis of the capacity to love and the wish to live for the rest of the child's life. Children who are denied this primary experience tend to feel alone and disconnected—feelings that perhaps extend throughout their lives.

Likewise, when a child is abruptly cut off from his or her parent's love and empathic bond, that child may very well wither away. The importance of empathic love and understanding became clear to me more than 20 years ago when, with much trepidation, I entered the field of mental health.

LISA AND BETTY

In 1977, I was hired as a milieu therapist in the psychosomatic unit at Children's Hospital in Boston. I was scared. I was new to the field of mental health and felt professionally vulnerable. After all, Children's is a world-famous Harvard teaching hospital, and I felt that I would be surrounded by clinical geniuses—among whom I was certainly not one. Despite my anxiety, the head of the unit told me that she thought I had a therapeutic personality (whatever that meant) and she had a hunch that I would be able to help the children.

I always loved children. I was, however, terrified when I saw the twelve children who were residents of the psychosomatic unit on the second floor of the Judge Baker Guidance Center, which was part of Children's Hospital at the time. Four of the children were so thin they looked like death-camp survivors. Others were obese, and some had severe asthma. Then there were the failure-to-thrive infants. At the time I wondered, What do I know about infants? After all, women are the ones who are the natural mothers. So, needless to say, I was shocked and amazed when I was told that my first patients would be Betty, a single mother, and her 5-month-old daughter, Lisa.

Despite her chronological age, Lisa was the size—in both height and weight—of a 2-month-old. Lisa's delayed development was the reason the hospital had referred mother and child to our specialized inpatient unit for

evaluation. Betty worked during the day as a secretary and spent the nights at the hospital with Lisa.

At the time, my only experience with babies had been with my sister's child who was by then 5 years old. Before that, I had never even held an infant! I was told just to observe the communication between mother and daughter while becoming attuned to my own inner responses as I tried to understand what was going on (or not going on) between Lisa and her mom. So I observed the two of them. (My instructors and supervisors further assured me that, in issues of life and death, intuitive knowledge can be more valuable than academic credentials.)

Lisa had big, brown eyes, which stared back at me vacantly, and a wide-open face. She looked as if she could take in the whole world, if she only knew how. I noticed that Betty made no eye contact with Lisa while she was eating, even when Lisa was having difficulty taking her bottle. In addition, Betty seemed very tense while she was holding Lisa. When speaking to me, Betty rarely looked at me and communicated with little emotion. Her demeanor reminded me of little Lisa's disconnection. I had the feeling that she too had never been held lovingly, either emotionally or physically.

If Betty herself had been denied that basic warm, empathic bond, how could she possibly establish such a tie with her daughter? As it turned out, not

only was Betty a single mother, but Betty's mother had been a single parent as well and had raised Betty alone under tremendous emotional and financial stress.

I decided, after discussing the situation with my supervisors, that I would attempt to establish an empathic relationship with Betty and, in doing so, I'd be letting her know that she wasn't alone and that she wasn't an inadequate mother if only her nurturing instincts could be awakened. By forming a bond with both Lisa and Betty, I would hopefully be passing on and filling her with positive emotions that would hopefully ignite the life energy in her, which she could then pass on to Lisa. So together we chatted and played with Lisa. I held Lisa in a very relaxed and loving way and laughed when Lisa smiled or seemed to be enjoying herself, reflecting and reinforcing Lisa's experiences. I also held Lisa close to my heart when she took her bottle so that she might feel my heart beating while she ate.

I held her close to me and simultaneously tried to hold Betty emotionally close to me as well. I talked to her about how wonderful her baby was and used humor to help Betty overcome her feelings of inadequacy as a mother. I told her that clearly I could never be the mother she was. Betty would laugh. I said, in fact, sitting next to a real mother inspired me to be nurturing, and I thanked her for helping me.

As the weeks went on, Betty began making eye contact with me, while Lisa began making eye contact with her mother, who now held her child close to her heart and had become very relaxed and cheerful when feeding her. Soon Betty began to point out to me better mothering responses to Lisa that I could never have instinctually been in touch with. The more emotionally connected Betty and I became, the more emotional connections she made with Lisa. In response, Lisa grew and gained weight dramatically, going from a pallid, sickly looking child to a rosy-cheeked, healthy baby. Whether Betty unconsciously saw me as a father, husband, or mother figure (or maybe all three) didn't matter. I believed she felt that I regarded her with respect, empathy, and love, despite her own feelings of low self-esteem.

My intuitive responses worked therapeutically, and I felt that if she knew how inadequate and vulnerable I was feeling, it might help her feel even more empowered. But then again, how can I be so sure that she wasn't already aware of my feelings? That may have also, in fact, been a major curative factor for both Betty and Lisa. Mother and child ended up leaving the psychosomatic unit after 3 months and were followed up for 1 year. Both have continued to thrive.

JACK

Jack was the second patient I was assigned to work with on the

psychosomatic unit. I had seen this boy, who looked like he was 9 or 10 years old, walking onto the unit. He was carrying two suitcases, as if he were planning to move in permanently. He had a very sensitive-looking face, and I had the feeling that he wasn't admitted for behavioral difficulties. I wondered, however, why a 9- or 10-year old had been admitted to an adolescent and infant-toddler unit.

At the unit meeting, I learned that Jack was not 9 years old but almost 13. Remarkably, both parents had died of stomach cancer within a year of each other. His dad had died first, then his mother. When she died, he stopped growing. When she stopped breathing, he stopped developing. I was astounded. Impossible! Such a thing couldn't happen. Although he had been regularly given milkshakes, he was unable to digest them and was even experiencing gastric distress himself. He had been given medical checkups, but no physical basis could be found for his stunted development. He was therefore diagnosed with psychosocial dwarfism—the stunting or stopping of physical growth as a result of emotional trauma.

When I introduced myself to Jack, he, like Betty, made no direct eye contact with me. For that matter, I thought that he was looking at someone behind me, and I actually turned around to see who he was looking at. Not surprisingly, Jack had sad eyes. As I looked at him, I thought to myself, "How can I help this boy who's been to hell and back?" The loss of a parent is a

child's greatest loss and can cause the greatest emotional damage. And in a horrendous twist of fate, Jack had lost both parents!

Like most adolescents, Jack didn't talk much at first, but he did like playing Ping-Pong. And he did seem willing to develop a relationship while playing the game. He also liked basketball. Ping-Pong I could handle; basketball was another story. I had been an awkward athlete during my childhood and adolescence. No one ever wanted me to play on his team, and I was often the brunt of insensitive jokes. So here I was trying to help a kid who loved sports. But despite my feelings of inadequacy, I played. I played all the basketball he wanted to play and was beaten over and over again. My efforts paid off; eventually, Jack began to talk about his life. I believe that my being able to show him my vulnerabilities created the safe and trusting environment he needed so that he could open up and be vulnerable himself. He talked about the almost unbearable pain of watching first one then his other parent waste away before his eyes. He spoke of how he fantasized about discovering a cure that would save them in time. Jack thought that if he were older—much older—he could have become a scientist and been able to find a way to make his parents well.

After his father died and his mother became ill, he thought that he might as well die too. He didn't actually want to kill himself; he just wanted to fade away with his mom, and that's just what he was doing. He believed that he

should have been born earlier so that he'd be older by now, and he imagined that his parents died because they really didn't like him. My heart went out to this kid. I was so moved, I could barely contain my emotions. I tried to remind myself of my training and that I should maintain an attitude of concerned but detached objectivity. Instead, I decided to use my intuitive wisdom and to try to form an empathic relationship with Jack— that is, to be who I am and to allow the patient to know me emotionally, which, in this case, was indicated therapeutically.

So I said to Jack that no parent could ever wish for a more wonderful son and that I would be very happy to have a son just like him one day. Jack's eyes welled with tears, and he said that he wished that I were his dad. Then he hugged me. I felt as if I wanted to adopt him then and there. But I was also feeling guilty. I was experiencing all the wrong emotions, and I feared I was becoming inappropriately over involved with this patient. But intuitively, I also believed that Jack needed to be aware of my feelings so that he could get better.

But things got worse for Jack before they got better. Before being admitted as an inpatient, Jack had been living with his brother and sister-in-law. And one day during the course of Jack's hospital stay, his brother and sister-in-law told the staff that Jack could no longer live with them. They had their own children to raise, and having Jack was too much of a burden. When Jack

found this out, he became hysterical and out of control. He destroyed his room and sobbed for 2 hours. I held him, sobbing too and telling him that I would personally make sure that he would be taken care of.

Following that event, I told a colleague that I thought I wasn't suited for this work because I was getting too emotionally involved with my patients. This colleague told me that I was too well suited for the job and that even though I might get sick from the job, my patients would probably get better. Well, my colleague was partly right: Jack did get better, but I didn't get sick. Jack left the psychosomatic unit after 5 months, having gained 20 pounds and grown 2 inches. Jack's brother and sister-in-law decided to keep him after all.

Before he left, I asked Jack what it was about our relationship that he thought helped the most. He then told me that when I held him and genuinely cried with him that made him grow. He realized that he wasn't alone in his pain because I was there sharing it with him.

Jack wasn't the only one who grew from an empathic relationship. My experience with him contributed profoundly to my emotional growth— both personally and professionally.

8

The Patient's Need to Love

Therese Ragen

A child has a great need to feel and express love to her or his parents as well as to be loved by them. The idea that it is critical for a child to be loved by parents is a basic assumption in psychoanalytic thought. The notion that it is crucial for a child to know that parents accept and value the child's love has been largely overlooked in psychoanalysis. When a child has been left uncertain about this, object relations, ego development, and sense of self are all adversely affected. In its radical shift toward exploring the importance of experiencing both parent and analyst as subject as well as object, the relational paradigm of inter-subjectivity opens the door to looking anew at the need to love. With a patient whose need to love has been thwarted treatment will inevitably and importantly involve her or his need to give love. As analysts we empathize with a patients need to love and allow ourselves to be recognized as having our own subjectivity within which we take in and value the love a patient offers to us.

This chapter explores the patients love as one of the many movements

in the analytic relationship. As Fairbairn wrote (1952), "the greatest need of a child is to obtain conclusive assurance (a) that he is genuinely loved as a person by his parents, (b) that his parents genuinely accept his love" (p. 39). The idea that it is critical that a child be loved by her or his parents is an assumption that is basic in psychoanalytic thought. It is central to our theories of child development, psychodynamics, and psychopathology and it is core to our clinical work. We readily empathize with our patients' need to be loved.

The notion that the child also has a great need to feel love and express love to her or his parents is neither basic to our psychoanalytic assumptions nor central to our thinking or work. It is seldom discussed as a need in and of itself. It has been largely overlooked both in theory and in practice. We don't so readily think of and empathize with our patient's need to love. On reflection, this seems curious. The importance of having the opportunity to love is fundamental to believing in and developing one's own capacity to love.

The paradigm of inter-subjectivity which has recently begun to be so richly elaborated within psychoanalysis opens the door to looking anew at the need to love, both the developmental need of the child as well as the need of the adult in treatment. A radical shift is occurring in the field in which both the parent and the analyst are being conceptualized not merely as objects but also as subjects. It is a critical factor in the growth of the child as well as the

patient that the other, whether parent or analyst, come to be experienced not only as object but also as subject.

It was only as recently as 1989 that Chodorow offered the apt critique that "most object relations theorists still take the point of view of the child, with the mother as object" (p. 253). It is remarkable how dramatically the field has moved in just a matter of years. Contemporary object relations literature is deeply involved now in questions of the subject status of both parent and analyst. Current work on psychoanalytic treatment focuses on such areas as the subjectivity of the analyst (Aron, 1991, 1992), social constructivism (Hoffman, 1991, 1992a, 1992b; Orange, 1992; Stern, 1992), and mutuality, symmetry and asymmetry, (Aron, 1992; Burke, 1992). Each piece within this growing body of clinical literature grapples with the issue of the analyst as subject.

Similarly, contemporary developmental research (Beebe, 1985; Beebe & Lachmann, 1988; Beebe & Stern, 1977; Stern, 1974, 1977, 1985) has demonstrated that not only do parents influence the child but the child mutually influences the parent and has shown that this is crucial for the child's development. Benjamin's (1988, 1990) work on inter-subjectivity and the mother-child bond squarely repositions the mother from object to subject in psychoanalytic developmental theory as she develops this idea to a degree far exceeding that of any prior object relations theorist and draws our

attention to the trajectory of intersubjective development in childhood. As conceptualized by her, the core element of inter-subjectivity is mutual recognition in which the child comes to recognize the mother as an independent subject, a person in her own right. It is essential that the child comes to see the mother not only as an object of the child's need, attachment, desire but also as a person apart from the child with her own needs, feelings, thoughts. A child can only develop the capacity for mutuality, for giving, for love in the context of a relationship in which the mother is recognized as other, that is, as the relationship increasingly comes to be one between two subjects. There is, then, not just a parent who needs to love and a child who needs to be loved, there is also a child who needs to love and a parent who needs to be loved.

Melanie Klein (1977), speaking about "a benign circle" of love, depicted the process in this way:

> . . . in the first place we gain trust and love in relation to our parents, next we take them, with all this love and trust, as it were, into ourselves; and then we can give from this wealth of loving feelings to the outer world again (p. 340).

We are largely accustomed to thinking of the root breakdown in this benign circle as existing at the point of being loved. However, the break can also occur at the point of giving love. In Klein's terms, the outer world may not be able to accept or receive one's love. Framed in intersubjective theory,

there may be a breakdown in the process of the mother allowing the child to recognize and relate to her as another with her own subjectivity who values and wants her child's love. The relationship between patient and analyst can contribute a great deal toward healing these breaks so that the patient can more fully set in motion "the benign circle" of mutual love with the people about whom she or he cares.

What is it like for a child not to have her or his love accepted by the parent? What are the psychological consequences? What does this experience look and feel like when a parent is unable or unwilling to really take in and cherish the child's love? In the face of the child's loving expression the parent may be remote, preoccupied, stiff or angry, indifferent, depressed, anxious. The parent is not really touched by the child's loving. There is a barrier, invisible, which the child cannot penetrate. The child reaches out with warmth and love but the door is closed. The loving gesture is politely acknowledged, passed over, goes unheard or unseen, gets lost in the shuffle or is actively rejected or diminished. She or he cannot seem to reach the parent's heart.

The child knows the parent has not genuinely accepted her or his love. She or he feels it keenly. The anticipatory moment filled with delightful expectation of shared love suddenly becomes a moment of hurt and confusion, bewilderment and embarrassment. The child thought she or he was

offering a gift of love—be it a touch, a word, a smile, a concrete present and now stands feeling empty-handed. The gift of love has been refused, gone unaccepted.

What does the child make of this? What does the child make of her or himself? Maybe love is not a good thing or maybe it is one's own love that is not good or good enough. The child feels poignantly alone and lonely. Sense of self and sense of efficacy are deflated. She or he has been rendered unable in efforts to give love. Confidence in the goodness of her or his love dwindles. The child withdraws, becomes more cautious, inhibited, indirect in loving and less certain of her or himself. She or he experiences a disjunction with the world. The child's feeling or action seems to have no effect, no value. In the paradox of inter-subjectivity, the child goes unrecognized because of the parent's inability or unwillingness to be recognized. In a profound way, the child is not loving because the parent will not be loved.

Fairbairn (1952), Suttie (1935), and Winnicott (1971) all offer ideas about what occurs when the child's love is not really taken in by the parent. Fairbairn characterizes this as a "highly traumatic situation" through which "the child comes to regard outward expressions of his own love as bad, with the result that, in an attempt to keep his love as good as possible, he tends to retain his love inside himself." A further consequence is that "the child comes to feel that love relationships with external objects in general are bad, or at

least precarious" (p. 18). The child then becomes timid and uncertain in expressing love. This inhibition, as Suttie observed, is then "usually misconceived as a primary selfishness," compounding the feeling of badness the child already has (p. 58).

A different aspect of the experience is picked up by Winnicott. With beautiful simplicity he describes the painful plight of these children saying, "Many babies have to have a long experience of not getting back what they are giving" (p. 131). One of the main detrimental effects of this is that "their own creative capacity begins to atrophy, and in some way or other they look around for other ways of getting something of themselves back from the environment" (p. 132).

When this child has become an adult and seeks treatment, what will her or his past experiences with having tried to love mean for the analytic relationship? What will she or he be expecting to occur between her or himself and the analyst? What will she or he need? Treatment with this patient will inevitably and importantly involve the patient's need to give love. The patient is searching for her or his loving self.

Making room for such an inherently relational experience as the need to love expands our understanding of the notion of empathy as well as the boundaries of clinical practice based on intersubjective theory. It requires

analysts to be in relationship in a significantly new way. We typically think of empathy as an emotional act of identifying with and so comprehending the subjective state of the other. In considering the need to love another dimension is added. The patient's need to love necessarily involves a reciprocal affective state in the analyst, a state of openness or receptivity to the patient's love so that patient and analyst join together in a shared intersubjective state. Empathy with the patient's need to love calls upon the analyst to experience being loved. If the patient is to go further in developing the capacity to love, the analyst must be on the other side allowing her or himself to receive the patient's love and to have the experience of being loved by this particular patient. I believe it is at this experiential level that the deepest, most radical implications of a truly intersubjective approach unfold. Unless we are available as an actively experiencing subject, what is occurring is not an interaction between two subjects but between a subject and an object. While the experiencing is not necessarily symmetrical between patient and analyst, it is profoundly mutual (Aron, 1992).

As is the case with the development of the child's capacity to love, a patient's ability to love will become more highly differentiated and elaborated as the patient increasingly comes to see the analyst as truly other, recognizing the analyst has her or his own subjectivity. For a child, the capacity to love begins with "the infant's feeling of happy satisfaction" and becomes "the growing child's and adult's capacity to feel for the object" (Guntrip, 1969, p.

31). “It has its first beginnings in simple infantile needs” and in its fullness it is “a highly developed achievement” (Ibid., p. 32). There is a developmental trajectory of intersubjective relatedness which culminates in the child’s recognition of the subjectivity of the mother and a capacity to relate to her and give to her on the basis of that recognition (Benjamin, 1990). As we rework this trajectory with patients they move in their affectional feelings, from loving us more as objects to loving us more as subjects. This entails their coming to see us as less idealized as well as more multidimensional human beings, learning that “good people have a bad side too and that even though they have their faults we can love them” (Fromm in Fromm and Brown, 1986, p. 325). In its fullest realization the love between analyst and patient is the love between adult friends (Guntrip, 1969, p. 36). It is the love of “the most important kind of relationship of which human beings are capable . . . deep mutual affectionate understanding of each other (Ibid., pp. 353 and 354).

As Eagle (1984) states, “clinically, one frequently observes that it is precisely the person deprived of love and empathy who is most conflict-ridden in regard to being loved” (p. 129). Similarly, the inpidual who has a history of not having their love accepted is conflicted over giving love. One would expect their wishes to love to be accompanied by anxiety and loving gestures to be mixed with avoidant and aversive behavior. Treatment then involves working through the fears of loving.

It is generally expected that the analyst will act in loving ways. The analyst is expected to be understanding, thoughtful, caring, concerned, respectful, empathic. The patient needs to receive this kind of care from the analyst. The patient also needs to give it to the analyst. This is especially true of the patient who has grown up feeling her or his fond feelings were really neither accepted nor valued by the parents. If the analytic relationship is to be healing it has to allow for the patients need to actively experiment with love in order to find her or his way back to the full life of the repressed loving capacities which have been replaced with dim echoes of their original vitality.

The patients first efforts to express love may be groping, guarded, cautious. She or he is highly attuned to the analyst's response and is given to distorting it into the anticipated lack of acceptance. The patient is likely to be surprised or anxious, though glad, if the analyst accepts with pleasure the expression of fondness. These expressions may run the developmental gamut of love. They may emanate from simple infantile needs and a view of the analyst as object or more from an understanding of and feeling for the person of the analyst as one who is a subject. The patient's feelings may find expression in a smile, a compliment, an empathic observation, an inquiry of concern, a thought of the analyst between sessions, a gift, an expression of gratitude, an article or object thought to be of interest to the analyst, a touch, a fantasy, a direct expression of feeling. Whatever form it takes if the analyst genuinely values these expressions of love, the patient's capacity to love

others begins to flourish within and outside of the analytic relationship. Simply analyzing and interpreting these feelings would be tantamount to refusing to accept them, a repetition of the initial pathogenic situation.

Of course, as with anything else in treatment, outward expressions of caring can be motivated by any number of inner experiences. At times they may not be gestures of the true self, but rather defensive expressions of the false self. They may fully, partly, or not at all be determined by transference. They may vary in the extent to which they are rooted in the subjectivity of each inpidual and in the intersubjective relationship they have created together. They may be more or less congruent with what is actually occurring at a given moment in the relationship.

Perhaps Christopher Bollas (1989) speaks best about the discrimination which the analyst needs to make. One's use of self is the ultimate guide to understanding the sense of these moments. How does what the patient has said or done feel to the analyst? Is there a fit between the patient's expression and what seems to be occurring at that time both within the patient as well as within the relationship between the patient and analyst? Or does the analyst feel forced into an emotional position which does not fit? (pp. 17 and 18). It is one's comfort with receiving along with the use of one's self that the analyst relies on to understand and respond in these moments. When there is no emotional fit the analyst needs to open the moment up for exploration and

analysis between her or himself and the patient, working together to understand the disjunction between the patient's expression and the analyst's experience.

In addition to freeing their potential for loving others in their lives, patients discover a strong sense of self in the expanding relational capacities they develop in their relationship with the analyst. Relational or intersubjective theories of self posit that self-development occurs in relationships through the recognition of the other. Certain aspects of self can only emerge and grow in interaction with others as they have an inherently and essentially relational nature. One dimension of loving is an experience of self as being one who loves, an experience of self which can only be had in relationship.

Guntrip (1969) speaks most incisively about the dynamic and intricate interplay between ego and object relations development. He states:

> The experience of growing as a positive secure person can only be had by freedom to express oneself actively in a good relationship, receiving, giving, loving, creating in mutuality ... If we take the term love to stand for the quality of a good relationship then we shall say that a stable ego can only grow in the atmosphere of loving relationships. Its most important characteristic is its capacity to give love (p. 105).

It is interesting to think about Guntrip's ability to speak so profoundly about the importance of love in child development as well as in treatment in light of his description of how loving his own analytic relationship was

between Winnicott and himself. Commenting on how Winnicott's expression of feeling for him affected him, Guntrip (1975) said, "Here at last I had a mother who could value her child, so that I could cope with what was to come" (p. 62). Searles (1979) and Ferenczi (1932), two analysts known for their mutual expressiveness with patients, also discuss how their patients' self-esteem was deeply affected when they acknowledged the ways in which their patients had positively influenced them.

The notion that a patient needs to feel and express her or his love for the analyst ultimately leads to the issue of the analyst's subjectivity in the relationship. The vision which emerges here is one of a patient who is actively and expressly loving and giving in the relationship. The analyst's very self is thus opened up to the patient as a deeply personal place in which the patient touches the analyst, moves, gratifies, gives to, and finally loves the analyst.

When the patient needs to find her or himself in her or his capacity to love, the analyst's feelings about being loved necessarily come into play. While we often speak of Winnicott's (1971) notion of the patient's need to "destroy" the analyst and the therapeutic importance of our ability to contain and tolerate these moments, we rarely speak of the patient's need to love us and the importance of our capacity to receive their love. Perhaps in some ways it is even harder for us to sit with being loved than being hated. The complexities, the potential unforeseeable and intense complications for

ourselves and the patient incline us to draw back. However, struggling with our own capacity to be loved, allowing our own feelings about being loved to emerge is critical.

To the extent the analyst is unable to be loved, given to by the patient, the pathological situation of childhood is recreated as the analyst becomes the parent who did not really take in the child's love. The patient sinks deeper into her or his felt inability to love and its concomitant negative self-valuation. The chance for the rediscovery of loving potential through a loving experience with the analyst is lost.

Conversely, the analyst who permits the patient emotional access to her or himself necessarily allows the patient to know something about what it means to the analyst to be loved. In experiencing the analyst pleasurably taking in the caring that is offered, the patient embraces her or his own love as something powerfully valuable. Delighting someone, bringing happiness to someone with one's love is a profound experience of self and other.

REFERENCES

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, I, 29-51.

Aron , L. (1992). Interpretation as expression of the analyst's subjectivity. *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, 2, 475-508.

Beebe, B. (1985). Mother-infant mutual influence and precursors of self and object representations. In J. Masling (Ed.), *Empirical studies of psychoanalytic theories* (Vol. 2). Hillsdale, NJ: Lawrence Erlbaum.

Beebe, B., & Lackmann, F. M. (1988). The contributions of mother-infant mutual influence to the origins of self and object representations. *Psychoanalytic Psychology*, 5, 305-337.

Beebe, B,, & Stern, D. (1977). Engagement-disengagement and early object experiences. In N. Freedman, and S. Frand (Eds.), *Communicative structures and psychic structures.* New York: Plenum Press.

Benjamin, J. (1988). *The bonds of love: Psychoanalysis, feminism, and the problem of domination*. New York: Plenum Press.

Benjamin, J. (1990). An outline of inter-subjectivity: The development of recognition. *Psychoanalytic Psychology*, 7, (Suppl.), 33-46.

Bollas, C. (1989). *Forces of destiny: Psychoanalysis and human idiom.* London: Free Association Books.

Burke, W. F. (1992). Countertransference disclosure and the asymmetry/mutuality dilemma. *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, 2, 241-271.

Chodorow, N. (1989). *Feminism and psychoanalytic theory.* New Haven: Yale University Press.

Eagle, M. (1984). *Developmental defect versus dynamic conflict*. New York: McGraw-Hill.

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality.* London: Routledge & Kiegan Paul Limited.

Ferenczi, S. (1932, 1988). *Clinical diary* Cambridge, MA: Harvard University Press.

Fromm, E., & Brown, D. (1986). *Hypnotherapy and hypnoanalysis.* Hillsdale, NJ & London: Lawrence Erlbaum.

Guntrip, H. (1969). *Schizoid phenomena, object-relations and the self.* New York: International

Universities Press, Inc.

Hoffman, I. Z. (1991). Discussion: Toward a social-constructivist view of the psychoanalytic situation. *Psychoanalytic Dialogues: A Journal of Relational Perspectives,* 1, 74-105.

Hoffman, I. Z. (1992a). Reply to Orange. *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, 2, 567-570.

Hoffman, I. Z. (1992b). Some practical implications of a social-constructivist view of the psychoanalytic situation. *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, 2, 287-304.

Klein, M. (1977). *Love, guilt and reparation & other works, 1921-1945.* New York: Dell Publishing Co., Inc.

Orange, D. M. (1992). Commentary on Irwin Hoffman's "Discussion: Toward a social-constructivist view of the psychoanalytic situation" (PD, 1 [1], 1991). *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, 2, 561-566.

Searles, H. F. (1979). *Countertransference and related subjects.* New York: International Universities Press, Inc.

Stern, D. (1974). Mother and infant at play: The dyadic interaction involving facial, vocal and gaze behavior. In M. Lewis, & L. Rosenblum (Eds.), *The effect of the infant on its caregiver.* New York: John Wiley.

Stern, D. (1977). *The first relationship: Infant and mother.* Cambridge, MA: Harvard University Press.

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Stern, D. B. (1992). Commentary on constructivism in clinical psychoanalysis. *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, 2, 331-364.

Suttie, I. (1935). *The origins of love & hate.* London: Kegan, Paul, French, Trubner.

Winnicott, D. W. (1971). *Playing and reality.* Middlesex, England: Penguin Books Ltd.

III

Innovative Models for Therapy and Training

9

Creating an Empathic Environment at the San Joaquin Psychotherapy Center

Kevin F. McCready

For over a decade, San Joaquin Psychotherapy Center has offered a genuine alternative to the bio-psychiatric or disease model of treatment for people suffering from emotional or psychological distress. This alternative model is called an “Integrative Milieu.” “Integrative” because it seeks to value and integrate all aspects of the inpidual including the often disturbing but meaningful expressions of distress called “symptoms.” “Milieu” because the primary focus of “treatment” is to create an environment that facilitates this integration. These elements promote the inherent growth and healing functions of the human psyche. In contrast to the disease model of treatment the Integrated Milieu strives to expand the depth and breadth of a person’s humanity to overcome distress and dysfunction rather than restriction of humanity through an attempt to control symptoms.

Located in the unlikely area of Fresno in California clients find this modest clinic from as far away as Venezuela and New Zealand. The center has

been highly successful in treating clients without harmful psychiatric drugs and helping clients get off the dangerous psychiatric drugs they have been forced or coerced to take. In almost 10 years of treating patients some of whom have been labeled with the most severe psychiatric diagnoses and declared to be "untreatable" without from six to ten psychotropic drugs. There have been no suicides, no incidents of significant violence and although there have been times when other parties have intervened or interfered we have never returned a patient to a psychiatric hospital.

According to the prevailing propaganda of bio-psychiatry this can't be done.

Not How—Why:
A Different Way of Thinking Yields Different Results

I am often asked: "How do you treat patients?" or "What do you do differently?" This is a difficult question to answer. Not because I don't know what it is that we do differently. But in a materialistic, technique oriented culture it is so difficult to convey that what we do is derived not from a different method but from a different paradigm. We do not so much "treat" or even "heal" patients. We create an environment in which they may heal. Please note the deliberate use of the word "may." One of the pillars on which this paradigm is based is that free will and personal responsibility are essential. I would go as far as to say that the devaluation of inpidual freedom

and personal responsibility is one of the primary sources of iatrogenic problems in therapy.

Patients or family members will ask how long will they have to be in treatment. My response is simply—"As long as you want to be." To ask how much treatment is needed is like asking how much education one needs. Some people are satisfied with a bachelor's degree; some want half a dozen PhDs and a Cosmetology License. This is not a model where people are sick and ask the doctor to fix them. This is a place where one overcomes problems by growing as a human being not by stifling one's humanity. When you are satisfied with your work here then I assume you will leave.

I am also frequently asked questions that raise spurious issues such as . . . " but what would you do if . . . then some extreme stereotypical behavior or perceived threat or dangerousness is postulated in order to justify dehumanizing interventions. Often these behaviors can be traced to the reaction human beings have to being betrayed by those who purport to help them—if only they will surrender their humanity to serve as scapegoats for the collective pervasive, if unspoken, belief of our profession that those identified as "mentally ill" have something wrong or inferior about them that we are safe from as long as we can identify its existence in someone else. Or as Thomas Szasz once put the problem (comparing it to the biological principle of "kill or be killed") in the mental health community it is "label or

be labeled."

Often, much of what we do in the first stages of treatment for people who have been in the psychiatric system for prolonged periods is to in essence "deprogram" them to stop acting like "mental patients." Even those who have never been formally treated in the prevailing mental health system; even some who are well aware of the inhumanity of this system need both intellectual and emotional clarification of the distinctions between what is fact, fiction, politics and propaganda. In fact, it is true that even patients who come to us well-informed, angry, and opposed to bio-psychiatry's way of thinking still require some degree of attention to the subtle and often superstitious pressures of this oppressive model. Indeed, I often find myself intimidated by the propaganda both for imagined and actual reasons.

TWELVE PRINCIPLES TO CREATE AN EMPATHIC MILIEU

This list of principles is neither exhaustive nor exclusive. Some of the ideas obviously overlap as they should in an integrated system. The list is articulated to specifically aid in the creation of an integrated treatment program. While these principles are meant to be applied to designing a treatment system it will be easy to see how they may be applied as well to the internal "milieu" of the therapist. Because of limited space there is little elaboration within the list but the underlying rationale for each is easily

gleaned from this chapter in its entirety.

Personal responsibility for life, well-being, and behavior belongs unequivocally to the patient.

1. The physical environment of the facility must reflects these principles. (It would be impossible to expect someone to speak freely, no matter how sincerely encouraged, in a room displaying a Nazi party swastika.)

2. Philosophy is more important than technique.

3. The most important job of the therapist is to create an empathic, healing environment.

4. The therapist must eschew the arrogance that she or he "fixes" the patient and recognize that the capacity for healing is inherent in the psychological and spiritual makeup of the patient.

5. Symptoms of psychological distress must be regarded as meaningful expressions rather than as parasites to be eliminated.

6. The therapists passion for the work and meaning of psychotherapy must dominate the fears and insecurities of the work.

7. It must be recognized that the primary means of healing employed by the human psyche is through expression in the context of an empathic relationship or community.

8. The milieu must stress security not safety; constancy not immediate gratification and the development of personal autonomy not infantile dependency.

9. Human suffering must be regarded as both inevitable and purposeful. The avoidance of suffering is one of, if not the primary causes, of psychological or spiritual crisis. The problem is how to make suffering a constructive experience that increases empathy and enriches our humanity rather than a destructive force that drives us away from our humanity.

10. Remember the caveat of C.S. Lewis: "There is no tyranny so great as that which is practiced for the sincere benefit of its victims."

11. . . . and especially for students—C.G. Jung's dictum: "Learn your theories well but be prepared to abandon them when faced with the miracle of the living soul."

A Day in the Life of SJPC

The activities of each day at SJPC are organized around five different group hours. Patients also meet with their inpidual therapist one or several times per week. Each group in the day program has its unique purpose and role. Overall the structure of the day is designed to wax and then wane in regard to depth and formality of structure while providing a variety of means by which the patients' psyches can express their needs.

The program is generally designed to approximate a work environment. There are no degrading level systems. Patients are not "sorted" out according to diagnosis.

We all suffer from fears, confusions and griefs. Some of us are more overwhelmed than others by our struggles with these experiences and manifest meaningful expressions of these struggles that are called "symptoms" but we are all trying to cope with the same basic elements of being human. Recognition of what we share as human beings brings us together in our humanity. Emphasizing our distinctions in labeling separates us.

Attendance is not mandatory. There are few official policies or posted rules. Instead there is an unwavering expectation of respectful behavior.

There is a job to do. Each person involved in the program, whether staff or patient, plays a part in the work. The work is dedicated to the growth of each human being participating in the program both inpidually and collectively. The “work” is to help human beings grow. It is not to identify symptoms to be eliminated.

Beginning at nine in the morning the patients gather with staff members for a community meeting. This meeting serves as something of a “warmup.” A member of the patient community is selected by his or her peers to conduct this meeting. It is intended to function as something of a business meeting and has an informal agenda.

Everyone is greeted and given an opportunity to comment on how they are feeling that day. News and announcements are made. Community Issues are discussed and inpidual and group goals are set. However, all the tasks of this agenda are secondary to and in fact in service to the needs of the participants.

After a short break the group reconvenes at 10:00 for an expressive arts group. In this group members have an opportunity to express their humanity through various media that are less dependent upon the cognitive/verbal skills that we have best developed yet can often be co-opted by our fears to avoid intimacy and growth.

At 11:00 a traditional group therapy session is scheduled. This is the heart of the Integrated Milieu. Patients explore their fears, their wishes, their wounds.

At noon there is a lunch break. In keeping with the notion of approximating a work environment there is no specified nor mandatory means by which any patient or staff member pass the lunch hour. Some bring a sack lunch. Some will cook something alone or for the group. Some will run errands or go out to lunch. Some will take a nap, etc.

At one o'clock another group begins. This time it is a discussion group. A topic is chosen by the group. Ideas are shared. Thoughts discussed. The world figured out—at least until tomorrow.

At two the day ends with a recreation hour. The purpose and necessity of play is often underappreciated in our culture. It is a time to bond, to relax, to re-create.

At the end of the recreation group the program day ends. Patients are then on their own until nine the next morning.

The structure of the milieu program is designed to maximize the ability for the therapists to facilitate the healing. Structure, regularity, and constancy tempered by flexibility, empathy and nurturance are essential to a healing

environment. But there is no magic formula. As emphasized previously, it is the philosophy of the integrated milieu that determines the form. Not the other way around. The exact same form as used at SJPC may be duplicated by any facility. Indeed the program model is a classic template used in many psychiatric facilities. But without absolute commitment to the humanity of the inpidual it is a lifeless, soulless shell.

The use of a strictly day treatment milieu is also deliberate. While it is important to provide an environment or program of intensive and multidimensional therapeutic activities there must be a beginning and an end. An over structured 24 hour environment can easily infantilize patients. Ending the "work" day preserves the patients ability to comfort, care for, and entertain themselves increasing not only their basic sense of autonomy but also reinforcing the confidence and trust that they can in fact, "make it through the night" and do not need to structure their lives and the lives of everyone in their environment to be geared to the demands of immediate gratification. It is much more psychologically secure to know that there is a tomorrow than to try to create and sustain an illusion that we will never have to feel alone or afraid.

Finally, the therapeutic milieu must be a stable beacon, not a search and rescue operation. Certainly, there are times when people need immediate and direct intervention in their lives. This is important to our lives as a

community. But this is not psychotherapy. Psychotherapy's power is dependent upon constancy and reasonableness. Psychotherapy has no potency in areas where panic and hysteria reign. That is the domain of pathology and dysfunction. A milieu geared to react to panic will soon be in service of it. In other words, if someone is given the mixed message that she or he is responsible for his or her own life and well-being unless they present with a crisis at which time the constancy of the milieu will be discarded. People who dread taking responsibility for themselves (as we all do) will be behaviorally trained by the milieu to be in crisis. In this way they can avoid the terror of personal responsibility or gain control over the situation or simply gain immediate but ultimately, ungratifying attention.

What About Drugs?

Although many people seek out SJPC because of our unique service of helping people discontinue psychiatric drugs it is not the primary mission of the clinic. The primary mission is to provide in depth psychotherapy uncompromised by dehumanizing attitudes, technologies or techniques. Psychiatric drugging is simply one of the more obvious and currently the most pervasive means of dehumanizing patients.

Patients wishing to decrease or eliminate their use of psychotropic drugs follow a customized titration protocol that addresses both the physical

and psychological issues of withdrawal from these drugs. However, it is strongly emphasized that neither the method nor the goal is focused on merely discontinuing psychotropic drugs. The purpose of the program is to substitute immersion in a high quality, intense, in-depth sophisticated and empathically based treatment program for drugs and other technologies in order to enrich the person's humanity and thus alter their struggles with suffering from a destructive dehumanizing form to a constructive uplifting form.

Empathy 101: Student Trainees Confront Bio-psychiatric Attitudes

Among the most rewarding results about the creation of an empathic environment is that the potency of a healthy integrative milieu can enhance the positive assets of a reasonably good staff while also mitigating their limitations. Most of the day-to-day treatment at San Joaquin Psychotherapy Center (SJPC) is not provided by extremely sophisticated and vastly experienced therapists. It is done by relatively raw, inexperienced trainees, interns and students. Yet these "novices" manage to consistently achieve results the bio-psychiatric industries insist can't happen. Of course, unlike bio--psychiatric-oriented systems the goal of a truly empathic milieu is to develop patients' humanity not control their symptoms.

By no means is my intent to suggest that the men and women who have

trained at SJPC are not special, remarkable people. They have consistently been intelligent, dedicated, caring, and courageous souls. They have been willing to work "without a net" and focus on the needs of the patients rather than embrace the dehumanizing paradigm and practices currently characteristic of the mental health profession.

Many, if not most of these student therapists have been indoctrinated in almost cult like fashion. They have been led to believe that the dominating medical model of "treatment" with its inherent lack of, if not outright opposition to empathic treatment is not only valid but is the exclusive means of legitimate psychotherapy.

Mostly by word of mouth they hear about a training opportunity available that resonates with what they all have in common and what led them to this field in the first place. They all share a fundamental conviction that psychotherapy is an empathic, human and ultimately spiritual endeavor. Even though their initial training experiences often attempt to extinguish these beliefs they find their way to this milieu. In this environment they first learn to not indulge the personal and professional arrogance of believing that they can "fix" deviant people. Instead, by empathically engaging with the healing function of each patient they allow the milieu to use them to help many troubled inpiduals grow as human beings.

They Themselves Also Grow

I asked current or former students, interns, post-doctoral fellows, etc. at SJPC to describe their experiences of training at SJPC in regard to issues of empathy, especially as contrasted to other training experiences in their academic careers.

Marij Bouwmans, MFT, offers the unusual perspective of a therapist

raised in the Netherlands. She notes that the word "empathy" translates to the Dutch "Invoelen." Literally translated, "Invoelen" means: "To feel into." Ms. Bouwmans relates a story about "feeling into the heart of one of her young patients using his own voice:

> One day my therapist and I were outside. We had planted flower seeds in a pot inside weeks ago. And now it was time to plant them outside. We took the planting tools and I dug holes in the little garden in front of her office. When my therapist took the plants out of the pot you could see all the little roots of the different seedlings. They were all entangled and really thin. She said that these plants all belonged in one family in that pot and that we were now separating them. She let me separate the roots, some broke, some came apart.
>
> She said that this looked a little like my life. That at one time I lived with my mom and dad and brother in a house and then we were all separated. Every time I move to another foster home my roots are being dug up and replanted from family to family. It is hard for roots to become strong when they are being taken out all the time. She said that was like me. that maybe sometimes I don't feel strong and good about myself because my roots have not had the chance to grow strong yet. I think that she is right. That felt really sad . . . but also good that she told me. Now I understand.

Ms. Bouwmans concludes by commenting that as this young man let her "feel into" his pain she "simultaneously reached into my own feelings of uprootedness—loss of culture, loss of language, loss of friends and family ties.

Dr. Damon Elgie discusses how much he learned about empathy from the empathic sensibilities of the patients themselves while in his role as a group therapist:

> The healing of the clients seemed to come from the ability of therapist and clients to sit within the deepest pain of their psyches and have empathy for each other as the process occurs. We were all working together toward the same goal: to allow them to experience their pain in a secure environment without the hindrance of psychotropics. This allowed all parties to feel empathy towards one another in the experience.

Benjamin Franklin once said "Those who love security over liberty will soon have neither." Doctor Emily Piper discusses how she came to see that the nature of bio-psychiatric-based treatment environments sacrifice both empathy and humanity in favor of control and security. She describes how likewise, she came to realize that she also had to make the choice and sacrifice some of her own sense of security in order to free her own ability to grow as a therapist:

> I began working at (a local private psychiatric) hospital with the intention of receiving financial support while in graduate school. I vowed to maintain employment regardless of what I would witness ... I was clearly not prepared for what I saw. I observed a horrific display of inhumane treatment promoted by a world of lethal medication, engulfed within an unforgiving society . . . SJPC provided me with the education to recognize

> and distinguish the purest from the most deceptive healing practices ... I ended my workday at SJPC with an understanding about the humane process of treatment. After leaving the hospital, I felt inhumane . . . I terminated my employment at the hospital . . . I could no longer justify or rationalize why I was there.

Like Dr. Piper, Dr. Denise Eytchison relates how she learned that it is often necessary to sacrifice security for both liberty and integrity. She offers a disturbing insight and firsthand account of the consequences of an environment that has sacrificed empathy.

> At a County Mental Health Clinic ... I watched a psychiatrist give a 16- year-old boy four forced injections, then recount the incident smugly bragging how effective she was at showing him "who was boss." I watched a 5-year-old girl be sentenced to informal probation through the juvenile court system for acting out at school. I saw colleagues coerce parents to follow their treatment recommendations at the risk of losing their children because the therapist threatened to pursue charges of "medical neglect." "If that woman can't keep her children safe, I will place them with a mother who can." I heard such statements on multiple occasions, and was instructed to make the same threats.

Dr. Eytchison continues describing the consequences of resisting the culture of a professional environment that has sacrificed any sense of empathy and must ensure that there are no dissonant voices:

> Personal attacks (escalated from calling me offensive to arrogant to incompetent, negligent, then finally, "sick." It was not enough that I did not think in the same hyper-controlling, sometimes fascist manner, or that I refused to actively participate in destroying my patients in body and spirit. I was there . . . any hope I had that horrors such as these were reserved for novels and wars, have been irreparably destroyed. I cannot overstate the danger of any organization masquerading as "therapeutic" that is willing

> to threaten, hurt, and destroy anyone who interferes with its own ideas of "appropriate" behavior. My patients were all casualties of this. So was I.

Dr. Troy Hayes offers an impassioned description and insight into his sense of the spiritual nature of psychotherapy and the necessity to rely on empathy not technology. He advises us to treat each person as an inpidual, not as a diagnosis and recognize that "Psychotherapy," as he so movingly states, " ... is not a journey of simple behavior change, but one of soul."

> With bended knee, we pray to the gods of drugs, ECT, and other inhumane activities to take away our clients' "inappropriate behaviors." With this symptom reduction comes escape and avoidance of a feeling of impotence when one recognizes the inability to "fix" others. There is no room for genuine empathy in this kind of model.

Finally, Cheryl Seufert notes that although she had wished to become a psychologist even as a high school student she found herself doubting that choice after her first years of training as a graduate student. She warns how easy it is to become desensitized to the nature of human suffering in an environment emphasizing control, technology, and compliance and, as her peers have written above how absolutely essential is empathy both for her patients and for herself as a human being.

> Forcing compliance, via prescriptions of drugs or behavior modification techniques seems to negate the human element that is essential to healing the soul. Perhaps many professionals lose sight of this fact once they engage in the rat race of treating as many clients as possible in an attempt to make a decent living. What I have learned at SJPC has been invaluable not only in my practice but in my life as well. The concept of respect.

> Respect for the inpidual, respect for their pain and respect for their healing process is what makes psychotherapy profound and humanistic. In order to be helpful in the healing process it is imperative that the therapist attempt to understand the client's material as the client understands his/her material. This cannot be done if empathy is absent. I believe it is impossible to be empathetic if the focus of therapy is to gain compliance. It is with an empathetic ear and a willingness to understand the client that a therapist can genuinely tap into what the client is likely feeling and thus formulate interventions based on this understanding. I think the greatest disservice psychologists can do to their clients is to trivialize their pain by placing a one word label on the client's entire life experience. I have a great respect for the healing process and each client's experience of pain as a result of particular life events. I have come to realize an effective therapist must first be comfortable enough to journey to the depths of pain with their client and in doing so foster an environment that is supportive and safe to share without fear of judgment.

These are difficult times for the profession, indeed for the soul of psychotherapy. But it is encouraging to know that there are students in the field who see through the Faustian promises of bio-psychiatry.

These students and many more like them have been like blades of grass. Almost miraculously they push themselves up through the oppressive concrete of bio-psychiatric indoctrination. They reach out to the light of empathy and humanity to nurture and guide them in their formative years as psychotherapists. I offer them my deepest appreciation, affection and admiration for their sacrifices, their courage and their humanity.

As for new students and seasoned professionals alike hoping to rediscover the empathy, sensitivity and humanity that once called them to

this profession, the best advice I can offer is to quote Carl Jung. He once boldly asserted "Learn your theories well. But be prepared to abandon them when faced with the miracle of the living soul."

AN INTEGRATIVE CONCLUSION

I held my first job in this field at age sixteen. I was a "Play Therapy Aide" at Boston's Children's Hospital. I worked on a ward that was designated for children who were terminally ill. In a paper written years later as an undergraduate for a Medical Sociology course I noted that I found myself most impressed that the children there, although undeniably dying, were most busy being children. They were living.

At that time there were many children at the hospital who suffered from various cancers. Many had limbs removed to stop the disease. It was the best they could do at the time. But no one in the field ever said that it was good enough treatment to rid the cancer from these unfortunate children by compromising their wholeness.

The entire field of medicine has always advanced when it has concentrated not so much on stopping the disease as preserving and advancing the integrity of the person. This must be our goal for those who suffer psychological distress as well. The necessary evil argument that controlling symptoms at the expense of human dignity and integrity cannot

be good enough for an empathic, spiritually-oriented psychotherapy.

Human beings are designed to heal from their suffering; even to grow from it. But the source of healing is not found in drugs and electric shock or surgery or the other trappings of bio-psychiatry. These things dehumanize us. Instead of techniques and technologies that further impair our humanity the sources of healing must be sought in the things that make us human. These things include literature, art, music, laughter, play, community and of course, basic human empathy. We must seek always to struggle productively with our suffering; expanding, deepening, expressing and sharing our humanity.

As John Steinbeck proclaimed so eloquently in his introduction to "East of Eden," his quintessential novel of human nature:

> And this I believe: that the free exploring mind of the inpidual human is the most valuable thing in the world. And this I would fight for: the freedom of the mind to take any direction it wishes, undirected. And this I must fight against: any idea, religion or government which limits or destroys the inpidual. This is what I am and what I am about. I can understand why a system built on a pattern must try to destroy the free mind, for that is the one thing which can by inspection destroy such a system. Surely I can understand this, and I hate it and I will fight against it to preserve the only thing that separates us from the uncreative beasts.
>
> If the glory can be killed, we are lost!

10

The Role of Empathy in the Wraparound Model[1]

Sharon Morrison-Velasco

For more than 40 years the term "empathy" has waxed and waned through the therapeutic community. As a necessary component of therapeutic change, the concept was the subject of substantial research during the 1970s and has returned to the center of attention in the 1990s. The learning that has taken place during the last 20 years is best summed up by Bohart and Greenburg (1997):

> (as seen here) empathy (is) far more central to therapeutic change and far more than just acknowledging the client's perspective and being warm and supportive. . . . First, empathy includes the making of deep and sustained psychological contact with another in which one is highly attentive to, and aware of, the experience of the other as a unique other. . . . Second, empathic exploration includes deep sustained empathic inquiry or immersing of oneself in the experience of the other. . . . Third, empathic exploration includes a resonant grasping of the "edges" or implicit aspects of a client's experience to help create new meaning, (p.5)

If these three forms of empathy are each important, albeit at different times, for positive therapeutic outcome and change, one might certainly question why they would not be applied beyond the therapy room. This

chapter is dedicated to the discussion of just such a practice, moving empathy beyond the therapy room into mental health systems, specifically systems of care for children, adolescents and their families, by using the Wraparound Model.

Wraparound Defined

John van den Berg and Mary Grealish (1998), leaders in the area of wraparound, define it as:

> . . . a simple process of people helping people. It means that a community starts with the child and the family around them, and the friends and kin around the family, and asks a crucial question—'What do this child and family, and sometimes the people around them, need to have a better life?' When we ask that question we really mean it—if the child and family need something our services do not offer, we create a way to meet the identified needs with something new, inpidualized to the strengths, culture, preferences, and 'ways' of the child and family, (p. 2)

This simple definition has profound implications for the practice of therapeutic services within systems. First, wraparound puts families in charge of their own service delivery from the standpoint that the *family* defines their needs and goals, rather than a system defining their diagnosis and then assigning corresponding services. Parents must be included in every level of development of the process (van den Berg & Grealish, 1996). Services in the wraparound model are inpidualized by creating services which meet the family needs and goals and are defined in a way which takes greatest

advantage of their strengths. Second, the family need not rely solely on a family therapist or an inpidual therapist for a challenged child. Rather, the family, with the assistance of a "team leader," builds around them a support team consisting of such professional supports as a probation officer, Teacher and/ or Child Protective Services Social Worker, and such "informal supports" as extended family members, mentors, and/or fellow church members. Finally, to truly understand a family's strengths and needs, and to be able to genuinely call upon the strengths of the team, one must have the most developed empathy skills involving all of the three types of empathy noted previously.[2]

Wraparound and Empathy

Traditional forms of psychological assessment usually include some type of "Intake" procedure which involves a brief family psychological and treatment history. Information is gathered from the client(s), structured in such a way as to elicit a problem and what may have been tried in the past to deal with the problem. Some of the limitations to this approach are obvious, but include the rather blatant omissions of a client's strengths, as well as a deeper understanding of the client's worldview. While "worldview" has been discussed with regard to a client's ethnic culture (Dana, 1995), world view is used here to incorporate a client's/family's ethnic culture, values, beliefs, moral views and perceptions. Taken collectively, these aspects contribute to

making a family who they are. The therapist and/or "team leader" is called upon to understand no less than what this family considers to be important in life behaviorally, philosophically, emotionally, spiritually, financially, and ethically as it relates to the family goals.[3]

The "Intake" procedure in the wraparound process, then, includes a strengths assessment. Asking a family member what his/her strengths may be is not sufficient. Many people have difficulty defining their strengths and rarely see the internal gifts which have assisted them through times of crisis. Therefore, for those who can offer a reply to the strengths question, the answer often includes tasks at which people can excel such as cooking, baseball, dancing, etc. To tap into an inpidual's strengths and assist in defining them, one must understand the persons worldview without judgment. Does this person value family above all else? Is independence the value which drives this person most? Is the greatest source of pride in this family that they have always supported themselves, never seeking public assistance? Can mother's fastidiousness be used as a strength rather than a burden to other family members?

Seeking and genuinely understanding the answers to these types of questions requires the "immersing of oneself in the experience of the other." It also requires "sustained psychological contact with another" such that "one is highly attentive to, and aware of, the experience of the other." Finally, if one

is to assist in using these strengths to define a service plan which will assist the family in solving their problems, the process also requires a "resonant grasping of the 'edges' of the family experience" in order to create new meaning.

The story which follows is an illustration of the wraparound process as well as an example of calling upon empathy from deeper levels than systems usually permit. Under more usual circumstances, the adolescent in the following story would have been dropped from the rolls of the program due to "resistance" or "lack of cooperation" and would have had no one to turn to when he finally realized he needed help.

A WRAPAROUND STORY[4]

Samuel was a 16-year-old Mexican-American male in trouble with the law. He was hanging around with a gang, using drugs (methamphetamine) and breaking the law because of his drug use. He was arrested for burglary and possession of illegal drugs and was incarcerated for more than 6 months. Upon his release, he was referred to a therapeutic program practicing the Wraparound process. He returned home to his mother, younger brother who became heavily gang-involved, a young sister, a 2-year-old brother and an estranged father who lived in a trailer on the property of the house rented by Samuel's mother. Father was unemployed and spent much of his time

drinking or collecting items to sell. To support her children, mother worked as a maid in a hotel; she considered herself responsible for feeding, clothing and providing shelter for her children.

The Wraparound therapist entered into Samuel's world without the intention to change it, but to discover it. As discussed previously, in the Wraparound sense, cultural exploration does not merely mean understanding the Mexican-American background of the family. It means, in essence, "the immersing of oneself in the experience of the other" for the purpose of understanding and assessing strengths. When Samuel would disappear during scheduled meeting times, the Wraparound therapist would spend time with Samuel's mother, being "highly attentive to and aware of" the experience of her as a unique other. Through this exploration, the therapist came to understand her values, preferences and strengths. Mrs. Martinez's greatest strength was her intense love for her children. She acknowledged that she needed to be "a better parent." What this meant to her, was that she knew only how to "yell" at them in her frustration.

Initially, the Wraparound team consisted only of the Probation Officer, Wraparound therapist, Samuel's mother and the program's youth counselor. To build upon Mrs. Martinez's strengths, including her desire to learn parenting techniques other than "yelling," a specialized parenting class was created for three of the parents on the caseload of this therapist. As these

parents learned inventions for youth who acted out through gangs and drugs, they also learned to become a support group for each other. As a result, Mrs. Martinez began to change her interactions with her son. As she became stronger in setting limits without yelling, Samuel began to talk with her more.

In an attempt to reach Samuel, the youth counselor began to knock on Samuel's door to visit, before he could "disappear." He began to "hang" with Samuel during his few hours at home or to be on grounds, waiting for him, when his school day ended. When the youth counselor had to change jobs, an AmeriCorps volunteer joined the team and picked up spending time with Samuel. This particular AmeriCorps volunteer became a special mentor for Samuel; he had shared some of Samuel's experiences as a youth and was able to offer his perspective from the view of a young Mexican-American male. Each time Samuel avoided help, the program remained. When Samuel disappeared, the program remained. When Samuel's mother called, the program answered. When Samuel violated his probation, the Probation Officer, as a member of the team, was there to follow through with appropriate consequences in a time-sensitive manner. The Probation Officer began to involve himself with the team in a way which showed the family that he cared; that he was not simply someone to pull youth from their homes and "lock them up." That is, each team member was closely *paying attention,* ready to revise service plans when they were not working, rather than blame the client for being "resistant," and ready to create the services necessary to

support family needs and strengths. Therefore, after the initial plan did not work, the second plan included the parenting skills class and the addition of the AmeriCorps worker to assist with "supervision" the parents could not provide.

Samuel reached a turning point approximately 9 months into planning; he discovered his girlfriend was going to have a baby. For the first time, he reached out to the team, asking for assistance. The team listened. The Wraparound therapist established a relationship with Samuel's girlfriend and took her to doctor visits. Samuel and his girlfriend asked for, and were provided with, parenting classes. Samuel asked for assistance in finding a job. Resume preparation and interviewing skills training were provided, along with transportation to job interviews. Samuel moved into the home of his girlfriend's parents and they were added to the team. Samuel began working on his GED. As Samuel's mother became stronger, he talked with her more; the more he shared with her, the more she felt her son had "returned" to her and she responded with even greater strength, which in turn permitted Samuel to move even closer to her; that is, strength built upon strength. Evidence of the shift in family relationships came in the form of Samuel's eighteenth birthday party. The party was given by his mother and sister, space provided by his father and was attended by his girlfriend and her family as well as his brothers and sisters. Samuel had *never* had a birthday party before.

According to the therapist,[5] her experience with the Martinez family not only required that she go to the "edges" of the client/family experience, but also to the "edges" of her own world. She describes this as a process which required that she expand her own world view in four different directions. First, she was not a member of the "Latino culture" and "stretched" to understand the family values reflected through the Latino lens. Next, was her required acceptance of Samuel's father's alcoholism. He remained on the outskirts of his family both physically and psychologically, a "force" not actively participating, yet always present. For the therapist to attempt intervention with father or with the family regarding father would have alienated all of them. Third, an understanding of the influence of Mr. Martinez on Mrs. Martinez was required. Had the therapist resorted to her own traditional views, she would have classified the marital relationship as "dysfunctional" and attempted to intervene. Yet no one was asking for that type of assistance. Nor was it alluded to as a family need or defined as a family goal. Finally, the therapist had to take the most "foreign" journey of all— into the world of Samuel's gang. Prior to this experience, the therapist had an "objectified" association of "gangs." To be able to reach Samuel, she had to permit Samuel to teach her. She learned to see gangs as composed of people and to see those people as Samuel's friends. She came to understand that the unpredictability of Samuel's family had caused him to seek someone outside the family upon whom he could rely. As she relinquished the view of her dominant culture,

the therapist offered, “you almost had to include the gang as his extended family to gain his trust.”

In understanding the effect of “wrapping with empathy,” perhaps most important is Samuel’s own words: “My mind was blank without any motivation and I just didn’t care. ... I didn’t know who I could trust, so at first I just kept avoiding people at *(the program).* . . . I was (also) avoiding them because I thought I didn’t need help. . . . The people at (the program) did a lot of things to help me. They listened, asked questions, got me involved in recreational activities, counseled me, and encouraged me all the way. . . . I will always be grateful to the people at the . . . program because they never gave up on me.” In his letter to the therapist at case termination, Samuel says, “How did GOD know that I needed someone to give me a hand?” Samuel’s story is unique because it is his. His need—to have someone never give up on him—is not. In the Wraparound process, empathy is taken to the level of entry into all domains of a family’s life, devising ways to meet the most pressing needs expressed by the family in the areas of emotion, relationship, finance, religion, education and law, to name a few. The process also enters into the world of the family without preconceived paradigms into which the family must fit so that “appropriate” services which already exist can be provided for them. Therefore, services are not limited to psychiatric medication, inpidual psychotherapy, family therapy, and parenting classes.

Systems of Care, Empathy and Wraparound

It is probable that few readers have actually experienced mental health systems as "patients." Some may be able to understand the incredible feelings of helplessness which occur in dealing with such systems by thinking of a recent experience with an HMO. Regardless of need to ask questions, understand, receive guidance and/or regardless of sense of urgency, many people are thwarted at the HMO gate by being told that, because their need is not life-threatening, they will have to wait 3 months for an appointment, or that their need cannot be answered because the service suggested by such a need is not "covered." Similar experiences happen each and every day to families turning to mental health systems for assistance. Doors are closed because a particular client does not meet "medical necessity," fall into a particular category treated by a particular program, or because long waiting lists make timely guidance impossible. In addition, families are dropped from program rolls for "treatment noncompliance," simply because the system could not adequately and empathically address the family needs and they "gave up." Families in desperate need of being heard are given inadequate or incorrect information (Gutkind, 1993), treated as though they are solely to blame for their children's pain, and/or told they must follow "treatment plans" which don't make sense to them.

The genuine needs of families and the models upon which service sys-

tems are designed to serve those needs have never really joined hands. Also unfortunate are the "solutions" we have chosen for our children. With few truly creative interventions offered, our system children are diagnosed, medicated and locked away from the communities in which they must someday learn how to live. Mental illness in children is devastating. However, one must ask how has one eased the pain if you have diagnosed mental illness where there is none, overmedicated the "illness" if there is one, and/ or removed the child from all "natural" supports (communities where they feel at home, away from siblings, relatives, friends and familiar schools) to be interred in a foreign environment (group homes, residential treatment centers and foster care).

These are not the acts of "bad" people, nor has all "treatment" offered been detrimental. It simply has not worked. As a result, Wraparound came into being on the grassroots level. Then, in partial recognition of the blatant lack of empathy in a system designed to provide empathic services, federal and state dollars in recent years have been provided to assist local mental health systems to redesign themselves (Stroul & Friedman, 1986; Burns & Goldman, 1999). Many of these systems have chosen to incorporate the Wraparound process. If the Wraparound process is attempted without the deeper understanding of the empathy required to perform the process, Wraparound will be unsuccessful, just as therapy without the empathic response needed by the inpidual at the time may be unsuccessful. (Bohart &

Greenberg, 1997)

It is inevitable that in any discussion of service systems, the issue of cost must be addressed. While the use of the Wraparound process may initially appear cost prohibitive, in actuality many supports provided to a family can be inexpensive and/or free. Mentors, volunteers, and AmeriCorps members provide invaluable aid at no cost. Pulling together extended family members and community supports, such as neighbors, can be accomplished at no cost. Making use of frequently forgotten community resources and programs often costs little or nothing. Ultimately, the cost of staff and flexible funding dollars is less than the cost of residential treatment centers and prolonged stays in juvenile retention centers. Initial data provided on financial analyses suggests substantial cost reduction over time, particularly when considering restrictiveness of living environment (Burns & Goldman, 1999).

CONCLUSION

Historically, social scientists in the psychological fields have searched for what works in therapy. With notable exceptions (Bohart & Tallman, 1999; Bohart & Greenberg, 1997; Bachelor & Horvath, 1999), practitioners and researchers have set out to "prove" one theoretical orientation is more successful than another, one set of techniques works better than another, one particular diagnosis is more amenable to one model over another, or that

certain client demographics and characteristics determine success or failure in therapy. To step outside the barrage of studies, information and, sometimes heated, discussion brings a moment of peace and clarity which permits remembering what we are here for—assisting others in assisting themselves. In our search for empirically validated treatments have we lost sight of what matters? Or, in these days of managed care, is it possible to integrate what we do know empirically with what we do know intuitively and, with a little common sense, ultimately become better mental health practitioners as well as better members of our community?

It can now be substantiated empirically that empathy continues to stand out as a major factor determining client's perception of helpful assistance. Under the rubric of "relationship factors," this class of factors is said to account for 30% of the successful outcome variance in therapy (Hubble, Duncan & Miller, 1999). It has also been substantiated that healthy "bonding" is a significant factor in children's resistance to drugs and crime (Hawkins & Catalano, 1992). A little common sense would probably have told us the same things. However, once empathy moves out of the therapy room into the community and throughout the system of care, we have a much better chance of reaching our future generations.

REFERENCES

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, &

S. C. Miller (Eds.), *The heart & soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.

Bohart, A. C., & Greenberg, L. S. (1997). *Empathy reconsidered: New directions in psychotherapy.* Washington, D. C.: American Psychological Association.

Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing.* Washington, DC: American Psychological Association.

Burchard, J.D., & Clarke, R.T. (1990). The role of inpidualized care in a service delivery system for children and adolescents with severely maladjusted behavior. *The Journal of Mental Health Administration,* 17(1), 48-60.

Burns, B.J., & Goldman, S.K. (Eds.). (1999). Promising practices in wraparound for children with serious emotional disturbance and their families. *Systems of care: Promising practices in children's mental health* (1998 Series, Vol. IV). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Bums, B. J., & Goldman, S. K. (1998). *Promising practices in wraparound for children and families with severe emotional disorders.* Washington, DC: Substance Abuse and Mental Health Services Administration.

Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Needham Heights, MA: Allyn and Bacon.

Efran, J. S., & Greene, M. A. (1996). Psychotherapeutic theory and practice: Contributions from Maturana's structure determinism. In H. Rosen, & K. T. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists* (pp. 71-113). San Francisco: Jossey-Bass Inc., Publishers.

Dutton, D.G. (1998). *The abusive personality.* New York: The Guilford Press.

Gutkind, L. (1993). *Stuck in time.* New York: Henry Holt and Company.

Hawkins, J.D., & Catalano, R.F. & Associates. (1992). *Communities that care.* San Francisco: Jossey-Bass, Inc., Publishers.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: what works in therapy.* Washington, DC: American Psychological Association.

Lykken, D. T. (1998). The case for parental licensure. In T. Millon, E. Simonsen, M. Birket-Smith, & R. D. Davis (Eds.), *Psychopathy: Antisocial, criminal, and violent behavior* (pp. 122-143). New York: The Guilford Press.

Rosenblatt, Abram. (1996). Bows and ribbons, tape and twine: Wrapping the wraparound process for children with multi-system needs. *Journal of Child and Family Studies*, 5, 101-107.

St. Clair, M. (1996). *Object relations and self-psychology* (2nd ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.

Stroul, B.A., & Friedman, R.M. (1986). *A system of care for children and youth with severe emotional disturbances.* (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

van den Berg, J. E., & Grealish, E. M. (1996). Inpidualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child and Family Studies*, 5, 1-11.

van den Berg, J. E., & Grealish, E. M. (1998). *The wraparound process training manual.* Pittsburgh: John van den Berg, PhD (412) 366-6428.

Notes

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2 More thorough discussions of Wraparound can be found in Burchard, 1990, Rosenblatt, 1996 and Burns, 1999.

3 This point implies that the family system exists with one collective world view. It is offered for ease of discussion as related to types of empathy and is not intended to negate social constructionist theory. (Efan & Greene, 1996, p. 103—5.)

4 At the time of this writing, grave concern about the youth of America is being expressed throughout all corners of society. Outrage and shock can be heard as people mourn the results of youth violence in America. There are, of course, no simple answers. There is no one factor that has caused the pain which many of our youths now experience in their lives. It is therefore not sufficient to say we must change our television programs or, simply, eliminate some of our computer games. It is, however, common sense as well as the results of years of psychological study (Dutton, 1998; Lykken, 1998; St. Clair, 1996; Hawkins & Catalano, 1992, etc.) to say that we must pay attention to the lives of and the quality of our relationships with our children. And to pay attention to our children necessitates, in part, the practice of all forms of empathy.

5 Special thanks are extended to Lana Clark, Ph.D. of the B.E.S.T. Program (Building Effective Solutions Together) in San Diego, California for the honesty in sharing her process and for her enduring empathy and compassion for the families with whom she works.

11

Accompanied Auto-analysis: An Empathic Approach to Helping Deeply Disturbed Persons[1]

Alberto Fergusson

Through accompanied auto-analysis, people can become experts regarding their own minds and thus arrange the lifestyle that suits them. In this process empathy becomes one of the most powerful assets we have to help others help themselves. Nevertheless we must not forget that empathy has its limits, given the immense personal capacity and interest required to know someone intimately. People have to do that for themselves. In the long run, everyone depends on what I would call "auto-empathy." Much has been said about the power of empathy in relation to others, but the importance of "auto-empathy" has been left aside.

We know that people usually "invent" others instead of discovering how others really are. But what is even more surprising is that people also "invent" themselves while they nonetheless often refuse to become experts on themselves. As we shall see, accompanied auto-analysis illustrates the

importance of empathy, insofar as it allows others to be themselves, no matter why they are the way they are.

If we accept that empathy is the power to understand and imaginatively enter into another person's feelings, then we also realize that not being empathic influences the depth of our understanding of the other person. Lack of empathy toward so-called psychiatric patients has contributed to much of the abuse that sometimes goes on under the name of therapy. In this sense, being empathic makes it difficult for therapists acting in good faith to harm their patients. Similarly, self-hate and self-destructive practices grow from lack of empathy for oneself.

BACKGROUND TO THE PRACTICE OF ACCOMPANIED AUTOANALYSIS

Fungrata is an institution dedicated to the rehabilitation of homeless, so-called psychotics. Working since 1976 in private practice and at Fungrata (Fergusson, 1986) since 1982 with at least 500 persons diagnosed as schizophrenics,[2] has allowed me to develop the approach I now call accompanied auto-analysis.

Although initially accompanied auto-analysis was publicly described mainly with so-called psychotic people, it has always been used in all sorts of mental states, including the rehabilitation process of so-called physical patients. It is in fact often referred to as Accompanied Auto-rehabilitation.

Recognizing my failures was the first and most important factor in developing accompanied auto-analysis. The fact that I repeatedly failed to achieve my objectives led me to adopt a humble scientific attitude that both invited and allowed me to look for new approaches. It also led me to a *profound awareness of my ignorance.* I accepted, not without pain, that I ignored how the brain really functions, that I had no idea what schizophrenia really was, if indeed it was an identifiable condition. Scientific knowledge was far from sufficient to justify the types of treatment I was using.

I therefore decided *to hand over the responsibility of the treatment to my patients.* It was as if I had said to them: "Look my friend, I am very sorry. I have done my best but I have failed. I don't know what should be done. You now have to assume full responsibility for yourself and your treatment. The most I can do is to be by your side while you work on yourself." This was the origin of the two key words: Auto-analysis (you do the work) and Accompanied (I shall be close to you). Self-reliance and autonomy on the part of the patient—rather than authority, coercion, and dependence—seemed to be the only way forward.

I observed that *mental health professionals usually try to maintain a monopoly on scientific knowledge.* Therefore, if patients were going to be responsible for their own rehabilitation process, it seemed obvious that I should share with them all available knowledge about the mind and the brain, as well

as my own ignorance about these matters.

As a consequence of the information I provided, plus the self-knowledge they acquired while I accompanied them, my clients spontaneously began to consider making all sorts of *changes in their everyday lifestyles.* Creatively, they began to find new ways to live their lives so that their risk of becoming psychotic diminished. All I did was to encourage their creativity and accompany them during the process.

At the same time, I began to seriously consider the popular myth according to which mental health professionals are mad themselves. If there is an element of truth in this myth, then becoming a mental health professional would constitute some sort of auto-therapy. I realized that becoming a mental health professional means basically that you can have access to knowledge and information about the mind and the brain. If having that knowledge improves the prognosis of some of those professionals—in my view because it happens to help one design one's life—everyone could benefit from having that knowledge without having to become a mental health professional.

Eventually I accepted that, at least in theory, most clients could live with few or even no further psychotic breakdowns, if they became experts on themselves and found the lifestyle that suited them. People have the right to

try to seek that lifestyle as often as they can and wish. In practice, most therapies (biological, psychological, or social) offer few such opportunities.

Harding and Zahnister (1994) demonstrated that "once a schizophrenic always a schizophrenic" is a false idea. I have observed that it can sometimes take 10 or 20 years for a schizophrenic state to disappear. Most often the healing occurs in spite of therapy. The least we can do is to try not to impede natural healing forces.

According to our current scientific knowledge, schizophrenic states cannot be confidently considered illnesses. However, we do know that being diagnosed schizophrenic has complicated social, psychological, and biological consequences. The latter flow from the coercion, repression and, we have to admit it, sometimes even torture-like procedures that some use under the generic label of "treatment." Being diagnosed as schizophrenic in itself causes a peculiar kind of illness, or at least a very severe trauma, that has to be dealt with.

As Robbins (1997) pointed out, "I have repeatedly discovered that persons who pass as experts on the treatment of schizophrenia have never or almost never actually involved themselves in intensive and protracted relationships with inpidual schizophrenic patients." This is mainly due to the high emotional cost that treating schizophrenic states has for the therapist.

Therapists all too often end up being victims of the procedures they created. I therefore decided that accompanied auto-analysis should be friendly to the caregiver. One need not be masochistic to accompany people undergoing schizophrenic states. As far as possible, the whole process should be a pleasant and enriching experience for both parties.

I realized that society has been designed so that even in the best of cases only so-called normal people can satisfy their basic needs. People considered mentally or physically handicapped are in my view those who have difficulties with apparently simple, everyday tasks and situations that do not cause such stress to the majority of the population. Society still does not make enough effort to create a friendly environment for the so-called handicapped who usually have to do that for themselves. People who suffer from schizophrenic states are no exception to this rule.

I also entertain the hypothesis that there is an interdependence between lifestyle and some biochemical changes in the brain. Certain lifestyles can sometimes bring more favorable changes in the biochemical balance of the brain than those induced by medication, with far fewer undesirable effects. Of course, we are ignorant of the details of those putative changes, but neither do we know the exact nature of the changes brought about by medication.

In my work I have tried to integrate scientific knowledge with the defense of the human rights and civil liberties of those labeled as mentally ill. Although science and human rights movements should work hand in hand, they often fail to do so. That is why it is so important to seriously attempt to take a critical look at some of the conclusions of official scientific literature. The recent work of Breggin (1991, 1997) constitutes a useful contribution in that direction.

Basic Hypotheses of Accompanied Auto-analysis

The basic hypothesis is that most schizophrenic states occur when people with a predisposition to those states (Cullberg, 1998) force themselves to live according to certain standards that do not suit them. However, most of these people can find an inpidual and peculiar lifestyle that suits their inner mental world and diminishes their risk of entering a psychotic state. They can discover such a lifestyle if they become real experts about themselves and assume full responsibility for organizing their lives. Through accompanied auto-analysis people can become experts on themselves and seek the lifestyle they need. If they persist they can try again and again until they finally succeed.

Unfortunately most current therapies work in the wrong direction, impeding real self-knowledge and creative encounters with new lifestyles. Most

therapies convey a strong and wrong message that therapy will bring about desirable change. In reality, the outcome of schizophrenic states is to a large extent dependent on the amount of self-commitment. Only those who accept that the current status of scientific knowledge and mental health expertise is very limited, and that they have to find the way by themselves, really have a chance to reach their objectives. It is desirable to try and overcome any dependence on biological, psychological or social therapy. That is why I speak of "Auto-analysis," and propose that the best and most effective way to try to help is to "Accompany" those who are working on their Auto-analysis.

THE PROCESS OF ACCOMPANIED AUTOANALYSIS

Accompanied auto-analysis was arrived at gradually, through trial and error. Suggestions given by the Accompanied Persons as well as the theoretical considerations about schizophrenic states were most useful in the process. I have been able to use accompanied auto-analysis in its complete structure mainly in my private practice. I am gradually finding ways to use it with low-income people and especially with homeless people at Fungrata. I have observed that genuine scientific knowledge about one's own mind, no matter how limited it is, has in itself a healing and humanizing power, probably because it is never absolute and has a dynamic and collective character. This may be why it tends to generate change and psychological growth.

By scientific knowledge about one's own mind I do not mean the knowledge that you can find in scientific literature. I mean scientific knowledge about the everyday functioning of one's own mind. Unfortunately, the viewpoint provided by the mental health establishment very often contains pseudoscientific conclusions. Therefore the Accompanied Person must have tools to enable him to distinguish between pseudoscientific and scientific knowledge.

The process of accompanied auto-analysis can be pided into three main phases: Preparatory, Intensive, and Permanent.

Preparatory Phase

During this phase the Accompanied Person's basic goal is to become, as far as possible, an expert on what is known about the mind in general and on their own minds. During this phase the Accompanied Person learns about psychotic states, schizophrenic states, and general psychopathology. That knowledge must include clinical experience, in the sense that those who receive it must have been in touch with people suffering from a variety of psychological conditions. Accompanied Persons learn how to elaborate a good biography and clinical history, so that they can prepare their own. Our model of clinical history includes different levels of functioning and psychosocial aspects (Fergusson, 1994). The self-knowledge obtained

through accompanied auto-analysis differs from insights usually obtained in long-term psychotherapy or psychoanalysis. During this and all other phases, accompanied auto-analysis may or may not replace other psychotherapies. The Accompanied Person has to become well aware of all the details and theoretical foundations of accompanied auto-analysis.

Intensive Phase

The Accompanied Person can initiate the "intensive" phase at a time that is agreed upon with the Accompanying Person. The basic goal of this phase is to design a new flexible way of life. Throughout the whole of accompanied auto-analysis it is assumed that scientific knowledge about the mind in general, and especially about one's own mind, tends to generate changes in one's lifestyle.

Most lifestyle changes consciously or unconsciously aim at avoiding what I term Psychological Damage, Destruction, and Decomposition. This concept emphasizes that mental life is part of the material (biological) world and as such is subject to all the vicissitudes of living things. We tend to forget that mental life can be damaged or destroyed and might decompose. We realize that we can break another person's bones, but we tend to forget that people can literally, not only metaphorically, destroy parts of another person's mental life.

The Accompanied and Accompanying Persons must commit themselves to the intensive phase, making it a priority in their daily life. Accompanied Persons must be in a social, psychological, and economic position that allows them to persist in this phase for as long as they wish to do so. For example, they must be able to choose how and where they are going to live, according to their realistic wishes, and using common sense.

During this phase the Accompanying and the Accompanied Persons should meet at least twice a week. The latter should determine the duration of each meeting as far as possible. Taking obvious human limitations into account, meetings might be 10 minutes or 6 hours long. The Accompanying Persons must try to organize their time in order to satisfy such needs.

Besides planned meetings, Accompanying Persons must be available by phone and/or by e-mail. Video conferences through the Internet can also be useful. The Accompanying Persons' basic task is to listen and express occasional insights to the Accompanied Persons, who do the essential work. At the end of the intensive phase, Accompanied Persons have designed and started to put into practice a new, realistic, and flexible lifestyle according to their acquired knowledge.

Permanent Phase

During this phase the participants maintain and improve what has been

practiced and learned throughout the preparatory and intensive phases. They must meet at least once every 3 months, and, if possible, whenever the Accompanied Person wishes. At least twice a year, for at least 15 days, the intensive phase must be repeated as described above. Flexibility in the lifestyle and in any emotional or working activity in which the person is involved must be maintained. A system to obtain new scientific information must be established. As examples, a subscription to a journal and attending conferences can be useful.

GENERAL CONSIDERATIONS ABOUT ACCOMPANIED AUTOANALYSIS

Becoming an expert on one's own mind and redesigning one's life in a creative manner in accordance to such knowledge constitutes accompanied auto-analysis' main objective. By that I mean that people become experts in *how they are.*

The hypotheses people make about *why they are* the way they are, tend to remain speculative. The "why" becomes important in developing a sense of freedom—knowing and taking into account inexorable social, psychological, and biological laws. In this sense, to be free is not to do what one wishes. It is rather to know "why" you wish what you wish. Thanks to knowledge of the "whys" human alienation is diminished and a more complete biological, psychological, and social human being can begin to develop.

Accompanied auto-analysis promotes the civil liberties and rights of people diagnosed with schizophrenic states, thereby integrating the political with the scientific. The traditional dichotomy between politics and science has been negative for both of them. Instead we must find ways to relate to those people without violating their basic liberties and rights. Accompanied auto-analysis is an attempt in that direction.

Accompanied auto-analysis tries to promote changes in the attitude toward "mental illness." What other authors have called the subjective experience of schizophrenics (Strauss, 1989; Jenkins, 1991) changes with accompanied auto-analysis. The Accompanied and Accompanying Persons' ambivalence toward mental illness often changes, especially in regard to the attitude toward so-called crises. The word crisis has been more or less synonymous with failure, and is therefore feared by patients, therapists, and the public in general. Fear of so-called madness and its crises are among the main reasons why mad people are discriminated against.

Accompanying Persons must be able to create an atmosphere that will help all participants to enjoy the whole process no matter how hard it is. A great deal of enthusiasm has to be transmitted to the Accompanied Persons so that they become optimistic about the possibility of becoming experts on their own minds and redesigning their own lives. Sense of humor should be used whenever possible.

Respecting Choice

Accompanying persons must allow Accompanied Persons to be creative and ingenious. They must view c*hanging and/or not changing* as equally important and feasible possibilities for the Accompanied Persons to choose. Accompanying Persons must not be overly moralistic, and it is desirable that they realize that no one seriously and scientifically knows what others should do with their lives. Sometimes the only way people are able to avoid madness is to live in a so-called mad way.

A BRIEF CASE ILLUSTRATION

JB is 35 years old. From the age of 20 until the age of 29, he went through a "typical" psychiatric illness and treatment. Fie was diagnosed as paranoid schizophrenic, hospitalized four times and prescribed many "antipsychotic" drugs. For 4 years he underwent psychoanalysis (with a Winnicott-oriented analyst) and he also received 2 years of psychoanalytically-oriented psychotherapy and 10 months of systemic and cognitive-oriented therapy.

After a crisis, he had to leave the university where he was studying industrial engineering. Fie tried several low-key jobs, but was fired each time a crisis occurred. He married, had one daughter, and porced after only 12 months. In classical psychiatric terms, he presented incoherence and

derailment in his speech, delusions, hallucinations, disorganized behavior, affective flattening, and mood swings. His symptoms were persistent and increased from time to time.

I first saw him when he was 29 years old. I explained accompanied auto-analysis to him and for 13 months we worked in the preparatory phase. He studied texts on psychiatry, psychology, and psychoanalysis; reviewed different psychological schools of thought; and used the Internet to obtain information. He attended conferences and lectures on biological psychiatry, psychology, and psychoanalysis, sometimes concealing his real identity in order to be admitted. He reviewed different theories about the etiology of schizophrenia (genetic, biochemical, infectious, psychological, social, and so on), and read conventional anti-psychiatric literature. While studying, he gradually elaborated on his own clinical history and autobiography.

During the preparatory phase he once entered into a severe crisis that was nevertheless dealt with at home. He began to reduce medication but he had to increase it again, mainly because at that time we were not as aware of the withdrawal symptoms that vary enormously in each inpidual.

He identified many things that triggered his crises and began to recognize ways to handle them. For example, he realized that if he spent the whole night holding someone's hand, with the light on, and with the possibility of

contacting the Accompanying person on the phone, he could handle the crisis. Nevertheless, although he suffered less and felt positive about himself, all the symptoms persisted during the entire preparatory phase. As far as his personal knowledge was concerned, he identified his resentments, the typical provocative situations that stressed him and his most intense guilt feelings. He also began to identify the adequate intensity for his interpersonal relationships.

By resentment I mean a process through which people renounce their original wishes because they feel they would not be able to gratify them and instead develop false wishes. Thereafter, any gratification they obtain will necessarily be false and they will never forgive the false gratifying object because it is not the originally desired one. It is only with great psychological pain that people manage to recapture their original wishes and goals, yet real wishes and goals are the best way to reverse previous Psychological Damage, Destruction, and Decomposition.

By provocative situations I mean those that make people do what they do not want to do. Accompanied Persons have to become real experts in detecting situations that provoke them. Reactions to provocative acts constitute the main cause of Psychological Damage, Destruction, and Decomposition.

In general those who have schizophrenic states must learn to avoid provocative situations. It is not sufficient to have self-knowledge if one doesn't adjust one's lifestyle accordingly. It was not until he entered a 4-month intensive phase and began to change his lifestyle that some of JB s symptoms began to disappear. All his changes were related to his newly acquired knowledge. Most were very simple ones, and they corresponded to everyday life choices. He changed the place where he lived and with whom he lived. He modified his sexual habits and changed his type of friends. He developed new ways of relating and, for example, realized that he had to live with a dog and to sleep close to it.

He got in the habit of calling me, sometimes with great enthusiasm, when a crisis was beginning, so that we might discuss the details of it. He learned to welcome crises.

He realized that he felt better with older women and men. He decided never again to visit people who could damage him. He decided that he should develop new friendships, so that he would not have to interact with those who had already labeled him as a mentally ill person, and so on. Before he underwent accompanied auto-analysis, JB had concentrated his efforts on understanding *why* he was like he was, instead of learning in the greatest detail possible *how* he was.

During accompanied auto-analysis, people try to arrange their life according to the way they are, independently from the motives that led them to be like that. This does not mean that they cannot try to find out why it is that they are how they are. They can do that, and while doing it they might change or they might not. *Nevertheless, merely understanding without changing is a luxury that people suffering from schizophrenic states cannot afford. The consequences are severe psychological Damage, Destruction, and/or Decomposition.*

JB has been in his Permanent Phase for the last 5 years. He has been medication-free for the past 2 years. He has repeated the Intensive phase twice a year.

Psychosis as Psychological Damage, Destruction, and Decomposition

Observation has led me to propose that, psychologically speaking, psychotic states are equivalent to Psychological Damage, Destruction, and Decomposition. This suggests that psychotic states as such are "leftovers." For instance, all the symptoms of schizophrenic states are largely evidence of psychological remains and detritus. Those states occur when the "real being" and the "psychological life" of the human being cannot and do not prevail.

Psychotic symptoms often have no special meaning. They are not defenses. They are what is left of what once was the original "real being" of

"psychological life." The question is not really why some people become delusional or what it means to be incoherent. The question is: What is the "psychological life" that is being damaged or destroyed, or is already decomposing?

This process is similar to what happens to the body of a human being after biological death. Continuing processes take place in the body, even though it is dead. While in a psychotic state, humans are *not being.* We have spent too much energy on understanding what psychotic states are and very little on what they are not.

By my definition, psychological damage is always reversible and psychological destruction and decomposition are irreversible. Nevertheless, in practice hope cannot be lost, and in fact, many surprises are encountered. Sometimes psychological material is, so to speak, buried alive. In schizophrenic states, what is at stake is a struggle between psychological life and psychological death.

CONCLUSION

People with a predisposition to enter into schizophrenic states can take no chances with their lifestyle. If they do not adjust their lifestyle permanently, psychological damage and/or destruction and decomposition can occur and thus they can enter into a schizophrenic state. They have to

become experts on how their own minds function and how to design a lifestyle according to that knowledge.

As I said at the beginning, no one has the capacity or the interest to know someone else in the degree of detail that is required for this endeavor. People must do that for themselves. Accompanied auto-analysis seeks self-reliance and autonomy.

REFERENCES

Breggin, P. R. (1991). *Toxic psychiatry: Why therapy, empathy, and love must replace the drugs, electroshock, and biochemical theories of the "new psychiatry. "* New York: St. Martin's Press.

Breggin, P. R. (1997). *Brain-disabling treatments in psychiatry: Drugs, electroshock, and the role of the FDA*. New York: Springer Publishing.

Cullberg, J. (1998, December 5). *Facilitating and obstructing factors in the healing of psychosis*. Paper presented at Santillana Foundation, Bogota, Colombia.

Fergusson, A. (1986). *Fundadion de Asistencia Colombiana (Foundation for the Assistance of Columbia) [Fungrata pamphlet published by the Bank of the Republic of Colombia],* Bogota, Colombia: Escala.

Fergusson, A. (1994). *What it means to be in shape as a psychoanalyst.* Journal of the Colombian Society of Psychoanalysis, 19(1), 48-53.

Fergusson, A. (1997, October). *The technique of Accompanied Auto-analysis and the theory of psychosis as psychological destruction and decomposition*. Paper presented at the 12th International Symposium for the Psychotherapy of Schizophrenia, London.

Fergusson, A. (1997, October). The scientific recovery of the mind. Discussion at the panel

originally entitled *Demonstrating the efficacy of psychoanalytic psychotherapy of schizophrenia*. The 12th International Symposium for the Psychotherapy of Schizophrenia, London.

Harding, C. M., & Zahniser, J. H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavica*, 90(Suppl. 384), 140-146.

Jenkins, J. H. (1991). Anthropology, expressed emotion, and schizophrenia. *Ethos: The Journal of the Society for Psychological Anthropology*, 19, 387-431.

Robbins, M. (1997, October). *Demonstrating the efficacy of psychoanalytically informed therapy of schizophrenia*. Panel ISPS 97 the 12th International Symposium for the Psychotherapy of Schizophrenia. London.

Strauss, J. (1989). *Mediating processes in schizophrenia: Toward a new dynamic psychiatry*. British Journal of Psychiatry, 155 (suppl. 5 No. 2), 22-28.

Szasz, T. S. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Hoeber-Harper.

Szasz, T. S. (1978). *The myth of psychotherapy*. Garden City, NY: Anchor Press.

Notes

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2 Together with other authors such as Thomas Szasz (1961, 1978), I have serious doubts with regard to the validity of words and concepts such as therapist, patient, mental illness, mental health, psychotherapy, psychiatrist, schizophrenia, madness, psychosis, and so on. The reader must always assume a "so-called" before those words whenever they appear in this article. Nevertheless they are used because it is otherwise difficult to ensure that we are all referring to the same thing. As far as schizophrenia is concerned, I prefer to speak of *schizophrenic states*.

13

Culture and Empathy: Case Studies in Cross-Cultural Counseling

Rita Chi-Ying Chung, Fred Bemak, and Afet Kilinc

The definition of traditional empathy draws from the various disciplines of philosophy, psychology, sociology, social work, counseling and anthropology. Originating centuries ago from the Greek word *empatheia,* empathy means understanding others by entering their world and placing oneself inside the client's frame of reference and then having the ability to effectively communicate one's understanding of that world. Therefore, empathy is a core condition for providing effective psychotherapy.

There has been consensus that empathy is critical during psychotherapy and transcends developmental stages in the counseling process (Gladstein, 1983; Hackney, 1978; Rogers, 1975, 1980; Truax & Mitchell, 1971). Rogers (1961) described empathy as the therapist's ability to enter the client's world, to think *with* the client rather than *for* or about the client (Brammer, Abrego, & Shostrum, 1993) and feel *with* the client rather than feel *for* the client (Capuzzi & Gross, 1999). Therapeutic empathy requires the therapist to

experience oneself symbolically in the place of the client and understand their world. Rogers (1961) posited that empathy was communicated only if the client perceived and believed that the therapist to be empathic. Thus empathy is an interactive relationship where the therapist must have the ability and skill to communicate and demonstrate empathic understanding.

For decades empathy has been identified as a core concept in psychotherapy, however, the primary focus has been with mainstream populations, which raises the question of how applicable is the use of traditional empathy for cross-cultural psychotherapy. There has been a noticeable lack of attention to empathy as a concept to consider across cultures. Pedersen (1991) clearly established the importance of culture in psychotherapy, requiring that therapist be aware, understand and appreciate the influence of culture on psychotherapy. Yet with a concept as critical to core conditions for healing as empathy, there has been minimal attention given to cross- cultural differences. In fact, what may be an effective psychotherapeutic technique for mainstream populations may not only be ineffective, but in some cases offensive, to different ethnic/cultural groups. As the U.S. becomes increasingly ethnically perse it is critical to address the issue of the relationship between culture and empathy. Given the complexity of culture, an issue for psychotherapists to consider is how one displays empathy effectively across cultures. This chapter will begin with a brief review of cultural differences in worldviews, followed by a discussion on the

interaction of culture and empathy and case studies to illustrate cultural empathy.

Cultural Worldviews

Pedersen (1991) defined culture as a tool that defines the reality for members of a particular culture. He postulated that culture is shared learned perspectives and common universals that members agree on (p.6). Within this worldview, there is a defined existential meaning for life and subsequent prescribed and acceptable behavior. The values, beliefs, and behaviors of a culture furnish its members with personal and social meaning so that the cultural norms are learned through tradition and transmitted from generation to generation (Kagawa-Singer & Chung, 1994). The cultural patterns of belief and rules for behavior enable members to maintain social and behavioral consistency so that they are recognizable and result in the facilitation of social interaction and integration. Therefore beliefs and/or behaviors that are taken in isolation or out of context may be misinterpreted or even disregarded as maladaptive. For example, an Asian client may offer a gift to their psychotherapist, which would be a culturally appropriate and culturally sanctioned gesture. The psychotherapist may find this improper and question the motives of the Asian client, crossing professional boundaries, and establishing a level of intimacy that would be unacceptable in western psychotherapy.

The way inpiduals conceptualize, perceive, and think about their world, and their relationship to the world is their worldview (Ivey, Ivey & Simek-Downing, 1987; Sue 1991). Worldviews are made up of attitudes, values, beliefs, opinions, and concepts, and affect various facets of our lives such as how we think, make decisions, behave, define and interpret events (Sue & Sue, 1990). Worldviews are also influenced by culture (Ibrahim, 1985) and become learned ways of discerning one's environment, thus becoming an important factor in shaping the way that inpiduals understand each other and interact. Thus worldviews can be used to demonstrate how distinct cultural groups tend to experience the world in different ways, and therefore may be utilized as a way of examining possible misinterpretations that can arise in a therapeutic situation where the therapist and client are from different cultural backgrounds. For example, a client's conceptualization of mental illness may be attributed to evil spirits, therefore the culturally appropriate healing method will be to seek help from a spiritualist to rid the body of evil spirits and eliminate the illness. That cultural perspective on the world would be important for the therapist to acknowledge and accept rather than discount as irrational and problematic practices that interfere with western therapeutic interventions. Conflictual worldviews between the client and therapist are often based on examples like this one, and relate to differences in worldviews as well as different dimensions of worldviews (Brown & Landrum-Brown, 1995; Myers, 1991; Nichols, 1976; Nobles, 1972). Therefore

for therapists to be effective with clients from different cultural backgrounds, it is critical that they are aware, understand and accept the client's perception of the world as well as their own worldview. By comparing worldviews therapists are able to examine possible misinterpretations that can arise in a therapeutic situation.

Culture and Empathy

In general, psychotherapists in cross-cultural therapeutic situations will rely on empathetic concepts and precepts that are based on their training and work with mainstream populations. The concept of empathy is based on and influenced by western European-American values, and does not take into account the applicability of traditional empathy cross-cultures. That is, the western or traditional definition of empathy is defined without the knowledge, awareness, and understanding of the complexities and multidimensional nature of culture. Therefore, the issue of culturally sensitive empathy needs to be examined, since it has not been clearly defined as to how it differentiates from the traditional definition and practice of empathy. Cultural empathy has been described as "seeing the world through another's eyes, hearing as they might hear, and feeling and experiencing their internal world," which does not involve "mixing your own thoughts and actions with those of the client" (Ivey, Ivey, & Simek-Morgan, 1993, p.21). Therefore, for therapists to be culturally empathic they not only retain their separate

cultural identity, but are simultaneously aware and accept the clients cultural values and beliefs. Behavior aspects of the definition of cultural empathy therefore have similarities to traditional empathy. However, cultural empathy requires an integration of not only behavior, but also the cognitive and affective factors as well. That is, the therapist is able to understand, accept, and feel the client's situation, while simultaneously maintaining a separate sense of self, and therefore bridge the cultural gap therapist and client (Ridley, 1995). This separateness of self, or inpiduality is perceived differently by disparate cultures. In inpidualistic societies, it may be a highly valued trait and an ultimate goal in defining the self, while in collectivist societies the boundaries of separateness and personal and spiritual independence may be less honored. For example, in many collectivistic cultures, a 15-year-old child who was not working hard in school would reflect poorly on the entire family. If the student was referred for psychotherapy, it would be to not only assist the student in improving grades, but also has implications for the larger family system. Better grades would reflect on good upbringing, values, respect for elders, and a family- based work ethic, rather than simply an accomplishment by the inpidual student. Therapists from inpidualist cultures may erroneously focus on inpidual achievement and self-esteem, highlighting the personal accomplishments of the student, rather than the success of the family through the child's success. Therefore therapeutic empathy must take into account the cultural context

and worldview, so that the same problem presented in two distinct cultures would warrant in different culturally specific responses. This has important implications and points to the need for cultural understanding and the ability to identify, at least in part, with the client so that the therapist is able to "feel as the client feels."

Yamamoto (1982) coined the term "active empathy" to describe his work with Asian clients whereby therapists actively communicate appreciation about all aspects of client's lives. It was suggested that by incorporating the knowledge of the Asian culture (family-oriented) the therapist should acknowledge and communicate empathy towards the client's family and include the family in treatment, thus demonstrating knowledge of the culture as well as respect for Asian value of collectivity (Yamamoto & Chang, 1987). Cultural empathy is therefore complex and multidimensional. The challenge for therapist is expressing their understanding and empathy and being understood may be different across cultures.

Each inpidual's experience is influenced by culture while empathic understanding that is culturally based is a process where the therapist perceives the meaning of the client's personal experience from another culture. Therefore, the therapist must assess how cultural values and explicit and implicit assumptions influence client's personal experience (Stewart, 1981).

Misunderstanding of clients from another culture by the therapist is commonplace if the therapist does not understand the clients background and experience or have cultural knowledge, awareness or understanding. Cultural misunderstanding partially occurs because of therapists indiscriminately applying textbook norms and failing to maintain a posture of naiveté and a role as learner (Ridley, 1995).

A major problem in cross-cultural work is the tendency for therapists to impose their cultural values onto their clients (Ridley, 1995), which may occur on a conscious or unconscious level. This problem is accentuated by therapists' cultural encapsulation (Wrenn, 1962) and cultural tunnel vision (Corey, Corey, & Callanan, 1993), leading to the expectation that clients will embrace the therapists' cultural values. Subsequently a major cognitive task in achieving cultural empathy is for therapist to differentiate their own culture and the associated biases from those of their clients. An examination of cultural influences personal belief system, values, customs, behaviors, and the like are essential to explore. Gaining an in-depth self-awareness provides the therapist with the awareness to resolve cultural stereotypes and biases and experience the true world of the client rather than seeing the client through their own cultural lens. For example, a therapist may empathize with newly arrived refugee clients who have lost their spouse. If the therapist did not come from a war-torn country or lost his/her spouse during the war and doesn't have firsthand experience as a refugee, it would not be genuine for

the therapist to respond as if they had experienced refugee status. However, the therapist may have experienced loss of family member or a close friend and know what it is like to have lost a loved one. These experiences may be generalized to better understand the client while maintaining an awareness of cultural barriers and the subsequent limitations of the cultural transference of the experience. The next section will provide case study examples to illustrate cultural empathy.

CASE STUDY 1

John is a middle-aged African-American who is concerned about his closest childhood friend named Samuel who John describes as "*my real* brother." Samuel is going through personal and legal trouble regarding domestic violence charges that could lead to a prison sentence. During counseling, John often reflects on Samuel's problems and expresses anger that his friend is being treated unfairly by the legal system. John is adamant that his loyalty to Samuel is unconditional regardless of what happens, ignoring the prosecuting lawyer's threats about the serious consequences for perjury in court.

Even so, John is firm that he is willing to do "anything" to help Samuel. The fact that his "real brother" is "going down" makes him feel personally obligated to come to his aid and keep him out of prison at any cost. During

counseling, John's is very emotional about this situation, often hitting his fists against each other or rubbing his hands together in agitation, insisting that it is "Us against the world."

There are several cultural aspects presented by the client that a therapist from a different ethnic background may misinterpret or misunderstand. The first involves the African-American concept of family. The definition of family includes not only biological and/or the legal term for family, but also friends, neighbors and the wider community who may be particularly close to the extended family (Lee & Bailey, 1997). Therefore, the therapist may not understand the closeness, devotion, and intense emotion John is expressing regarding this problem facing his "*real* brother." Furthermore, African-American culture has a basis in being a collectivistic culture, focusing on family, group, and community rather than only on the inpidual. Therefore, the problem of John's "real brother" is not just the inpidual's problem, it is a group problem. A therapist from an inpidualistic cultural perspective may have a difficult time understanding and accepting a client who is willing to take serious personal risks to help someone else who may be viewed from their social construction of reality as only a friend. It would be important in this situation for the psychotherapist to have knowledge, understanding and awareness of the historical and sociopolitical background of African-Americans, as well as issues of oppression, discrimination and racism, and an historical context of the legal system in

relationship to African-Americans. Thus the therapist must comprehend the client's worldview, the impact of societal and institutional racism, the history of victimization, and the resultant resentment and anger in order to provide authentic cross-cultural empathy.

CASE STUDY 2

Cindy is a 19 year-old Chinese-American student majoring in medicine. Cindy stated that she is depressed, anxious, not able to sleep, and does not have an appetite. She explains to the therapist that she is not interested in pursuing a career in medicine, and is only in this area to fulfill her parents' wishes. Cindy feels that she cannot talk to her parents, family or friends about this situation. Her family immigrated to the U.S. for a better life and education for the children and Cindy is the first generation to be born and raised in the United States. She feels that her parents have made tremendous sacrifices for her and her siblings to provide them with a good education that is reinforced by her mother who constantly reminds Cindy about her sacrifices. Cindy feels guilty and confused for not being interested in medicine, conflicted because she wants her parents to be proud of her and not let them down. During the session, Cindy has blunted affect, speaks softly, and avoids direct eye contact with the therapist.

The therapist may perceive Cindy as lacking assertiveness, too

dependent on her family, and exhibiting too much passivity toward her parents, family and friends. The therapist may suggest that Cindy participate in assertiveness training and become more independent, as well as, encourage her to express her anger and frustration towards family members, possibly encouraging role playing to rehearse ways to more effectively approach her parents. If Cindy refuses to participate in these activities or follow the therapists suggestions the therapist may perceive her as being resistant or passive-aggressive and enmeshed in the family.

It is important for the therapist to understand the Asian culture and worldview as it relates to family, the concept of filial piety and the cultural issues of loss of face and shame. The client is obviously experiencing tremendous pressure to succeed in the field of medicine. The therapist must understand and be aware that in many Asian cultures the success of children is viewed as the success of the parents and family. The behavior and accomplishments of children is a reflection on the family so that each person identifies themselves within the social matrix of the family. Furthermore, the concept of filial piety refers to respect for parents, and the child's sensitivity, obligation and loyalty to his/her lineage and parents. Thus Asian children are expected to comply with family wishes, even to the point of sacrificing their own personal desires and ambitions. Shame and guilt are methods used by parents to reinforce expectations and proper behavior so that improper behavior, such as disobeying your parents, brings shame and loss of face and

may cause significant others, including the family and community to withdraw support. Instead of encouraging independence, it is culturally appropriate for the client to listen to the family's wishes and not express inpidual views and desires. Thus the therapist may express cultural empathy through understanding the cultural context of the family, filial piety, and obligation children have for their parents and family. To focus and encourage autonomy for Cindy would be culturally insensitive. Cultural empathy by a therapist from a different culture must include a deep understanding of the cultural issues related to family, social role, obligation, and Cindy's serious personal dilemma. Therapeutic interventions must take these cultural factors into account, with cross-cultural empathy transcending one's own value system and responding to the culturally bound difficulty that Cindy must face.

CASE STUDY 3

Michael is a middle-aged Mexican-American who has been in the U.S. for 2 years and referred through the courts for counseling for domestic violence. In counseling Michael reports that he is experiencing headaches, anxiety, and depression to the point where he finds it difficult to get out of bed in the morning. When the therapist asked him why he is having difficulties sleeping, Michael explained that he has reoccurring nightmares regarding his escape from Mexico to the U.S. Michael recently lost his job because he believes that there are people watching him and has become increasingly afraid to leave

his house. He finds himself staying at home, watching TV, and drinking which is leading to marital conflicts with his wife, who complains that he is not a "man" because he does not contribute financially to the household. His wife has angrily insisted that Michael should do the housework now that he is unemployed and at home, since she is working full time during the week, which led to the domestic violence charge. Michael's English is limited but understandable. A few of Michael's friends have contacted the therapist to say that a cure would be "curanderismo" (folk medicine).

To display cultural empathy the therapist must understand several cultural issues that have been brought up in the therapy session. The first issue is that Michael speaks passable but limited English, so that the therapist may consider using a bilingual translator to assist as a cultural narrator. It is also important for the therapist to understand Michael's immigration process. From his description of reoccurring nightmares and symptoms Michael may be undergoing post-traumatic stress disorder. The therapist also needs to be aware of cultural gender roles and the concept of machismo. For Mexican-Americans there are clearly defined gender roles in all aspects of life, from home, school, work and social life. Women and men are expected to behave and interact in ways that are culturally appropriate for their gender. The Mexican culture is where men pride themselves on "being men" so that doing household chores is most likely antithetical to Michael's worldview. For Michael to assume the role of cleaning the house may be culturally link to a

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In summary, to be effective with clients from culturally perse backgrounds, it is critical that therapist display empathy in a culturally sensitive manner. Without cultural empathy there is a high probability of premature termination. Therapists must recognize and accept that traditional empathy may not be appropriate cross-culturally and must make a concentrated effort to demonstrate cultural empathy to their clients.

REFERENCES

Brammer, L. M., Abrego, P., & Shostrum, E. (1993). *Therapeutic counseling and psychotherapy* (6th ed.). Upper Saddle River, NJ: Merrill/Prentice Hall.

Brown, M. T., & Landrum-Brown, J. (1995). Counselor supervision: Cross-cultural perspectives. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 263-286). Thousand Oaks, CA: Sage Publications.

Capuzzi, D., & Gross, D. R. (1999). *Counseling and psychotherapy* (2nd ed.). New Jersey: Prentice Hall.

Corey, G., Corey, M. S., & Callanan, P. (1993). *Issues and ethics in the helping professions* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental, and social psychology perspectives. *Journal of Counseling Psychology*, 30, 467-482.

Hackney, H. (1978). The evolution of empathy. *Personnel and Guidance Journal*, 57, 35-38.

Ibrahim, F. A. (1985). Effective cross-cultural counseling and psychotherapy: A framework. *The Counseling Psychologist*, 13, 625-638.

Ivey, A. E., Ivey, M. B., & Simek-Downing, L. (1987). The empathic attitude: Inpidual, family and culture. In A. Ivey, M. Ivey, & L. Simek-Morgan (Eds.), *Counseling and psychotherapy: A multicultural perspective* (3rd ed., pp. 21-44). Boston: Allyn & Bacon.

Ivey, A. (1993). *Psychotherapy as liberation.* Presented to the Round Table on Cross-Cultural Counseling, Columbia University, New York.

Kagawa-Singer, M., & Chung, R.C-Y. (1994). A paradigm for culturally based care in ethnic minority populations. *Journal of Community Psychology,* 22(2), 192-208.

Lee, C. C., & Bailey, D. F. (1997). Counseling African American male youth and men. In C.C. Lee (Ed.), *Multicultural issues in counseling: New approaches to persity* (2nd ed, pp. 123-154). Alexandria, VA: American Counseling Association.

Myers, L. J. (1991). Expanding the psychology of knowledge optimally: The importance of worldview revisited. In R.L. Jones (Ed.), *Black psychology* (3rd ed., pp. 15-28). Berkeley, CA: Cobb & Henry.

Nichols, E. (1976). *The philosophical aspects of cultural differences.* Paper presented at the conference of the World Psychiatric Association, Ibadan, Nigeria.

Nobles, W. (1972). African philosophy: Foundation for Black psychology. In R.L. Jones (Ed.), *Black psychology* (1st ed., pp. 18-32). New York: Harper & Row.

Pedersen, P. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development*, 70, 6-12.

Ridley, C. R. (1995). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional interventions.* Thousand Oaks, CA: Sage Publications.

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy.* Boston: Houghton Mifflin.

Rogers, C. R. (1975). Empathic: An unappreciated way of being. *Counseling Psychologist*, 5, 2-10.

Rogers, C. R. (1980). *A way of being.* Boston, MA: Houghton Mifflin.

Stewart, E. C. (1981). Cultural sensitivities in counseling. In P.B. Pedersen, J.G. Draguns, W.J. Lonner, & J.E. Trimble (Eds.), *Counseling across cultures* (pp.6l- 68). Honolulu, HI: University Press of Hawaii.

Sue, D. W. (1991). *Counseling the culturally different.* New York: John Wiley.

Sue, D.W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice.* New York: John Wiley.

Truax, C., & Mitchell, K. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A.E. Bergin, & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (pp. 299-344). New York: John Wiley.

Wrenn, C.G. (1962). The culturally encapsulated counselor. *Harvard Educational Review*, 32, 444-449.

Yamamoto, J. (1982). *Psychotherapy for Asian Americans.* Paper presented at the Second Pacific Congress of Psychiatry, Korea Extension Meeting, Korean Neuropsychiatric Association, Seoul, Korea.

Yamamoto, J., & Chang, C. (1987, August). *Empathy for the family and inpidual in the racial context.* Paper presented at the Interactive Forum on Transference and Empathy in

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IV

Empathy in Cross-Cultural Therapy

13

Culture and Empathy: Case Studies in Cross-Cultural Counseling

Rita Chi-Ying Chung, Fred Bemak, and Afet Kilinc

The definition of traditional empathy draws from the various disciplines of philosophy, psychology, sociology, social work, counseling and anthropology. Originating centuries ago from the Greek word *empatheia,* empathy means understanding others by entering their world and placing oneself inside the client's frame of reference and then having the ability to effectively communicate one's understanding of that world. Therefore, empathy is a core condition for providing effective psychotherapy.

There has been consensus that empathy is critical during psychotherapy and transcends developmental stages in the counseling process (Gladstein, 1983; Hackney, 1978; Rogers, 1975, 1980; Truax & Mitchell, 1971). Rogers (1961) described empathy as the therapist's ability to enter the client's world, to think *with* the client rather than *for* or about the client (Brammer, Abrego, & Shostrum, 1993) and feel *with* the client rather than feel *for* the client (Capuzzi & Gross, 1999). Therapeutic empathy requires the therapist to

experience oneself symbolically in the place of the client and understand their world. Rogers (1961) posited that empathy was communicated only if the client perceived and believed that the therapist to be empathic. Thus empathy is an interactive relationship where the therapist must have the ability and skill to communicate and demonstrate empathic understanding.

For decades empathy has been identified as a core concept in psychotherapy, however, the primary focus has been with mainstream populations, which raises the question of how applicable is the use of traditional empathy for cross-cultural psychotherapy. There has been a noticeable lack of attention to empathy as a concept to consider across cultures. Pedersen (1991) clearly established the importance of culture in psychotherapy, requiring that therapist be aware, understand and appreciate the influence of culture on psychotherapy. Yet with a concept as critical to core conditions for healing as empathy, there has been minimal attention given to cross- cultural differences. In fact, what may be an effective psychotherapeutic technique for mainstream populations may not only be ineffective, but in some cases offensive, to different ethnic/cultural groups. As the U.S. becomes increasingly ethnically perse it is critical to address the issue of the relationship between culture and empathy. Given the complexity of culture, an issue for psychotherapists to consider is how one displays empathy effectively across cultures. This chapter will begin with a brief review of cultural differences in worldviews, followed by a discussion on the

interaction of culture and empathy and case studies to illustrate cultural empathy.

Cultural Worldviews

Pedersen (1991) defined culture as a tool that defines the reality for members of a particular culture. He postulated that culture is shared learned perspectives and common universals that members agree on (p.6). Within this worldview, there is a defined existential meaning for life and subsequent prescribed and acceptable behavior. The values, beliefs, and behaviors of a culture furnish its members with personal and social meaning so that the cultural norms are learned through tradition and transmitted from generation to generation (Kagawa-Singer & Chung, 1994). The cultural patterns of belief and rules for behavior enable members to maintain social and behavioral consistency so that they are recognizable and result in the facilitation of social interaction and integration. Therefore beliefs and/or behaviors that are taken in isolation or out of context may be misinterpreted or even disregarded as maladaptive. For example, an Asian client may offer a gift to their psychotherapist, which would be a culturally appropriate and culturally sanctioned gesture. The psychotherapist may find this improper and question the motives of the Asian client, crossing professional boundaries, and establishing a level of intimacy that would be unacceptable in western psychotherapy.

The way inpiduals conceptualize, perceive, and think about their world, and their relationship to the world is their worldview (Ivey, Ivey & Simek-Downing, 1987; Sue 1991). Worldviews are made up of attitudes, values, beliefs, opinions, and concepts, and affect various facets of our lives such as how we think, make decisions, behave, define and interpret events (Sue & Sue, 1990). Worldviews are also influenced by culture (Ibrahim, 1985) and become learned ways of discerning one's environment, thus becoming an important factor in shaping the way that inpiduals understand each other and interact. Thus worldviews can be used to demonstrate how distinct cultural groups tend to experience the world in different ways, and therefore may be utilized as a way of examining possible misinterpretations that can arise in a therapeutic situation where the therapist and client are from different cultural backgrounds. For example, a client's conceptualization of mental illness may be attributed to evil spirits, therefore the culturally appropriate healing method will be to seek help from a spiritualist to rid the body of evil spirits and eliminate the illness. That cultural perspective on the world would be important for the therapist to acknowledge and accept rather than discount as irrational and problematic practices that interfere with western therapeutic interventions. Conflictual worldviews between the client and therapist are often based on examples like this one, and relate to differences in worldviews as well as different dimensions of worldviews (Brown & Landrum-Brown, 1995; Myers, 1991; Nichols, 1976; Nobles, 1972). Therefore

for therapists to be effective with clients from different cultural backgrounds, it is critical that they are aware, understand and accept the client's perception of the world as well as their own worldview. By comparing worldviews therapists are able to examine possible misinterpretations that can arise in a therapeutic situation.

Culture and Empathy

In general, psychotherapists in cross-cultural therapeutic situations will rely on empathetic concepts and precepts that are based on their training and work with mainstream populations. The concept of empathy is based on and influenced by western European-American values, and does not take into account the applicability of traditional empathy cross-cultures. That is, the western or traditional definition of empathy is defined without the knowledge, awareness, and understanding of the complexities and multidimensional nature of culture. Therefore, the issue of culturally sensitive empathy needs to be examined, since it has not been clearly defined as to how it differentiates from the traditional definition and practice of empathy. Cultural empathy has been described as "seeing the world through another's eyes, hearing as they might hear, and feeling and experiencing their internal world," which does not involve "mixing your own thoughts and actions with those of the client" (Ivey, Ivey, & Simek-Morgan, 1993, p.21). Therefore, for therapists to be culturally empathic they not only retain their separate

cultural identity, but are simultaneously aware and accept the clients cultural values and beliefs. Behavior aspects of the definition of cultural empathy therefore have similarities to traditional empathy. However, cultural empathy requires an integration of not only behavior, but also the cognitive and affective factors as well. That is, the therapist is able to understand, accept, and feel the client's situation, while simultaneously maintaining a separate sense of self, and therefore bridge the cultural gap therapist and client (Ridley, 1995). This separateness of self, or inpiduality is perceived differently by disparate cultures. In inpidualistic societies, it may be a highly valued trait and an ultimate goal in defining the self, while in collectivist societies the boundaries of separateness and personal and spiritual independence may be less honored. For example, in many collectivistic cultures, a 15-year-old child who was not working hard in school would reflect poorly on the entire family. If the student was referred for psychotherapy, it would be to not only assist the student in improving grades, but also has implications for the larger family system. Better grades would reflect on good upbringing, values, respect for elders, and a family- based work ethic, rather than simply an accomplishment by the inpidual student. Therapists from inpidualist cultures may erroneously focus on inpidual achievement and self-esteem, highlighting the personal accomplishments of the student, rather than the success of the family through the child's success. Therefore therapeutic empathy must take into account the cultural context

and worldview, so that the same problem presented in two distinct cultures would warrant in different culturally specific responses. This has important implications and points to the need for cultural understanding and the ability to identify, at least in part, with the client so that the therapist is able to "feel as the client feels."

Yamamoto (1982) coined the term "active empathy" to describe his work with Asian clients whereby therapists actively communicate appreciation about all aspects of client's lives. It was suggested that by incorporating the knowledge of the Asian culture (family-oriented) the therapist should acknowledge and communicate empathy towards the client's family and include the family in treatment, thus demonstrating knowledge of the culture as well as respect for Asian value of collectivity (Yamamoto & Chang, 1987). Cultural empathy is therefore complex and multidimensional. The challenge for therapist is expressing their understanding and empathy and being understood may be different across cultures.

Each inpidual's experience is influenced by culture while empathic understanding that is culturally based is a process where the therapist perceives the meaning of the client's personal experience from another culture. Therefore, the therapist must assess how cultural values and explicit and implicit assumptions influence client's personal experience (Stewart, 1981).

Misunderstanding of clients from another culture by the therapist is commonplace if the therapist does not understand the clients background and experience or have cultural knowledge, awareness or understanding. Cultural misunderstanding partially occurs because of therapists indiscriminately applying textbook norms and failing to maintain a posture of naiveté and a role as learner (Ridley, 1995).

A major problem in cross-cultural work is the tendency for therapists to impose their cultural values onto their clients (Ridley, 1995), which may occur on a conscious or unconscious level. This problem is accentuated by therapists' cultural encapsulation (Wrenn, 1962) and cultural tunnel vision (Corey, Corey, & Callanan, 1993), leading to the expectation that clients will embrace the therapists' cultural values. Subsequently a major cognitive task in achieving cultural empathy is for therapist to differentiate their own culture and the associated biases from those of their clients. An examination of cultural influences personal belief system, values, customs, behaviors, and the like are essential to explore. Gaining an in-depth self-awareness provides the therapist with the awareness to resolve cultural stereotypes and biases and experience the true world of the client rather than seeing the client through their own cultural lens. For example, a therapist may empathize with newly arrived refugee clients who have lost their spouse. If the therapist did not come from a war-torn country or lost his/her spouse during the war and doesn't have firsthand experience as a refugee, it would not be genuine for

the therapist to respond as if they had experienced refugee status. However, the therapist may have experienced loss of family member or a close friend and know what it is like to have lost a loved one. These experiences may be generalized to better understand the client while maintaining an awareness of cultural barriers and the subsequent limitations of the cultural transference of the experience. The next section will provide case study examples to illustrate cultural empathy.

CASE STUDY 1

John is a middle-aged African-American who is concerned about his closest childhood friend named Samuel who John describes as "*my real* brother." Samuel is going through personal and legal trouble regarding domestic violence charges that could lead to a prison sentence. During counseling, John often reflects on Samuel's problems and expresses anger that his friend is being treated unfairly by the legal system. John is adamant that his loyalty to Samuel is unconditional regardless of what happens, ignoring the prosecuting lawyer's threats about the serious consequences for perjury in court.

Even so, John is firm that he is willing to do "anything" to help Samuel. The fact that his "real brother" is "going down" makes him feel personally obligated to come to his aid and keep him out of prison at any cost. During

counseling, John's is very emotional about this situation, often hitting his fists against each other or rubbing his hands together in agitation, insisting that it is "Us against the world."

There are several cultural aspects presented by the client that a therapist from a different ethnic background may misinterpret or misunderstand. The first involves the African-American concept of family. The definition of family includes not only biological and/or the legal term for family, but also friends, neighbors and the wider community who may be particularly close to the extended family (Lee & Bailey, 1997). Therefore, the therapist may not understand the closeness, devotion, and intense emotion John is expressing regarding this problem facing his "*real* brother." Furthermore, African-American culture has a basis in being a collectivistic culture, focusing on family, group, and community rather than only on the inpidual. Therefore, the problem of John's "real brother" is not just the inpidual's problem, it is a group problem. A therapist from an inpidualistic cultural perspective may have a difficult time understanding and accepting a client who is willing to take serious personal risks to help someone else who may be viewed from their social construction of reality as only a friend. It would be important in this situation for the psychotherapist to have knowledge, understanding and awareness of the historical and sociopolitical background of African-Americans, as well as issues of oppression, discrimination and racism, and an historical context of the legal system in

relationship to African-Americans. Thus the therapist must comprehend the client's worldview, the impact of societal and institutional racism, the history of victimization, and the resultant resentment and anger in order to provide authentic cross-cultural empathy.

CASE STUDY 2

Cindy is a 19 year-old Chinese-American student majoring in medicine. Cindy stated that she is depressed, anxious, not able to sleep, and does not have an appetite. She explains to the therapist that she is not interested in pursuing a career in medicine, and is only in this area to fulfill her parents' wishes. Cindy feels that she cannot talk to her parents, family or friends about this situation. Her family immigrated to the U.S. for a better life and education for the children and Cindy is the first generation to be born and raised in the United States. She feels that her parents have made tremendous sacrifices for her and her siblings to provide them with a good education that is reinforced by her mother who constantly reminds Cindy about her sacrifices. Cindy feels guilty and confused for not being interested in medicine, conflicted because she wants her parents to be proud of her and not let them down. During the session, Cindy has blunted affect, speaks softly, and avoids direct eye contact with the therapist.

The therapist may perceive Cindy as lacking assertiveness, too

dependent on her family, and exhibiting too much passivity toward her parents, family and friends. The therapist may suggest that Cindy participate in assertiveness training and become more independent, as well as, encourage her to express her anger and frustration towards family members, possibly encouraging role playing to rehearse ways to more effectively approach her parents. If Cindy refuses to participate in these activities or follow the therapists suggestions the therapist may perceive her as being resistant or passive-aggressive and enmeshed in the family.

It is important for the therapist to understand the Asian culture and worldview as it relates to family, the concept of filial piety and the cultural issues of loss of face and shame. The client is obviously experiencing tremendous pressure to succeed in the field of medicine. The therapist must understand and be aware that in many Asian cultures the success of children is viewed as the success of the parents and family. The behavior and accomplishments of children is a reflection on the family so that each person identifies themselves within the social matrix of the family. Furthermore, the concept of filial piety refers to respect for parents, and the child's sensitivity, obligation and loyalty to his/her lineage and parents. Thus Asian children are expected to comply with family wishes, even to the point of sacrificing their own personal desires and ambitions. Shame and guilt are methods used by parents to reinforce expectations and proper behavior so that improper behavior, such as disobeying your parents, brings shame and loss of face and

may cause significant others, including the family and community to withdraw support. Instead of encouraging independence, it is culturally appropriate for the client to listen to the family's wishes and not express inpidual views and desires. Thus the therapist may express cultural empathy through understanding the cultural context of the family, filial piety, and obligation children have for their parents and family. To focus and encourage autonomy for Cindy would be culturally insensitive. Cultural empathy by a therapist from a different culture must include a deep understanding of the cultural issues related to family, social role, obligation, and Cindy's serious personal dilemma. Therapeutic interventions must take these cultural factors into account, with cross-cultural empathy transcending one's own value system and responding to the culturally bound difficulty that Cindy must face.

CASE STUDY 3

Michael is a middle-aged Mexican-American who has been in the U.S. for 2 years and referred through the courts for counseling for domestic violence. In counseling Michael reports that he is experiencing headaches, anxiety, and depression to the point where he finds it difficult to get out of bed in the morning. When the therapist asked him why he is having difficulties sleeping, Michael explained that he has reoccurring nightmares regarding his escape from Mexico to the U.S. Michael recently lost his job because he believes that there are people watching him and has become increasingly afraid to leave

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Brammer, L. M., Abrego, P., & Shostrum, E. (1993). *Therapeutic counseling and psychotherapy* (6th ed.). Upper Saddle River, NJ: Merrill/Prentice Hall.

Brown, M. T., & Landrum-Brown, J. (1995). Counselor supervision: Cross-cultural perspectives. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 263-286). Thousand Oaks, CA: Sage Publications.

Capuzzi, D., & Gross, D. R. (1999). *Counseling and psychotherapy* (2nd ed.). New Jersey: Prentice Hall.

Corey, G., Corey, M. S., & Callanan, P. (1993). *Issues and ethics in the helping professions* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental, and social psychology perspectives. *Journal of Counseling Psychology*, 30, 467-482.

Hackney, H. (1978). The evolution of empathy. *Personnel and Guidance Journal*, 57, 35-38.

Ibrahim, F. A. (1985). Effective cross-cultural counseling and psychotherapy: A framework. *The Counseling Psychologist*, 13, 625-638.

Ivey, A. E., Ivey, M. B., & Simek-Downing, L. (1987). The empathic attitude: Inpidual, family and culture. In A. Ivey, M. Ivey, & L. Simek-Morgan (Eds.), *Counseling and psychotherapy: A multicultural perspective* (3rd ed., pp. 21-44). Boston: Allyn & Bacon.

Ivey, A. (1993). *Psychotherapy as liberation.* Presented to the Round Table on Cross-Cultural Counseling, Columbia University, New York.

Kagawa-Singer, M., & Chung, R.C-Y. (1994). A paradigm for culturally based care in ethnic minority populations. *Journal of Community Psychology,* 22(2), 192-208.

Lee, C. C., & Bailey, D. F. (1997). Counseling African American male youth and men. In C.C. Lee (Ed.), *Multicultural issues in counseling: New approaches to persity* (2nd ed, pp. 123-154). Alexandria, VA: American Counseling Association.

Myers, L. J. (1991). Expanding the psychology of knowledge optimally: The importance of worldview revisited. In R.L. Jones (Ed.), *Black psychology* (3rd ed., pp. 15-28). Berkeley, CA: Cobb & Henry.

Nichols, E. (1976). *The philosophical aspects of cultural differences.* Paper presented at the conference of the World Psychiatric Association, Ibadan, Nigeria.

Nobles, W. (1972). African philosophy: Foundation for Black psychology. In R.L. Jones (Ed.), *Black psychology* (1st ed., pp. 18-32). New York: Harper & Row.

Pedersen, P. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development*, 70, 6-12.

Ridley, C. R. (1995). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional interventions.* Thousand Oaks, CA: Sage Publications.

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy.* Boston: Houghton Mifflin.

Rogers, C. R. (1975). Empathic: An unappreciated way of being. *Counseling Psychologist*, 5, 2-10.

Rogers, C. R. (1980). *A way of being.* Boston, MA: Houghton Mifflin.

Stewart, E. C. (1981). Cultural sensitivities in counseling. In P.B. Pedersen, J.G. Draguns, W.J. Lonner, & J.E. Trimble (Eds.), *Counseling across cultures* (pp.6l- 68). Honolulu, HI: University Press of Hawaii.

Sue, D. W. (1991). *Counseling the culturally different.* New York: John Wiley.

Sue, D.W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice.* New York: John Wiley.

Truax, C., & Mitchell, K. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A.E. Bergin, & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (pp. 299-344). New York: John Wiley.

Wrenn, C.G. (1962). The culturally encapsulated counselor. *Harvard Educational Review*, 32, 444-449.

Yamamoto, J. (1982). *Psychotherapy for Asian Americans.* Paper presented at the Second Pacific Congress of Psychiatry, Korea Extension Meeting, Korean Neuropsychiatric Association, Seoul, Korea.

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14

Empathy in Cross-Cultural Psychotherapy

Clemmont E. Vontress

Interest in and knowledge about cross-cultural psychotherapy continues to flourish. A large literature now exists on it in the United States and abroad. At annual conventions, local, state, national, and international psychotherapeutic associations feature numerous content programs on theories and practices advocated in counseling culturally different clients. However, little if any attention has been devoted to an important consideration in cross-cultural therapeutic interactions—empathy. The purpose of this chapter is to argue for the position that empathy is basic to human nature. Therefore, it occurs in all helping relationships. Several therapeutic encounters are briefly described to support the contention.

There are four levels of empathy innate to the human species. First, universal empathy is species-related. Human beings understand the feelings of others simply because they are members of the same species. Second, ecological empathy joins people who share the same physical environment. It is difficult for humans residing in Alaska to identity with the challenges of

surviving in the tropics of West Africa and conversely. Third, there is a national empathy which is the product of people experiencing the demands and expectations implicit in living in a given country. Inpiduals become accustomed to the freedoms or lack of them and conduct themselves accordingly. Third, there is a regional culture which includes an empathy which in turn makes it possible for people from that region to understand and identify with others from the same part of the country. Finally, there is a racio-ethnic culture and the concomitant empathy which enable inpiduals from a culture, racial, or ethnic enclave to feel the emotions of their cultural peers. Therefore, everybody has the innate ability to empathize with others on at least two or more levels, regardless of their cultural heritage.

CLOSE ENCOUNTERS WITH OTHERS

During my over 30 years of counseling culturally different clients, I recall several therapeutic relationships which illustrate cross-cultural empathy. The first one involved Ho Hing Ming, a 27-year-old Korean graduate student who consulted me, complaining that he could not sleep nights. The third of four sons in a wealthy family, his father had planned each one's future, including choice of occupation and spouse. Having recently married, he indicated that he did not love his wife. She, unlike him, was not interested in his intellectual pursuits. They could not talk about anything of mutual interest. He would like to porce her but does not want to upset his father, who

had always given him whatever material things he wanted.

His father wanted him to be a university professor, but he preferred to be a businessman. Anxiety-ridden, my client was confronted with choices he did not realize he had. I helped him to realize that there were choices still available to him. Primary among them was how he reacted to his father's ready-made choices. He could choose to learn to love his wife or not. Besides, he would probably learn to live with whatever choice he made. I also helped him to understand that it was he and he alone who would decide how he responded to his father's occupational choice for him. I empathized with my client, because I, too, have been confronted with choices over which I have agonized, robbing me of my nights of sleep. The fact that he was Korean was not a barrier to my ability to empathize with him.

I had another client from Cote d'Ivoire, a country I know well, having traveled there several times over the last 15 years. Twenty-eight-years-old, Francois came to the United States intending to enroll in a university to work toward a MBS, a prestigious degree in Africa. Unfortunately, his money ran out much too soon and he had to drop out of school. He was overwhelmed by anxiety, because he had found himself in this country on an F-l visa but not in school. He was an illegal alien, who could be deported. Moreover, lonely, he tried to connect with several young women, thinking that if he married an American, he could become "legal" and remain in the country. However, his

courting skills were not immediately transferable from one country to another. He never found a wife.

Although he spoke academic English very well, he had trouble communicating his deep feelings in a foreign language. He wanted to acculturate to the American culture but seemed ladened with one problem after another. He did not know what to do. He was suffering from *cultural anxiety,* a diagnostic construct not found in the *DSM-IV.* However, it is an emotion which I have felt often during my travel in foreign countries. The anxiety is situational. The more culturally different the environment, the greater is the anxiety which inpiduals feel. I understood his problem very well and was able to help him to get admitted to a university, where he obtained part-time work on campus, a move which restored his F-l visa status. He soon began to feel acculturated, received a MBA, returned to his country, married his childhood sweetheart, has a family, and now occupies a high position in the federal government.

A native of Burkina Faso, West Africa, Albert was an undergraduate student at a major American university where he majored in accounting. He consulted me because he was afraid of his father, who treats him like a "little boy." A very good student he wanted to be a university professor; his father, however, a prominent businessman in Ougadougou, the capital of the country, insisted that he pursue a MBA degree in graduate school and return home to take a good job in a foreign company there and "be somebody." The client, on

the other hand, wanted to determine his own future. To do that, he needed help in communicating with this stern father "man- to-man." I could identify with his dilemma. Although my father was not as dictatorial as he described his, I could identify with what he was feeling; that is, not wanting to disrespect his father, but at the same time needing to be true to himself. I asked my client if he had an uncle back home with whom he could ask to intervene on his behalf. He indicated that this is a role that uncles often play in African societies, but that he had no such uncle who could help him. Since there was no one in his extended family to help him, I saw no other option than to coach my client in how to communicate more effectively with his father, when he got home after completing his undergraduate degree. In role playing his father, I first saw my client perspire and stutter as he responded to my assertiveness. However, as the sessions went on, Albert became more assertive as he talked about his aspirations for the future.

In sessions which immediately preceded his departure for home, he reported that he had talked with his father by telephone. He indicated that he was able to get more words in than before by inviting his father to slow down, so he could say something, too. In the past, he usually sat as the silent listener. Soon after he got home, he wrote to tell me that "It worked." I had encouraged him to be more assertive in conversations with his father. In approaching his father thus, I assured him that he would gain respect from him, since he would see him as a man. I shared with him how my response to my father

changed from that of a boy to a man.

Sometime ago I saw a middle-aged client from Venezuela. She had come to the United States to pursue a PhD in psychology. From a small rural community back home, she was somewhat anxious about her pursuit of an advanced degree, since most women in her country get married at an early age and have rather large families. However, her father was a highly educated man with four daughters. He wanted his oldest one, my client, who was not married, to be a university professor and bring honor to the rest of the family, as he would have wanted his oldest son to have done, had there been one.

During the first 3 years of her degree program, Elizabeth did very well. Her grades were excellent. As she neared the final hurdle, the dissertation and its defense, she became immobilized by fear and self-doubt. What if she fails? How would she explain her failure to her father and to people back home who were singing her praises to everybody in the neighborhood? She kept postponing the completion of the dissertation until she was informed that the time allocated for the fulfillment of all the requirements for the degree was about to expire. She sought my help. I understood her procrastination because I have gone through graduate school, too. Even though she had straight As in all of her course work, she doubted that she knew enough statistics to write and defend a dissertation. Existentially speaking, she was stuck, fixated, unable to take the next step necessary to achieve her goal. I

suggested that she do what I did when I was in a similar situation: hire a tutor to help her with the research design and strategies for defending her dissertation. She sought the assistance of a retired professor of research, who consulted with her as she wrote and prepared the defense of her dissertation. Elizabeth graduated with distinction and is now back home in the capital city of her country where she is a professor of psychology in a university there. Recently, she wrote me to say that her father, who is now advanced in age, has encouraged her to get married. He is helping her to find a suitable husband. She said that she was happy and was optimist about her future.

John was an Anglo-American client who came to see me, complaining of depression. He sobbed uncontrollably as he told me that he had recently been diagnosed HIV positive. He just knew that he was doing to die. In anticipating that end, he had closed his bank account, quit his job, stopped eating, began to drink heavily, and spent most of his time in bed. Prior to the diagnosis, he had a very active social life, going from one gay party to another. He reported that he was also a "neat freak," always wanting his apartment to look like it was right out of *Good Housekeeping.* However, since his "death sentence," he had "just let things go, including myself." He stopped answering the telephone and the doorbell. He was terrified of death. I told him that I understood. It was a normal reaction. I said that I, too, was afraid of death, but had learned to accept things over which I have no control and to change those which I have the power to change. Although neither he nor I can change our death

sentences, we can change our attitude toward it. We can learn to use more effectively the days allotted to us in earth.

My client and I met for several sessions, in which I helped him to understand and accept the fact that everything that lives dies, but that most creatures hold on tenaciously to life as long as possible. We also discussed the research which reveals that most inpiduals, when first diagnosed with HIV, go through a 90—day tailspin. Finally, the depression began to lift. He started to eat and take care of himself again. He reestablished social relationships and joined an HIV support group. John has been living with HIV for 8 years and remains asymptomatic. He called a few weeks ago to tell me that he had gone back to work, reopened his bank account, and was waiting for "the cure."

When Suzanne came to the United States from France 25 years ago, she was a beautiful young woman who had just turned 23. Although her English was not perfect, it was sufficient to propel her into the social scene of Washington, DC. She enjoyed the attention of prosperous people in high places. Even though she had several opportunities to marry "well-off," she did not want to tie herself down with the responsibilities of children and a home to look after. Alone in this country, she had a few relatives back in France whom she visited from time to time. However, as time went by, her visits became less and less frequent. She reported that her mother and father died when she was a child and that she mainly had cousins in France.

One day Suzanne realized that she was alone in a foreign country, where she had really made no plans for her golden years. Suddenly she became frightened. She had lost her social contacts in France and had not really acquired any solid ones in the United States. She was nearly 50 when she consulted me, wanting to know what she could do to put a stop to the panic attacks which continued to rob her each night of much needed sleep. Instead of being the beautiful young woman of a quarter of a century ago, she was fighting a weight problem, circles under her eyes, and a face which was beginning to sag under the weight of years.

Suzanne was experiencing existential anxiety. She feared aging and its implications. Having chosen to not become involved with others as her existence unfolded, she was now overwhelmed by the realization that she was alone and frightened. In the therapy sessions with her, I assured her that I understood her situation, that we are all alone. We come into the world alone and we leave alone. However, our stay here is made easier by huddling with others in the same boat, so to speak. I encouraged her to reach out to others and to share herself spiritually with them. Her panic attacks were wake-up calls for her. She could now take stock of her life, assume full responsibility for it, and change it, if she really wanted to.

Suzanne was experiencing what many human beings feel at various points throughout life. Her experience was aggravated by her being alone

without family or significant others in a country that she had not yet adopted as her own. Even though she had lived here for over 25 years, she was still a stranger, mainly because she was a stranger to herself. Indeed, I empathized with her and her situation, because I have "been there." In fact, I am still in search of myself, because self-discovery is never-ending. Unfortunately, my client had enjoyed so much the distracting fun and games of life that she had never started the journey to self-discovery. Once she set in motion the quest for self-knowledge, she renewed a friendship with a man whose wife had died, married him, became stepmother to his children, and found meaning in her life for the first time ever.

CONCLUSIONS

Empathy is basic to human nature. People are innately endowed with the capacity to connect with others, regardless of cultural differences which may separate them. Nature intended that humans be able to empathize with one another. It is only when we deny this instinct that we complicate our existence. Instead of responding to everybody as fellow human beings, we too often react to them as if they were different and therefore exclude them from our community.

The cases described here illustrate that the challenges of human existence are pretty much the same, no matter who we are. There are no

shortcuts in life. There is no easy way to live out our existence. One thing seems clear, however: whoever or wherever we may be, our existence is more fulfilling when we realize how much we all need to understand and support one another. It is also especially important for therapists to realize the empathic bonds which allow them to reach out to culturally different clients and help them through their life's journey.

V

The Personal Discovery and Use of Empathy

15

Recollection, Empathy, and Reverie

Gerald J. Gargiulo

Understanding who we are is a never-ending task. Philosophy and literature, religion and psychoanalysis, among the humanistic sciences, testify to our desire and need to pursue such a search. Freud, as his contribution to this common quest, mapped the human mind. With his understanding of inpidual defensive dynamics and unconscious processes, he opened new paths for inquiry. As psychoanalysts have reflected and explored this terrain, they have come to appreciate more deeply the relational processes between therapist and patient, signaling the importance of empathy for experiencing and for understanding another human being.

Can one human being understand another? What does it mean to stand in another person's shoes? It certainly means more than an intellectual grasp of feelings, thoughts and/or motivations. Does it have to do with becoming them, allowing ourselves to take on the shape of their inner terrain, so to speak? And if we do so, does that mean that empathy enables us to walk on level ground with another? Freud knew that in order to hear another person

we have to be able to hear ourselves. By extension, we can say that in order to feel for another person, to walk his/her path, one has to be able to experience one's own feelings, to have full access to the range of feelings of which we humans are capable. In the words of the Roman playwright Terrence, we have to *count nothing human as alien....* Simple words, even profound, but difficult to live.

Caught in the web of the personal, historical, cultural moments in which we live, we are molded by such forces to see and to feel the world in a particular manner. Our inpidual history, in all its ramifications, makes our life relative. History shows us, however, that we are constantly tempted to make our perceptions, our thoughts, and our personal, historically conditioned values absolute—as if in doing so we are buffered against the transitory. In our anxiety to have a place to stand upon firmly we often define ourselves as against, as different from the other. Only when such defensive maneuvers prove unworkable is there the possibility for growth. We need empathy as a bridge from our momentary selves, our historical Is, to this other world we experience. Paradoxically, to walk this bridge to the other we have to go back into ourselves, we have to allow ourselves to feel our pain, our joys, our triumphs and our mishaps.

How do we learn to empathize? Among the many possible ways is in our capacity for recollection and for reverie. Reverie, although implying day-

dreaming, has more to do with memory mixed with a little make-believe, with desire reaching for the possible. It has been dismissed in *scientific* circles as not being a viable conduit of knowledge—as subjectivity, the arena of poets. Yet reverie, in the service of recollection, can be an empathy- building bridge between listening ears. To hear another's words in depth we have to listen to the echoes of our memories—back to oneself in order to be with another. Actually, our capacity for reverie and empathy revisits the medieval philosophical inquiry as to whether there is one mind, with many manifestations, or, as would seem most obvious, many minds. Such a seemingly obtuse question is not the result of ungrounded speculation, as if we were asking how many angels could fit on the head of a pin; rather it reflects a dim awareness of the universality of human consciousness. Psychoanalysis, in its theorizing about drives, defenses and the unconscious, has operated with such a premise since its inception. Freud, particularly as evidenced through his self-analysis, implied that to know one's mind and its conflicts was to know of human conflicts in general. (Telepathy and clairvoyance, subjects which both Sandor Ferenczi and Freud had great interest in, become more understandable within this context.)

Empathy, consequently, is not extrinsic to experiencing another person, it is intrinsic. A physician without empathy is dangerous, a teacher without empathy alienating, a friend without empathy a stranger, and a psychotherapist without empathy is not only ignorant but useless. All this is rather

obvious. What I would like to highlight is our capacity for recollection and reverie, as preambles, so to speak, to experiencing empathy. Such a capacity for reverie is close to Freud's notion of free hovering attention (Freud, 1911 — 1914). Theodor Reik (1956), in *Listening With The Third Ear,* emphasized this ability in his discussion about how we humans hear each other.

Were we to formulate this awareness into a thesis, we could say that as a patient is telling his/her story we have to be writing our own autobiography. Is that, perhaps, the patient's gift to us—in order to hear them we have to refind and re-own our own lives? No amount of experience seems to limit the endless corners of memories, thoughts, or fantasies where we can find ourselves as we interact with others. The following clinical case will clarify, I hope, these thoughts on recollection, reverie and empathy.

Thinking about my first few years in practice, my mind goes to a particular patient I treated, a young man in his mid-twenties. He was, as he comes back to me, a quiet man who seemed particularly out of place in the business of mid-Manhattan. He grew up in a rural environment and had, just a year or so ago, moved to New York City. Henry seemed both innocent and bewildered; he was hardly able to articulate why he was in my office at all. During those first few sessions I felt not only concern for, but also protective of this unknown stranger. I was, however, puzzled by my feelings. Although bewildered and innocent his manner was also cold and disconnected,

qualities which, ordinarily, would not evoke protective feelings in me.

In retrospect I believe I connected Henry with myself when, as a young child, I had great difficulty learning, when I was, in my own way, mute in class. The image of myself as that dark-eyed bewildered boy has always been present to me. I particularly recall my graduation from sixth grade grammar school when I participated in a school show pantomiming a dunce, to the music of *I'm Forever Blowing Bubbles.* I remember the audience's laughter and applause and my pleasure as well as my puzzlement. How was I able to conceive and execute this performance and yet, seemingly, have no capacity to learn? I did not understand that my refusal to learn was a self-called general strike, so to speak. It would take many years, beginning with visits to a child psychiatrist as well as periodic encounters with some loving and patient teachers, for me to call off the picket lines and join life with my fellow students.

The memories of myself as a puzzled, isolated, young boy echoed in my mind as I encountered this lonely, confused, pale young man; no wonder my initial feelings of protection. He was a painter, he said, as well as a political activist; he participated, so he informed me, in Marxist study groups. He spoke of his father, who had left the family many years ago, and his mother in such distant terms that I was barely able to sense their presence. Tall, thin and blond, Henry was awkward and somewhat clumsy in his movements.

After work, except when he went to his political discussion groups, he would go to his apartment and either read or play the piano. Henry had no girlfriends and showed no indications of any sexual conflicts; he seemed to be asexual and nonaggressive in his responses to others. After speaking of his personal history in the most general of terms, he was quite content to sit opposite me, on a twice-a-week basis, and say nothing, often for 5-10 minutes, to my listening ears. Only when I would ask a direct question would he answer and then very briefly.

I had been taught (during the mid-nineteen sixties) to listen carefully and consistently to patients. I had been taught that a patient's *freed speech* would lead to forgotten fantasies, memories and desires. I had not been taught how to respond to silent flatness. I began to feel inept and mildly irritated. To my gentle reminders that he try to say whatever might occur to him, with as little self-judgment as possible, Henry would smile uncomfortably, conveying bewilderment as to how he was supposed to speak of his insides. After a few months of what seemed like a standoff, it became clear that I was not handling this case well. Henry wondered if therapy was for him, while I, in my beginner's enthusiasm, felt frustrated. My white-haired psychiatrist of my youth had made me feel safe and understood; other therapists, along the way, had also. Remembering such experiences, I was unwilling to lay the absence of progress solely at Henry's feet.

I do not remember when it occurred to me to ask the most obvious of questions. I asked Henry what it was like when there was so much silence between us. And in a quiet, calm voice he said that he was used to it. There was, he continued, hardly any speaking in his household when he was growing up. At the dinner table, for example, only the most perfunctory of interchanges would occur, that is, *can I have more potatoes?* After dinner, he would go to his room, play piano or read. Frequently he would hear his parents fighting. When he said this it became clear to me that our work together had replicated and was repeating Henry's childhood experiences. That was why he did not experience my relatively silent presence as a possibility for self-discovery. Henry did not know, in practice, anything about personal communicating. The space between us was cluttered with a dead emptiness; an emptiness I wanted to bridge.

Along with any identification I had with Henry, I remembered George, my classmate in the seventh grade. George who would not speak to anyone when our class was in recess in the schoolyard—George whose face was white with fear and who seemed to hear only with his eyes. I remember walking up to him and saying that I too was frightened and that it was okay to talk—I would listen. George would not answer; he would nervously smile, acknowledge my presence with his eyes and then slowly walk away. I knew that for all the difficulties I had at home, with an angry and demanding father, I had, paradoxically, with my parents' vitality, links to the world. Henry

brought to mind not only my childhood, but also George, imprisoned by his fears. With such memories budding within me, I had a sense that I understood Henry and that together we could find the words to express that understanding. The empathy I had felt for Henry made progressively more sense to me.

Fortunately, at this time, I was rereading many of the works of Donald Winnicott (1965) and refinding his concept of a play-space between patient and analyst. Henry, I began to think, could not communicate in any "playful" interactive way because he had been so injured by self-preoccupied and remarkably non-communicative parents. His injuries were as real as if he had been physically abused.

If Henry had no bridge to reach me, then I would give him words, as building blocks. I decided, therefore, to speak and no longer to quietly wait for his thoughts, dreams or associations. If one essential task of life is to create the found world, as Winnicott suggests, then language becomes a crucial building block, a bridge to the world of others. I began to speak about anything that touched on Henry's world, painting, politics, piano playing, etc. Henry listened and did not turn away as George had. Ever so slowly, he began to answer, not with the dead language he had used until then but almost imperceptibly with a growing presence of tone and color in his voice and a desire to connect in his intentions. There was also a slight note of surprise in

his responses; surprise that I was talking about such ordinary topics.

If a person cannot play, it is as if they have no mind yet; they only have functioning. To have a mind is to be able to enjoy the play of metaphors, the play of relating, even, perhaps especially, the play of remembering.

I changed my technical approach, however, not without some misgivings. I had recently left full time college teaching with some regret; had I, I wondered, fallen back into it? Substituting, thereby, some unrecognized personal need to be the good parent for an analytic discipline that would be a better guarantee of the patient's eventual autonomy? I read as much of Winnicott as possible, as well as Sandor Ferenczi; I knew that the words I read would have no strength until I could make them real by my interactions with Henry. Is that what Winnicott meant by each inpidual's task to *create* the *found* world? At this early stage of my analytic practice, I now recognize, I was operating more on empathic intuition than intellectual conviction. Only gradually, as I experienced Henry's more personal responses, were my concerns lessened.

Henry continued for another year, sitting opposite me twice weekly, before he accepted my proposal that he come more frequently and try using the couch. Even when he was experiencing analysis in a more traditional way, however, I tried not to lose sight of the therapy-playground in which we

found ourselves. As we worked together, Henry gradually appreciated how his parents' lack of emotional connectedness had abused him, by omission, and had left him stranded in his own inner world. His childhood had been a series of cumulative traumas. We both came to understand that he had not been able to live in the present since he had no emotional memory of personal connectedness upon which he could stand.

Transference, as we know, uncreates the present. No wonder our first few months dramatically replicated his growing up years. As treatment progressed, Henry was able to distinguish his sense of the now, his life in the present, from the timeless, speechless blur of his past.

As analysis continued, Henry experienced what can be characterized as an adolescent stage of development. This developmental stage was dramatically brought home to me, one session, when he announced, from the couch, that his Marxist study group had concluded that psychoanalytic therapy was oppressive and designed to support a paternalistic capitalistic economic system. He stated further, as if reciting a script, that if he continued to pay my fee, he was, in fact, supporting a system that celebrated a capitalistic reward for the performance of a necessary human task. Furthermore, he proclaimed, since he earned considerably less an hour than I did, I was, in fact, exploiting him with the arbitrary fee I had set.

I was taken aback by his announcement. I felt bewildered and, given all the work we had done, somewhat irritated. Initially I fell back on what I suspected were the underlying issues, at least as I understood the dynamics of transference. I spoke of his forgotten and repressed rage at his father, as well as his distrust for his distant mother. I tried, over the next few sessions, to relate his rage at exploitation to the lack of personal care evident in his early home and to his feeling that there was no way he could affect the parental circle. I also acknowledged that elements of capitalism were oppressive and exploitative but that both of us were living in such an economic system and we had little, if any, power to change it. All to no avail. Henry decided to leave therapy.

At this point, puzzled as to how to proceed, I asked if he himself saw any solution to the inequality he had come to articulate and to hate. He answered, after some minutes of pensive silence, that the only way he could establish equality between us was if he paid me what he himself earned, that is, three and a half dollars an hour. *(And somewhere on the edge of my consciousness I remembered working in my own father's business, feeling both exploited and powerless) . . .* After a few moments of reflection, I agreed. I now understand that my answer was an empathetic response to his feelings of vulnerability, humiliation and desire for equality. Such feelings were, in my own growing up, not foreign to me. At the time, however, I was not sure quite what I was doing; I knew that Henry needed to feel that the ground between us was level.

I also knew that I did not want to lose Henry as a patient; we had both worked too hard to get where we were. Our financial arrangement would last for about 1 1/2 years.

At the end of this period of time Henry began joking with me that as his business improved, and he had his own painting firm, he was going to charge the same outrageous fees as I did. He added, around this time, that he had been thinking that since I had mastered more than he had for now, he could pay me my fee without feeling exploited.

In retrospect, I understand that I was able to let Henry create his world via his relationship with me, rather than just interpret his need to do so. He contributed to the rules of the play, so to speak, of his analysis. I was able to provide building-block words that helped Henry give speech to his feelings, particularly those of exploitation and oppression. By agreeing to a change in fee, I gave him actual power over my income. Empathetic responses that do not issue, on occasion, in a therapist's changing some basic procedures can easily be experienced by a patient as hollow, or as a therapist's formalistic concern. As I look back now, after so many years, I am convinced that my personal reveries enabled me to hear Henry's yearning to connect as well as his difficulties in doing so. Because my mind wandered among the memories, as well as the pain, of my own exploitative father, because my reveries slipped back to the school yard of P.S. 68 in the northeast Bronx and to my

schoolmate George, who never spoke back to me, because my own mother had, at least, kept talking to me and because of my own therapeutic experiences for these, as well other reasons, I could be Henry's other side, metaphorically speaking. The side facing the world. The side he needed if he would ever be able to refind his own childhood and have some mastery over its events. I believe that empathy enables one to function, in a given case, in such a way.

Henry stayed another 2 years or so and left feeling more alive, less frightened and in better command of himself. A year before he left, however, he said, rather blandly one day, that his mother had called and told him that the father he had not seen for years had collapsed in a small Vermont village, the victim of a sudden heart attack. Although I explored his possible feelings for the now dead father, Henry was not able to express any anger or grief, at his loss.

A year later he began speaking of ending treatment. I recall asking him how he would feel leaving therapy and our no longer working together. He knew that he was in a different place now than when we started and he felt good and was anxious to be on his own. He appreciated all the work that had been done. I knew that I would miss Henry, our years together had created a bond. His treatment, I have subsequently come to recognize, helped me enormously. It helped me to actualize what I somewhere inside myself

already knew, that is, without the play of imagination translated into what we call technique, psychoanalytic treatment is a ritualized, if not dead, experience. Without an empathetic experience on the therapist's side a patient can, all too easily, be a stranger, locked away in his/her own history. Similarly a patient must bring an empathetic hearing of a therapist's words or they will be experienced as seeds dropping on rocky soil.

Notwithstanding any shortcomings on my part that I inevitably brought to Henry's treatment, I believe that my capacity to identify with him, to sense how wounded he was, created the good environment that Henry needed. Notwithstanding all of our work together, however, Henry left treatment, I believe, somewhat prematurely. He had little desire to go much further. I accepted his decision. His desire as well as his capacity to take fuller ownership of his life overshadowed whatever reservations I had. He left, as I have said, a more happy, warm young man. There were smiles where only bewilderment had been, color where before I had seen only pallor, personal ambition instead of isolating depression. He was living with a girlfriend at the time; the relationship was serious and satisfying. He called a number of months after he left, to tell me that he was getting married. I have not heard from him since.

Empathy alone did not cure Henry, but without it he would not have been able to use the therapy. Experiencing my wanting to reach him, Henry

both wanted and was able to use the analytic playground of our therapy together. Any cure, which occurred, came out of that experience. Thinking about empathy, I would characterize it as a willingness to revisit the wounding experiences of our own lives in order to find common ground with another. My own reverie and recollections, revisiting some of my childhood experiences with George in the schoolyard of my youth enabled me to find such a space where both Henry and I could walk.

Henry is part of my memories and my reveries while I am listening to others unfold their stories. I know, as I have just mentioned, that Henry helped me find myself as a psychoanalyst. As the days gather into years in his life, I hope Henry will be able to muse about his therapy and to revisit what was good in his childhood. In doing so, he will find himself once more. And if he has children, my sense is that he will be able to stand in their shoes, an experience so sorely needed in his own childhood.

REFERENCES

Freud, S. (1911-1914). Papers on technique. *Standard Edition,* 12, 85-172.

Reik, Theodor. (1956). *Listening with the third ear.* New York: Grove Press.

Winnicott, D.W. (1965). *The maturational processes and the facilitating environment.* Madison, CT: International University Press.

16

A Doctors Reflections on Empathy

Sharon A. Collins

Empathy. The dictionary defines it as "understanding so intimate that the feelings, thoughts and motives of one person are readily understood by another." May I change it a little? It is understanding so intimate that the feelings, thoughts, motives and needs of one person are readily understood by another.

Sympathy on the other hand, was defined as "a feeling or expression of pity or sorrow for the distress of another." What is the difference and why is it even important?

Recently an adolescent patient of mine was brought in by her mother for a recheck after having been diagnosed as having Infectious Mononucleosis. She was seen at one of the Instant Care clinics in our area the previous weekend. This young woman looked quite fatigued and drained of all energy. She was still running low-grade fevers but was going to school and trying to keep up with her usual school assignments. I asked her why she wasn't at home in bed since she felt so bad. Her mother then told me that she

had asked the nurse who took care of her at the clinic what her activities for the coming week should be. She was a very busy high school student. The nurse told her there was no reason she shouldn't go to school. Then added, "I have to come to work when I'm sick." This nurse displayed neither sympathy nor empathy.

One night, I was called to the emergency room to see a 3-year-old girl who was vomiting repeatedly for a week. She didn't look particularly ill, but because of the nature of the vomiting, I ordered a CAT scan of her brain. The huge tumor sitting in her brain brought forth expressions of pity and sorrow from everyone in the department for this child and her mother. Because we knew in some way what this meant for the family if the child survived. We could sympathize with them.

A family's youngest child had just died after a tragic accident. We were horrified and got together to make meals and delegated someone to take the meals over to them. When I visited her weeks later, she admitted that she had tons of food in the freezer—food left from the many meals we made for her. She was grateful for all that we did, but her eyes lit up when she spoke about the woman who came over one afternoon and, without saying much, washed three loads of laundry, ironed and folded the clothes and washed her dishes. The woman had had a miscarriage 3 years before. She was intimately acquainted with this woman's needs during this difficult time. She showed

empathy.

I have always felt sympathy for the plight of others. But I don't know how I became aware of my own lack of empathy for others or if I even recognized it as such. I just know I wanted to care more and feel more.

In church, we are always told to put God first, others second and yourself last. If I was perfectly honest with myself, I would have to admit that it was God first, me second and others third. But the Bible also says, ". . . And thou shalt love thy neighbor as thyself."

In this context love has to do with the practice or conduct of us as social beings in relationship to one another. I could also rephrase this in the following way, "Thou shalt treat your neighbor as you treat yourself." In fact, we will treat our neighbor just like we treat ourselves.

You cannot love or empathize with another if you have not first loved and been empathic to yourself. You cannot give what you haven't received—what you don't possess. I was living proof.

My parents were immigrants from Central America—very hardworking people who came to America to make a better living for themselves and their children. My grandmother died when my mother was thirteen. Since she was the oldest girl in a family of five children, she became the domestic engineer

for the family. All her needs were ignored as the family fought to survive this devastation. My father, on the other hand, was the youngest in a family of eight. His mother was pregnant with him when his father died of a ruptured appendix. His mother became so distraught at the death of her husband, that my father was essentially left to fend for himself a lot as a young child. He tells of a time, when at the age of seven or eight, he was down at the boat dock by himself looking for work.

My parents were very loving and caring people, who, when they married were determined to provide for their family. They were determined that their children would have more than they did, and worked very hard to see to it. But as I look at my young life, I can see some things that were omitted.

I was the oldest child. At the age of 6 I was given the keys to the apartment and was essentially told that I was in charge of myself and my sister while my parents worked. They tried having the landlords baby-sit for us, but when the landlords proved to be less than reliable, I was put in charge. So at the age of 6, I would go to kindergarten, come home at noon, pick up my sister at the landlord's apartment downstairs, go to our apartment, lock the door, call my mother at work, and stay inside and watch my sister until my mother got home at 5:30 PM. When my sister entered kindergarten, we never had another sitter. We were not allowed to go outside and play with friends.

This went on for several years.

My parents both had some very important emotional needs that were not met when they were young. They were not allowed to be children. Even though they were not consciously aware of it at the time, they suppressed the pain of that loss in order to do what was required of them by learning to ignore and deny some very basic needs. They had been pretty independent at very young ages, and they made it through, so they expected me to do the same. They were blind to my legitimate needs for dependence—for childhood. They could not empathize with me in that area of my life.

When I decided to go to medical school I had very altruistic motives. I don't think I would have chosen medicine if I understood all that it entailed. I wanted to help people. I had no idea that it would mean that I would be required to crucify some basic physical and emotional needs in order to succeed in the system. The medical school I went to was known for being more humane than many. Yet, even there, few of the people in authority seemed to understand how overwhelmed with work we were. We were essentially told to keep up at any time, or consider that maybe this wasn't the path for us to take. We were even told that these experiences prepared us for what medicine was really like. Only the strong survived. We were shamed into denying our need for a balance of sleep, exercise, good nutrition, and recreation.

The one thing that helped me emotionally was that I kept the Jewish Sabbath, and took 24 hours out of the week to go to church and recreate. I was able to distance myself from this thinking for a few hours every week. But I was punished for taking that time off. The professor that had a small group meeting on Saturday mornings made it difficult for me to get the material they covered. He was hostile to my needs and couldn't understand why I wouldn't comply with his requirements.

In residency, staying awake 24 to 36 hours was routine every third night. It was common for me to fall asleep at the stop light on my way home from the hospital after a night on call.

By the time I became a practicing physician, the only acceptance and applause I received was when I denied my needs in deference to others' and stuffed the pain I experienced as a result.

I was unaware of what was actually happening. All I knew was that I had feelings I couldn't explain, that I couldn't care less about what was happening around me except in my small circle of influence, and I was constantly self-focused. When I tried to explain how I was feeling, I was told that this was the way things were. Everyone had the same problem and they weren't complaining. Why was I? So I stuffed even more and with a stiff upper lip, proceeded to accomplish the goals I set for myself.

I have no idea when I came to the full realization of what had happened. It was a process. Since I am an introspective, spiritual person, this process took many forms—prayer, journaling, and counseling. I do know that having children was one crisis point. The lack of sleep and the need to defer my own needs only compounded my feelings of self-focus. It was then I had to deal with the emotions I had. I loved my children dearly and my husband and I made some serious, radical decisions to see that their needs were being met. But I was aware of the potential for problems in my interaction with them especially when I hadn't slept all night. So I searched for answers.

A good friend of mine recounted with shame how she treated her 5-year-old daughter who came to her sobbing because she had hurt herself. My friend tried to comfort her but the child would not be comforted. Finally, exasperated, she said, "Get over it!" She was unable to recognize the real hurt of her daughter. This little girl was trying to get the much needed attention from her now very tired and frazzled mother who had just given birth to her baby sister. During an especially long and painful labor, her husband got up to leave and get some coffee. She was afraid and begged him to stay. The nurse, who had shamed her several times before this, grabbed her face, forcibly turned it to look at her husband and said, "Look at him. Look how tired he is. You're not the only one in pain." In other words, "Get over it!" Instead of recognizing that comment for what it was, she felt ashamed, stuffed the emotional pain and denied her need. Once she did that, she subconsciously

resented the same need in someone else and was unable to empathize.

Frequently, the person who has endured but denied the most pain while ignoring basic needs is the one who is least likely to understand and empathize with similar needs in someone else. This person is not doing this willfully or consciously. He actually cannot see the other person's needs over his own. He is treating his neighbor like he treats himself.

To some extent, we are all caught in this trap, but physicians, teachers, and mothers get a double dose. Society encourages us to deny our humanness. Have you experienced these impositions? No one will actually tell you these things because that would be ludicrous, but the expectations of others speak volumes to us.

- We must always be in control of our behavior at all times and in all circumstances.

- We must suppress all emotions. It is less than noble and probably wrong to feel and express anger, sadness, fear, inadequacy, and so forth.

- We must never make a mistake. Actually, we must already be proficient in all things. If there is something we need to learn to do, we must learn to do them quickly, easily and perfectly, if not, we are not intelligent or good or capable.

- We must never acknowledge that we make a mistake. Instead,

blame someone or something else for the problem.

Look at how we treat our children. Have you ever heard yourself say, "You shouldn't feel that way. Come on, perk up!" I have heard teachers tell parents that their child was "too sensitive" and cried or was hurt too easily. Most children suffering from emotional turmoil, behavior problems or feelings of anger, sadness or grief receive very little sympathy or empathy. Sometimes the only time a person feels that he can receive sympathy is when he is ill. I believe this is because many of us have been damaged emotionally more than we have physically and this causes us to not recognize the emotional need in our children.

Some of my most difficult cases are those children whose parents have been emotionally injured. One mother whose child's behavior was unbearable to her told me of times when her needs as a child were repeatedly dismissed or ignored, or when she was shamed into compliance. But as she told me the stories, she denied that those needs were legitimate and she applauded her parents for treating her like they did. She used these stories to justify her beliefs about her own son's behavior. She sees him as whiney and demanding, and expects him to comply, adjust and conform like she did. The child's maternal grandmother still interferes, shaming her into doing what she thinks is needed. When I told her that her mother was acting in an inappropriate way, she rose up to defend her, totally unable to see her own

needs, the needs of her son and the damage her mother's behavior is causing both of them.

When this mother first came to me, she would go on and on for hours about how her son was inconveniencing her, making her life miserable, disrupting the entire family, and making life hard for himself also. The teachers were also complaining about his behaviors. It didn't take me long to figure out the problem here, but there was no way she could see what she was doing to her son, and why he was screaming for her affirmation and attention until she was heard. She had to speak of her own pain first. She couldn't see his needs until hers had been acknowledged and dealt with.

We understand this in the physical realm, but have a much harder time seeing this in the spiritual and emotional realms.

Luckily this family was financially able to afford counseling, and between me and the counselor, she received the empathy she needed. Now she is able to recognize some of her son's needs and is more empathic towards him. The more she meets his needs, the more she is able to recognize her own deep needs and how to get them met. The more she does this, the richer and more satisfied she becomes, and the more she is able to empathize with her son.

When parents bring their misbehaving child to me, they believe they are

seeking help for their child—something to fix him. I believe what they are really seeking is empathy. They are seeking for someone to hear them, to acknowledge their need, their loss of a dream, their pain.

If we don't empathize with them, they will go to someone whom they feel will hear them and heal their pain. Drugs given to the child at that time will deaden the pain for a while. But when the child develops tolerance to the drug, the problem will again rear its ugly head.

Sometimes the empathic thing may be to give a drug for a short time until one can be heard, but my experience is that once the offending behavior is removed, no one wants to deal with a "supposed problem" anymore.

In fact, empathy goes farther than feeling another's pain, and trying to deaden it. By treating with drugs, we deny both the child and the parent the opportunity to really know who they are, what their unmet needs are and their reaction to them. The empathic thing to do is to help the person through this difficult, sometimes obscure process to get to the other side where there is true healing and a fulfilled, satisfied life. This process is sometimes a very painful one, and my experience is that most people will not commit to this discipline, opting rather to deaden the pain over and over again until the problem looms very large. At that time, they will either seek empathic help or will continue to drug the child and themselves. I have patients who are on

three or four medications and whose parents are also on antidepressants—all because they haven't recognized what it is they really need.

Our medical system diagnoses and prescribes. It is hard for the system to be empathic. People expect quick relief. This is fortunately becoming more possible in the physical realm.

So we are expecting this in the spiritual and emotional realms, as well. Insurance companies understand that the process to spiritual and emotional wholeness and humanness is a long process which requires time, discipline, determination, and money. They don't feel that they can afford to do this. After all, there are now large numbers of people who need this. So insurance companies have opted to endorse the virtual reality of wholeness— drugs.

Unfortunately, this doesn't solve the problem, and will actually perpetuate and expand the problem as more and more people live in denial of their needs and become less and less empathic to one another.

When I see the growing numbers of children on drugs who don't get any kind of emotional help, I sometimes get discouraged. How can I help enough people in my sphere of influence to really make a difference in this world?

But I am reminded of an e-mail my son forwarded me not too long ago. "A friend of ours was walking down a deserted Mexican beach at sunset. As he

walked along, he began to see another man in the distance. As he grew nearer, he noticed that the local kept leaning down, picking something up, and throwing it out into the water. Time and again he kept hurling things out into the ocean. As our friend approached even closer, he noticed that the man was picking up starfish that had been washed up on to the beach, and one at a time, he was throwing them back into the water. Our friend was puzzled. He approached the man and said, "Good evening, friend I was wondering what you are doing."

"I'm throwing these starfish back into the ocean. You see, it's low tide right now and all these starfish have been washed up on to the shore. If I don't throw them back into the sea, they'll die up here from lack of oxygen."

"I understand" my friend replied, "But there must be thousands of starfish on this beach. You can't possibly get to all of them. There are simply too many. And don't you realize that this is probably happening on hundreds of beaches all up and down this coast. Can't you see that you can't possibly make a difference?"

The local native smile, bent down and picked up yet another starfish, and as he threw it back into the sea, he replied, "Made a difference to that one!"

The world is changed one person at a time. But the results will be

dramatic one day as those healthier people raise healthy children.

But where do I start?

I started working through my own pain on my Sabbaths away from medical school. Those times helped me to refocus. I became very introspective. God was able to speak to me about me. But what a blessing it was when I also had someone human whom I trusted validate my emotions. This brought healing faster.

In medicine, we abort this process. We take away the pain. Although no one in medicine will tell you that pain is universally bad, our actions speak volumes. We are quick to medicate to relieve a person's pain, because we see it as suffering. Suffering is not the pain we are going through. It is instead the reaction we have to the pain. We can see the pain as hopeless and excruciating. These reactions cause us to suffer with the pain. What we need is to find someone who will validate our feelings, validate that the pain is real and, without judgment, refrain from labeling, and instead, build us up. But in medicine we are usually labeled, and medicated to keep us from experiencing what we are experiencing. And by doing so, we delay wholeness. Once the pain is gone, so is the motivation to work on a solution. Also the person may not have this pain right now, but life is never without pain. We just choose our pain.

When a child is struggling in school or misbehaving, don't immediately jump to the conclusions that this child has a brain disorder, ADD, ADHD, ODD, LD, or a variety of other disorders. See a child who is in the process of change —of developing and changing as s/he learns. We can either enhance the development of that child, or stunt his growth.

One way to care for the child is to give him confidence that he is loved unconditionally—that he can be who he is was meant to be without fear that he will be abandoned by me because of disapproval. This does not mean that I approve of his behaviors at this time, but it does mean that I can empathize with him and will help him be all that he can be. That means that I don't cut the process short by just drugging the child. I do for him what I would want to have done for me if I were in that situation. He needs to be heard. He needs to be accepted, to be understood, to be free, to be empowered to be all that he can be.

I think of who Helen Keller would have been if Anne Sullivan did not see in Helen not who she was then, but who she had the potential of becoming. Helen began to see herself through her teacher's eyes and in her autobiography described herself as a "mass of possibilities." Anne Sullivan was empathic to Helen. And by the age of 16, Helen had learned to read and write well enough to be admitted to Radcliff College in Boston, a real accomplishment for a child who at the age of seven didn't know how to

behave, much less learn.

In summary, I cannot understand or even perceive what it is you need if my needs in this area have not been met. My ability to empathize with others depends on recognizing my own needs, acknowledging the pain of not having those needs met, or those dreams fulfilled, and then empathizing with myself. We cannot abort the process. Pain is a part of life. We can't choose a life without pain. The only real choice we have is choosing what pain we live with. Once we do this successfully, we can also give others the opportunity to grow in their pain, supporting them, and showing and telling them they are able to triumph over their problems.

17

Self-Understanding: The Path to Empathy

Lawrence R. Epp

Describing the concept of self-understanding is excruciatingly difficult for me, because it is a delicate issue with which I struggle daily. I have known so many others who seem to instinctively understand and love themselves. They walk with a distinctive air; their voice resonates with authority and self-confidence. By contrast, I have always doubted myself. While I was never critical to the point of self-loathing, neither was I mercifully kind to myself. Like a perfectionistic plastic surgeon or psychologist, I could always find a part of my inner or outer self that could be reshaped or reinvented in a more appealing way. It took many years for me to understand and appreciate myself. My path to genuine empathy—to deeply understanding and appreciating others—was detoured by this inability to understand and appreciate myself.

Unlike Narcissus of Greek mythology, who would fall hopelessly in love with his own reflection, whenever I saw my profile reflected in a mirror or store window, a shudder ran down my spine. I saw a bespectacled young

man, timid and a little too gentle, whose eyebrows were knotted in concentration upon some weighty concern, so unlike the strong, handsome blade I fantasized myself to be. Occasionally, I noticed a warm smile across my face, like the Cheshire cat's smile, that I took great pride in, because it radiated the humor and love of life that simmered inside. My smile was the feature of my appearance that I most appreciated. I would see myself in a reflection and wonder who that person was; I whimsically regretted that I did not see a presence as distinguished as Gregory Peck or as hip as Brad Pitt. I saw me—and with some disappointment.

I remember one of my friends sharing her honest opinion of me in a heated argument. Each of her statements was so critical that it brought me to the verge of tears. I could not bear to hear that at times I am overly sensitive to the point of being girlish, unsuccessful in financial pursuits, and so novel in my opinions that I was puzzling to my peers. She enumerated some of my many wonderful qualities to buffer the assault of hearing all of my frailties revealed, but I could not appreciate them, because my mind was so fixated on assimilating my inadequacies. I realized then that I did not know myself because if I had, I would not have been shocked at hearing the inevitable litany of positive and negative traits that we all possess. In fact, when I heard myself described, just as I did not recognize my own profile in a reflection, I could not believe that I was the person to whom my friend referred.

After I earned my doctorate in counseling, I thought I had been anointed with a special understanding of human psychology, only to discover that I was no more enlightened. I acquired reams of factual information on diagnosis, counseling techniques, normal and abnormal development, statistics, research methods, and the like, but I had learned so little about myself I began to feel like an imposter. How could I help a client gain insight and self-love when I had not myself achieved these attributes? Somehow my capacity to empathize with my clients was tied to my ability to understand myself, but the connection was intellectually fuzzy. My intuition prompted me to seek my own psychotherapy, because emotionally I knew that I had to know and love myself before I could claim to understand and soothe another's psyche and to bring them to a similar place of self-love.

Each time I sat with my psychotherapist, I learned something new about myself and came to recognize further mysteries to be explored. I welled up with sadness whenever I was confronted in therapy by a behavior of my own that may have caused pain to others or brought about my own suffering. I came to realize that I created distortions about myself in order to accept and love myself, but my true growth and self-love came when I accepted myself as I am, in all my contradictions. The greatest article of self-understanding was the realization that I, like everyone else, am fallible and inconsistent; I share with others this imperfection and inconsistency of personality as a core characteristic. Accepting the inconsistency in my own character allowed my

deeper understanding of this once puzzling phenomenon in my clients and friends.

From Self-Understanding to Empathy

Self-understanding for me began in an exploration of my childhood. While I am not a staunch advocate of Freudian technique, reviewing my childhood in therapy helped me to gain insight into who I am. I realized that I am in part an inexact mixture of my mother's and father's qualities, both good and bad. It was enlightening to accept this fact, which I had so long denied. I was humbled to relearn the lessons of high school biology books in my own therapy: so much of me was a reflection of my genes and parenting. Yet there was an area of my personality that could not be traced to genes or parents. There was a huge part of me that was made by me.

So many of my clients fall into the trap of using psychotherapy as a place to assign blame to parents, siblings, or others for their current suffering. As a therapist, I was once their willing coconspirator in this endeavor, until I saw in my own life that the number of persons and circumstances who I could assign blame for my current personality was so numerous that the whole universe could conceivably be guilty for causing me to become me. I learned that in true empathy for both self and others, we must withhold blame; for blame diminishes our ability to see a balanced reality, even ennobling self-

blame. We move through life touched by manifold persons and forces, often beyond our control, with different intentions for us.

In psychotherapy, we do best when we chronicle life's complexity, forgive, and move on. I saw in the complexity of my own life the futility of explaining me or anyone else by any one person or element. Ultimately, I saw the futility and simplicity of blaming.

While my family was normal in many respects, it was also very unusual. I was brought up with a very idealistic value system, steeped in an intellectual curiosity, in a seemingly materialistic and anti-intellectual society. While this might sound like a fortunate circumstance, it was also a source of misunderstanding with others. I kept encountering people who experienced my intellectual qualities and generosity negatively. I was completely perplexed, for my parents had always taught me that learning and giving to others were two of the highest virtues. Ironically, it was in my own moral and intellectual loneliness that I learned to appreciate the loneliness of others who, while unlike myself in other ways, choose or appear to be different.

Interestingly, in my solitude I learned an important lesson: To learn to be happy by yourself is the greatest article of personal growth. Learning to be emotionally self-sufficient helps remove the "neediness" for others, but not the desire for them. Ironically, as soon as I learned to be happy on my own,

my choice of friends and companions improved, because I was suddenly guided by wisdom instead of the desperate need to fill the void of loneliness.

When I attempt to understand others, I try to draw from my own personal struggle to understand myself. It is important for me to recall the depth and intensity of my own feelings in order to truly appreciate a client's similar issues. I have come to a simple realization about empathy: The more we can understand ourselves, in both our imperfections and inconsistencies, the more we can empathize with others. Genuine empathy begins in self-understanding.

What I Learned From Myself that I Share

When I counsel others, I try to assume their perspective—to fathom their pain as they see it. For me, this is the heart of empathy. But psychotherapy cannot stop at my own understanding of the client's issues—that would make it an empty academic enterprise. The client's self-understanding and eventual self-love is paramount. Once I understand the client, I strive to help the client understand himself or herself. I want to become a mirror that reflects to the client as much of his or her unseen goodness and struggle as I can.

Often I hear clients relate a litany of self-criticism—they are too fat, too plain, too short, too naive, and so on. Ironically, the clients who share this

with me are often in other ways very attractive and intelligent people, but someone along the way a parent or other intimate used their one vulnerability or imperfection as a way to hurt or reject them. I suspect that because we are all imperfect in some way, we each harbor an Achilles heel, a psychological vulnerability that others can use to hurt us.

Many therapists focus on the issue the client brings instead of on the client. I have found that over-dissection of an issue often gives the issue greater importance than it is worth. What most clients yearn is not resolution of an issue per se, but to acquire the ability to feel love and empathy from others. I remember distinctly one young woman who I assessed for suicidal ideation. I will never forget her blue and expressive eyes. She was truly beautiful; and I remember listening with a nervous awe how much she hated herself, how much of a failure she thought she was, and how life had brought her nothing but heartache. Her parents were both alcoholics; and her boyfriend was an abusive cocaine addict who once knocked her down in anger. Contrary to all my training and sense of professionalism, I remarked, "You are so beautiful and charming, I know so many people must love you and are going to love you. I feel so sorry you feel the way you do." As a male therapist, I initially regretted what I had said, thinking it could be taken the wrong way. But the client started crying and then a serenity came over her. I had said exactly what she needed to hear—that somebody would love her.

I like to focus at some point in therapy on what's special about the client, irrespective of what brought the client to me. I am often surprised at how many handsome people think they are ugly, how many of the gifted think they are ordinary, and how many especially kind and caring people think they are too selfish.

We are living in a highly critical culture: praising others with sincerity does not come as easily to us as tearing them down. With so many negative messages circulating, it has become commonplace for many people to carry around a distorted image of themselves. They cannot understand themselves, because those in their world did not accurately reflect to them their good attributes and, perhaps, overemphasized their failings. A course of therapy with a strong, healing emphasis on positive regard often counterbalances the negative messages received in the home, workplace, and street.

I urge my clients to ignore the messages of our culture that put undue emphasis on the most superficial aspects of human life—youth, beauty, sexuality, wealth, and fame. Our culture virtually sets us up for unhappiness, as great wealth will only be attained by the few; and youthful beauty and fame are only transient states. Sexuality is not the same as love and it grows empty without love as its motive. When all is said and done, acts of pure love, whether love of a person, a noble cause, or of humanity, bring us the most enduring happiness. I also believe that measures we take to show love for

ourselves, such as further education, exercise, or even psychotherapy, are paths to greater contentment.

Clients fail to understand that the path to happiness is often paved with painful self-discovery. We often consciously and unconsciously impede happiness from entering our lives by erecting the defense mechanisms that once protected us from pain, but are now only archaic remnants of a world that no longer exists. I remember one client who was abandoned by his mother as child. His mother was diagnosed with schizophrenia and drowned her delusions and hallucinations in alcohol as the only humane self-medication. My client, in his craving for love, would aggressively attempt to meet women. But, then, after a date or two, would become elusive and drop the relationship, only to start the pattern over—a self-made Sisyphus.

I tried to point out this pattern to him, at first delicately and then with some resolve. He would resist my comments and always find the problem in the woman. She was always lacking in some way and not worthy of his love. Of course, deep in his psyche the problem was the woman—the first woman in his life, his mother, who abandoned him. He rejected these women because he could not bear to allow them to hurt him as his mother had. His actions were a defense mechanism that originally enabled him to psychologically survive his painful relationship with his mother, but now this pattern of defensive behavior was interfering with his attaining the love he craved.

Facing this self-destructive pattern caused a great deal of pain because it uncovered an imperfection in him. But his self-knowledge enabled him to enter relationships for longer periods of time and, finally, to achieve the love and happiness he desired.

Self-understanding is never a linear process. The "self" is an intricate labyrinth in which we often lose our way on the path to self-understanding. When we have gained an understanding of one dimension, another becomes mysterious. This is especially likely to happen when we find ourselves enmeshed in a crisis or when we encounter a new or unexpected experience, such as birth, death, or betrayal, and discover that we are surprised by our reaction to it. I do not expect my clients to exhaustively understand themselves, as of course I have not myself reached anything like a state of perfected self-understanding. Nor do I believe that I, or anyone else, is capable of reaching a static state of complete self-understanding. Some aspects of ourselves remain a mystery forever and are probably better left that way. It is perhaps the mystery of ourselves that peaks our lifelong introspection and growth. A state of absolute self-knowledge would be stagnant and boring.

Our scientific culture gives us the false optimism that everything can be reduced to logical rules or postulates; and some psychotherapists gravitate to this rigidly scientific, simplistic worldview. I believe that mystery is our

eternal companion. While I have a passionate desire to explain some aspects of human behavior, especially those that may hurt or intrigue me, it can be very healing to chalk them up to mystery. In all living systems there is an irrationality or "chaos" that cannot be translated into a logical theorem of science. I believe that there are aspects of ourselves and our loved ones that cannot be known or accurately predicted, but must be accepted as mysterious and unpredictable.

I was trying to help a client understand why her teenage sister had committed suicide in a ghastly manner by slashing her wrists. We explored the theory that the sister did not really want to die, but wanted someone to find her "barely living" as a way to symbolize the intensity of her inner pain. My client believed that her sister had always been happy until a recent break up with her boyfriend. She was puzzled that her sister had abruptly killed herself at a time when she seemed to be recovering from the loss and betrayal. I explained that sometimes the resolution to die gives a transient serenity before one commits suicide—at least that is what the textbooks say.

Then, I realized that neither I nor anyone else really knew why previously happy-go-lucky teenager would react so tragically to the breakup of a relationship. Clearly, many adolescents survive these crises, especially when they seem to have had a happy childhood. It was a mystery that could not be done justice by the theories of psychology.

A psychiatrist had told my client that she believed a "biological imbalance" was responsible for her sister's suicide. I recall the psychiatrist making that pronouncement while wearing a white lab coat and speaking with the precision and demeanor of a scientist. The explanation seemed to be comforting to my client, who now had something concrete to hold onto that seemed "logical." A beloved sister, with so much potential, committing suicide because of a broken heart was too "illogical" for my client to fathom. I, too, felt comforted that an irrational act could be attributed to a malfunctioning brain, freeing the survivors from guilt and freeing those of us with a "normal" brain from the vulnerability that a passing irrational impulse could endanger us. But I also sensed that the notion of a "biological imbalance" was too convenient to be true. I would stick with the mystery of the suicide despite the discomfort of living with unanswered questions and wonderment.

I discourage clients from conceptualizing the events of their lives from a single theory, whether biological, sociological or philosophical. All human behaviors are influenced simultaneously by a multitude of factors, encompassing many dimensions of the person and environment, both known and unknown. Our difficulty in explaining behavioral phenomena may reside in the poverty of our language, cognition, and memory to integrate and summarize all the forces that impinge on the person. I consider the acronym "biopsychosocial" as the best and most expedient summary of the multiple factors influencing human behavior. Yet, given our mind's inclination to

assume one paradigm at a time—the way that we can only wear one pair of glasses at a time—I can understand why many seemingly espouse a "biopsychosocial" outlook while retreating to that single paradigm their mind can most comfortably handle.

CONCLUSION

The struggle to attain self-knowledge enhances our ability to empathize with others. I am very wary of psychotherapists who have never undergone painful soul-searching on their own, in therapy, or through other means. Our own struggle for self-understanding makes us more sensitive to the painful process that others must also go through toward the goal of self-understanding. I have often awakened in the middle of the night wondering about my purpose in life, worrying about aging and death, attempting to define love and friendship, and mulling over countless other problems of existence. At moments that I have faced life's mystery in new ways, my work as a psychotherapist has been enhanced. I can then face my own clients with the humility that comes from peering into the mystery of myself and knowing that I, like they, are a work in progress.

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The Use of Empathy in a Woman's Writing Workshop: An Instructors Perspective

Erika Duncan

I had been teaching fiction and autobiographical writing for more than 25 years. Certain admonitions had become almost rote, for example: "You cannot allow a character to die or make love on page two. There is no way a reader can care enough at that point to either experience loss or to enjoy the happiness of a stranger, even if the stranger is, in the case of autobiography, the writers own self."

This was a hard lesson in humility, always, for the beginning writer who felt that whatever was most important to herself, in her own life, should somehow immediately translate into a story that would be of interest to anyone encountering it.

"Being told stories that are too personal before you know the cast of characters is like looking at photographs of someone else's grandchildren, which is something you can only do if you already care about the

grandparents. Caring about someone else's joys and pains in their details can only come gradually." "And yet," I would continue, "if you cannot find a way to create an immediate illusion of empathy on page one, the reader will not find the impetus to continue." We would speak of the necessity of helping a reader to enter into the experience of another as if she or he were already inside that other, even though in the beginning of any written text, the reader knows nothing at all about the one who is wrestling for attention.

The more that my students were able to grasp certain basic principles in the creation of empathy, the more easily I found they were able to solve fairly complicated problems of narrative structure and voice. I wasn't prepared for the richness and complexity of the reactions to the mandate not to take reader-involvement for granted, when I found myself leading a memoir writing group for women who were victims of extreme trauma, who for the most part hadn't yet developed much sense of self- worth.

It was a time when memoirs by unknown men and women were just beginning to be taken seriously by the reading public and suddenly there was a roomful of women, many of whom were uneducated, coming from backgrounds of poverty, sexual abuse, and war, wanting to write book- length projects about their own lives. Most of them were mothers who were deeply concerned about telling their stories so that the cycle of patterns passed down through generations might stop.

In response to the need that these women expressed, the town of Southampton had offered us space in their Cultural Center. The New York State Council on the Arts and the Long Island Fund for Women and Girls offered us support. I didn't realize, back in March of 1996 when this started, that this was to be a project that would change my life.

As I think back over the first week of our meetings, when I still didn't know what to expect, the first person I picture is Dorothy. She takes out the pictures of herself and her two sisters, to show to each newcomer, whoever will look, calling herself "poor little Dorothy." "It is time for me to tell little Dorothy's story," she says over and over.

The photographs are nearly 50-years-old, and date from the time when Dorothy discovered her father in bed with her two sisters. When she reported this to another family member, the four children were sent to an orphanage where they spent their growing-up years. She tells us how in her own search for love she had lived with a man who had abused her children. When the story had come out, she had even gone to court against her children, to try to save the man. But so much has changed since then. Writing from the inside about what made her repeat such a terrible pattern might help other mothers and daughters, she says.

Next to Dorothy sits Pat, but unlike Dorothy, she tells nothing about her

own childhood. She seems a bit out of place in the group. She says she wants to write about home schooling and home birthing, and why she made those choices in the mothering of her own two children. She writes even less than she speaks, but only every once in a while there is a hint of something beneath the surface, as easily, almost too easily, whenever she comes to a line, poorly rendered because it is so incomplete, evoking experiences in nature, she will burst into tears.

Then Hazel comes. Time is a funny master, when it comes to memory. In this case two events a year apart are fused, because their consequences were eventually so intertwined. It is a dangerously icy night when we first hear what is to become the familiar sound of Hazel's metal crutches as she makes her way pantingly, but without halting through the double sets of heavy doors, her face expectant and beautiful, and her whole being lull of words.

As the details of her story come back, as she first told them without even looking around to see who her audience was, everything about her seems to ask for our empathy: the fact that she was the "well child" in a family where three of the children died of sickle-cell anemia, and that therefore a serious birth injury which caused severe back pain was never looked into in child-hood, when she might have been saved the paralysis that afflicts her now; the fact that she out of the family's surviving six children (out of nine) is the one who, wheelchair bound, has returned to Southampton to take care of her 80-

year-old mother, rushing around in her wheelchair baking eight coconut custard pies for her mother's birthday; that even paralyzed she raised her own child and the child of the sister who died of sickle-cell anemia, sending them both through college.

This whole list, which we received rapid-fire in our first 10 minutes with Hazel—as similarly we had received Dorothy's "list"—of course inspired tremendous compassion along with an almost unbounded admiration.

Yet I found, simultaneously, even as Hazel was still speaking, I was becoming increasingly worn-out, and almost counterintuitively a distance was developing between us. I could see, as I looked around the room, that the other women were beginning to have a similar experience.

What had happened? Everything being told was ordering me to know that I cared, but I found that in another part of me I was warding the caring away. I was turning the woman in front of me into a stranger, a case history.

I think it is important for me to say here that as the child of a therapist there were things I had absorbed, both life-giving and intrusive, that ran in my blood and deeply colored my way of working with other people.

For me the teaching of writing provided an important way of reaching into the recesses of parts of the self that had been silenced, while providing

the boundaries—the sense of aiming for a product that was separate from the self—that I never was allowed to know in childhood.

I have carried inside me, ever since I was old enough to have my own knowledge of the psychoanalytic process, a deep respect for the delaying of insights, until the patient is ready to properly feel them. I would come to realize, very profoundly, as I worked with Hazel and the other women in the group, that the joint mission of delaying of empathy, and striving for it even before it can properly occur, was one of the most precious things that the writing of autobiography could offer to people who had grown up feeling wounded and alone.

Hazel had been right in the middle of giving the goriest imaginable description of her birth, told in the Black "Church English" of her preacher father, when I stopped her. I will never forget her words as she described the way her father had been told that because of her position in her mother's womb there was no way for both the mother and the baby to survive, so with seven children already at home, they had no choice but to dismember this new one.

It was a quite conscious decision I made at that moment not to ask why they didn't attempt a Cesarean, nor to probe into that Biblical rendition of the "beginning of the dismemberment with forceps," that scarred her forehead

and permanently maimed her spine, “before my mother suddenly cried out God Bless and I was born!!”—and then suddenly, when I felt that I should have been listening most intently, I felt caught in a nightmare so private that instead of feeling anything more, I was warding it all away into the area of another person’s fantasy, perhaps not true, and even if true, not having anything to do with me.

“We must backtrack,” I said to Hazel. “While once we have known you a while, we will care about this very profoundly, for right now there is no way a reader can enter into this with the depth of feeling that you deserve.”

In the course of her rhythmically galloping crescendos and diminuendos, equal only to the sermons I later was to hear in her church, she had mentioned that when her younger sister Cathy became pregnant at the age of seventeen, she had asked Hazel, then twenty-two, if she were to die from sickle-cell anemia after giving birth, would Hazel agree to raise her baby.

The doctors had told Cathy never to get pregnant, Hazel said, for that would hasten her death. And even as Hazel said those words, I knew that this was where her written story must begin. It was a place where even a stranger might feel empathy: a midway point where caring would be inevitable, yet we would have time to get to know the characters as slowly as we realistically must. I could tell, also, by looking at Hazel’s face, that this was a place where

she was able to let her own feelings give way to respect for the listeners' separateness, until she found her proper way and voice. It was neither too close nor too distant from caring.

I cannot describe what it meant to help Hazel to "stay in the room" with her sister long enough, for what turned out to be over a hundred pages and many months of work, so that we were all able to feel the story in its full impact.

Every woman in the room helped Hazel to stay there, caring for every detail, even before Hazel could dare to know how much she herself cared.

Every woman helped her to slow down, until the scene with the sisters in the room took on all of their childhoods and all of their hopes and fears.

It took a great deal for Hazel to be able to write of how furious she was that she who was ostracized by the family for having a child out of wedlock, who had not wanted to have a child, must accept the fact that her "baby sister" had gotten pregnant very deliberately, in absolute defiance of the doctor's orders, so strong was the mandate inside Cathy—as Hazel would finally be able to depict it—to make life.

I will never forget Pat's and Dorothy's tears when Hazel arrived at that moment, deliberately delayed until the reader could feel the full impact, when

Cathy finally says: “If I die, will you promise to raise my baby.”

Although it had been this very line, when Hazel spoke it on that very first night, that had been my beacon to know where Hazel was going, it was important that she take ever so many pages and months of writing time to get there, in order for true empathy to develop.

As I worked with the women in the group, I was very careful not to get into areas that I felt untrained to handle, minding that admonition from psychoanalysis, not to stir up premature insights. The fact that we were writing with the deliberate goal of creating finished products for others to read made it relatively easy to separate what was needed for a reader—that is, a narrative structure where not too much was learned to soon—from what the writer herself might otherwise have been seduced into revealing too quickly, had “self-expression” rather than formal production been the intent.

I had long ago observed that when not enough play space (in Winnicott’s sense) existed between writer and product, the reader would be forced to over-identify, in a counterproductive merger. Or else she would detach herself entirely, in the kind of effort to break free that I had experienced when Hazel first began to tell her tale.

Hazel’s writing was moving forward at a rate that was leaving most of the other women in the group behind. Part of it was a natural narrative gift,

taken from her childhood of listening to religious storytelling, but as I thought of the wonderful lilting Irish story telling voices that Pat had grown up with as well as the immigrant languages that many of the other women had heard, I knew that something else was at play.

What aided me in not attempting to tamper with bringing up insights that might be detrimentally premature was the fact that material that a writer wasn't ready to deal with was invariably so poorly written or so badly misplaced in the text, there was every reason to implore the writer to save it for later, without going into the psychological reasons why.

I will never forget the time when Hazel tried to deal with her memories of incest too soon. It was in the middle of a section she had been writing when she first began to take seriously the fact that her newly pregnant "baby sister" might die, and for many reasons this was a very difficult section to write. Suddenly she broke with her voice and inserted a story in the voice of a previously absent older sister whom she clearly disliked, a story so obviously out of place in the text and of such an intrusive quality, it so broke the emotion occurring between the two sisters and so violated my listeners trust, I found myself escaping into wondering what I would be having for dinner, always, for me, a sure sign that a writer has "gone off."

Deliberately I had trained myself not to listen too carefully, when I

found my mind naturally wandering, that way I could replicate what would probably happen to a reader. I had found it was helpful to the writers in the group when I shared these mental wanderings, so that they too could begin to experience their own lapses in attention, and know where their writing had begun to fail.

Because I knew that Hazel wrote well and wanted to be pushed, and also that she had a good sense of humor, I was able to tease her about the moment when I started to wonder quite specifically about whether I wanted fish or vegetables. Usually the group members enjoyed my sharing of those mental meandering, which so echoed what happened to the reader once the tension of being inside the head and the heart of another had been broken. But this night the others in the group, who were not yet relaxed enough to listen as selectively as I did, were positively furious at me. How could I talk about wanting to eat dinner when Hazel was writing about her uncle's brutal sexual attack on her when she was 8 years old, they had asked.

For a moment I too felt embarrassed and ashamed. Then I drew a deep breath. I began to explain that this was too important a memory to give to a false voice, that of the disliked sister, where it was sure to be diminished and lost, and that it did a disservice to Hazel, who clearly was all there talking to her hurt pregnant other sister, to break into such a moving moment in that way.

It was the first time in all of Hazel's writing that I'd heard her express so little empathy for herself, and I had reacted by not even hearing the content. While for the other women in the group my "not hearing" had a momentarily jarring effect, for Hazel herself it would occasion a major breakthrough.

Meanwhile Dorothy, whose telling of her story evoked such instant empathy, had stopped writing almost entirely, still coming to the group but mostly putting herself in the role of the one who would be deeply moved by the writings of others, continually showing the "sweet" pictures of her sisters and herself to every newcomer and saying: "I was the one who was punished for speaking when I was a child. When I told people what I had seen, all four of us children were taken away from our mother and put in an orphanage.

"Now it is time for little Dorothy to try once again to speak."

But once she had said this, it was as if she had no other words. She could neither find "little Dorothy" in a true sense, with the more three dimensional rounding of adult retrospect, nor be with her in replicating scenes that would bring back the confusion by not trying to protect all the players from the reader's listening ear. Only once when another woman in the group suddenly turned on me and said: "But you don't understand why I am so afraid to tell my family secrets, because your life wasn't threatened every day, you weren't beaten!"—and going around the room every woman said, yes, she'd been

beaten, I had said, “But no Dorothy wasn’t.” It was then that Dorothy had to confess that her sainted mother had beaten all of the children brutally, and we began to speak of the ways in which she was kept from telling her full story out of the need to keep her mother, beautiful, innocent and good.

Pat, on the other hand, after 6 months of writing about being a good mother in her choices of home birthing and home schooling, listening avidly to everyone else’s childhood stories while leaving her own childhood out, suddenly began to write about watching her father rip off her mother’s clothes and call her brutal names, in response to her mother’s affair with her grandfather. As she began to go about trying to recapture what it was like for her to be a child, she would go down on the floor and try to rediscover her childhood ways of praying, looking backwards in order to rediscover the language, as she alternated her movements from the computer to the floor and back up.

There was a great deal of concern about not wanting to seem like victims among the women in the group, and not wanting to “whine” or elicit pity instead of respect, and this in turn led to our beginning to talk about aggression, as we found examples from the works of such writers as Jamaica Kincaid and Dorothy Allison in which all of the feistiness and spitefulness of the child in danger was vibrantly portrayed, and all of the frailties of the others around were let in, works in which no characters or family members

held either all goodness or all badness, and even "victim children" were never entirely passive.

We spoke about the activeness of hope and of joy, and how hard it was to portray those beautiful or hopeful moments which are the legacy of every survivor, when the writer already knows how those hopes will be dashed. It was then that Pat wrote her first real breakthrough piece, "The Green Bottle," about being taken to a doctor because something was wrong with her nerves, and being confused even in memory about why in this family where there was never enough money for medical help they had chosen to take her there.

When she came into the room that day I could tell that something major had released in her face. "It is strange," she said, "I used to think it was so terrible and frightening. Now I know that they were all just people, and it was a shame, but this is what they did, and it happened." In the course of her writing two incidents she had never put together were suddenly combined by a link that now seemed both creatively interesting and plausible: "Perhaps it was because I knocked my brother unconscious with a mallet" and "They had taken me to the doctor." With the passive Pat gone that protected the anger that this unprotected child must have felt, and the angry Pat allowed on the scene, suddenly she was no longer merely the empathic listener. Her writing took on all the poetry and the emotional complexity of the books that she loved to read.

“It just happened. And there it all was. I neither loved them nor hated them, nor did I try to understand them,” she repeated. “It was no longer a haunt,” she said in a voice I will never forget, as the word “haunt,” used that way, from then on took on a special meaning also for me.

As Pat began to experiment—and again I think of Winnicott’s play space—with techniques and voices separate from the attempt merely to relive her trauma, she came in one day with that wonderful lilting “I’ve got threeeeeee kids and a dog. I can’t just say those words. I’ve got to sing 'em. Give them the rhythm my father did when he was drinking . . . “ And then suddenly she was really inside her father’s voice, his words melded with her own lilting with all the sung remembering.

She had pushed aside an enormous milestone in coming to terms with her ambivalence around giving up the demonized pictures of her parents that she previously carried, and letting in the empathy that allowed her to write that last line, half her father’s and half her own: “I’m just a kid myself, a kid who needs love.”

It was not accidental that this happened around the same time as her giving up the notion of “Patty perfect,” finally daring to create the Pat that we could really love, so sad and so angry. At about the same time we noticed she could write about beautiful experiences in nature without crying, but could

give them enough fullness so that we, her listeners, cried instead.

As one by one the women in the group let in more empathy for previously demonized and hated family members though allowing themselves to recreate scenes and memories more fully, the challenge was extended to the group as a whole: to care about all of the players all along that complex chain of "story," cause and effect, and to deal with the writing blocks and breakthroughs that such unexpected caring suddenly calls forth.

Hazel had taken quite seriously my mandate not to let something as powerful as an incest memory be trivialized by bringing it in at a moment when neither the writer nor the narrator could feel it, and several months had gone by in which we had all but forgotten the incident with uncle Bob, so busy were we with what went on between the two sisters. But now the Hazel teller, 22 years old in book-time, was seated in a hospital room, while her mother, so absent for Hazel, tended the sick, pregnant Cathy.

How differently this time we were able to approach the 8-year-old child, sitting between the tall weeds, hiding from the taunts of her teasing sisters and brothers as she took in the sensuousness of the earth and sunlight, trying to make herself happy, catching bugs, far away from the others who would mock that activity, calling her dirty. How poignant was that moment when uncle Bob comes down to the child's level and takes her into his lap, giving

her the cuddling she so craves, and helps her catch the small fascinating creatures, seemingly sharing her fascination which the others just think is dirty and strange. And how terrible then is the betrayal, the pain of the uncle's most brutal and most heartless rape of a child. How painfully alone is the child in the bathroom, in her blood and confusion, as she tries without knowing what has happened to wash herself clean.

All changed for the child who was Hazel in that moment, yet there would have been no way for her to have written of that expectation broken without the slow months she had spent letting a deeper kind of caring for herself develop.

I will never forget Dorothy's tearstained face as Hazel read, nor how Dorothy spoke so softly of loving the child who was Hazel, nor how Pat, who was not very physically demonstrative, had cried alone in her chair, while Dorothy came over to hug Hazel.

At the close of our session, I warned Hazel not to be surprised if she had a hard couple of days, having revealed so much that had been dark and secret before. Not surprisingly, the following meeting, Hazel looked tired and worn, and confessed that she had not slept. She, who had written constantly since she joined the group, had been unable to write.

What Hazel gave as her reason, however, was something that I wasn't

prepared for, and it came to me as a piece of a wisdom that I had been looking for, almost without knowing it, over many years.

> "I was completely devastated by how much you all cared," Hazel said. "I had promised my 8-year-old child, my inner child inside me, that I would never betray our secret. It belonged to the two of us only, and whenever things would get hard for me she would come to me and comfort me. We were all alone with this always, and now, by telling other people, I have betrayed her."

I looked over as Dorothy sat in her chair, saying: "But Hazel, I would give anything to do the kind of writing that made people care so much for the hurt little Dorothy," and I knew in that moment that what was blocking Dorothy most was her not understanding what would upset the person who once, long ago, had had no listeners, to abandon that past child and pattern, by suddenly having listeners now.

> "And I feel especially terrible that I had told this secret to white people, when no one in my own family or community knows," Hazel added.

I thought of Dorothy's holding Hazel, after Hazel finished reading; Dorothy's pink suntanned hand resting so lovingly on Hazel's darker shoulder, Hazel's crutches, lying like some sort of reminder at their feet.

Interestingly, when it came to the moment in Hazel's writing, several months later, when she was looking down at her baby and suddenly saw the baby's father's eyes, Dorothy would be among those who dared Hazel to write

about the happy and romantic moments of the sexual experience, before Hazel had felt so abandoned and betrayed.

> "All I feel about him is bitterness and hatred," Hazel had said. I wanted to do away with my baby when I saw her father's features in her."
>
> "But you must have felt something else," Dorothy and the others had said.

Months later as Hazel spent long homebound days in rekindling in writing the romantic feeling that had led her towards Walter, we would speak of how betrayal couldn't be real unless there had been something beautiful once, to have been betrayed. She would arrive at the moment when the feelings of her 22-year-old self allowed her, even though her memories of her uncle and her fears, to wish for full sexual consummation with Walter, writing slowly about the sensuality of the preparatory bath, her lighting of candles and to the rhythm of jazz pulling down the bed covers in waiting, when suddenly she looked in the mirror and instead of herself she saw "a very sad and frightened little girl, with reddened eyes and hands holding her face.

> "She was angry with me. She spoke, and shame became my patron. 'Look at you, what are you doing?' she cried out. 'Please, no don't do that, you know he's going to hurt us . . . I tell you all the time that we can't ever, never do anything like that, not ever . . . How could you forget what happened to us!' "

With a precision of feeling that to this day sends goose bumps up my spine, Hazel had brought back the inner voice of the 8-year-old "abandoned,"

to whom she felt she had broken her promise on that day when she first told her secret.

> "I had no immediate feelings, as my body seemed to sink deep, deep into an abyss. A river of water sprang from my eyes . . . I could hear myself crying but the sound was hollow because above it all, the little girl was yet scolding me for my actions. 'I'm sorry, I'm sorry,' I pleaded over and over again. 'I just wanted to feel like everybody else. They all say it's O.K. if they do it when you're ready, and want them to. It's only bad if they make you do it . . . Can't you understand that? . . . I won't let anybody ever hurt us again."

Hazel knew nothing about the literature of incest or dissociation, and yet, in trying to explore her empathy for the frightened parts of herself she wrote: "I was sure my little girl was there, for we were inseparable and somehow I could feel her about, yet something or someone else was also present in my bedroom. I could feel that other someone in me, wanting to come forth, be recognized and it was oblivious to my presence and the presence of my little girl."

Was the precision of her thoughts or the Victorian quality of her language more startling as she wrote: "Seemingly, I had split into three personages, the me (which was my real self), the abandoned, (my sad little girl) and now appeared the broker, who would mediate the me 22 year old "me's" desire to be appropriately sexual and the fears of "the abandoned" who only remembered how she wished to be comfortably held?

I will never forget the expression of release on Hazel's face when later, in a dream sequence the "me" let go to all its power to forgive, telling the still reticent "abandoned," who still won't allow herself to be touched, that "some hearts are very cold and uncaring and that was not supposed to be, and whoever had mistreated her was so wrong and probably unhappy themselves . . .

"Then I began talking about a real heart, true and loving caring heart. About a heart that would never leave her alone again . . . " In a passage reminiscent of some of the lesser known passages in Hans Christian Andersen, as "the abandoned" still rebuffs her advances, she continues to explain "that some hearts are so unhappy that all they know is how to spread sadness, and loneliness, isolation and misery. But that's because they, at some time in their lives, felt just like she was feeling," until finally "The little girl turned around and looked at me. She never spoke a word, but I know she was feeling happy because she reached her hand out and wanted to hold mine. Just as I reached and touched hers, the door to the apartment opened and in walked Walter."

It had been a long journey for Hazel to find the love for the hurt, abandoned part of herself that had been seen by no one. And yet, I wonder, did Hazel, Pat and even Dorothy, always, in some small surviving corners of themselves, keep pure that love, feeling that it could only stay intact in most

dire secrecy?

More than anyone else I have worked with Hazel was able to share her fears about allowing others to enter into the circle of her carefully guarded self-empathy, and also eventually to share the joys of making known the parts of her that even through the worst times of her trauma kept the love for the abandoned child alive.

I thought once again about my refusal to give lip service empathy to the unknown person behind Hazel's initial "case history" of her trauma, before she had chosen to show us the whole person, striving for integration, whom we too had needed time and slow introduction in order to love. How empowering it was to show that fuller person whom the other might care for, only ever so slowly, as one was able to leave behind the unlistened-to self and to accept care.

I thought about how slowly Pat had let us see enough of her family interaction, so that our feelings, as listeners and readers, for the people who had hurt her, would never gallop ahead of her own.

And what about Dorothy, who for all of her seemingly immediate evocation of empathy, repeated with the advent of each new stranger, seemed ultimately to be leaving herself behind.

What Hazel had said about feeling that she had betrayed her "8-year-old abandoned" by letting us listen to her story and care, along with Dorothy's not being able to understand why Hazel or anyone should feel that way, gave me an important clue as to how to work with Dorothy.

While Dorothy continued to "protest too much" about wanting nothing more than to have others care for "little Dorothy," Hazel's description of her unexpected ambivalence when that care finally came, made me begin to suspect that underneath her many statements that she wanted to be heard, Dorothy probably carried a similar, or even much stronger ambivalence about leaving the old unheard "little child Dorothy" behind.

Deliberately I stopped trying to help Dorothy speak. I stopped trying to help her understand her silence by replaying over and over again the source of its roots. For a while she stopped coming. But even after she came back, I decided to take her word whenever she said that what she wrote was not worth reading aloud and let her come and go without trying to encourage her. She came, she said, because even when she herself couldn't write she said it made her feel empowered to see other women breaking through.

Only every once in a while a woman would join the group who, to my horror, would say that she envied Dorothy her story, for it would make such a good book. And inside myself I would get very angry, understanding why

Dorothy was holding back, not wanting the compassion that came from the cruelty of life experiences one could not control.

I know there were those who were confused when I continually warded away the advances of all who were trying to force Dorothy to write "because her story was so important to be told." But it was only when everyone else in the group was finally comfortable enough to "let" Dorothy relax and listen, even if she never again felt the urge to write, that Dorothy said, "I found a whole new way to start." She then began to read to us about walking with a woman who was dressed in black from head to toe, trying to reach up to a partially covered ear which finally came down to her level and whispering: "My Daddy did something bad. He hurt us," trying over and over again to find the words for what her father did, while she watched a finger cover the unknown woman's mouth, gesturing a shhhhhh she barely was old enough to understand and saying "You must never speak of this again, or you will burn in Hell. It is a sin to speak like that."

Each detail of that little bit of prose that day rang vivid and true, coming from the time before the silencing had happened with the child's quite natural urge to speak, when nuns were blackened creatures with big ears and fingers who did not have names or reasons to say what they did, and fathers weren't supposed to do things that children couldn't understand.

And after Dorothy read, when the discussion centered on why her approach had worked, she said, almost in little Dorothy's voice, "This time I'll let you talk about me." Surrounded by the other women who for so long had offered their listening ears, I felt that she had come at last to know that she could speak also alone, and find her own way slowly, to her own self empathy, even as she wrote about the moment of a silence that had been imposed on her, the breaking of the silence would belong to Dorothy alone.

As I watched not only the breakthroughs but the backslidings, I thought about how only when the shapes and rhythms of revealing were within one's own speed and control, could true empathic sharing come. Only then could the caring of another—whether stranger, reader, workshop friend, lover or family member—be given to a whole and richly modulated self. Never ever, no matter how powerful, could a story be separated from its teller, and given away to another.

I felt that it had been a long journey for us all.

VI

Final Thoughts

19

Empathic Self-Transformation in Therapy

Peter R. Breggin

Empathy lies at the heart of being helpful to other human beings (Breggin, 1997a, b). However, empathy does not necessarily spring forth spontaneously from us in all situations or toward all of our patients and clients. Many clients will challenge our ability to understand and to feel sympathy for their experience and viewpoint of life. We must be aware of our level of empathy toward each client; and we must transform ourselves when necessary to reach out as much as possible to all those who seek help from us. I call this process empathic self-transformation. Given the innumerable barriers within us to feeling empathy toward each and every person, empathic self-transformation should become a daily part of our lives as therapists.

BARRIERS TO EMPATHY

One person may seem too angry to us, another too helpless. One person's self-absorption or another's self-sacrifice might put us off. Some of

us are more comfortable with people who communicate intellectually and abstractly, others of us may feel more at ease with people who readily share feelings. We might have difficulty reaching out emotionally to parents who mistreat their children or children who reject their parents. My own medical and forensic consultations on behalf of murderers sometimes tests my empathic abilities.

The barriers we experience to becoming empathic are sometimes built so deeply into us that they affect how we relate to most or all people, including many of our patients. For example, our professional training may make it difficult for us to open our hearts in a caring way to our clients or patients. The temptation to diagnose or categorize them may get in the way. Or we may have problems relating in a vulnerable fashion to the opposite sex, or perhaps to the same sex.

Sometimes we may be unaware of why we have difficulty feeling or expressing empathy for another human being. Barriers to empathy can develop in our own early experience with caregivers, even before we have become fully sentient and verbal. Regardless of whether or not we can figure out why we have hardened our hearts at any given moment or toward any specific person, we need to be especially alert for those unexpected, inexplicable failures to remain empathic.

To help other people in almost any professional or personal role, we must be willing to change ourselves to become as responsive as we can to their feelings, needs, and viewpoint. Empathic self-transformation is the necessary ingredient in creating a healing presence with a client, friend, or family member—with anyone who puts their trust in us.

HEALING PRESENCE

The capacity and the willingness to be empathic lies at the heart of what I call "healing presence." Healing presence is a way of being with our clients that reassures and encourages them, helps them to feel understood and appreciated, and inspires courage and confidence that they can overcome suffering and continue to grow.

The development of our capacity to create a healing presence begins with empathy for ourselves. Empathic self-transformation must spring from a constant renewal of the way we care for and understand ourselves. Some of what I'm about to describe may seem obvious, but I often have to remind myself about one or another principle in order to be at my best in my work. Basically, these principles require an empathic attitude toward ourselves as therapists to facilitate our creating an environment in which we can radiate empathy and caring for others.

To create a healing presence requires, first and foremost, a feeling of

safety within one's own space and within the professional relationship. If you find the other person threatening or dangerous in some fashion, you will be hampered in creating a healing presence. Your feelings of threat or distrust should be dealt with as openly and directly as possible in an effort to create a safe space for you to work within.

Feeling that you are getting what you need and deserve professionally from the relationship is also important. For example, if you resent having to work so hard, or if you believe you're getting paid too little (or even too much), you will have difficulty maintaining an empathic view of the other human being. In fact, resentment of any kind is one of the greatest barriers to empathy. If you don't greatly enjoy doing therapy, you may end up doing more harm than good.

Feeling comfortable and happy in your space is also very important to the creation of a healing presence. Your own office should, as closely as possible, meet your personal ideals for a workplace. Rather than conforming to a seemingly professional standard, it should meet your personal standard for an inspiring environment. If you feel safe and comfortable, even inspired, in your space—you will communicate safety and comfort, and even inspiration, to your clients from the beginning of your work together.

Allowing sufficient time to be helpful is indispensable. Therapists who

work on 15-minute schedules cannot possibly offer a healing presence to their patients. To create a healing presence, you must communicate in effect, “We’ve got plenty of time to handle your problems.” While therapists will differ in their sense of required time, I find that anything less than fifty-five or sixty minutes makes me feel rushed.

It is impossible to create a healing presence without adhering closely to your highest ethical standards. Unfortunately, ethical therapy has become increasingly difficult to achieve for many therapists who feel compelled to encourage or to prescribe medications against their own clinical judgement. Many therapists have voiced to me a fear that they will get sued if they fail to prescribe medication or to refer their patients to doctors who can prescribe. In reality, relatively few lawsuits have been brought against therapists for their failure to encourage medication. By contrast, my medical colleagues are sued in large numbers each year as a result of their prescription practices. I have been a medical expert in many such cases against physicians. In almost every malpractice case in which I have been a medical expert, the patient or family who brought the suit felt that the doctor “didn’t care” or was outright callous. Empathic self-transformation and the creation of a healing presence is the best protection against being sued. But far more importantly, it’s the best approach to helping people.

To create a healing presence, you must feel truly glad and even grateful

for the opportunity to spend time with your clients and patients. The grateful therapist is the most effective therapist. You must be able to greet your clients or patients happily and even joyfully. Some religions speak of "greeting the God" within each person we encounter. Whatever your humanistic or spiritual philosophy, as a therapist you must feel honored to have the opportunity to work with each inpidual. If you don't feel this way toward one or another client, you need to apply yourself to empathic self-transformation —to finding within yourself the ability to feel empathy and caring toward this inpidual.

Ultimately, you must find peace and joy in yourself and in your own life in order to radiate these feelings in your work. To help people learn to love each other—and to love life itself—the therapist must love people and life.

LOVE, EMPATHY AND HEALING PRESENCE

The conduct of therapy, much as the conduct of life requires articulated concepts of empathy and love that make sense as attainable ideals to the participants. If there are differences of opinion about love, they should be discussed. Attempts to work without a conscious, shared ideal about love will itself communicate a potentially disastrous value—that relationships can succeed and be improved in a spiritual void. This flawed viewpoint will compound the confusion and despair that's already felt by those seeking help.

When it seems appropriate and useful, I explain to my clients my simplified definition of love. Love is a joyful awareness of another person, of nature, or art, of life, of God (Breggin 1992, 1997a). When we feel love, we also tend to feel reverent and treasuring, and we tend to create a healing presence.

My definition of love as joyful awareness also applies to empathy. Genuine empathy involves a joyful awareness of other persons in all of their aspects. In fact, the words love and empathy can be used interchangeably in many situations and for most purposes. However, when speaking of empathy, we often mean a particular kind of loving attitude—one that reaches toward another person who is suffering to understand that person's painful feelings and experiences.

THE IDEAL OF LOVE

People who seek help from me frequently remark that their earlier therapies failed to confront lifelong destructive ways of thinking, acting and communicating. My emphasis on empathy and love helps throw their negative behaviors into more obvious relief. The ideal of love provides a standard against which to measure each person's communications, decisions, and conduct. Without love as a guiding principle, therapy and relationships in general are likely to flounder or fall short of their full potential, and very

negative approaches to life can go unnoticed.

Principled living is central to the creation of more loving relationships (Breggin, 1997a). Inpiduals and families who come for help usually lack a set of coherent, rational ideas about how to conduct their lives. They especially lack an articulated concept of love, including how to express and to receive it. They don't know how to insist upon or to carry out courteous, respectful communication without which the development of vulnerability and love is impossible. As inpiduals or couples, they may have worked with prior therapists who compounded their confusion by failing to stop or even by encouraging hateful expressions. Their previous therapists may have cynically dismissed love. Usually they have failed to measure the quality of relationships by the quality of love that they generate.

My definition of love as joyful awareness with aspects of caring, reverence and treasuring, although somewhat simplified, has proven helpful to people in couples and family therapy. Love is essentially happy or joyful, even ecstatic at times. Depending on the viewpoint of the participants, it bathes loving relationships with secular reverence or spiritual holiness. It allows us to set the goal of communication as the nurturing of respectful, empathic and loving relationships.

ROMANTIC LOVE

Romantic love is sexually passionate love. Romance uses physical intimacy to create or amplify closeness and mutual fulfillment. Romantic love is not an illusion. It expresses the most profound reality of human life—our capacity to take extraordinary delight in each other, to be joyful in knowing or experiencing each other, to be devoted to each other through the good and the bad times, and to feel blessed by each other's existence. In loving relationships, passionate love can become a part of everyday life. Lovemaking can become part of a reverence for each other and for life.

The role of empathy in lovemaking receives much too little attention in therapy or in married life. For lovemaking to become truly fulfilling, each person must bring a deep concern with the partner's fulfillment. That is, we must feel empathic toward our partner's sexual joy in order to offer as much as we can.

LOVE AND RELATIONSHIP

Love is not the same as a relationship. Love can be felt without any reciprocity or mutuality. We can love people who have disappeared from our lives, and even people we've never met face-to-face. Similarly, we can also love persons who don't love us, who have rejected us, or who have betrayed us.

Love is our own self-generated feeling toward someone or something

else. As I emphasize in *Beyond Conflict,* unconditional love is possible because love is generated, felt, and expressed from within us without requiring reciprocity or even a relationship.

Yet unfulfilled love is also deeply painful. Rejection from loved ones can easily cause us to withdraw our love. The challenge of life is to remain loving —to generate unconditional love—in the face of the inevitable vulnerabilities that it creates.

Loving relationships—the sharing of love and the expression of love with others—is one of life's most fulfilling experiences. But relationships can also endanger and undo love. A loving relationship is much more complex than love itself. It requires hard work to remain loving through the ups and downs of relationship.

Often one of my clients will arrive in the office flush with feelings of love but equally awash in fear. They have begun to fall in love and the experience is both exhilarating and terrifying. But most of the emotional pain that seems associated with love is actually caused by relationships, including our past and ongoing experiences of rejection, abandonment, and betrayal. A feeling of love can re-stimulate the pain of earlier painful relationships. By encouraging so much hope, love also raises the specter of disappointment. However, attempts to remain safe by denying feelings of love can mire people down in

helplessness, self-pity, and depression.

The painful emotions so often falsely ascribed to love can occur in relationships that utterly lack love. They can occur in hateful relationships. When people collapse emotionally after losing someone, it's not necessarily a sign of their love. It can signal the intensity of their helpless dependency with its fear, resentment and other negative emotions.

RECLAIMING AND ENCOURAGING LOVE

As a therapist, I usually talk briefly but directly about the importance of love, offering my definition of love as joyful awareness with caring, reverence and treasuring. But I discuss my ideals only to the extent that people feel it provides helpful direction and only a few minutes at a time are explicitly devoted to my views.

When clients seem baffled about love, I help them to find examples of love to help them understand what it's about. A careful search may disclose that the person loved an animal, a tree, or a place in childhood. Perhaps there was an aunt or grandparent, or a baby-sitter, whose very presence made them happy. Perhaps a hobby or a book still elicits joyful awareness. Perhaps a recreational activity or a work project continues to capture their full attention in a way that delights them. Most important in couples work, perhaps there was a time—hopefully there are still moments—when the

participants felt love for each other.

When people have always felt cynical and hopeless about love, they usually have been exposed to rejection and abandonment from their own parents or childhood caregivers. When they have not recovered from these experiences, even after years of treatment with other therapists, I frequently find that they remain mired down in loveless or even hateful interactions with one or more of their parents. If the person being helped remains unable to grasp the idea of love—the therapist should carefully examine whether or not current relationships, especially with parents, are reinforcing their cynicism or disbelief about love (Breggin, 2001b).

By the time they seek help, inpiduals and families are usually enmeshed in complex, subtle but devastating conflicts. In couples work, it quickly becomes apparent that they have lost empathy for each other. Even if they profess love for each other, they are likely to emphasize the least flattering interpretation of every aspect of the other's behavior. They have usually lost sight of love and no longer believe in it. They may be bitter, cynical and skeptical about the very idea of love. They need help in turning that cynicism around. Remembering, recognizing and recovering lost love is a central aspect of healing relationships.

To recover lost love, I encourage inpiduals and couples to recall and to

talk about times when they took delight in each other. I may ask directly about moments in the past, however brief, when the mere thought or sight of the loved one or each other made their hearts sing. Often they have forgotten or repressed the wonderful promise that blossomed early in their relationship and then withered with unresolved, escalating conflicts. If love has been present in the past, then it's cause for increased optimism in regard to healing the relationship.

Simply asking a person to talk a little about love often results in the immediate confession of immense frustration and confusion. In therapy, I try to identify the person's ideas about love, and then to trace them back to their origins in past experiences. I keep a watchful eye on how the participants communicate their feelings to me and to each other, always against the backdrop of my viewpoint that loving communication is the goal.

The therapist can point out each destructive communication and show how it perpetuates conflict and suffering. If the inpiduals are well motivated, awareness of these largely unconscious or reflexive patterns may be quickly appreciated. If more positive alternatives can be drawn to their attention and illustrated, the participants may rapidly begin to work on changing their behavior. When the goal of a more rational and loving life together is made explicit, progress can proceed even more readily.

HEALING PRESENCE IN FAMILY THERAPY

Toward the aim of cultivating my own healing presence in each session, I actively discourage hateful and destructive communications toward me. At the same time, I discourage them from being made toward each other in couples therapy. It's important for people to acknowledge how frustrated they have become with each other; but it's more important for them not to take it out on each other. Anger as an expression of emotional pain can be helpful; anger as an intentional tool for retaliating or causing injury is not.

Rather than enforcing an artificial, superficial sense of love, I encourage the flowering of love by clearing away the threats and communications that make vulnerability too dangerous to risk. I point out negative communications each time they occur and encourage everyone involved to think about more benign and hopefully more nurturing alternatives for getting across to each other. I try to show people that respectful communication is required before anyone will dare to express underlying feelings and needs. Only when people are determined to avoid purposely hurting each other, can they begin to show their more tender sides to each other.

It is difficult to help people love each other if, as helping persons, we don't respond with empathy and affection to them as inpiduals and to their positive feelings for each other. Therapists should feel free to show delight as their clients recover their capacity to love each other. However, empathic self-

transformation may be required to overcome the stultifying effects of professional training. It's up to us as therapists, teachers, parents or friends to find in ourselves the capacity to treasure the people we are trying to help and to delight in their experiences of love.

Relationships can generate very destructive feelings and it's important not to gloss over these in our emphasis on the ideal of love. By the time parents seek help about their children, for example, they may be secretly wishing for the death of their offspring. Husbands and wives in severe conflict may be harboring murderous feelings toward each other.

People are usually relieved to know that intimate relationships frequently generate feelings of violence. These feelings reflect on the degree to which people feel dependent on each other. The therapist, of course, must be comfortable with his or her own similar reactions to stress and conflict with loved ones. The therapists healing presence can help to ease anxiety over aggressive and violent feelings.

ADVANTAGES OF FAMILY THERAPY

Most of my practice involves inpidual therapy but family therapy is often the most challenging and potentially productive. Working with families is a particular challenge to our empathic capacities because it requires feeling empathic toward two or more different people who are in conflict with each

other. For example, therapists must learn to be empathic not only toward the abused or neglected child, but also toward the stressed, confused parents who perpetrate the abuse and neglect.

Working with couples and families can become one of the most exciting opportunities because it can help the clients themselves learn to help each other live more loving lives. Even young children can participate in loving, empathic relationships, and sometimes they can lead the way for their parents during therapy (Breggin, 2001a). Family therapy should teach the participants to develop a healing presence for each other.

Family therapy can bring to light issues that too easily remain hidden during inpidual therapy. A man may seem a model of patience and understanding when talking with his therapist, only to become short-tempered, hostile and manipulative when his wife arrives with him for a session. A young boy who is intensely focused while working with me alone may become "hyperactive" and "distractible" the moment his parents enter the office. A woman may hide her alcoholism; a man may hide his sexual fears and difficulties—until a spouse discloses the secret in a couples session.

More subtle conflicts may quickly become apparent in family therapy. People withhold love, express disdain, and make threats in subtle fashions within their families. An arched eyebrow may mean, "I'll get you for that

when we get home." A slight smile may mean, "You're being a jerk again." A frown may indicate, "I'm going to act depressed the entire weekend." In inpidual therapy without the husband or wife, these communication styles may never surface. In the presence of the spouse, they may quickly become apparent.

People who are very emotionally injured and distressed, including those who carry the diagnosis of "schizophrenia," can often benefit from family therapy. Like everyone else, their way of being has been influenced by significant other people in their lives during their formative years. In the case of especially impaired people, some of whom continue to live at home in a dependent fashion, ongoing family relationships are critical to their healing. By helping families develop less conflicted, more loving communication and relationship, we help to heal the most emotionally disabled member (Leff and Berkowitz, 1996). At the heart of the experience of "schizophrenia" lies shame and alienation from other human beings and withdrawal into a private world of humiliation and anger (Breggin, 1991). The way out is through more trusting, safer relationships with people.

OUR IMPORTANCE TO EACH OTHER

People not only need to love each other, they simply need each other. These truths about human nature can be dealt with most directly in family

work. Even without very negative childhood experiences, or harmful adult relationships, modern society and modern therapy tends to disparage love and relationships. This denigration of human connectedness is seen in the emphasis on being "independent" to the degree of denying our fundamental interdependence with each other.

There is too much emphasis in our society on what might be called pseudo-independence—making believe we don't need or affect each other. I have also called it non-dependency—the failure to relate masquerading as independence. Therapists too often tell their clients, "No one can make you feel unhappy or make you feel happy. It has to come from within yourself." Nonsense. From birth to death, our lives are so interwoven with others that when we try to handle life on our own, we are literally tearing apart our own fabric.

People have an extraordinary capacity to make each other miserable and to bring joy to each other. There is too much emphasis on "getting along" in oppressive relationships. Grown children are often encouraged to "make up" with their parents, or to reach an accommodation, without the parents changing their abusive ways or learning to be more loving. One of the keys to successful living is to learn how to surround oneself with loving, empowering, ethical people. As I describe in the *Antidepressant Fact Book* (Breggin, 2001b), this can begin with setting higher standards for how we are treated, and how

we treat others, especially in our own families.

BIOLOGICAL PSYCHIATRY AND EMPATHY

The technological view has long competed with the psychological, social and spiritual views of therapy and life; but in recent years, insurance cut backs and controls have pushed the balance toward the mechanics of the assembly line. Cost cutting, and hence brevity, dominate the philosophy of managed care.

Biological psychiatry sometimes tries to grab the high ground of empathy. Organized psychiatry and the drug companies are currently spending millions of dollars on the "Anti-Stigma" campaign which essentially preaches that "mental illness" is a physical disease exactly like diabetes or heart disease. Therefore, they conclude, depressed or anxious feelings are not caused by our life experiences or by our own conflicts and conduct. In the extreme, even sexually abusive parents are not blamed for the "mental illness" in their children (cited in Breggin, 2001a).

Ironically, the advocates of biological psychiatry call "uncaring" those who are critical of psychiatric diagnosis, electroshock, medication, and involuntary treatment. Supposedly, if we cared we would do anything—including involuntary shock and lobotomy—to relieve symptoms and suffering.

Unfortunately, when we become overly focused on symptom relief, we forgot to look more deeply into the roots of the persons suffering. And when we leap too quickly to relieve suffering, we often do so out of our inability to listen to and share the person's suffering. We fail to find the time, patience, or wisdom required for understanding the inpidual's suffering. Diagnosing and medicating patients is often the doctor's method of escaping from the difficult process of empathizing with the patient.

The act of diagnosis, for example, telling someone that they have "clinical depression" or "schizophrenia," crams the inpidual into an artificial category. The diagnosis becomes the period at the end of a very brief sentence about the inpidual's emotional life. Once the diagnosis has been made, its existence reduces our motivation to deepen our understanding of the person's struggle with life. Empathy and understanding require instead an understanding of the inpidual's life story—how the inpidual became enmeshed in the psychological state and life that feels so painful and overwhelming.

The act of medicating a person in effect declares that the inpidual's personal efforts and the therapeutic relationship are inadequate to deal with the person's suffering and confusion. The patient's agreement to accept the prescription can become a form of surrender to the authority of the doctor and to the medical viewpoint that the inpidual is helpless in the face of his or

her “disease” (Breggin, 1992).

Once the psychoactive drug is taken, it invariably distorts the mental and psychological life of the inpidual. I have written extensively about how psychiatric drugs—each and every one of them—work by disabling the highest functions of the brain and mind (e.g., Breggin, 1997a; Breggin, 2001b; Breggin and Cohen, 1999). Whether the inpidual experiences a lobotomy-like indifference, emotional anesthesia, or an artificial euphoria—the end result is a person with less awareness and less capacity to enter into an empathic relationship.

Overall, the medical model turns people into objects. Both the patient and the therapist are encouraged to view the patient as a defective mechanism rather than as a struggling, thinking, feeling, choice-making human being. This effectively blocks any kind of empathic exchange between the patient and the doctor.

INVOLUNTARY TREATMENT

Organized psychiatry has been successful in recent years in increasing the power of health professionals to drug people against their will, even after they have been released from a hospital. Involuntary outpatient treatment is now lawful and increasingly practiced in many states. Advocates of involuntary treatment on occasion will claim that locking up someone for their own

good is an ethical and even loving act.

Setting aside the complex legal and constitutional issues that make involuntary treatment wrong in principle—it is also wrong as a therapeutic approach. Coercion discourages empathy and is incompatible with a healing presence. As I describe in detail in *Beyond Conflict* (Breggin, 1992), whenever we coerce people, we lose interest in understanding them. Instead, we seek to get them to do what we want them to do, and resort to threats and ultimately to force as our means. At such times, we usually prefer not to see ourselves through the eyes of the people whose lives we control through force. We don't want to experience their resentment.

Conversely, the people we coerce will tend to hide themselves from us. Thus patients on hospital wards will talk secretly among themselves about how to avoid getting more drugs, electroshock, or a lengthier enforced hospitalization. None of this will reach the ears of the doctors. Put simply, it's not in the interest of the victims of coercion to share their intimate thoughts with their oppressors (Breggin, 1992).

Coercion of course can take many subtle forms. We can imply to our patients that they cannot get along without us or that they will suffer grievously if they reject our help. We can act as if our feelings are hurt in order to make our patients feel guilty about defying or rejecting us. To create

a healing presence, we must respect the autonomy, separateness, and free will of our clients. We must seek always to empower our clients to make choices—even choices that we don't agree with.

In the meanwhile, it's up to us to take a stand on principle against the dehumanizing biological model and drugs. Our therapeutic relationships can be conducted from the perspective of maximizing the empathy and respect for inpiduality that we bring to our work. We can learn to reach out to our fullest capacity to all of those who seek help from us.

REFERENCES

Breggin, P. (1991). *Toxic psychiatry: Why empathy, therapy and love must replace the drugs, electroshock and biochemical theories of the 'new psychiatry'*. New York: St. Martin's Press.

Breggin, P. (1992). *Beyond conflict: From self-help and psychotherapy to peacemaking.* New York: St. Martin's Press.

Breggin, P. (1997a). *The heart of being helpful: Empathy and the creation of a healing presence*. New York: Springer Publishing.

Breggin, P. (1997b). Psychotherapy in emotional crises without resort to psychiatric medications. *The Humanistic Psychologist*, 25, 2-14.

Breggin, P. (2001a). *Talking back to Ritalin* (Revised edition). Cambridge, MA: Perseus Books.

Breggin, P. (2001b). *The antidepressant fact book*. Cambridge, MA: Perseus Books.

Breggin, P., and Cohen, D. (1999). *Your drug may be your problem: Why and how to stop taking*

psychiatric medications. Cambridge, MA: Perseus Books.

Leff, J., and Berkowitz, R. (1996). Working with the families of schizophrenic patients. In P. Breggin, & E. M. Stern (Eds.), *Psychosocial approaches to deeply disturbed persons* (pp. 185-211). New York: Haworth Press.

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