Empathy is considered to be an essential element in both the therapeutic and the developmental processes, and is often invoked to explain at least in part, a successful outcome. Generally, empathy has been defined as the act of putting oneself in the other's place, or entering into the other's state of mind. It is a useful term for designating a psychological stance toward the other that can be distinguished from other stances, such as confronting, advising, correcting, or teaching the other. But as an explanatory concept, empathy is often used in a global way, shedding little light on the particular aspects of the other's experience that are "entered into," on the particular processes involved in assuming an empathic stance, or on the variety of exchanges and consequences that can occur. This paper attempts to articulate at least some of the complexity of this phenomenon by viewing empathy through the lens of affect. It is argued that affect provides a useful conceptual framework for understanding infant-mother exchanges and perhaps, by extension, for understanding adult-adult exchanges as well.

This discussion departs from other approaches to empathy in several ways. First, it deals primarily with infancy, with a focus on the infant's experience of the caregiver. Second, it stresses the notion that empathy always involves making inferences about the other's inner experience from observable behaviors (including verbal statements), and describes the observational data and methods used to make such inferences about parents and infants. Third, it attempts to delineate the specific components of the infant's inner experience and the behav-
ioral manifestations of that experience which elicit parental responses, highlighting the role of affect in this process. Fourth, it defines empathy as a data-gathering process and distinguishes it from parental action toward the infant, which may or may not be informed by the empathic data-gathering process. Fifth, it discusses the phenomenon of affective resonance and its role in the empathic process by invoking Silvan Tomkins’ theory of affect. And sixth, it describes six types of exchanges comprised of combinations of parental perceptions, understandings, and actions in the context of specific affective and intentional infant behaviors.

Method

The data for the formulations presented here are derived from videotaped records of home observations during the first two years of the infants’ lives. Data from two studies are utilized. The first study involved 12 infant-mother pairs, videotaped monthly over a six-month period, with four infants starting at age six months, four at age 12 months, and four at age 18 months. The second study involved two infant-mother pairs, videotaped biweekly from the infant’s second week of life to two years of life. The first study contained equal numbers of male and female infants at each age level; the second study involved two female infants. In both studies filmings occurred at all times of day and captured the ongoing household activities. Every effort was made to put the families at ease.

In analyzing the videotapes, we adopted an empathic approach seeking to view the world from the infant’s vantage point. As I have already indicated, in any effort to empathize with another, one is always in the position of trying to make inferences about the other’s inner state from a particular set of observable behaviors. Even in seemingly straightforward verbal exchanges between adults, where words convey conventional meaning, inferences about the other’s psychological state are made on the basis of the particular choice of words, their timing, the voice quality, and intensity, its pitch, gaze behavior, facial expression, and prior knowledge of the other. In other words, empathy involves going beyond the perception of behaviors produced by the other, and attaching a meaning to these behaviors that is consonant with the meaning experienced by the other. The process of empathizing with an infant is essentially the same, even though during the first two years of life the communication between the infant and the caregiver is predominantly nonverbal.

Both the observer of the infant-mother pair and the mother tending the infant must depend for the most part on the vocalizations, facial expressions, and motor behaviors that the infant produces. They may also use information that is not communicated directly by the infant, such as how long it has been since the last feeding or last nap, knowledge of what infants in general are supposed to be like, or memories of what this particular infant was like on previous occasions. But to the extent that the observer or the mother pay attention to what the infant is doing, the nonverbal cues are paramount. These cues—a combination of facial expressions, vocalizations, and body movements—convey information primarily about the infant’s affective state and the infant’s plans or goals in relation to that state. Indeed, before the advent of language and other symbolic forms of representation, the infant’s affective expressive behaviors are probably the only reliable and valid indication of the saliency of events for the infant; they thereby constitute the primary medium of communication and meaning in the infant-mother system. Thus, assuming an empathic stance toward the infant necessarily involves making inferences about the infant’s affective experience by paying attention to a variety of behaviors. What are the components of that experience and how are they manifested in behavior?

Components of Affective Experience

As I have outlined elsewhere (Demos, 1984), there are three components in all affective experience: (1) the triggering event or stimulus, (2) the affective experience per se, and (3) the response of the organism to its own affective experience, which involves the recruitment in memory of past experiences, as well as motor responses and plans. In the article cited above, I highlighted the variety of ways in which learning can occur in relation to those components; here, however, I wish to stress how each component, although conceptualized as a facet of inner experience, can nevertheless be manifested in observable behaviors that may elicit responses from others. If, for example, a pair of scissors happens to be within the visual range of a young child, and that child is observed to look at, approach, and reach for the scissors, I would argue that these behaviors indicate simultaneously the child’s affective state of interest, the focus of that interest on the scissors, and the child’s response (approaching and reaching toward the object of interest with a plan to explore the object further by handling it). All three components of the child’s experience can be inferred from behav-
ior, and any one, or all, of these components may evoke a response from the caregiver. Because the three components occur simultaneously in the child’s experience, whatever the caregiver’s response, it will provide the child with information about all three components.

Having just argued that the three components of the child’s affective experience can be perceived and understood by observing the child’s behavior, it is now necessary to acknowledge some limitations in this observational method. The components differ in the degree to which their presence may be manifested in behavior, and in the degree of specificity of the behaviors.

The first component is perhaps the most difficult to obtain certainty about through observation alone. The triggering event or stimulus is often internal—a sensation of hunger, a sequence of thoughts, a memory, or an association. Even when an external event or stimulus occurs, one cannot assume that the meaning for the child is the same as the meaning for the adult caregiver or the observer. Thus, in a number of instances it is impossible to know with certainty which stimulus or aspect of an event triggered the child’s expressive and planful behaviors.

The second component, the affective experience per se, is comprised of a set of correlated vascular, autonomic, vocal, and facial responses. The vocal and facial expressions of affect are readily observable, and there are specific patterns of facial movements or vocal expressions for each discrete affect. Tomkins (1962), in describing the innate patterns of facial expression for each affect, designates nine primary affects. Listed in their mild and intense form they are: interest—excitement, enjoyment—joy, surprise—startle, fear—terror, distress—anguish, anger—rage, shame—humiliation, cotept, and disgust. Ekman (1972, 1977) and Izard (1971) demonstrate the presence of these expressions in a variety of cultures and argue for their universality. There is less extensive work describing vocal expressive patterns for each affect. These innate patterns are subject to a variety of learned modifications, yet they are still quite discernible in the first two years of life. Thus, both the degree of behavioral manifestation and the degree of specificity of the behaviors are very high for this component of affective experience. (The amplifying function of these expressive behaviors and their potential to evoke affect in the observer are discussed in a later section.)

The third component, namely the child’s response to his (or her) own affective experience, refers to what one learns to do with one’s emotions. This response is twofold, involving both the recruitment in memory of past experiences and the formation of current plans and behavioral responses. Only the latter, the behavioral responses, are visible to the observer, and these behaviors are theoretically limitless in their diversity. In contrast to the highly specific facial patterns associated with the experience of each discrete affect described above, there is no such specificity associated with the responses to affect. Within some broad, general limits, one can learn to do practically anything in response to feeling angry, or sad, or excited, or happy, etc. Thus, although this third component is often manifested in behavior, the meaning of the behavior may be idiosyncratic, thereby making it difficult for an observer or caregiver to interpret.

Taken separately, then, each component of the child’s affective experience differs in the degree of behavioral manifestations and in the specificity of information conveyed to an observer. Nevertheless, when the information available to the observer from each component is combined, the probability of making an accurate inference about the infant’s inner experience increases markedly.

One final aspect of the components’ potential for eliciting responses from the caregiver should be mentioned. Any one component can monopolize the parent’s or observer’s attention, often at the expense of perception of the other components which are simultaneously present. In our example of the scissors lying within reach of the child, for instance, the stimulus may monopolize the adult’s attention, so that the adult responds only to the danger represented by the scissors, and ignores the affective state of interest evoked in the child, as well as the related exploratory behaviors that have been activated. Or, in terms of the affective state per se, the expressive vocalizations associated with distress may monopolize the parent’s attention and activate attempts to stop the child’s crying, without attention to the event or stimulus that triggered the crying, or to coping behaviors the child may be engaged in. In the same way, the behavioral responses to affect—for example, hitting, throwing, or biting in response to anger—may monopolize the parent’s attention and mobilize efforts to stop the behavior, without direct attention to the triggering event or stimulus, or to the affective state per se. To anticipate my discussion somewhat, in any parent-child transaction, the parent, in an effort to empathize with the child, may focus on only one, or on two, or on all three components of the child’s experience. Each of these possibilities will, I believe, produce a distinctly different experience for the child.

Parental Response as Distinct from Empathy

So far I have emphasized that empathy necessarily involves making inferences about the other’s inner experience and have argued for the role of three distinct components of the child’s experience in the caregiver’s response. It is also the case that there are many situations that are likely to require a specific response to the child, even if the child’s emotional state is not one of distress or interest. For example, the adult may very well need to take action to prevent the child from doing something dangerous, or to get the child to do something that is necessary for the child’s or the adult’s welfare. In some situations, the adult may also need to take action to prevent the child from doing something dangerous or to get the child to do something necessary. However, when the adult takes action in these situations, it is not necessarily the case that the child is experiencing distress or interest. In fact, it may be the case that the child is experiencing no emotion at all. In these situations, the adult’s response may be more appropriately described as a parental response, rather than as an empathetic response. A parental response is one in which the adult acts to prevent the child from doing something dangerous or to get the child to do something necessary. In contrast, an empathetic response is one in which the adult acts to prevent the child from doing something dangerous or to get the child to do something necessary in order to understand the child’s emotional state.
centrality of affect in this process, which requires one to pay attention to a variety of behaviors produced by the other and to understand their meaning in terms of all three components of the other's affective experience. In other words, empathy is essentially a method of gathering data about the other. This formulation leaves open the question of what someone then chooses to do with the information gathered through an empathic process. It assumes that the data-gathering process and the behavioral responses directed to the other are separate aspects of any transactional exchange, and that they can vary independently. A mother, for example, may perceive her child's affective state correctly, and understand its meaning for the child, yet she may act so as to invalidate the experience or block the child's plans and goals. A variety of other factors may come into play and influence the parent's response, such as ideological or familial beliefs about how children should feel or behave, or how they should be treated; temporary lapses in energy level or patience; competing affects or concerns that override the child's state or goals, etc. The empathic data-gathering process is only one among several factors that may determine a parental response, and even when it is an active factor, it may not be the dominant one (Schwaber, 1981).

If we now return to our view of the world from the child's vantage point, it becomes clear that the child is in the same situation that the adult is in—namely, the child can only get information about the parent's intentions and feelings by making inferences based on the parent's behaviors. In other words, it is only through the parent's responses to the child that the child experiences the result of the parent's empathic or nonempathic data gathering. However necessary, empathic data gathering is not sufficient to guarantee that the child will feel accepted and understood. The information gathered in this mode must also infuse the parent's responses to the child. What would characterize such responses?

In general, it might be said that the human organism strives to maximize opportunities for positive experience and to minimize opportunities for negative ones. We assume that children are continually trying to learn how to enhance or sustain their positive experiences and how to master or cope with their negative ones. Parental responses shaped by the empathic process would attempt to foster these goals. They would extend the empathic data-gathering process by communicating the message: “I know what you are experiencing; it's all right, and I'm here to help.” Various terms in the literature capture this quality of responding, such as Kohut's (1971) concept of mirroring, and Stern's (1983) description of “mental state sharing.” These terms are deceptively appealing, for it is easy to imagine mirroring or sharing positive experiences. But it is harder to imagine how one can constructively share or mirror negative experiences, since merely to respond to anger with anger or to distress with distress is rarely helpful. An additional assumption is needed. The caregiver must share and perhaps even absorb the child's experience while still maintaining an independent motivational stance. One might, for example, acknowledge the child's distress or anger, and offer comfort or help in coping; or join in the child's fun and excitement without intruding or dominating the play. Empathically determined responses therefore seem to have a dual quality—reflecting both where the child is at the moment (e.g., crying), and where the child would like to be in the future (e.g., mastering the situation). This formulation stresses the asymmetry of infant-adult transactions, in which the adult possesses far more capabilities than the infant for elaborating, attenuating, exaggerating, suppressing, coping with, or mastering an affective experience. It requires that the adult not only join the child by producing a response that is somewhat similar in intensity and duration to the child's response, but also lead the child onto the next step by helping the child to fashion a response to his affective experience.

To talk about sharing and absorbing the other's experience raises questions about affective resonance, by which I mean the tendency to experience the same affect that is being experienced by the other. What role does this phenomenon play in empathic data gathering and in subsequent responses? And even more basically: How do we understand the power of affect to evoke similar affect in a participant observer?

**Affective Resonance**

Silvan Tomkins' (1962, 1963, 1980) theory of affect is central to an understanding of the contagious quality of affect. Tomkins argues that there are a limited number of discrete affects, each with innately patterned responses and innate activators. A particular affect is activated by a variant of a general characteristic of neural stimulation, namely its density, where “density” is defined as the number of neural firings per unit time. There are three classes of variants: stimulation increases, stimulation levels, and stimulation decreases. If, for example, internal or external sources of neural firing suddenly increase, the organism will startle, become afraid, or become interested, depending on the suddenness of the increase. If sources of neural firing reach and
maintain a high, nonoptimal level of stimulation, the organism will experience anger or distress, depending on the level of stimulation. And if the sources of neural firing suddenly decrease, the organism will laugh or smile with enjoyment, depending on the suddenness of the decrease. Shame is activated when positive affect (e.g., interest) is interrupted and attenuated, without being completely reduced.

The discrete affects evoked in this way act as amplifiers. They generate an analog of the stimulus’ gradient and intensity by means of correlated sets of facial-muscle, blood-flow, visceral, respiratory, vocal, and skeletal response. A gun shot, for example, will evoke a startle response—a sudden, intense jerk of the body. The suddenness and intensity of the jerk are an amplified analog of the suddenness and loudness of the gun shot. That is, each affect amplifies in an analogic way the gradient or level and the intensity of its stimulus; it also imprints the immediate behavioral response with the analog. As Tomkins explains: “An excited response is accelerating in speed whether in walking or talking. An enjoyable response is decelerating in speed and relaxed as a motor or perceptual savouring response” (1981, p. 322). The biological importance of this amplification through affect is to make the organism care about quite different kinds of events in different ways. In Tomkins’ words: “affect either makes good things better or bad things worse by conjointly simulating its activator in its profile of neural firing and by adding a special analogic quality that is intensely rewarding or punishing” (1980, p. 148).

By extending this model of affect, it is possible to understand affective resonance. If an affective expression is an amplified simulation of the original stimulus, then it will tend to evoke more of the same affect in a positive feedback loop, both within the person experiencing the affect and in the observer. For example, the infant’s expressive pattern of distress (including facial expression, vocal cry, and bodily movements) is evoked by a nonoptimal level of stimulation; in turn it produces through amplification a nonoptimal level of stimulation that tends to evoke more distress both in the infant and in the observer. The degree of distress evoked in the observer depends on a number of factors, such as other competing affects, the context and meaning for the observer of the infant’s distress, the degree of responsibility felt by the observer for doing something about the infant’s distress, and the degree of defensiveness of the observer with regard to distress. Wiesendfeld, Malatesta, and DeLoach (1981) report that mothers show more automatic responsibility to their own infants’ distress cries than fathers do, and more than they do to an unfamiliar infant’s distress cry. Hence there is no simple, direct relationship between the intensity and kind of affect expressed by the infant and the intensity and kind of affect evoked in the observer. Nevertheless, because of the amplifying function of affect, and the relatively higher intensity and density of affect expressed by infants, it is likely that a caregiver who is engaged with the infant will experience a variant of the affect expressed by the infant.

Now let us return to the role of affective resonance in empathizing with an infant. It would seem to play a large role. When affective resonance does occur—for instance, when the infant’s distress evokes distress in the caregiver—then the caregiver’s ability to understand the infant’s experience from the infant’s point of view, and to maintain an independent motivational stance, will depend on the caregiver’s response to his (or her) own affective experience at that particular moment. This response may vary in characterological ways, according to defense mechanisms or learned affective sequences (such as distress followed by anger, or excitement followed by shame). It may vary from situation to situation; for instance, what is acceptable in private may not be acceptable in public, or in front of particular people. It may vary from affect to affect, in that distress may be acceptable, but not anger, or vice versa. It may vary from moment to moment, or day to day, depending on mood, fatigue level, cumulative factors, or other competing concerns. The experience of affective resonance thus activates the caregiver’s unique personal history of learning relevant to the affect. These responses evoked within the caregiver complicate the task of perceiving and understanding the infant’s experience from the infant’s point of view, and maintaining an independent motivational stance.

It should be clear that I am not arguing that affective resonance is a necessary element in empathy, only a prominent one. There are many situations in which the caregiver is able to anticipate the infant’s needs before the infant has expressed distress or discomfort, because of their shared history together. In such cases the infant’s behaviors have probably evoked in the caregiver memories of similar situations in the past that eventually led to distress. In the present situation, then, the caregiver can act to avert or prevent a problem without distress itself being evoked in either the infant or in the caregiver.

Types of Infant-Caregiver Exchanges

If we combine our model of the components of affective experience with the various aspects of an empathetic data-gathering process and the subsequent response, a range of possible exchanges between the in-
fant and the caregiver emerges. Stated in the most general terms, a mother can perceive none, some, or all three components of the infant's experience; she can understand the meaning of none, some, or all three components of the infant’s experience; she can decide to respond to none, some, or all three components; and her response can take a variety of forms. Again, my assumption is that each of these possibilities represents a different kind of experience for the child.

I have selected six types of exchanges out of the range of possibilities. Briefly, the six types are: (1) The caregiver accurately perceives and understands the three components of the child's experience and acts so that the child’s positive experiences are prolonged and enhanced, and the child's negative experiences are reduced or brought to an end. (2) The caregiver accurately perceives and understands the three components of the child’s negative experiences and acts so that the child is helped to endure them and master them. (3) The caregiver accurately perceives and understands the three components of the child’s positive experiences but acts so that the child experiences a reduction in positive affect. (4) the caregiver accurately perceives and understands the three components of the child’s negative experience but acts so that the child experiences an increase in negative affect. (This may or may not be done in a hostile manner.) (5) The caregiver misperceives or misunderstands all or some of the three components of the child's experiences and acts according to this misperception or misunderstanding. And (6) the caregiver appears not to perceive the child and acts as if the child were not present.

This ordering might be seen as beginning with an ideal type of exchange and ending with an absence of an exchange. Yet such a view is only partially correct. I would not, for example, argue that type 2 is any less ideal than type 1. Nor is it clear that type 4 is experienced by the child as more empathic than type 5. Furthermore, it should not be assumed that these six types are pure and invariable. A caregiver may begin by responding in a type 1 or type 2 manner and then become derailed by a shift in the child’s affective state, or by a particular behavior produced by the child, and end up responding in a type 4 or 5 manner. Or a caregiver can begin with a type 4 or 5 response, and because of the child's reaction, shift into a type 1 or 2 response. In other words, these types of exchanges do not represent types of caregivers, but rather types of perceptions, inferences, and responses that any caregiver may employ. Moreover, although my primary focus is on the child, and the child's experience of these exchanges, it is not always possible to determine from observation the effect on the child of the different types of exchanges.

A final note of caution is needed: in the following discussion, although I will cite single instances for illustrative purposes, I do not assume that the empathic quality of any single exchange has a determining impact on the child. Nevertheless, each type of exchange does produce a distinctive type of experience for the child, and if such experiences become a chronic characteristic of the infant-mother system, then they will begin to shape the child’s developing sense of self. (See Demos [1984] for a discussion of the relationship between affect and the maintenance of self-esteem.)

**Type 1**

In the ideal paradigm the mother correctly perceives and understands the stimulus, the infant's affective state, and the intention or plan represented in the infant's behaviors; she then responds in a way that communicates her empathy—facilitating or prolonging the infant’s positive states of interest and enjoyment, or trying to reduce and end the infant's negative states of distress, fear, shame, or anger by comforting the infant or removing the offending stimulus. To continue with the earlier example of the interested child who is reaching toward a pair of scissors: in this ideal type of exchange the mother might distract the child from the scissors by presenting another, safer object that evokes the child's interest. She would thereby prevent possible injury, but at the same time facilitate a continuation or prolongation of the child's state of interest and the child's plan to explore an object of interest. For the child, there is the chance to discover that more than one object can be interesting, and to experience having both his state of interest and his plan to explore understood, accepted, and facilitated. Or, to take the classic example of the hungry infant experiencing distress, a mother acting in accordance with our paradigm would correctly perceive and understand the infant's state of distress and its cause, and would soothe and feed the infant. In terms of the infant's experience, a negative state of distress and hunger and the helplessness related to it have been perceived and brought to an end by the mother.

**Type 2**

A variant of type 1 occurs when the mother correctly perceives and understands the infant's negative affective state and the infant's intent, but her response does not prevent or end the negative experience. This may occur in several ways. First of all, there are situations
in the infant’s life that the mother knows are negatively experienced by the infant, but they are unavoidable—for example, an inoculation, a fever, or taking medicine. In such situations, the mother may act to help the infant endure the negative experience, and her efforts may succeed in lowering the intensity of the negative affect, without shortening its duration or removing its cause. On such occasions the infant may experience that pain or discomfort amplified by distress and/or anger is unpleasant but can be tolerated and managed without losing control, and that this negative experience can be shared and understood by an accepting and supportive other. Even when the mother cannot reduce the intensity of a particular negative experience, if, on future occasions, she continues to be there, to remain calm, and to offer support and comfort, the child may, over time, experience her empathy.

In one videotape, for example, a mother is seen bathing her nine-day-old daughter. The infant cries in an intense, angry way throughout the bath. The mother seems to perceive and understand the infant’s experience correctly, for she tries to comfort her daughter with her soothing voice and gentle handling. The infant, however, stops crying only when the mother begins to dress her at the end of the bath. In this case, the intensity of the crying is a product of the particular infant’s temperament (she characteristically showed high-intensity responses) and of the massive increases in stimulation resulting from being naked and thereby released from the more constant stimulation of clothing (a common source of distress in early infancy, according to Wolff [1969]). Thus, even though the mother remains calm and soothing throughout the infant’s state of distress and anger, her actions are not effective in significantly reducing the density of negative affect experienced by her daughter. On this occasion, the child could not experience her mother’s empathy. The immaturity of a nine-day-old infant’s nervous system does not allow her to manage such an increase in stimulation, nor can she yet draw on her memory of past experiences of having been comforted or bathed that would enable her, with her mother’s help, to modulate the intensity of her distress and anger. On subsequent occasions, however, the mother is able to remain calm and soothing, and as the infant’s nervous system matures, and nakedness no longer results in such a massive increase in stimulation, baths do become intensely pleasurable for this child.

Another situation that is very likely to evoke unavoidable negative affect occurs when children attempt to master a task at the limits of their capabilities. At such times children tend to alternate between moments of interest and enjoyment, with the goal to master the task, and moments of distress, anger, and shame, with a wish to give up. There is a fine line between challenge and defeat. In our study, we observed that mothers who took into account all three components of the child’s experience—the task, the child’s alternating affects, and the related alternating goals—might do any or all of the following things. They might actively structure or redefine the task so that the child experienced just the right amount of difficulty. Or they might offer understanding during moments of distress and anger, and encouragement to continue. Or they might offer just enough help in performing the task for the child to succeed and still feel a sense of mastery.

A particularly striking example of this alternating pattern of motivation in the face of a challenge and the mother’s steady support occurred with a ten-month-old infant and his mother. They were involved in a game in which he would throw his blanket over the side of the playpen, she would throw it back in or cover both their heads with it, and he would try to pull it off or pull it over his head. In one four-minute sequence, the child alternated at least 10 times between moments of intense joy and excitement when he succeeded, moments of interest as he concentrated, and moments of distress and anger when he became tangled in the blanket or could not get the blanket to go where he wanted. Over this time period, there was a gradual attenuation of the positive moments, and an increase in the intensity and duration of the negative ones. His mother shared in his enjoyment and excitement, remained intensely involved throughout, and as his distress and anger peaked, she increased her efforts to help him with the blanket and offered soothing words—“What's the matter, won't it do what you want it to?” This child’s capacity to rally and to bounce back each time, after repeated experiences of distress and anger, was impressive. We assume that he, and in general any child that experiences similar exchanges, is learning that the task at hand is doable, and that distress and anger do not signal the end of the exchange or the need to give up. These states are tolerable, manageable—with renewed effort and persistence, one can master the task, and once again experience enjoyment and excitement. If such exchanges occur frequently in a child’s life, a sequence of positive affect—negative affective—positive affect may become established and contribute to a general feeling of optimism and confidence in relation to approaching new tasks.

Another common situation that is likely to evoke unavoidable negative affect, particularly in the second year of life, involves the need to set limits on the child’s activities, or to deny gratification of a particular wish. Often limits can be set without evoking negative affect in the
In this type of exchange, children's perception and understanding of the other child's feelings and thoughts are not always accurate. Children may misinterpret the other child's intentions or feelings, leading to misunderstandings and conflicts. It is important for parents and caregivers to actively listen and communicate with children to help them develop healthy relationships and understanding of others.
negative affects, such as distress or anger, are likely to be added to the sequence.

This same sequence—of a child’s expressions of interest, excitement, and joy ending in shame, distress, and anger—can occur even when the adult initially responds positively and enters into the child’s play. For inevitably the adult “wears out” before the child does. If the adult ends the play too abruptly or with negative and irritated comments, such as “Stop it now!” “You’re getting too silly,” or “I can’t stand the noise any longer,” the child is likely to experience shame.

The observation that grownups tire more quickly than young children of the playful antics and roughhousing typical of early childhood is a common one. And it is generally assumed that the repetitiveness of these games is a large factor in the adult’s loss of interest. Our observations suggest that the high intensity of the child’s excitement and joy is another factor. There is nothing inherently intolerable about intense positive affect; indeed, many children act as if they could go on forever, asking for more and more. Nevertheless, parents often appear to be uncomfortable with such prolonged intensity and try to modulate or tone down the child’s exuberance. Although this can be done gently, and apologetically, it should be noted that the need for modulation is coming from the parent and the parent’s own capacity to tolerate the combination of repetitiveness and intense positive affect. At such times the child does not appear to experience shame, or lack of support, but rather learns how and when to modulate his exuberance. This is an example of the subtle shaping of innate shame, or lack of support, but rather learns how and when to modulate his exuberance.

This type of exchange involves the experience of motivated states of interest—excitement and enjoyment—joy, with the elaboration of plans and fantasies fueled by such positive affect states. Although these states were perceived and understood by parents, they were not enhanced by them, and were sometimes discouraged and curtailed. Presenting such exchanges as a separate type lays stress on the importance of positive affect in its own right, requiring nurturance and support, as opposed to the implicit assumption in much psychiatric writing that in the absence of negative affect, positive affect will flourish unaided. One should also note that a common source of shame in childhood is the sudden attenuation of positive affect.

**Type 4**

In this type of exchange the caregiver again accurately perceives and understands the three components of the child’s experience, but acts in a way that increases the negative aspect of the experience. This may or may not be done with a hostile intent. Earlier, in describing the second type of exchange, I pointed to several situations involving pain, mastery of a difficult task, or disappointment, where the experience of negative affect was unavoidable and the parent helped the child to tolerate and endure the experience. Type 4 differs in that in this case the parent is unable to help the child and instead heightens the intensity of the negative affect.

A type 4 exchange may arise if a mother who is affectively resonating with her child becomes distressed by her child’s distress. She may then become unduly anxious, unable to remain sufficiently calm to offer any comfort or help to the child. In the early months of infancy, for instance, when the infant seems inconsolable for no apparent reason, the parents may become tense and add their own distress and anxiety to that of the infant, thus intensifying the negative experience. Such episodes may end with the exhausted infant falling asleep, or with
the intervention of a more neutral, calm third party, such as a grandparent or family friend. A similar negative spiral may occur when a child becomes seriously ill, suddenly runs a high fever, or falls out of the crib. At such times the mother’s usual comportment may be contamin-
ated by a sudden increase in anxiety, which interferes with her ability to comfort and calm her child. It is assumed that the caregiver accurately perceives and understands all three components of the child’s experience at such times, but that her ability to maintain an independent motivational stance is disrupted by the intensity of her own affective-cognitive response to the situation, which may entail anxiety about her competence as a mother, anxiety about the infant’s survival, or anger toward the infant for evoking distress. Her response is then dominated by her own intense reactions, rather than by the empathic data-gathering process.

A type 4 exchange may also occur when the child is trying to master a difficult task. A typical sequence observed in our study involved an initial supportive exchange between the mother and the infant until, during one of the alternating periods of discouragement or frustration, the infant “acted out” the negative feelings—throwing a puzzle piece on the floor, stamping his feet, or beginning to cry. At this point the mother’s response changed. Whereas at first her responses were dominated by the empathic data-gathering process and facilitated and supported the child’s goals, now her responses became dominated by other factors, such as child-rearing beliefs about “good” and “bad” behaviors, anger at the child, or anxiety about the child’s or her own failure. Her efforts were then directed exclusively toward controlling the child’s “bad” behavior. Negative sanctions were often used, such as scolding, shaming, or withdrawing her participation and leaving the child to fend for himself. The mother’s focus might be on the affect itself (e.g., crying or pouting) or on the related behaviors (e.g., the throwing or kicking), both. For the child, the result was the same: what started as a challenging task ended in failure. The task remained undoable and the strategies and skills needed to master it remained unlearned. Moreover, it was the expression of negative feelings that signaled the end of the task, evoking more negative feelings (e.g., intensified distress, anger, and shame). If these feelings are magnified over a number of similar situations, the child may come to feel isolated and incompetent, unable to trust his ability to manage negative affect.

Another variant of this type of exchange may occur when the caregiver must set limits and disappoint the child. Once again, the parent may begin by accurately perceiving and understanding all three components of the child’s experience, including the wish, the disappoint-
ment, and the effort to cope with the disappointment. But if child expresses distress or anger over the disappointment, the caregiver’s response may then be dominated by an effort to “toughen up” the child (teaching the child to cope by suppressing feelings) or by a demand for unquestioning obedience. These goals often involve berating or shaming the child for any sign of weakness or softness, or punishing the child for failing to comply immediately. For the child, the distress and anger evoked by the disappointment of a wish are compounded and intensified by the shame, distress, and anger evoked by the scolding or punishment, which the child must also suppress. The child’s larger goal of wanting to please the parent is achieved through suppression rather than mastery, thus leaving the child vulnerable to intrusions of unmanageable negative affect.

Parental anger or overt hostility may be added to any of the exchanges just described. When this happens, particularly when the parental anger occurs suddenly, the child is likely to experience fear as well as the other intensified negative affects. Fear will contribute its own toxic quality to the experience and increases the child’s efforts to cope with the situation. In any case, for the child, the type 4 exchanges result in an experience of a positive-negative-negative affective sequence, in which the initial negative experience is intensified by the parental response. In contrast to the positive-negative-positive affective sequence discussed earlier, the effect of this intensified negative sequence is to leave the child feeling either defeated and overwhelmed, or very angry and vengeful. If such experiences are repeated often, magnified over time and in multiple contexts, the child may become increasingly compliant and pessimistic about mastering a variety of situations, thus leading to a constriction of initiative. Or the child may become increasingly defiant, adopting a reactive or oppositional stance that also severely restricts the child’s initiative.

**Type 5**

In this type of exchange the caregiver misperceives or misunderstands all or some of the three components of the child’s experience, and acts according to this misperception or misunderstanding. There are a number of possible combinations and permutations, but I shall focus on only a few that occurred with some frequency in our sample. Perhaps the most common example of this type of exchange arose when the child was engaged in play with toys designed for a particular kind of activity—stacking toys, pull toys, building blocks, balls, etc. Almost all children derive pleasure from using these toys in nonstan-
standard ways, unanticipated by toy designers and parents alike. The child’s goal at such times seems to be to explore the object, to do something interesting with it, or to practice his repertoire of skills on it without concern for proper usage. One kind of misunderstanding occurs when a parent becomes focused on doing the task properly (e.g., stacking the rings in the right order) and essentially discounts the child’s goal or misjudges the child’s capabilities. The parent may then begin to instruct the child in a didactic manner, ask for a level of performance beyond the child’s comprehension and skill, or try to take over the activity when the child “makes a mistake” or “fumbles” in some way.

One way in which this can affect the child was illustrated by a mother and her 15-month-old daughter. Mother and daughter were outside in their yard, with the child playing in the sandbox and the mother nearby in a chair. A neighbor boy had just thrown a ball to the girl in the sandbox. She picked up the ball and “threw” it back. As often happens at this age, the ball dropped about two inches in front of her. Nevertheless, she was delighted with her efforts, smiled broadly at the boy, and clapped her hands. The mother said, “You can’t clap yet; the ball didn’t go out of the sandbox. Try again.” The girl looked a little puzzled, but did try again, with much the same result and the same excitement and joy. The mother again insisted that the girl had not achieved “her” goal. By the third and fourth repetitions of this sequence, the child’s expression had become sober; she was no longer clapping. Indeed, she soon lost all interest in throwing the ball and turned to other objects in the sandbox. From the child’s point of view, joining the game of catch and “throwing” the ball back to the boy probably meant simply moving her arm and letting go of the ball, which was as close as she could come to imitating the boy’s action. Her joyful, excited response clearly indicated that, by her lights, she had succeeded. The mother’s refusal to accept her goal (i.e., to see her efforts as an achievement) and to share in her excitement and joy, instead holding out for a better throw, left the child feeling perplexed and unsupported. Not understanding how she had failed or how to succeed and please her mother, she gave up the task.

A similar type of exchange may occur when the child is involved in relatively unfocused play with a toy. At such times, the child may have no particular goal in mind, or may still be developing an idea about what to do with the toy. A parent, uncomfortable with the child’s apparent lack of a goal, may step in prematurely with suggestions or actions, before the child has had sufficient time to mobilize his own initiative. The child then often becomes a passive observer, or wan-
ing, she would also quickly look away again. This particular pair never
developed the elaborate face-to-face play that is so characteristic of
infant-mother interactions during the infant’s second trimester of life.
Such play, however, did develop between this infant and her father,
and to some extent with her sibling as well. Thus, the pattern of
looking away after a brief exchange was characteristic of this infant
only when she interacted with her mother. This is an example of the
young infant’s impressive ability to discriminate between people, and
to respond differentially to them. One of the things she seems to have
learned from her mother’s misinterpretation of her intense gazing is
that mother does not like to engage in face-to-face play, but father and
brother do.

Type 6

In the last type of exchange to be discussed, the caregiver does not
seem to notice or respond to the child, although the child is present in
the room and may be seeking a response. There are probably degrees
of not noticing, with the most extreme case being a parent who looks
right through a child, or walks right by, as if the child did not exist. We
did not observe this extreme. In our study the most common example
occurred when the mother was conversing with visitors and perhaps
reached down in an absent-minded way to pat her child’s head, but
neither looked at nor addressed the child during a particular segment
of time. It seems that during this time the caregiver does not perceive,
and thus cannot understand or respond to, the three components of
the child’s experience. Presumably the mother has not completely tuned
out the child, but has merely altered her threshold of awareness. An
intense scream or cry from the child would enter her awareness and
redirect her attention, whereas a low-intensity whine or ordinary
contented sounds would not. For the child, however, emitting a particular
set of actions and vocalizations does not result in the usual response
from the mother.

The child’s experience of this event, at any given moment, depends
on the urgency of the child’s wish, the child’s expectations of the moth-
er’s responsiveness derived from their shared history, the attractiveness
of alternative activities that might occupy the child until mother
becomes available again, etc. The children we observed showed a vari-
yety of responses. Some children escalated their demands, becoming
increasingly upset, until the mother finally responded; others, equally
persistent, whined and clung to the mother, but without escalating
this, until the mother responded. In both cases the children focused
exclusively on their mothers; they were unable to focus on anything
else during the period of her unavailability. It seemed that, for these
children, the experience was overwhelming and monopolistic in the
sense that it robbed them of their usual flexibility and prevented them
from drawing on their repertoire of coping strategies.

Other infants, at such times, would fuss for a second or two, wait,
look at mother, go back to whatever they were doing briefly, and then
repeat the whole sequence two or three times until mother responded.
In these cases it looked as if the child fully expected the mother to
respond, even if she had to be reminded a couple of times. Either
because of the strength of this expectation or because of the moderate
level of their needs, these children were able to wait and to maintain a
dual focus, with one eye on their own activities and the other eye on
mother.

Still other children seemed to be able to make themselves a part of
the situation. Although no one was interacting with them or respond-
ing to them, they would respond to the general affective quality of the
exchanges in the room. They might, for example, smile and vocalize as
others talked and laughed around them. Or, if the mother was describ-
ing something the child had done, the child might begin to perform the
activity the mother was describing, or listen intently. One might say
that these children were able to make the most of a meager situation;
they derived some nutrient from the general atmosphere, but at the
same time they seemed to accept their role as observers. That experi-
ence differs from participating in an interaction in which another per-
son responds contingently to one’s behaviors, in which a mutuality is
established and a “conversation” develops. If a child were chronically
placed in the role of observer rather than participant, it seems possible
that the child would gradually come to believe that his own emotions,
plans, and ideas counted for very little.

The Infant as an Accurate Observer

Before concluding, we need to consider briefly the infant’s ability to
accurately perceive and understand the adult’s behavior. Earlier I
stated that the infant is in essentially the same situation as the adult,
in that the infant has to make inferences about the adult’s feelings and
intentions from the adult’s behaviors. How good are infants at inter-
preting adult behavior? It is my impression that this ability is quite
variable within each infant.
Generally speaking, if infants are in a playful, positive state—well-rested, well-fed, and motivated by interest and enjoyment—they do not seem to notice the mother’s “mistakes,” such as bad timing, inattentiveness, rough handling, or impatience. Indeed, at such times it seems as if the mother’s total gestalt is more important as a sustaining source than any particular response or behavior she may produce. (I am assuming, of course, that these off-moments occur in the context of a generally gratifying infant-mother relationship.) It is striking, also, how even overtly hostile actions by siblings, such as a hard push or throwing a ball too hard, are interpreted by the good-natured infant as vigorous, exciting play. The infant seems either not to perceive or to ignore what, to the observer, looks like a clearly hostile act by the sibling.

If, however, infants are fussy, tired, hungry, and generally irritable, then they seem to become much more discerning and demanding partners, containing their irritation only if the mother is well tuned to their state. At such times even little “mistakes” are clearly perceived by the infant, and responded to with protest behaviors.

It is worth noting that, from early on, the infant seems to be capable of resonating to the adult’s affective state. But there is probably a gradual increase with age, due to cognitive, maturational, and experiential factors, in the infant’s ability to perceive and derive meaning from subtle nuances in the parent’s behaviors, or to achieve stable perceptions, independent from the internal state. Although we have looked at observable effects on infants of six types of parent-infant exchanges, it should be remembered that this is not a tightly coupled system. There is some leeway for misperception and slippage on both sides.

Conclusion

I have presented a conceptual framework that assigns a central position to affect. It specifies the components of both the affective experience and the empathic data-gathering process, while insisting that the parent’s actual responses to the child are multiply determined and may or may not be influenced by the empathic process. In part this view represents a reaction against the overuse of the term “empathy,” which, at an extreme, reduces all interactions to two broad categories—empathic or nonempathic—and blurs our understanding of the phenomenon. Yet this view also arises directly from observation of the complex transactions between parents and infants, in particular from the attempt to articulate subtle differences in the infant’s experience that seemed to be present.

I have maintained that when the different combinations of parental perceptions, understandings, and actions toward the child are combined with the three components of the child’s positive and negative affective states, they will produce a range of different experiential consequences for the child. On the basis of observational data, I have described the contemporaneous effects of at least six types of exchanges. Yet we need to go further. The conceptualization of affect and empathy presented here should help us to understand how a child comes to structure exchanges with the parent over time, and to begin to recognize the different types of character that may evolve out of different types of structured experiences. It should also help us to intervene more effectively with parents and children, by providing another way to understand the types of dysfunctions in the parent-child relationship.

REFERENCES


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A general view of human existence reveals fundamental, recurrent patterns similar to those exhibited by all life forms. As infants, we are born into a given society and culture which has its own history, extending into an immense past. Many histories are intertwined. We grow, learning the language and the ways of our society, working, achieving, and surviving, as events permit, in relation to the vicissitudes faced by our society in our time. We establish a career, marry, and have children of our own. We age and die, and the pattern repeats, age after age. Societal forms emerge, involving the use of language and reason in the task of living life; sustaining traditions develop. The world and the society into which we are born existed prior to our birth and will continue to exist after our death. We are born into and take on the language of that culture and its ways—we become what it is and in turn it is expressed through us and other humans like us. We cannot exist without it, nor it without us. Our inner being reflects our experience during these processes.

Communication and empathy are fundamental to human life. As an aspect of existence, they are prior to individual interactions. Such exchange or sharing is primary. Helen Keller, lacking sight and hearing, could still learn to communicate meaningfully through touch as the vehicle of thought. We inhabit a realm of being that has communicational structure. Thinking, walking, and communicating are all real activities involving interaction in the world of time and space. They all operate in connection with the rest of things and imply linked, interpenetrating reciprocities. We are not considering an agent that com-