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Dimensions of Empathic Therapy

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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.

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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.

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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 intersubjectivity, 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 multi-dimensional 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 individual 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.

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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 individual 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

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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

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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.

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