The self psychologically informed response to the question of how psychoanalytic treatment leads to a cure—a question to which, since it involves consideration of the whole personality of the patient and his psychic functions, there is no simple answer—can be condensed into this formulation: The psychoanalytic situation sets into motion a process which, via the optimal frustrations to which the analyst exposes the patient through more or less accurate and timely interpretations, leads to the transmuting internalization of the selfobject analyst and his functions and thus to the acquisition of psychic structure. But what exactly is the role of empathy in this process? Specifically, we must ask two interrelated questions that have not been systematically addressed to this point: (1) Is the empathy of the psychoanalytic self psychologist in essence different from the empathy employed by analysts before the advent of self psychology? (2) Do we achieve a cure via a novel kind of empathy? In the following, I will attempt to explain why my answers to both these questions are in principle in the negative.

I know that a number of my self psychological colleagues will not agree with my negative answer to the question of whether the self psychologist’s empathy is different from the empathy employed by analysts before self psychology came into existence. They will assert—and I not only understand their propensity to adopt this view but share it up to a point—that the empathy of the self psychologist is qualitatively different from the empathy at the disposal of his analytic predecessors. Specifically, they will make the claim that, with the advent of self psychology, the analyst is able for the first time to be empathic not only with the patient’s transference experience of the analyst as a target of love and hate, but also with the patient’s transference experience of him as a selfobject. Thus, through self psychology, the analyst acquires the ability to be empathic with the patient’s inner experience of himself as part of the analyst or of the analyst as part of himself. These colleagues will further claim that in the clinical practice of psychoanalytic self psychology, in contrast to the clinical practice of traditional psychoanalysis, the analyst truly grasps the patient’s perception of his psychic reality and accepts it as valid. This is tantamount to saying that the self psychologist does not confront the patient with an “objective” reality that is supposedly more “real” than his inner reality, but rather confirms the validity and legitimacy of the patient’s own perception of reality, however contrary it might be to the accepted view of reality held by most adults and by society at large.

Before I spell out my reasons for questioning the adequacy of this overall judgment, I would like to comment on a specific issue that is related to the self psychological perspective on empathy: what is our estimation of the role of confrontation in the psychoanalytic process? Here, I would give voice to the opinion that the “confrontations” to which analysts expose their analysands not only are often trite, superfluous, and experienced as patronizing by the patient, but also may repeat the essential trauma of childhood in a way that is especially harmful to the progress of the analysis. By failing to acknowledge the validity and legitimacy of the patient’s demands for development-enhancing selfobject responses, that is, the analyst fails the patient in the same way the parent had failed—often the more responsive parent to whom the child hopefully turned after the parent whose responses were even more flat, more severely distorted, and the like had failed him. That it may occasionally be helpful to an analysand, especially in the later phases of analysis, to hear from the analyst that old grievances, however valid and legitimate, must finally be relinquished, and that new and more responsive selfobjects must be sought in the present, goes without saying. On the basis of my clinical experience, however, including data gathered both from the period when I had not adopted my present stance and from present consultative work, I have come to the conclusion that confrontations should be used sparingly. They may shock the patient and momentarily enhance the analyst’s self-esteem when he sees the patient taken by surprise, but they provide nothing that is not already provided by the realities of adult life. It is not the task of the analyst to educate the patient via confrontations but, via the consistent interpretation of the selfobject transferences, to cure the defect in his self. As the working-through processes
concerning the psychic reality of childhood near completion during the late stages of analysis, then, the patient, in consequence of the new psychic structures that have gradually been acquired over the years of treatment, will be able to learn the lessons of realism from life itself.

But turning away from the narrow technical issue involving the relative desirability of confrontations, what of the broader theoretical assertion, in my opinion erroneous or at any rate overstated, that only with the emergence of self psychology can analysts be truly empathic with their patients, that only with self psychology can analysts truly accept the fact that, in the psychoanalytic situation, the psychic reality of the patient not only commands respect but is the only reality that matters?

I will not deny that these claims contain a modicum of truth. This pertains not only to the progression from nineteenth-century science with its sharp differentiation between observer and observed to twentieth-century science with its understanding of the observer and observed as a unit that is, in certain respects, indivisible (Kohut 1977, p. 68, and chap. 3). In the context of the psychoanalytic situation, it also pertains to those specific phenomena to which self psychology refers as selfobject transferences. Still, even though I accept the validity of these claims if their validity is applied to certain specific areas of psychological understanding (for an explicit statement on this topic, see Kohut 1977, pp. 63–69), I consider the claims erroneous when, as has happened at times, they are formulated without the necessary qualifications.

I believe that a careful distinction between the following three sets of functions employed by the psychoanalyst in the clinical situation—presented here in a condensed fashion but supported by references to previously published more extensive discussions—should make it easier to retain the essential truths contained in the statements of a number of my colleagues—I am thinking here especially of certain contributions by P. Ornstein (1979) and E. Schwaber (1981)—while avoiding conceptual and terminological inexactness. The three sets of functions that we must distinguish from one another are (1) the analyst’s use of empathy, (2) the analyst’s creation and use of theories, and (3) the analyst’s move from understanding to explaining in his communications to the analysand. If we examine the question of whether self psychology has introduced a new kind of empathy to psychoanalysis against the background of a clear distinction between these three separate activities, we will see the question in a different light and be able to respond to it with a different answer.

1. Empathy is the operation that defines the field of psychoanalysis. No psychology of complex mental states is conceivable without the employment of empathy. It is a value-neutral tool of observation which (a) can lead to correct or incorrect results, (b) can be used in the service of either compassionate, imitable, or dispassionate-neutral purposes, and (c) can be employed either rapidly and outside awareness or slowly and deliberately, with focused conscious attention. We define it as “vicarious introspection” or, more simply, as one person’s (attempt to) experience the inner life of another while simultaneously retaining the stance of an objective observer. When defined in this general way (see, for example, Kohut 1978b, 1:205–12; 1971, pp. 300–307; 1977, pp. 298–312; 1980, pp. 456–69, 482–88), the claim that self psychology has introduced a new kind of empathy in psychoanalysis cannot be supported.

2. Although self psychology must not claim that it has provided psychoanalysis with a new kind of empathy, it can claim that it has supplied analysis with new theories which broaden and deepen the field of empathic perception. The greatest geniuses of vision, not to mention ordinary men, had not seen that objects appear to diminish as they recede into the distance and that parallel lines converge toward a single vanishing point until Brunelleschi demonstrated these pivotal insights in his famous architectural drawings. Should we therefore say that Brunelleschi improved man’s vision, that he gave a new kind of vision to man, or rather that he gave us a new theory (supported by illustrations) which allowed us to perceive the world more correctly? I have no doubt that it is the latter statement, not the former, which describes Brunelleschi’s contribution more appropriately.

I will now add an important qualification to my reference to Brunelleschi and his discovery of “perspective.” I said that Brunelleschi introduced a new theory. I could also have said—and perhaps this is the preferable way of putting it—that he disabused visual man of an old theory, or, one might also say, of previous established knowledge. In order to demonstrate convincingly the validity of this observation, I will shift from Brunelleschi and his theory of perspective to a related change in visual theory. Painters had always known (via previous theory or previously established knowledge) that objects (people, animals) retained their size whether they were close to the observer or far away from him. It was this theory (knowledge) that prevented them from seeing that objects become smaller as the distance from the observer increases and therefore from appreciating the need to render objects that were farther from the observer smaller on the canvas. Within the framework of our visual perception of the universe, however, the statement that a man in the distance does not appear the same size as a man close by is just as true as the statement that the size of a man will increase if he moves closer to us or we to him, or that he will
appear larger to people close to him and smaller to people far away from him.

Does the lesson which the psychoanalyst can learn from these aforementioned facts still need to be spelled out? If a patient tells me how hurt he was because I was a minute late or because I did not respond to his prideful story of a success, should I tell him that his responses are unrealistic? Should I tell him that his perception of reality is distorted and that he is confusing me with his father or mother? Or should I rather say to him that we all are sensitive to the actions of people around us who have come to be as important to us as our parents were to us long ago and that, in view of his mother's unpredictability and his father's disinterest in him, his perception of the significance of his actions and omissions has been understandably heightened and his reactions to them intensified? Clearly, it is the second response that provides the patient with a more accurate assessment of that aspect of reality with which we deal in psychoanalysis. And to insist that we should tell him otherwise—that we should tell him with even the faintest trace of disapproval that he confuses the present and the past, that he mixes us up with his parents, and the like—is as misguided as to insist that our painters should go back to the medieval style and paint distant objects the same size as near ones.

But we must return now to the question in the service of which I introduced Brunelleschi's great lesson to the painter of the Renaissance. Has self psychology given us a new kind of empathy or has it advanced a new theory that informs our empathy? Clearly, what I sought to underscore with the aid of my example was this: no more than Brunelleschi gave a new kind of vision to the art of painting has self psychology given a new kind of empathy to the psychology of complex mental states. In both cases it was a matter of introducing a new theory that permitted the observer (the quattrocento painter, the contemporary psychoanalytic clinician) to perceive formerly unrecognized configurations or, at the very least, to increase his awareness of the significance of configurations he had but dimly perceived.

3. The last of the three psychological action patterns in clinical analysis that we must consider in assessing the question of whether self psychology has introduced a new kind of empathy is the analyst's continuously repeated move from a position of understanding to a position of explaining. And it bears stressing that the analyst's essential activities in each of these positions—not only the first one—are based on empathy.

In the understanding phase, the analyst verbalizes to the patient that he has grasped what the patient feels; he describes the patient's inner state to the patient, thus demonstrating to him that he has been "understood," that is, that another person has been able to experience, at least in approximation, what he himself experienced, whether, for example, the experience in question is one of inner emptiness and depression or of pride and enhanced self-esteem.

In certain analyses, the analyst has no need to restrict himself to the understanding phase, even at the very beginning of treatment; rather, he can employ the total understanding-explaining sequence from the start. Furthermore, in many instances, either ab initio or later, there is no clear operational separation between the two steps. Even though the division between them remains valid in principle, the actual activity of the analyst combines them or oscillates between them so rapidly that the operational distinction becomes blurred even with respect to a single intervention. But during particular phases of many analyses, especially analyses of certain severely traumatized patients, the understanding phase of treatment must remain the only phase for a very long time (see Kohut 1978b, 1:85–88). Eventually, however, and to an increasing degree, the total two-step sequence can be employed without undue trauma to the analysand, even the analysand who, at the beginning of the analysis, was traumatized by any move from the side of the analyst that went beyond the simple communication of his understanding.

It cannot be stressed enough, it seems to me, that there are patients with whom respectable analytic results can eventually be achieved who early in their analysis, and for subsequent, increasingly delimited periods extending through years of treatment, are unable to tolerate any interventions from the side of the analyst beyond the communication of his understanding. Occasionally, despite the analyst's sincere attempts to grasp the inner life of such patients, they will initially react to the inaccuracies of the analyst's understanding or simply to the foreignness, the remaining otherness of the analyst, in alarming ways. At these times, only the analyst's willingness to be an attentive silent listener will be tolerable to the patient.

Responses of this type do not usually occur right away, and the analyst's narcissistic balance may be severely upset when, after an initial period during which his analysand has responded with outside behavioral improvement as well as with a degree of gratitude toward the analyst and his interventions within the psychoanalytic situation, he is suddenly confronted with a seemingly ominous worsening of the analysand's condition. Such deterioration is characteristically accompanied by a barrage of reproaches from the side of the analysand that the analysis is ruining him, that the analysand's inept, misguided, bull-in-a-china shop interventions are destroying him. Why is there this period of calm before the storm? Why can the patient at first tolerate the analyst's unavoidable mistakes and errors in empathy only to become suddenly intolerant of them? The answer is simple to the
point of triteness, and every analyst, except at those times when he is himself traumatized and thus not at his best, should be expected to know it. What happens is nothing else but the transference clicking into place. Thus, during the calm before the storm, the analyst and the patient have jointly explored the patient's traumatic past, allied in the shared pursuit of a goal; once the storm breaks loose, however, the analytic situation has become the traumatic past and the analyst has become the traumatizing selfobject of early life.  

Clinical Vignette

I will illustrate the preceding insights about the vicissitudes of the understanding phase of treatment with the following vignette. A professional man in his late forties had attempted psychotherapy several times, including analysis with a colleague whom I knew to be a competent, well-regarded member of the profession. From what I could gather during the initial interview, the therapists, according to the patient, had all turned out to be grossly lacking in understanding and had reacted to his complaints of being treated incompetently either by attacking him—the analyst was quoted by the patient as shouting at him repeatedly that he was insane and belonged in a mental institution—or by withdrawing from him and suggesting that he seek the help of another therapist. The patient also spoke with great anger about his parents, especially his mother, a devout Southern Baptist, blaming them both for his serious lifelong emotional disturbance. I will not go into details about either the nature of the patient's illness—a very serious narcissistic personality disorder with chronic painful feelings of being unreal—or the traumas to which he had been exposed in childhood—the mother, according to the patient's complaint, was totally absorbed with her church and treated her children in accordance with prescribed dogma rather than their own emotional needs; the father, on the other hand, was blamed for withdrawing from the family and giving insufficient emotional sustenance to the boy, who made some short-lived attempts to turn to him for help. I will only say that the treatment with me apparently developed in the same way as the previous attempts at therapy, with the only difference—a significant difference, indeed—being that the treatment with me was not broken off.

The patient, who is not a mental health professional, came to me after hearing a series of open lectures I had presented under the aegis of a university. As he listened to me, he reported feeling that my humane, simple, and direct attitude contrasted favorably with the narrow outlook and artificial behavior of his previous therapists and that he suddenly had the thought that, perhaps through treatment with me, he had yet another chance.

I felt uneasy on first hearing the patient's story when he came to me and requested treatment. Although there was nothing in his contact with me to indicate psychotic ideation, I wondered whether his history of failures with previous therapists and the almost monotonous similarity of his complaints about their emotional crudeness toward him or distance from him did not in fact point to a psychotic paranoid core in his personality. Still, reassured by the patient's actual behavior toward me and drawing courage from the fact that I was able almost from the very beginning of our contact to form, on the basis of his account of his childhood and his description of his parents' personalities, a plausible hypothesis concerning the nature of the transference that had caused earlier attempts at therapy to come to grief, I decided I would accept the risk and undertake an analysis.

The treatment, as I mentioned earlier, began in an atmosphere of friendly cooperation. In line with what every student of analysis is taught to expect and, especially, in view of the patient's account of his previous attempts to avail himself of psychotherapeutic help (i.e., the regularity with which he developed an intensely derogatory attitude toward the therapist and felt mistreated by him), I thought that I was emotionally and intellectually prepared for the fact that the analytic honeymoon would not last forever and that a complete change in his attitude toward me was to be expected. I was hopeful I could weather the impending storm once it broke loose. At first, however, the therapy indeed proceeded in a calm fashion—at least as far as I could then discern. (The patient taught me later to recognize the harbingers of his dissatisfaction with me when the latter, in a vastly intensified form, began to be expressed with little inhibition and became a searing blaze of attacks on me, mainly but not exclusively in the form of verbalized reproaches.)

During the interlude of calmness, I listened attentively and, after a while, began to share with the patient the understanding at which I had arrived by connecting his present experiences, including what had transpired in his previous attempts at therapy, with his childhood experiences. These interventions were, on the whole, accepted by the patient in a friendly fashion. The only indicators that the analytic peace was only precariously maintained by my analyses—realized more in retrospect than during this early period of analysis—were the severe headaches he frequently developed before his sessions (which would sometimes lessen as the hour went on, but would not infrequently either remain the same or get worse) and the fact that he was totally unforgiving in his criticism of both his previous therapists and his parents, especially his mother. Accordingly, the patient would be-
come annoyed and impatient whenever he felt that I spoke of these people with a degree of objectivity—that is, whenever I looked upon them as transference images rather than the real villains who, he unyieldingly insisted, tried to destroy him and were his hated enemies.

Still, apart from these indicators of the patient's uncompromising, undying hatred toward certain people in his past, the analysis on the whole went quite smoothly, with clearly discernible positive feelings toward me as being helpful and with clear-cut evidence that his functioning outside the analytic situation was greatly improved. The big change took place after about a year. I had been away for a vacation, and for several weeks following my return the situation seemed unchanged. But then some alarming developments took place which indicated the presence of a serious psychic imbalance. In the course of several weeks, the patient's headaches changed in character; he filled hour after hour with detailed accounts about how they felt to him without being able either to clarify to himself just what he was trying to understand about their nature or to make me understand what he was trying to communicate. The headaches that had formerly caused him physical discomfort were no longer painful in the usual sense of the word, but they caused him unspeakable discomfort to the point that he could think and talk of nothing else, especially during the therapeutic sessions. When he was away from me, the problem was at first not incapacitating. Gradually, however, he came to feel more and more upset about these sensations in the head during all his waking hours to the point that even his work began to suffer—even though, comparatively speaking, his emotional life outside the analysis remained much less disturbed than his life within the analysis.

My initial approach to the problem was twofold. At first I focused on the preceding interruption of the treatment and encouraged the patient to tell me his feelings with regard to that event. I reminded him, in this connection, of earlier experiences of feeling deprived of support and abandoned, and, in consequence of experiencing such loss of support, of suffering hypochondriacal concerns about body changes and failing health. The patient's response to my attempt to establish a dynamic connection between the vacation and the change in his condition was, as far as I could discern, a negative one. He complained that my theory seemed inapplicable in the present, even though, as far as certain analogous events of the past were concerned, it made good sense. But not now. He had, after all, been neither unduly upset while I was gone nor unduly upset for several weeks after I returned. In any event, he felt certain, without being able to prove the point, that what I said was not helpful, that I was completely out of tune with him, and that he was wasting his time in coming to see me. I listened to the patient's rejection of my observations as dispassionately and open-mindedly as I could, and, after the emergence of some associative material that appeared to point to another set of circumstances that were relevant to the change that had taken place, I offered an alternative explanation. I suggested that, paradoxically, the worsening of the patient's condition was part and parcel of his improvement, that he had opened himself more to emotional interactions with the world, inside and outside the analysis, and that, as a consequence of his increased courage and enterprise, he now faced a variety of tasks that exposed him to anxieties and tensions from which he had formerly protected himself. As a further consequence, I continued, he felt continuously traumatized and overburdened since he was unused to performing on this level of activity and, consequently, unused to the unavoidable traumatizations that impinge on all of us.

At first, and immediately, the patient responded very favorably to what I said. His facial expression, which to that point had been one of angry despair, brightened visibly, and he began to talk about a variety of tasks he had recently taken on that taxed him and made him anxious. But the good feeling that was engendered by my new tack in attempting to understand what lay behind the worsening of his condition was comparatively short-lived. After two or three sessions during which he pursued the possibility that he felt overtaxed, a contingency that I thought I had discerned in his associations, he turned away from this theme and began once again to accuse me of lacking all understanding and of ruining him; his psychic condition worsened alarmingly. At this juncture, he not only complained of the painful head sensations with which he had been preoccupied for several months, but also, in a quasi-paranoid fashion, began to blame different people in his environment for his symptoms in a variety of ways. It was, in particular, the offensiveness of their voices (a shrillness, a harshness, or a grating rasping quality of their speech) that he suspected to be the cause of his suffering. And once, only once—I remember that moment as the peak of my concern about his state, a moment when I simply asked myself whether it would not be better to stop the treatment and send the patient to someone else to cool off, as it were—he not only harbored suspicious thoughts and told me about them, but proceeded to act on his conjectures. He believed at that moment that the sound of the television set in his house had become shrill and actually took it to a repair shop to ascertain that it had not been tampered with.

Yes, I became alarmed—but not as alarmed as I might have become and not as alarmed as, I believe, many of my colleagues would have become under similar circumstances. During the time I was treating this man I had already formed some of the notions that would later
jell into a cohesive psychoanalytic psychology of the self (Kohut 1971); I had grasped, intuitively, that even serious states of self fragmentation, if they occur as an intrinsic aspect of that layer of the therapeutic action which I later designated the selfobject transferences, are less dangerous than they appear to be—if a crucial “if” indeed—the analyst retains his analytic stance and, open-mindedly and nondefensively, attempts to resonate empathically with what the patient is experiencing. I thus persisted in my efforts to understand my patient, tolerated his attacks on me as best I could—even including a temporary phase in which he bad-mouthed me openly to a colleague of mine with whom he became briefly acquainted at a reception. That my own reactions were imperfect, that I often became defensive under the barrage of attacks, is understandable since the patient always reproached me for real flaws in my emotional responses and intellectual performance. And I learned—again, of course, imperfectly—not even to respond by telling the patient that however germane his criticisms might be, they were exaggerated and disproportionate. The patient, as I finally grasped, insisted—and had a right to insist—that I learn to see things exclusively in his way and not at all in my way. And as we finally came to see—or rather as I finally came to see, since the patient had seen it all along—the content of all my various interpretations had been cognitively correct but incomplete in a decisive direction. The patient had indeed reacted to my having been away; he had indeed felt overwhelmed by the traumatizations to which he was now exposed by virtue of his expanding activities, and he continued to react with prolonged, intense suffering as a result of remaining broadly engaged with the world. What I had not seen, however, was that the patient had felt additionally traumatized by feeling that all these explanations on my part came only from the outside: that I did not fully feel what he felt, that I gave him words but not real understanding, and that I thereby repeated the essential trauma of his early life. The task that the analyst faces at such moments—the crucial moment in which a “borderline” condition either will or will not become an analyzable narcissistic personality disorder—is largely one of self scrutiny. To hammer away at the analysand’s transference distortions brings no results; it only confirms the analysand’s conviction that the analyst is as dogmatic, as utterly sure of himself, as walled off in the self-righteousness of a distorted view as the pathogenic parents (or other selfobject) had been. Only the analyst’s continuing sincere acceptance of the patient’s reproaches as (psychologically) realistic, followed by a prolonged (and ultimately successful) attempt to look into himself and remove the inner barriers that stand in the way of his empathic grasp of the patient, ultimately have a chance to turn the tide. And if some of my colleagues will say at this juncture that this is not analysis—so be it. My inclination is to respond with the old adage that they should get out of the kitchen if they cannot stand the heat.

If the analyst is able to stand the heat, however, if he persists in extending his instrument of empathic observation to the patient rather than withdrawing from him by declaring him “unanalyzable” as if this term connoted an objective reality in which the analyst himself was not included—then he may be rewarded by witnessing the way in which a borderline case becomes a narcissistic personality disorder. In the specific instance of this case vignette—one that I am adding to illustrate what one might call “the principle of the relativity of diagnostic classification and the specific prognosis”—I was rewarded by a shift of the associative material into a new, unexpected, and at first not fully understood direction. The patient’s sensitivity to noise began to subside. Simultaneously, his reproaches toward me persisted, even though they changed in character, becoming more specific than they had previously been. In view of the fact that this is only an illustrative vignette and not a case presentation, I will only say that the new material related to the patient’s father and was a revival of frustrating experiences from a later period of the patient’s childhood. The reproaches were directed at his father for not fostering his male development. Specifically, the reproaches were directed at a father who was a physician himself—like the father and yet beyond him, other than him. The father and I—through my originally erroneous transference interpretations—insisted on being looked up to and imitated. The son had wanted the father to respond to his own (i.e., the son’s) potentials, suggestions, and ideas; he wanted to have the father’s experience and knowledge as an aid in his own growth and in the realization of his own potential. It follows, then, that we had not, as I erroneously believed at first, entered a phase of an idealizing transference but had—alogous to the patient’s similar move in childhood—entered a phase of mirroring needs vis-à-vis a different selfobject. The archaic mirror transference in which the seriously disturbed, unresponsive maternal environment of early life had been revived psychosomatically in the diffuse noise-hypersensitivity headache syndrome was now replaced by the more focused syndrome of transference reproaches directed at the nonmirroring father who was preoccupied with his own self enhancement and thus refused to respond to the son’s originality and talents. In terms of the dynamics of the sequence of selfobject transferences, one could say that the borderline state enacted via a “primary archaic mirror transference” had been secondary to the narcissistic personality disorder. The narcissistic personality disorder, on the other hand, was subsequently enacted via a secondary mirror transference at a higher level of self
development and not via a secondary idealizing transference as I, repeating the trauma of the so-called latency period, had at first believed.

I will now break off the account of the analysis of this patient. I adduced this clinical material not to depict the course of the analysis of a patient with a severe but analyzable narcissistic personality disturbance, but to illustrate the claim that the concept of “borderline” pathology (which I define as analyzable cryptopsychois [see 1971, p. 18]) is a relative one, depending, at least in a substantial number of cases, on the analyst’s ability or inability (a) to retain his attitude of “empathic intention” despite the serious narcissistic injuries to which he is exposed and (b) ultimately to enable the patient, via the understanding of his or her experience of the world, to reassemble his or her self sufficiently with the aid of the selfobject transference to make possible the gradual exploration of the dynamic and genetic causes of the underlying vulnerability.

Empathy and the Explaining Phase of Treatment

Returning to the mainstream of our theoretical inquiry into the nature of the self psychological contribution to the psychoanalytic elucidation of empathy, we will now shift our attention from the understanding phase to the explaining phase of the basic therapeutic unit of psychoanalytic therapy. I will stress first of all that the explanatory phase—or, as it might well be more accurate to put it, the explanatory aspect of the analyst’s interventions—is also based on empathy. But here, more so than was the case with respect to the understanding phase, the analyst’s theoretical equipment—for example, his grasp of the theory of selfobjects as it pertains to the patient’s experiences both in the transference and in childhood—will strongly influence the accuracy, breadth, and depth of his dynamic and genetic formulations. In a certain sense, therefore, it could be maintained that correct dynamic interpretations and genetic reconstructions provide no more for the analysand than further proof that another person has understood him.

It would seem to follow from the above that the explanatory phase of the basic therapeutic unit should be regarded as an extension and deepening of the understanding phase. But it would be erroneous to restrict our definition of the significance of the second part of the basic therapeutic unit in this way. The explanatory phase differs in an important sense from the understanding phase, not only cognitively but, more significantly, emotionally. The intensity of the archaic bond of an identity of inner experiences based on the analyst’s ability to perceive the patient accurately and then to communicate what he perceives is lessened as the analyst moves from understanding to explaining. Yet, and this is the crucial point, while the archaic merger bond is lessened, an empathic bond on a more mature level of experience supplants what has been left behind. The empathic connectedness between patient and analyst is thus retained and, beyond doubt, even deepened in its scope via the analyst’s imparting of his dynamic and genetic insights to the patient. As he engages in his explaining activity, the analyst enables the patient to continue to feel supported by the fact that he, the analyst, retains his selfobject functions and, ipso facto, enables the patient to become more objective vis-à-vis himself and his problems. Formerly, the analyst had simply shared with the patient his grasp of what the patient experienced. Now, in moving toward the greater objectivity embodied in his explanations, however, the analyst provides the patient with the opportunity to become more objective about himself while continuing to accept himself, just as the analyst continues to accept him in offering the dynamic and genetic explanations. The movement toward greater objectivity during the analysis should therefore be seen as a sign of developmental progress; it parallels the replacement of one selfobject experience with another, namely, the replacement of an archaic selfobject experience by a mature one, the replacement of a merger experience with the selfobject by the experience of empathic resonance from the side of the selfobject.

The foregoing formulations about the change in the experience of the selfobject and its functions, and the maturing of selfobject needs, provide me with the opportunity to stress, as I have done for many years (see Kohut 1978b, 1:427–60), that archaic narcissism belongs to a separate line of development. This means that narcissism, like object love, evolves from archaic to mature forms and that, under certain circumstances, we find it useful to examine these two developmental lines and their relative levels of maturity by focusing first on the one and then on the other. In any event, the formulation that narcissism is replaced by object love—that narcissism is archaic and object love mature—is in error (see Kohut 1978b, 2:757–70).

Furthermore, as I have pointed out before (1978b, 2:741–42), the formulations about the maturing of the selfobject experience that results from each of the innumerable two-phase basic therapeutic steps taken during an analysis and that, via the cumulative effect of these recurrent fractionated forward movements, leads to the gradual and increasingly firm establishment of a mature selfobject experience and of mature selfobject needs of the patient are in harmony with the basic tenet that certain crucial psychic events of adult life can best be understood when evaluated from the vantage point of childhood development. In our specific case, this means that the forward moves,
the progression of the therapeutic process toward a psychoanalytic cure, essentially repeats (though not in all details) the steps of normal childhood maturation—steps that had not been completed in early life but which can be brought to a degree of belated completion via the analytic process. Just as in normal childhood, so also in the analogous experiences of the adult analysand as the steps are taken from understanding to explaining, the physical distance between the self and the selfobject increases at the same time as empathic closeness is maintained.

Consider the following episode of early development. As a baby the little girl is picked up by her mother and thereby feels herself part of the omnipotent strength and calmness of the idealized selfobject. Later in childhood, however, when she walks away from her mother for the first time, the little girl will try to maintain the bond to her mother by turning around and looking back at the mother's face. If she is an emotionally healthy child who has been surrounded by a milieu of emotionally healthy selfobjects, she will do so not primarily because she is afraid and needs to be reassured that she can return, but rather to obtain the confirming reverberation of her mother's proud smile at her great new achievement. There is an analogue in analysis for the child's experience of increasing distance from the selfobject, particularly the child's developmental ability to replace physical merging with the selfobject milieu by a bond of empathic resonance with the selfobject; it is established as the analyst moves from an initial concentration on the understanding phase (the empathic grasp of the experiential state of the patient) to an increasing emphasis on the explaining phase (the empathic grasp of the dynamics of the transference interactions and their genetic precursors).

At this juncture, it may be advisable to return to a question that has surely arisen again in the minds of many readers: What exactly is it that constitutes normality? Is it really “normal,” let us say, for a little girl to walk away from the mother and turn around not with a fearful glance which seeks reassurance that the mother is still there and available to reestablish the merger, but with a proud smile which expects and gets confirmation and support in the form of the mother's pride in her? I will not respond to this question with a simple yes or no answer, although, as I hope to show in the following, I would indeed say yes if I were pressed for such an unambiguous reply. Instead, I will examine this paradigmatic event from two points of view which, I must stress immediately, can be separated only at a price since the different images that emerge are in fact interrelated. The two points of view concern (1) the more experience-distant issue of the significance which should be assigned to the event by the evaluating observer (and I am speaking not only of the relevant childhood events but also of the analogous events during psychoanalysis) and (2) the more experience-near issue of the actual behavior of the child who moves away (or of the analysand who, for example, allows himself to hold views which, he believes, are not shared by the analyst or to engage in activities which, he believes, are anathema to the analyst).

Why is it impossible to keep these two viewpoints entirely separate? The bond that unites them is given by the fact that the significance of the event of moving away is not only evaluated by the observer on the basis of experience-distant considerations; it is also felt, however vaguely and often nonverbally, by the principal actor in the drama, that is, by the child or the adult analysand. Specifically, the analyst and analytic child observer must realize that, in evaluating a developmental forward move, it is not only their objective theory-based opinions that count—opinions that are strongly influenced by their moral stance, by the values they hold—but also the opinion of the subject of the forward move, specifically, the precise way in which the child or the adult patient experiences such a move. In short, the analytic observer's empathic grasp of what the child or the analysand feels must be taken into account as he formulates a theoretical understanding of the significance of the forward move.

Having thus called attention to the necessary interrelatedness of the experience-distant and experience-near viewpoints (experience-distant theory, including the observer's values, influencing what can be perceived; experience-near theory, the configurationally organized data of the subject's experiences obtained through empathic observation, influencing the experience-distant theories the observer ultimately adopts), we will still find it useful to examine the significance of the forward moves under scrutiny from the standpoint of these two contrasting vantage points. We begin by posing the experience-distant question of the emotional significance that we should ascribe to the forward move. My answer is unambiguous: the forward move is in essence normal, and the normal response to this event is joy on the part of the self of the forward-moving subject (the child, the analysand) and the self of the observing selfobject (the parent, the analyst). In harmony with C. Daly King's definition that "the normal . . . is to be defined as that which functions in accordance with its design" (1943, p. 493; see p. 212), the significance of the forward move, to the degree that it manifests the actual readiness of the involved psychic structures for the move in question and is not in traditional terms, a "flight forward" undertaken to deny anxious insecurity, is that of a proud achievement. The psychic content of such a forward move—paradigmatically, of the child's walking toward some object that attracts him or simply walking into the open space—is not appropriately described by saying that a separation of the self and the selfobject has
However, even the smallest experiences can significantly influence the emotional content and the overall feeling of the observer. When we consider how the development of emotional memory is influenced by various factors, such as the emotional significance of the experience, our personal history, and the context in which it occurs, we can see that even a minor event can have a lasting impact on our mental state.

The experience of an emotional memory, whether positive or negative, can shape our future behavior and decisions. It is crucial to understand how these memories are formed and processed in the brain, as well as the factors that influence their development. By examining the mechanisms involved in the formation and retrieval of emotional memories, we can gain insights into how our experiences can shape our lives and the decisions we make.
inhibiting influence of anxiety from spreading unduly, from expanding into the land of depressive apathy.\(^8\)

It is in the light of the preceding interpretation of the clinical significance of normality—understood, following C. D. King, as a functioning that is in accordance with structural design—that two other related phenomena must be evaluated: the overestimation of children by their doting parents and the functionally analogous overvaluation of analysands by their analysts. We have in general been taught to look upon these attitudes as misguided, as manifestations of the fact that our sober judgment has been led astray by our emotions. And analysts in particular have interpreted their tendency to think more highly of their patients—their talents, their achievements—than others who know them in everyday life as variants of countertransference, that is, specifically, as variants of an attitude that must be mastered and eventually dissolved by self-analysis and insight into the dynamics and genetics of such distorted judgments. To my mind, however, there is another dimension to this attitude that pertains to both parents vis-à-vis their children and analysts vis-à-vis their patients. I believe, in short, that this overvaluing attitude too is “normal,” that it expresses the fact that, as parents and therapists, we are indeed functioning in accordance with our design and that an analyst who consciously eradicates this attitude and replaces it by cold objectivity (in accord with Freud’s 1912 metaphor of the analyst as surgeon) is as misguided as the Watson-guided “objective” mother of half a century ago (see Watson 1925).

The obvious fact, the fact that practically goes without saying, is that we are dealing not with an “either-or” dilemma but with an integration of aims and attitudes. To put this more precisely in terms of the principle I enunciated earlier, we are dealing not with an amalgamation of at times conflicting attitudes and aims, not with syncretism, as Bertram Lewin used to maintain (1958; Lewin and Ross 1960, pp. 46 ff.), but with a variety of experience-near acts and attitudes that are informed by an experience-distant principle on a higher level of abstraction, however deeply rooted in our psyche this principle may be. It follows that we must never confuse the deep human response called forth in us vis-à-vis another human being’s thoughts and emotions with sentimentality and companionship. Parents and analysts, respectively, will insist on the child’s and the analysand’s confronting unpleasant realities, including the limits that all of us have to recognize, but they will do so while simultaneously acknowledging the facts that all of us rightfully feel special and unique and that we cannot exist unless we feel that we are affirmed by others, including, and especially, by our parents and those who later come to have a parental self-object significance for us. All meaningful human interactions, specifically those between parent qua selfobject and child and between analyst qua selfobject and analysand, are not only broad in the sense of applying to a variety of experiences, but deep in the sense of being in contact with early, and, in form, archaic, experiences. When a friend puts his arm around our shoulder at the moment we need to be sustained by him, he does not know that his gesture implies a willingness to let us merge with the calmness and strength of his body, just as the selfobject mother once provided us with this experience when she lifted us, anxious and fragmenting, and held us to her. And the same thing happens between analyst and analysand.

However objective and limit-recognizing an analyst’s interpretations may be, if they are preceded by understanding and deepen the analysand’s recognition that he has been understood, then the old reassurance of a merger-bond, even on archaic levels, will reverberate, if ever so faintly, with the experience. Thus, whatever lip service some analysts may have given to scientific objectivity vis-à-vis their analysands, trying to “model themselves . . . on the surgeon” in accordance with Freud’s advice of 1912, and whatever lip service some mothers may have given to the scientific regularity of their responses, trying to live up to strict behaviorist tenets, in healthy specimens of analyst and mother alike the old adage naturam expellas furca, tamen usque recursur, “nature may be pushed aside, but it will always return,” will in the end prevail: in harmony with their human design, they will not interfere with their use as selfobjects by analysand and child, respectively.