Empathy—The Indispensable Ingredient in the Impossible Profession

David Kitron

"Poetry is what gets lost in translation" (Robert Frost)

"Poetry is what is gained in translation" (Joseph Brodsky)

Salman Rushdie (2009), in his article on film adaptations of novels, argues that the question of essence remains at the heart of the adaptive act. He believes that "As individuals, as communities, as nations, we are the constant adapters of ourselves, and must constantly ask ourselves the question...what are the things we cannot ever give up unless we wish to cease to be ourselves?" (p. 11). Rushdie defines adaptation broadly, as a general term that includes translation, migration, and metamorphosis, "all the things by which one thing becomes another" (p. 3). I think we could add psychotherapy to this list. A basic ingredient in Rushdie’s recipe for adaptation, very much like psychotherapy, is its being practiced by persons who understand and care for both the old and the new, "who can help the thing adapted to bridge the gulf and shine again in a different light" (p. 2). In therapy, however, the dearest thing is at stake, the essence of one’s very selfhood. According to Winnicott (1963), this very essence, the core of one’s true self, faces a fatal threat when it ceases to remain uncommunicado. When we ask patients to expose their innermost experience to us, empathy becomes the indispensable ingredient that enables the true self to be safeguarded. And if, according to Winnicott (1963), the therapist–patient environment, like the mother–infant environment, is to be facilitative and not impinging, then empathy means surrendering, in Ghent’s (1990) terms, but not submitting the therapist’s own subjectivity in favor of the patient’s subjectivity.

If the patient’s inner core is respected, psychotherapy, like translation, is freed of the dictum "translator equals traitor," and ceases to be a reductive, restrictive endeavor. Then we can adopt (or adapt) Paul Ricoeur’s (2004) notion of linguistic hospitality, an approach that, both in principle and in practice, does not aspire for universality, but accepts the other individual’s unique essence. This approach respects the fact that no absolute, perfect translation can ever be attainable. The analogy to empathy and its asymptotic character of getting closer, but never reaching, the absolute, as described by Kohut (1981b), is easy to draw. Like translation, like empathy, all the mediator (therapist/translator) can do is offer his roof and do his best as a benevolent host to the object. Neither translation nor empathic understanding can aspire to be identical to the original (language/subjective mind) but both can do their best to offer themselves as successful adaptations.

According to Ricoeur (2004), renouncing the illusion of the perfect translation carries with it the acceptance of the unbridgeable gap between the self and the other. We can draw the parallel

David Kitron is a supervising clinical psychologist, teaches and supervises at the Tel-Aviv University Program of Psychotherapy, works as scientific editor for Bookworm publishing house, and is in private practice.
between the never perfect translation and the never perfect self-object: in both the imperfection remains, even after the narrowing of the gap. Symbolically, the transition from self-object to selfobject demonstrates this narrowing. The selfobject as such, even with no hyphen, even if experienced as a part of me, solely serving me and my self and—voluntarily or involuntarily—completely denied of its own subjectivity, even when intersubjective recognition plays no apparent role whatsoever, always remains also an object, never quite one’s self, always someone other than me. But Brodsky reminds us that “Poetry is what is gained by translation.” In this reading, Kohut’s (1977) optimal frustration and Winnicott’s (1963) good-enough mothering are not technical precepts, but the forever remaining, existential gap that should not be abolished. Had the selfobject been perfect, wholly and totally merged with the subject/fused with the subject/lost within the subject, it would not—it could not—have been optimal, productive, or growth-promoting.

Ricoeur (2004) further argues that successful translation has to lead the reader to the author and lead the author to the reader. Thus, it has, at one and the same time, to serve and to betray these two masters. In that sense, being empathic means leading the patient as reader to the patient as author, reauthorizing and reappropriating his selfhood. At the same time, it also means leading the patient as author to the patient as reader, so as to help the patient to understand himself, to accept himself. In extreme cases, we must even help the patient to reclaim and reappropriate his conflated self. The therapist attempts to do this by use of his empathic transactions with, translations, and adaptations of the patient’s narratives.

“Poetry is what is gained in translation” also in a more radical sense, when dealing with empathetic attunement: Ghent (2001) speaks of recognition of needs, even prior to their exploration, as constitutive. He declares that, “the newly recognized need has been created out of the materials of buried stuff” (Ghent, 2001, p. 24, italics in original). This argues that an ecological shift in the person’s “forest of needs” has occurred, and this shift will now have consequences not only for the internal relations among the many other needs, but also for the external relations with the need systems of other human beings. This statement is radical in more than one respect. First of all, in respect to the curative, transformational force of empathy in itself; and second, in respect to the psychoanalytic quest altogether. As is discussed later on, the psychoanalytic mission aspires for much more than the modest removal of projections and repressions and aims at the healing, the resurrection, the broadening of the self, achieved by that which is added.

So, although, on the one hand, empathy, due to its asymptotic nature, as outlined by Kohut (1981b), has its limits and limitations, on the other hand it is a most potent, forceful, and productive tool. It was recognized as such more and more by Kohut (1981b) himself, during his lifetime, and continues to be given a growing central therapeutic position by his followers.

But empathy is also the actualization and the expression of a reciprocal and mutually interactive bond: Winnicott (1970) tells us that, “A sign of health in the mind is the ability of one individual to enter imaginatively and accurately into the thoughts and feelings and hopes and fears of another person; also to allow the other to do the same to us…” (p. 117). This reciprocal accessibility is missing in those cases that Winnicott (1986), though he does not use the word empathy, describes as boring: “If a person comes to you and, listening to him, you feel he is boring you, then he is sick, and needs psychiatric treatment. But if he sustains your interest, no matter how grave his distress or conflict, then you can help him alright” (p. 1, italics in original). Masud Khan (1986), elaborating on this quote, suggests that even boring patients present both demands and hopeful-
ness. I would expand that elaboration to include a demand and hopefulness in respect to empathic listening and understanding.

This brings me to the issue of cure and the question how analysis cures. As we know, Kohut (1981a, b, 1984), on the one hand, was quite outspoken, explicitly claiming that there is no such thing as a cure through love. Quite the opposite, he remained within orthodox limits in his formulations of cure as the two-step process, commencing with empathic understanding, but fully complete only when joined with genetic-interpretive explaining. The application of these two steps to nontraumatic empathic failures leads, via the accumulative process of transmuting internalization, to structuralization of psychological capacity originally provided by the selfobject. Despite this, Kohut’s (1959) seminal paper on empathy, written 50 years ago, was revisited and brought to completion, not just symbolically, but concretely, in his last lecture, four days prior to his death.

Once again, Kohut (1981b) drew a clear line between empathy and sympathy, reiterating the very specific meaning he attaches to the word empathy and to its definition as vicarious introspection. Nevertheless, Kohut (1984) declared, quite straightforwardly, that empathy, as a basic human need and characteristic, has curative qualities in itself. The same idea is expressed in a second paper, also written near to his death (1981a), embodying accumulative, conclusive formulations, and carrying the flavor of a legacy. I shall return to this important issue later in this article.

My personal belief is that in our postmodern, multifaceted world, we do not need to look anymore for one positive answer. We do not have to look anymore for the one true self, as argued by Mitchell (1993), Phillips (1997), and others, but can tolerate the plausibility of various selves, either cohabiting or rotating. Similarly, we do not have to look anymore for the one curative factor, the one ultimate answer to the one question: how analysis cures. The curative matrix is complex and multidetermined (Kitron, 2003a). This complexity represents a synthesis of many ingredients: a background of safety (Sandler, 1960) or a secure base (Bowlby, 1988) to which empathy, real relationship, and the therapeutic alliance serve as a bedrock; nontraumatic empathic failures; repetition-compulsion as a productive process which opens the road for new, corrective beginnings (Kitron, 2003b); the Bionian containing and the Winnicottian holding, enabling regression to the area of the basic fault (Balint, 1968). To these, I would add the nonsubmitive surrender of the therapist to the patient’s subjective experience (Ghent, 1990; Lenoff, 1998; Kitron, 2005). Those and other ingredients are interrelated, forming a gestalt bigger than its constituting parts.

And yet, everything starts with empathy and stands on empathy. Empathy plays a leading role as an indispensable ingredient, a preliminary condition without which the secure base, like the therapeutic alliance, is rendered unattainable and the repair of nontraumatic empathic failure, along with the emotionally significant insight, is rendered irrelevant.

I shall attempt to demonstrate this line of thought by the use of an anecdote of a 5-year-old child and her mother, as an example of natural, maternal empathy (see Kitron, 2003a): The 5-year-old girl had to wait too long a time for her mother—too long subjectively, of course, in the sense that she became rather anxious. Due to a misunderstanding, either the mother came to fetch her from kindergarten at the wrong time, or the girl waited at the wrong place. When the mother finally arrived, and after the happy reunion, the child—while sitting on the mother’s lap—told her with great excitement the whole story about how she had had to wait and wait until her mother finally showed up.

She recounted how she looked for her mother, and how she could not find her, and how worried she got, and how awful the waiting was. And yet, even after the whole story had been told in detail, the child still was not satisfied or relaxed, and seemed to be far from ready to rest her case. The
mother, sensing as much, simply, but with well-attuned empathy, said to the child: “Now tell me everything once again.”

At the end of the day, it was this empathic invitation to retell the distressing train of events that enabled the girl to be relieved of her anguish. In other words, the secure base and the parent–child alliance were restored by the high-level empathic intervention of the mother, who acknowledged the impact of the experience. The disruption, caused by the mother’s not being on time to pick up the girl, could be worked through only via the retelling of the story and the mother listening non-defensively to the child’s narrative. Not only did the mother enable the child to give voice to her dismay, thereby acknowledging her experience, but she also satisfied her need for what Wolf (1988) defines as an efficacy selfobject experience. (The self’s subjective experience of agency in influencing the object.)

Another moving anecdote has caught my eye when reading Ariel Hirschfeld’s (2006) book, Notes on Epiphany. The impingement had been caused in that case by a father who severely reprimanded his 5-year-old child when the little boy ran away from kindergarten and stayed away long enough to cause his parents quite a bit of worry and distress. When the boy finally got back, his father scolded him, saying, “In a low, grave voice ... the most terrible of all: ‘I am astonished by you’ and adding further, ‘I am angry with you.’” In his hurt and humiliation, the little boy reacted to his father harsh words by telling him, “You are not my daddy anymore.”

At first, the father responded intuitively from a realistic perspective, refuting the objectively absurd statement by saying, “That is impossible, I shall always be your daddy.” But the child, tearfully, and bitterly, insisted, “You shall always be a daddy, but not mine. You being my daddy—that is for me to decide. And I declare that you are not my dad. ... I am the one to decide on that; and I shall inform the city council as much.”

The father then set to repair the disruption. He offered his empathic acceptance of the boy’s statement as an expression of his deadly hurt feelings. Then he took the next step by both acknowledging and responding to an efficacy selfobject need: He simply said to the boy, “That is right; you are the one to decide on that.” And then, directing his gaze to the child, offering once more his hand to him, he added, “Maybe you will let me be your daddy just a little more?!” According to the boy’s own description, now as a grownup man, these words reached to the child’s innermost feelings and “silently, with tears choking my throat, I gave him my hand and we entered the house together” (Hirschfeld, 2006, pp. 102–103).

This extraordinary bit of empathy from the father’s part is remarkable because of the degree of humility it required on his part: He showed himself capable of putting aside completely the fact that, after all, his prior scolding of the child had been “justified,” from an “objective” point of view. But, in the repair of the disruption, what really mattered was his son’s point of view—his subjectivity—above anything else. In this case, the five-year-old apparently felt grieved, insulted, unbearably humiliated, and maybe even betrayed by his beloved father. And that, i.e., the crucial, and even exclusive, importance of the subject’s point of view is, in my eyes, perhaps the most important contribution of self psychology to psychoanalysis. This represents a theoretical contribution whose practical implications are embedded in the empathic stance.

Furthermore, I believe that one more important ingredient, a specific and extreme variant of empathy, is relevant to this episode. And that is what I call the unacknowledged knowledge and the need for a sanity-confirming selfobject (Kitron, 2005). This is the need to have one’s subjective perception of reality, including affective, sensory, and even physical reality, confirmed. In this specific case, the little boy required his father to confirm a very idiosyncratic subjective reality, ac-
EMPATHY, THE INDISPENSABLE INGREDIENT

me
dad
ged
up
ing
to
of
y in

ok,
ri-
ng
fa-
ou'
his
ely
ar-
hat
id I

y's
y-
ous
his
the
et-

of
of

rd
ex-
vus
E-

cording to which only a child has the right to decide upon his father's parenthood. I have demonstrated in the relevant paper, via clinical vignettes, how deep this need can be and how devastating its frustration.

A most forceful and famous example of the centrality of the need for a sanity confirming selfobject can be found in Margaret Little's (1990) account of her personal life history and of her analysis with Winnicott, after two previous failed analyses. I believe that Little's candid, valiant and moving story could be renamed: "The True Self Odyssey: Between the Scylla of Enslavement and the Charybdis of Depression." Winnicott's devotion, empathy, and courage enabled him to help Little in her desolate need to find and be found in the sense of her true self. Little's regression to dependence was, in her case, a precondition to the undoing of the false self's enslavement (masochistic submission, see Ghent, 1990) to her mother's selfobject needs. Specifically, Little's unacknowledged knowledge (Kitron, 2005)—the deprived acknowledgement of her inner, subjective experience, ridiculed, refuted, and distorted by her mother—had been a source of unbearable distress. Such a dire impingement carries with it the disastrous effect of doubting one's own subjective reality, in other words, doubting one's sanity. Healing this estrangement from one's separate subjective psychological matrix, essentially from one's selfhood, can be accomplished only through the reappropriation of those essential parts of the self. This restoration of the self is achieved when the patient receives confirmation, in terms of empathic mirroring, of her legitimate, individual perceptions and apperceptions. Such a confirmation made it possible for Little to undo the confusing, contradictory, sanity-distorting messages imposed on her by her mother.

Winnicott (1967) refers to an impinging mother, unresponsive to her infant and to her need to be provided with the mirror function, without which a sense of self cannot crystallize. Kohut (1981b), addressing the same developmental issue, speaks of an infant deprived of empathy as denied of psychological oxygen. He describes how such a denial is experienced as the confiscation of the infant's existence as a subject in himself. Instead, the infant is treated as an object, or—making use of Freud's (1914) expression in his seminal article on narcissism—as a pseudopodia, as an extension of the parental image. We could also refer to distorted empathy, manipulative empathy, or, in less malignant cases, to partial, insufficient empathy. In each variation, the only reality acknowledged by the parent is the one representing the parent's subjective reality. The caretaker enforces the parental view, the developmentally destructive insistence on knowing better than the child what the child actually feels. Once again, Margaret Little (1990) gives us very vivid and horrifying examples of such impingements. Along with Kohut (1977), other analysts have encountered this syndrome and chosen their own terminology to describe it. Ogden (1989) refers to "mismapping" and "misrecognition" of the child's feelings. Bowlby (1988), in a chapter titled "On knowing what you are not supposed to know and feeling what you are not supposed to feel" (p. 99), speaks of thoughts and feelings that are disconfirmed.

In such cases, the clinical provision of empathy is an ethical imperative. Despite this, we should keep in mind that empathy could also be experienced as dangerously trespassing on the privacy of a patient who does not yet feel safe in exposing his or her true self, or chooses not to expose its most parloined parts. In some cases, or at some moments, patients do not desire the explicit articulation of our empathic understanding. And it is our ethical duty to respect, in these cases, the explicit or implicit communication of that patient's need to be left to themselves, to be let be, to be undisturbed, so to speak.

Margaret Little (1990), in her moment of utter despair in the analysis, doubted whether she could "ever get Winnicott to understand anything" (p. 43). This can be reframed as her desperate
seeking of Winnicott’s empathic understanding; of his confirmation of her subjective experience. Little required the acknowledgment of her own sanity; a declaration of the independence of her psychological matrix, to enable her to retrieve her true self.

In such extreme cases, the therapist, in order to remain empathic, has to surrender, at least temporarily, to the patient’s subjective experience, in the sense of the complete suspension of his own subjectivity. This stance enables Winnicottian object-relating when even object-usage is not yet possible. This is empathy taken to its limit, the metaphorical removing of the hyphen of the self(-)object from between the self and its object. Kohut (1984), in his writing, continued to define empathy as an observational technique, serving to inform appropriate analytic intervention. Yet these cases demonstrate how, as Kohut (1981a, b) himself came to recognize, empathy is an indispensible therapeutic ingredient for the patient.

When the therapist is immersed in such an either/or interaction, there is no room for an intersubjective/relational meeting of minds, because only one subjectivity—that of the patient—is allowed to be recognized. This clinical situation explains Kohut’s (1984) postulate regarding the relativity of psycho-diagnosis in accordance to empathic attunement. It also bears relevance to Semrad’s (1980) famous remark, “And so often, when you get to know your patients they lose their diagnosis, you know” (p. 76). Being completely empathic to a patient’s subjective experience would mean setting aside any perspective of objective evaluation.

Of course, we do also have to keep in mind that, for the therapist, the demand to be empathic to such an extent takes its toll: Stepping aside by suspending one’s subjectivity is no trifling matter and requires a continuous, intense effort. Georges Simenon (1955), the famous (and very productive) French writer, is known to have said in an interview that having to enter into the mind of the main character of his books is such a demanding emotional and physical effort that he has to keep his novels short: “I don’t see anybody, I don’t speak to anybody, I don’t take a phone call. I just live like a monk. All the day I am one of my characters. I feel what he feels… in this character’s skin I have to be. And it’s almost unbearable after five or six days. After eleven days I can’t—it’s impossible… It’s physical. I am too tired” (p. 11, italics added).

In a sense, I am arguing for a dialectic juxtaposition of two natural tendencies. On the one hand, there is a tendency and an ethical, human striving toward an empathic stand. On the other hand, there is an opposite tendency toward clinging exclusively to one’s own subjective perspective and shunning of any different point of view. Such a different view may be experienced as competing with one’s own subjective view and as posing a threat or as demanding too great an effort.

The empathic, self-surrendering stand is beautifully expressed by the Italian writer Ari De Luca (2003), in his book The Contrary of One (Il Contrario di Uno). In the book, which is dedicated to mothers “because being a twosome begins with them,” the heroine (a girl) turns to the hero (a boy) with the simple but moving question: “Wouldn’t you like to be an object [or rather—self(object)] for someone once?” (p. 36). The self-protective stand is forcefully expressed in another book, entitled And This Is the Light, by the late Israeli poet and writer Lea Goldberg (2005): Goldberg renders a vivid description of the difficulties involved in noticing, not to speak of experiencing, the object—our fellow human being—as he is, and concludes by stating that, “And so we are living most of the time, at people and not with them” (p. 146, italics added).

Within a very different frame of reference, following the footsteps of Coltart (1993, 1996) and others, I would like to join the well-known trend of drawing analogies between Buddhist compassion and the psychotherapeutic stand. It is quite intriguing to dwell into the name given to the Buddha of compassion—Chanrezig—chan meaning the eye, re meaning the eye’s angle and zig mean-
ing to see. With all three ingredients taken together, the name means that, with the compassionate
eye, Chanrezig sees the needs of all beings. I believe that empathy, like Buddhist compassion, also
requires continuous effort, continuous discipline, and continuous exercise. More than this, taken
to the extreme, empathy—in the sense of setting aside one's subjectivity—can be compared to the
Buddhist aspiration of giving up one's ego.

I would argue that, all taken into consideration, it does justice neither to its difficult and de-
manding qualities nor to its ethical and moral role to define empathy as nothing more than a means
of gathering data, from the therapist's side. Manifesting empathy is at one and the same time a na-
tural need—as much as the receiving of empathy (though not always welcome)—and a strenuous,
disciplined effort.

Becoming attuned to our fellow men is a derivative of parental attunement to our infants.
This is both a natural tendency and an enormously demanding endeavor. Following Bowlby
(1988), we can argue for empathy as an ethologically based, natural component of the recipro-
cal parent-child bond. As such, it is a bare necessity for the thriving receiver, but also innately
rewarding for the donator. Notably, Winnicott (1967, 1986) regarded it as a sign of health from
both sides. In technical terms, empathy, beyond its applications in the realm of the transfer-
ence-countertransference matrix, is closely linked both to the therapeutic alliance and to the
real relationship.

Recognition of the moral consequences of empathy dates back as far as the biblical command:
"The stranger who sojourns with you shall be as a native from among you, and you shall love him
as yourself" (Leviticus, Ch. 19). This injunction can be translated into the demand to extend empa-
thy beyond people who resemble us to people different from us and unfamiliar to us. In order to be
able to surrender to this command/demand/heedquest, some of Kohut's followers have taken his
legacy further than he advised. (My personal belief is that Kohut would have been empathic with
such developments!) Geist (2007), for example, argues that the oscillating between experi-
ence-near, "understanding," and experience-distant "explaining," implies the danger of overshad-
owing empathic intuition by intellectually based theoretical assumptions (p. 17). He calls for sus-
tained, exclusive, empathic immersion throughout the understanding phase, to enable us
therapists to respond correctly to the patient, each unfolding moment.

Once again, our main therapeutic effort, I would argue, is toward establishing empathic
attunement, seeking the patient's unique, subjective perspective. For the sake of illustration, I shall
briefly present two therapeutic vignettes:

---

A patient, in his fourth year of psychoanalytic psychotherapy, has just started a new, highly
demanding job. The transition from his prior freelance position has been very difficult for him. In his
helpless frustration, he expressed his complaints in terms of having lost his liberty and being de-
prived of any free time and flexibility like being shut in a prison. On top of it all, he had to deal
with a "slave-driver," bullying boss. The whole situation was experienced as agonizing and as a
misfortune that the patient was neither prepared nor equipped to master. In the sessions, I have
noticed that, uncharacteristically for him, in describing his sufferings, he has repeatedly made refer-
ence to my own life and work. In drawing these parallels, he is seeking to make me understand
what he was going through. For example, he asked me rhetorically how I would feel if I had to
leave my comfortable consulting room and return to a grim office building, doing dreary work under an uncomprehending superior. In a different context, he also told me how he would like me to think of him not the way a psychologist thinks of his patient, but the way a concerned uncle would have thought of his nephew. We have arrived at the understanding that these highly charged exclamations expressed his distress and his urgent need to make me share his experience, and to mobilize my understanding, my compassion, and my concern.

Later on, he complained bitterly about his father, who told him that if he suffered so badly, then he had better quit the job. But this included a remark—in line with other references that expressed his father’s view of the patient as spoilt and as complaining—that other people “had even been through the holocaust!” I have come to understand that the necessary acknowledging of the confusing, double message of his father, which he legitimately experienced as a double message, was not enough. I had to go further and, as much as it may sound as a sacrilege, to declare explicitly that for him (i.e., from his subjective perspective) the experience was a personal holocaust.

In order not only to refer to his struggle in such language, but to actually mean what I was saying, I had to go to the extreme in my efforts to immerse myself in his experience. I had to suspend any critical, so-called objective, along with my own personal subjective, view. Thus, it called for the utmost effort of empathy and of attunement. Once uttered, my recognition of his experience, in his own language, had an immediate soothing effect. The patient responded by telling me, “I am glad you have said that.” I believe that my empathic response, while legitimizing his feelings, also enabled the patient, somewhat paradoxically, to tolerate his job a bit longer and to refrain from acting impulsively and leaving the job, until he found a better alternative.

---

A middle-aged patient started psychotherapy due to difficulties in his relations with his children. From the very beginning of the therapeutic encounter, the differences in our personal backgrounds were quite apparent to both of us. The patient had been raised in an orthodox religious family, was dressed accordingly, and could not fail to notice that I did not belong to the same milieu. He made, in some passing comment, reference to his right-wing, conservative political opinions. From the manner he expressed this, even without saying as much explicitly, he let on that he guessed, correctly, that my views contradicted his.

Notwithstanding this accurate, if implicit, perception of our differences, during one of the sessions, however, he expressed strong feelings regarding a certain politician, who represented in his eyes all that he despised and all that was opposed to his own values and beliefs. He described to me vividly how he did his best to educate his own children in line with an ideology as distant as possible from that of this specific politician and of his party in general.

I have felt his urging me to agree with him, to accept his views—by seeing things from his perspective—and appreciating his educational efforts with regard to his children. Nothing more had been demanded from me but silent empathy, expressed by nodding in understanding while listening to his preaching. All the same, my experience has been one of discomfort and strain. My distress derived from the pressure I felt, to suspend my own very different views in order to manifest my respect for his. (This brings to mind Voltaire’s famous idiom about the sacredness of freedom of expression!)

---

I believe that ethical, as well as therapeutic, empathy is involved (Lindner, 1973). I told him from my own subjective experience, that, at times, when we are so deeply involved in a case, we can lose our objectivity; that in such cases, empathic posture may be therapeutic as well as subjective. Empathy can be the basis for a therapeutic relationship. If a patient wants to be understood, the therapist must be able to empathize with him and believe he has a legitimate reason for thinking the way he does.

Empathy can also be a way of providing feedback. It is a way of letting the patient know that you understand what he is saying, and that you are paying attention. It can also be a way of helping the patient feel more comfortable in the therapist’s office, and of making him feel that you care about him. In short, empathy can be a powerful tool in the therapist’s arsenal.
I believe that this vignette can also demonstrate the gulf between the empathic stance, from an ethical, as well as a clinical, point of view, and the more orthodox, classical approach, demonstrated by Robert Lindner (1955). Writing in the 1950s about a patient who belonged to the Communist Party, Lindner describes with pride how his ethical understanding of his role as psychoanalyst involved the exposing (or rather the ferreting out) of his patient's "underlying motives" (Lindner, 1955). Lindner set out specifically to break down his patient's beliefs, and "liberate" him from his communist ideology. In this effort, Lindner was actually acting under the direction of his own subjective, political agenda.

I argue that such an undertaking is quite the opposite of empathic attunement; empathy requires us, as therapists (and not only as therapists) to respect and, furthermore, to do our best to achieve, understanding of our patients' values, beliefs, and ideologies, even when very different from our own or when very unfamiliar and strange to us. If we are incapable of doing that—and it is only natural and legitimate that each and every one of us does have his own personal limits—then we cannot create an empathic bond. Without this bond, neither a secure base nor a therapeutic alliance will be established. Our ethics and our personal integrity would require us, in such cases, to refer the patient to somebody else, who might be capable of establishing an empathic linkage with him, rather than attempt to convert the patient in line with his or her own personal weltanschauung.

Returning to my right-wing orthodox patient, I have not felt, in his case, a basic threat to the extent of being incapable of suspending my point of view and maintaining an empathic understanding with his. From his side, my patient's trust in my nonjudgmental empathic approach has enabled him to express his ideas and beliefs freely and without inhibitions. Clinically and ethically, I believe he should have this freedom, even when we are both aware of our different backgrounds and the likelihood (if not certainty) of different outlooks.

Empathy, then, is a life-saving, or rather a mind-saving, experience for the patient. I suggest the paraphrase: "I receive empathy, i.e., acknowledgement/recognition/understanding; therefore, I exist." Empathy is also an ethical quest, and paraphrasing the Bible, I would argue: "Thou shall be as empathic to thy fellow man as to thyself." Ecclesiastes may pessimistically make the statement, "That which is crooked cannot be made straight, and that which is wanting cannot be numbered" (Ch. 1.15). But we could heretically beg to differ. Kohut opposed Freud's pessimism and, along with contributors such as Winnicott (1986) and Balint (1968), he believed that psychoanalysis can provide and mend and heal.

Tracking his three major monographs, Kohut (1971, 1977, 1984) began by believing that analysis can analyze, came to the conclusion that analysis can not only restore the self but actually cure the self. If so, then we can conceive of therapy as terminable rather than interminable. We can view therapy as operating per via di porre (by adding or putting something in) and not per via di levare (by chiseling away or taking something off) by optimal environmental provision with the capacity to rehabilitate the self and undo the scars left by early impingements. For Kohut, empathy forms the basic tool serving these purposes, and the empathic therapist acts not as an opaque, neutral, abstinence mirror, but as an active, available, involved, and acknowledging one. (Needless to say, Freud himself is known to have acted that way in practice!) Therapy provides a responsive mirror, attuned to the distress of the deprived tragic man.

It could be argued that this new vision of psychoanalysis implies a complete transformation of its essence and of the analyst's quest. Such a transformation bears radical implications from various vantage points—ontological, epistemological, as well as practical. Interpretations, directed at
removing guilty man’s projections and repressions, are no longer the aim of therapeutic interaction. Quite the other way round, the aim of therapeutic interaction is to enable empathic understanding (Kohut, 1984); interpretations are a tool by which to convey empathy. Such interpretations include recognition of the limitations of empathy which, when acknowledged, lead to productive exploration of nontraumatic empathic failures. Translating the terminology, but retaining (or adding to, per Brodsky) the essential meaning: Therapeutic interaction is the crucial component of facilitative environmental holding (Winnicott, 1960), of containing (Bion, 1963), and, lately added, of reclamation (Alvarez, 1992).

The importance of empathy in psychoanalysis is gaining an ever-growing place after Kohut, and this could be regarded as his successful legacy. The continuous progress of the basic postulates of self psychology could be characterized as progress in the study of empathy and its applications. Our main therapeutic effort is conceived in terms of empathic attunement above anything else, seeking to perceive and apperceive the patient’s unique, subjective perspective.

And more than anything else, the therapeutic effort is itself a natural human striving. Empathy is best seen as a two-sided coin of needs: on the one side there is the need, nearly always, to receive empathy and on the other side—as difficult and as demanding as it sometimes is—there is the need, even the destiny, to give empathy.

REFERENCES


Goldberg, L. (2005), And This Is the Light. Tel-Aviv: Hasifiya Hachadasha (Hebrew).


3. Hata, Sofer St.

Tel-Aviv 62482, Israel
dikirom@012.net.il