Extending Empathic Understanding, 
Sharing an Attitude

Here Kohut continues the discussion of issues raised in Chapter 11, beginning with a question from one of the seminar participants.

From your discussion it would seem that assessing the situation in the first couple of sessions, and sharing this with the patient at the beginning, would foster an intellectual rather than an emotionally experienced understanding. Is it necessary to begin early by showing a patient how you think in formulative terms?

This cannot be answered simply. It depends very much on the patient and his difficulties. I think it also depends on your own mastery of a particular attitude, how it feels to show keen intellectual interest, but at the same time not to intellectualize. To be intelligent is not the same thing as intellectualizing, I think this is an old error.

What I attempted to say is that, in a sense by example, I teach the patient an attitude toward himself. I create an atmosphere—not artificially, however, because it truly is mine—in which a broadened understanding for oneself is encouraged. My own interest is in what is going on in the patient—not only in what he experiences, but also in how he experiences and relates to his difficulties. This is in essence an attitude of an expanded self-empathy—an expanded capacity to be empathic with one’s own past, with aspects of oneself that one really does not own, or does not own fully, including even aspects of oneself that have not yet expanded—in other words, one’s future possibilities.

The question that you raise is whether this is only an intellectual attitude in terms of abstract thoughts. I see nothing in what I said that would go in this direction. Emotions are as much included in self-understanding as anything else. It is true that words can be used as a hindrance to self-understanding in the same way that words can be
used as a hindrance to communication. But still, words are a means of communication, and understanding is a means of communication. Understanding can also be used defensively; and one must not begin in this way. If it is abused in this way, then I would include this particular abuse in the general expansion of understanding.

In other words, let us assume you have a student who has been reading psychology texts. He begins by telling you about his oedipus complex, and about certain psychodynamics that are characteristic for him. This is the kind of history he gives. I would certainly not object in the beginning.

My initial advice to anybody who works in this field would be not to pounce on the patient and tell him he is intellectualizing and that these are just words or formulae. I would wait until I could explain to him in a meaningful, positive way why he is doing what he's doing. I might say that I think intellectual understanding is a means of avoiding anxiety—and after all, we all want to avoid anxiety. In struggling to master ourselves and our impulses, and to avoid being pushed around by forces that we do not really understand, it is often a first step to see oneself in a more objective and abstract light. This allows one to be less frightened.

In the same way, when one is in a strange country and a foreign city, if one has a map and a general idea of the layout of the city, one is helped a bit. In other words, I would not object to what such a person is doing, but would expand his understanding about this particular mode of his functioning. To be afraid of the mere fact that one attempts to understand what is going on in a person, to see this as intellectualizing, as necessarily a hindrance rather than a help, is I think, an error. I think it is a confusion between being intelligent and intellectualizing.

Understanding, with its expression in words, is not anything that one should necessarily be afraid of. I have seen just the opposite being an obstacle, that is, people who cannot speak directly, but can only use terrific emotional terms. Why? Because they are afraid of intellectualizing.

If a patient consults a psychiatrist, why should he suddenly drop all the insights of psychiatry? When he talks about himself he will naturally speak in the language he is used to; if he is an intelligent person he will use intelligent terms. That never stands in the way of experiencing deep emotions. I would advise you, at least to begin with, not to be afraid of this kind of dichotomy. And I would advise you not to object even to the defensive use of intellectual communications too soon.

As a matter of fact, I would not object to intellectual communications, but I would weave in an understanding of this kind of communication as a general need to distance oneself from anxiety-provoking inner con-
conflicts. He has a right to protect himself. If you begin there, then you will not make an enemy of the patient.

I have often seen, when psychiatric residents first present their cases to me, that from the beginning the patient is looked at as somebody who is inimical, in a sense, and wants to pull the wool over your eyes. The idea of defense as a psychodynamically important thing, that the major function of the mind is defensive, is good, not bad. In other words, one has a stimulus barrier which is defensive. Then one does not get blown around. One maintains oneself in the structure and in the permanency that one is. For that one has defenses. In the same way as one has skin and nails, so one also has psychological defenses, a right to maintain oneself by defending against traumatic feelings.

If the patient has the feeling that the psychiatrist wants to inflict pain on him, then he will obviously fight the psychiatrist. This is not, or should not be, your intention at all. It is true that you can sometimes show the patient that the means he uses in maintaining himself in balance are not economical and are not necessary. The pain he fights against is not a real one: to look at things is not the same as being exposed to them. If you want to get to the point with the patient in which he will allow himself to face slightly difficult situations more consciously and more openly, then you must have first built up a feeling which allows him to do so.

It is like taking a child to the dentist. If as a first step the dentist pulls his tooth before the child knows what it is about and he experiences terrific pain, he will never trust a dentist again. However, if the dentist very cautiously and carefully first shows the child what the situation is and says, “This is about as much pain as there will be,” if the child has not been traumatized before, than he will later on be capable of tolerating some discomfort in the dentist’s chair.

And so with intellectualizing. I have not often found that intellectualizing is a serious hindrance in any treatment situation that I have become familiar with over the years. There are individuals who from way back in their lives have learned to live and survive as if they were living next to themselves. They were exposed prematurely when their psyche was ill-equipped with mental machinery for such a task. But to object to this without yet knowing how it grew, or when it first happened, is an error. This is the essence of their pathology. You do not at the outset ask such a person to give up the essence of his pathology so he can begin treatment.

At the present time, I have somebody in analysis who tends to intellectualize. He speaks distantly about himself, in the third person, and generally treats his life and the vicissitudes of his present and past diffi-
Extending Empathic Understanding

You will not, or sometimes in bad against how he will... and allows... in the... is... and... such a... and... difficulties with a kind of superior miles-away stance. Characteristically, he does the same thing with me. When I tell him something about himself he will hear me out patiently, and then will tell me in a very kindly way that he had heard I was supposed to be a good and experienced analyst. But the way I phrase my interpretations certainly does not bear out my reputation. There is, he says, a kind of vagueness in the way in which I speak. Frankly, I would not say this was just empty talk. There are some very fine perceptions about me involved in all this. He puts his finger on some weak spots in my personality. Nevertheless, nothing would be easier now than to rise up and defend myself, or worse, seemingly not to defend myself, but to tell him immediately that he is turning the treatment topsy-turvy. This is not a good method, because the patient is doing to me what he is doing to himself. By my general faithfulness to my particular outlook on such things, we have made a great deal of headway.

When this patient was three and a half years old, he was abandoned by both his parents, and for about a year and a half he had to adapt to a very strange and a very frightening environment, not knowing whether he would ever see his parents again or how he would survive. It was during that time that he began to live next to himself in order to survive.

He learned in a very primitive way, a precursor of what is now an ingrained characterological attitude, to handle difficulties as if he were observing himself. I think in essence that was indeed what enabled him to survive. I think that had he not been capable of distancing himself from himself at this particular time, the traumatic impact of the situation would have had much more deleterious results than it did have. My impulse is not to react to the patient, but to understand him. That does not mean that one does not have reactions, but one has trial reactions.

When this person in his detached way hurts my feelings, I am aware of the fact that my feelings are hurt. I do not, however, rise to my defense, but my reaction becomes a tiny aspect of that whole set of communications or that whole complex of information that I try to understand. I ask myself why he wants to hurt me when I am quite sure I did not want to hurt him. It is quite clear that everything about this situation is designed to hurt him. I cannot do anything but hurt him. The mere fact that I am looking at him and trying to understand him hurts. It hurts him because he has spun out this early attitude of living next to himself into something grandiose, and secondarily, enormously valuable. In this way he defends himself against being tossed around or shifted around without being asked anything, against the most important people in his life suddenly disappearing for a year and a half. These experiences are tremendous narcissistic blows of his early life. So he formed against this an
enormously effective attitude in which he lives a life superior to himself, like God looking upon himself and at other people. And when anything occurs that might possibly develop into a traumatic situation—for instance, attaching himself to me and then again being abandoned when he is most vulnerable, as he was at the age of three and a half—he defends himself against it. He says, “You’re not judging me only; I’m judging you.” Now to tell him, “Don’t be arrogant. This is an analysis, and you’d better cooperate, and don’t intellectualize,” would be a grave error. It might lead somewhere, but not where I want it to go.

To point out intellectualization does lead to a kind of cooperation, but not to the kind of a gradual sharing of an attitude that is the essence of analysis. I know you are not conducting analyses here, but I do not think this attitude is in any way at variance with the attitude of the general psychotherapist. What you might do, and how deep you want to go with it is another story. But I think to attack a person’s attitude immediately because essentially it usually interferes with the kind of fantasy you have of what the situation should be like is an injustice to the patient. It is not conducive to the best advances that are possible with him.

It is comparatively easy to talk about handling intellectualization, but it is not so easy without some experience in all this to live it in therapy. You can very easily become condescending in this kindness, and such condescension may be almost as bad as, or perhaps even worse than, an honest attack on the patient. You have to be able to do all this without being condescending. In other words, it really has to become part and parcel of yourself, and this does not happen without some inner struggle. I think my patients usually know when they have gotten under my skin, and I have to struggle a bit not to let myself lash out in response to that. I do not give them speeches about it, but I think it must shine through in some way. I am not pretending anything that I am not. But I think sooner or later people become convinced that to the best of my knowledge and ability I am trying to understand them. If I have reactions, I will even regret them, and then do better next time. They know I, too, am a human being.

That is a long answer to your question, but I think it gives you the answer to how I feel about it. To summarize, if somebody begins by intellectualizing I will not object. I will assess this as probably a necessary defense; the more ingrained it is the less likely will I be in any way to try to undermine it. It is a necessary aspect of the character of the personality and has its own meaning. I think the first thing that one can do is to explain this meaning to the patient. The patient will then very likely understand that this is not an attack. Then you have firm ground on which to stand. You have done it in the conviction and the overall
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I was quite right in pointing out the psychopath's difficulties and the need for further work. The patient, who is very self-aware, has been having consultations about his difficulties with anxiety, the statistical frequency of which has been noted in the clinic. Many of these are in acute decompensations, and have had so many consultations about patients who have been working with a lot of anxiety, the statistically more frequent. I think you're right in saying that you're not attacking him. That's why I was explaining the deceptiveness of defensive, or intelligent, ways of looking at what they're doing, and I've talked about your own feelings of guilt. Do you have any other questions?

I hope you did not see this in any way as opposition to what we've been talking about, because it is very much in line with what I've been saying.

The patient's work in the clinic has been very helpful in getting him to understand his difficulties with anxiety. The patient has been working with a lot of anxiety, the statistical frequency of which has been noted in the clinic. Many of these are in acute decompensations, and have had so many consultations about patients who have been working with a lot of anxiety, the statistically more frequent. I think you're right in saying that you're not attacking him. That's why I was explaining the deceptiveness of defensive, or intelligent, ways of looking at what they're doing, and I've talked about your own feelings of guilt. Do you have any other questions?

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thing—people from all areas of life, colleagues, and psychiatric residents who come to me in severe acute depressions.

In acute decompensations, what is needed is first an empathic assessment of the particular state in which the individual presents himself. If somebody comes to you who is flooded with anxiety, who is deeply depressed because of some acute decompensation, whether it is that he has just left home and finds himself in a new situation, or he has been jilted, or he is not able to mix with other students, or he has gotten into a terrific funk about an exam, or he has had intercourse and is terribly anxious about having contracted venereal disease—whatever the acute anxiety attacks of adolescence or late adolescence may be—certainly the first reaction will be to express your empathic understanding of the state the patient is in. This is already curative, helpful, therapeutic. This task now is shared and there is a strength that comes from sharing.

You recall the earlier session on the primitive wordless workings of an empathic melting together. It has a history that goes way back to a small child’s discomfort, a mother’s empathic resonance, a mother’s toning down this anxiety in resonating to the child’s anxiety but not denying it. The mother then includes the child in her own personality, often with physically embracing and carrying him. This you cannot and do not need to do with your patients, but symbolically you can. If a student comes in a real panic state, you can show a kind of likeness with him, but with a lessened anxiety, a kind of sharing, a showing of how understandable this is. You don’t have to say, “I too, when I was your age,” or anything like that. There is no need for that. The fact that you understand, and that you elaborate something about the anxiety state before the patient has told you about how he feels, allows him to think, “He knows that too. He must have been through that himself and still lives. He’s not so anxious, so I’m not so anxious.”

In other words, it is a kind of empathic enclosure that the person finds which is the first defense that you offer. While it may be obviously a defense, at some time or other, for a person to identify wholesale with another person, at this particular moment it is obviously a wholesome defense to share another’s personality temporarily. Explanations of the kind that you are bringing should come second. First, you establish this kind of a side-by-side feeling; then, on the basis of having enclosed the patient within your own boundaries, you have allowed him to enclose you within his boundaries (Kohut, 1984). On the basis of that particular new level, and then some intelligent discussion of the situation, some explanation about the ups and downs of his self-esteem would follow, but as a second step. To offer explanation from the beginning would be less effective. In a sense, it would increase the distance between you. It
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... does not mean, and it should not mean, that you are suffering as much as the patient.

I think we talked about this capacity to empathize without taking over the patient's task in the same context many weeks ago here (see Chapter 5, p. 63). I talked about what one does for a dying person. It does not necessarily mean that one pretends that one is dying. I think anybody who is dying and sees healthy people around him must be angry, must envy them, must have the feeling, "you don't know what it means. You will some day, but right now you don't." I think I recommended to you at that time the short story by Tolstoy, "The Death of Ivan Ilich." It is a beautiful description of a man who, as he is dying, becomes more and more aware of the gap between him and all the healthy people whose lives will go on. All the consolation they give him means nothing. But there is one person who helps him. There is an old servant who helps him by allowing physical contact, by being physically helpful to him. These are things, in a nonverbal way, to which people will respond. If one can combine it with an empathically given little gift that enhances the person's self-esteem when he is down, by congratulating the person, then you will help him. I think it is as true for a dying person as for the person who is in the throes of a severe traumatic state.

But to return to our consideration of the student. For the intelligent expansion of his ego, you have to strengthen the ego a little bit by allowing this empathic extension, by lending your own personality. When you have done that, then you can cautiously begin to give insight, something about the dynamics of the ups and downs. You allow the person to distance himself from himself. In other words, you do just the opposite of what we were afraid of at first, telling him that maybe he is too intellectual.

There are certainly times in analysis where the verbal approach to a chronic defensive attitude can be improved upon, in other words, where one can do more than just repeat the same formulae. Sometimes one gets the impression that just to tell the person more about it is not enough. Ferenczi (1950, p. 236), quoting Freud, said that there comes a time in the treatment of phobias when the patient just has to face the phobic situation; unless he has this extra bit of courage the treatment will bog down. Then you can encourage the patient by lending him some of your courage, as it were, to make some steps that seem to be like the muscular approach toward symptoms. It is not because you want to abolish the symptom, but because you want to get to the experience that the patient is avoiding. The phobia is not the true symptom. The phobia is a secondary avoidance reaction.

From the beginning Freud differentiated between anxiety hysteria and
phobia (1920). The phobia surrounds the anxiety experience. It protects against the experience. The condition begins with an anxiety attack; then there follows greater and greater spread of all kinds of defensive maneuvers, so that the situation in which the anxiety might occur again is avoided. An elaborate system of defenses protects the phobia. There are people who split off the experience of the analysis by defensively denying that it has any meaning outside the office and the couch. It is as if he says, “It’s all valid here,” but as soon as he crosses the threshold it doesn’t count any more. With such individuals one intuitively learns to do certain things. One gives an interpretation at the end of an hour; the patient gets up, and one says, “Wait a moment,” and then one tells him a little more. This is not orthodox technique; what is valid on the couch is valid now too. I have even run after a patient when he was trying to get on the elevator. I have called people up and said, “Listen, I thought about this dream you had last night. It just occurred to me, and I can’t wait until tomorrow. It is such a good thought that I want to tell you about it tonight before you go to sleep.” One doesn’t do this every day, but sometimes one has to be imaginative. It is the kind of thing which, if you do by rote, is absolute nonsense. The technique is perfectly reasonable, and this makes perfectly good sense, but like anything else, it can be abused. It is your job to see to it that it is not abused.

A most important issue raised in the last session was the general internal mental set of the therapist as he sees the case unfold and extends himself empathically to another person. These are preliminary steps only, but they require a particular kind of mental attitude that I think is very important. This is more easily defined in general terms than in specifics, for one can do all kinds of things if one has the right attitude. One can learn by rote what one should say or what one should not say, and treatment will not succeed. We talked about this with reference to the 19-year-old student when I mentioned that I sometimes find myself at variance with the reactivity of people and the kind of questions they ask when a case is being presented. I want to say, “Let me listen.” I want something to come to me, and questions disturb me. One wants to know, but the data will fall into place if one listens.

I’m trying to understand the nature of the average expectable response within such a patient when he’s responded so in the way you’ve described. On the surface, it may begin as an identification with your attitude toward him. He becomes interested again, not so much in whether he’s right or wrong, or good or bad, but because you’re interested in how his mind works. He cannot fail to be impressed with the fact that you explicitly want to understand.
I would hope the result would be a little different. What you are describing may very well be the result of this kind of an attitude if one sees a person several times a week in a very intimate kind of contact. But when one sees a person once a week, I would think that your real understanding of how his mind works, or at least a beginning grasp of why it became the way it is with reference to his parents, would allow the patient, with your help, to solve a specific circumscribed task better than he could alone. He can then say, "Seeing that I have this kind of mind, seeing that this is the way it grew with regard to my parents and the still existing intermeshing with them, grasping this, I know approximately what my anxieties are as I try to extricate myself from my parents and try to face an independent task such as schoolwork or living away from home."

I think this is essentially the problem here. It permits distance and allows one to be less automatic in one's responses. So that with the very circumscribed task for which he comes into treatment, namely that he is so anxiety-ridden vis-à-vis examinations and studies, this approach would help him to diminish his anxiety. There would be greater capacity for seeing the nature of the anxiety.

In other words, I do not envision, as in an analysis, the building up of a complex interpersonal relationship, on the basis of repeating something from the past, and then gradually extricating oneself in the experimental setting of the analysis. But rather, as an auxiliary ego to him, by understanding, you can add insight, giving him greater mastery over present tensions and allowing him greater ease in working himself out of a rather circumscribed problem. That would be my general aim.

The difficulty lies in the following: It is comparatively easy to pinpoint the content of specific internal conflicts. It is much harder, but I think much more important, to pinpoint the mode in which a particular mind works independent of the conflict. That is the focus of my attention in diffuse cases of this particular type.

He might have come in with another symptom at some other time. This happens to be something that drives him at the moment. But he could have come in three months later with something else. He would still be the same person, with the same basic problems, with his particular kind of mind. So with a diffuse problem of this particular type, I try to pinpoint, for my own feeling, how this mind works. Generally one finds out that it is neither positive nor negative, but both. This is an example of my trial identifications or my trial modes of empathy.

In other words, I pointed out his poetry and the way in which he saw himself sitting in the dorm, looking out and seeing the street as a river,
the cars as boats, and himself as a boat. His self-esteem is probably shaky, for after all, he sees himself as a boat. It is quite significant that he sees himself as an inanimate thing, as an object that is being driven by waves. But it is poetry. He obviously does not see himself as somebody who takes hold of things, as a man of action who is involved in things. He does not spin out fantasies, as other students might, of being a researcher, a great general, a great football player. He sees himself as a boat somehow driven by the waves, surrounded by other boats; there is very little human life in this imagery. Secondly, he offers this poetic fantasy to somebody for praise. He then is disappointed. He expected a good grade from his English professor and what he got was a negative grade. So the man did not understand.

To me, this is a good inroad into how a personality works: his sensitivity, his doubts about himself, spinning these out in internally elaborated fantasies, and then offering the fantasy secondarily, to make contact with others, to get, secondarily, some kind of boost to his self-esteem. There are both positives and negatives. The positive is the fine mind, the refinement, the differentiation of his fantasies, of the thinking processes. The negatives are the comparative passivity, the inability to see himself as an initiator of action, and the tremendous dependence on other people's empathic grasp of what is good about his mind. I am using this more as a mode, an example, of how to think when I see such an individual, not that this is a foolproof interpretation of his personality. I would like to hear more and develop further ideas. But having this kind of grasp, then I can tentatively communicate this to the patient.

However, I communicate this not with blame or with praise; rather, I attempt to show the advantages and disadvantages of his particular mode of functioning, so that he gets to know himself better. These are not things that he does not know about himself, but very likely he has never verbalized this to himself. And if he has, if he's very gifted psychologically as some people are, with insights beyond expectation, it does no harm if somebody else can understand too.

A kind of bond, then, is set up, allowing his insights to become even clearer. And this, to my mind, now broadens the basis on which the specific problems of the present situation can be tackled. He has an ally; he has a greater insight into who he is, what he is, and how he functions. One can see that he wants to resist his parents, to extricate himself from them, and one can also recognize that the parents act now exactly in the same way as when what we now consider his mind was formed. In other words, they intrude on him all the time, run his life for him, and very likely they continuously debunk him. After you have made a little inroad that way, then the patient, at least initially and generally, comes forti...
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forth with a tremendous amount of convincing and, to some extent, confirmatory material.

He will not necessarily confirm you in all things. The most satisfactory responses are those that are basically confirmatory, but with corrections. It is as if the patient were saying, “Yes, you are essentially right, but not quite. Here you are wrong.” Then one has the feeling one is understanding him and he feels understood. Knowing this, he will understand that his present task is to extricate himself from his parents and he will also realize that it is difficult. Then he will not blame himself too much for the kind of weakling he is. How could it be otherwise but very difficult since these same parents from whom he wants to separate himself are interfering now?

By the way, let me warn you right from the beginning not to take sides against parents. You do not start out fighting with him against others. This is, at least initially, a very poor policy. You are really doing the same thing the parents did before. You are taking the initiative rather than letting him find the initiative. He will gladly, as it were, fall into line again, but you will not get even the tiny bit of change that you hoped to achieve. Your task is to form some kind of a team with him in which his own base about himself is broadened. Then he will see, to some extent, the difficulty of the task. He will know it in terms of the history and of the present dynamics: that the parents who formerly interfered with his having initiative are now continuing to interfere. They probably make it even harder by being so solicitous. Then you show all the advantages he has from their solicitude but again, without blaming him, “It’s not that you’re a baby who wants to lean on others and cling. But this is the way your mind is now set, and it could not be otherwise.”

You do not try to persuade him to be anything he is not. First let him accept what he is; then, on the basis of this acceptance allow him to see that this task is quite a big one. “Of course you’re anxious when this happens. But anxiety is not necessarily a bad thing. This is something we will try to understand together.” By such an alliance you are not playing at an empty, flag-waving brotherhood, but real understanding, and modestly so, with the grasp in yourself of how likely you are to make mistakes. It is particularly difficult when the mind of the individual you are helping and his mode of functioning are indeed quite different from your own.

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1The therapist’s approximate understanding serves as optimal frustration. The individual then transmutes the therapist’s selfobject function into a self function. He not only understands what has been interpreted, he enlarges and modifies it or corrects it. It becomes reliable self understanding.
It is difficult to compare my therapy experiences in analysis with what I have gleaned from books. For books will never give you experience. The most well-written, gifted, insightful books will only prepare you for learning from clinical experiences. In other words, without my having studied Freud, as it were, I could not have learned from my patients. Still, what I learned from my patients, I did not learn from Freud essentially. This is only the background which has allowed me over the years to expand what I see. As I stated earlier, if you have worked in pathology, you know that one learns from looking through the microscope at innumerable pathology slides. So unless you have studied books that have originally given you the main configurations to search for, you have nothing to build on.

There is a patient that I have often drawn on here for illustrations. This is the same man who at one time made gross identification with me and then gradually subtler ones (Chapter 6, p. 77). This man's mind is actually very different from mine. He lacks many of the good qualities of my own mind, and I lack the very bent and splendid qualities of his mind. He has an enormously exact mind, and he will not let go of definitions in his own field, a very different field from psychiatry, until he has them down to the finest refinement. I have somewhat of a theoretical bent too, but his is a mathematical bent, and mine is not. The following situation arose: In the course of associating to a dream in a preceding session the patient associated in a way that seemed to me to get farther and farther away from the meaning of the dream. He associated, and he had associations to the associations. He took up one word and had a clang association to that word. I finally stopped him and said, "It seems to me that the way you're going about it, you're going farther and farther away from the mood of the dream. At the beginning we knew quite a bit more than where you seem to be going now."

He got furious at me for interrupting him. This was not the time to interrupt. This was his mode of thinking as against my mode of thinking. He thought it was leading somewhere, and my impatience had something to do with the fact that I could not give up the way I was for the way he was, something on that order. I was not in the best condition during that time, and I argued for a while, but I finally stopped. It wasn't easy for me. Sometimes one has days that are better than others.

This is the end of a long analysis in which the person has made tremendous progress. I have no doubt that some of his identifications with me gave me some kind of gratification that I'm probably now beginning to miss as he becomes more and more truly independent. His associations seemed almost like a caricature of independence, and there was kind of a battle between us. I had all kinds of splendid interpretations. I felt, "You my tong! who was supposed to have won."

The re-signifier what happened and have no idea. I This is what happened, and a new deep emotion was never before. For the sake of it, I feel the science—any after having specific it finally made.

In the following experience and made a rather big move which he governs the important patient. To take this unforced I've been depressed for some time to acquire anger, and had never spoken at all. So you today, as i
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...tions. I finally took my own advice to my students and supervisees to heart, "Whenever you want to say something, bite your tongue." So I bit my tongue and kept quiet. Even though I was right, it became a battle of who was going to have the last word, and it was obviously he who was supposed to have the last word, not I. So I achieved that tremendous victory over myself.

The reward came in the session afterward in the form of a flood of significant and important memories that I then recognized related to what happened the day before in our tiff about his free association and to what had happened all through his life. We had known this before. This is what one calls working-through, when the same thing comes up over and over again, as you have heard with this patient, and yet with new depth, new meaning and new emotions added to it. The major emotion was that he could do something to me the day before that he was never able to do before. He experienced how furious he was at his father for debunking him and for interfering, and he asserted himself in spite of it. The tiny trifle of newness was that he could, for the first time, feel the resentment fully and could maintain himself in the transferrence—and this is the important thing—in the actual rebellion against me for having interfered. I had interfered with his free associations in a specific way and that had led to a tiff with me in the previous session. I finally mastered my own reaction, which was a difficult thing for me to do.

In the following session the reward came when he told of an interesting experience. His father was strongly against a particular political party and made fun of it. While the patient was in college he was introduced to a rather liberal professor and began to attend many public functions at which he spoke. This was the first time that strong convictions about government had entered his life. Particular social issues became very important to him. It was sort of like a late adolescent experience for this patient. The parents came to visit him and the patient said he would like to take them to hear this man speak. When they walked out, there was an unforgettable moment when the father said, "The same goddamn stuff I've been hearing for 20 years." The patient did not have a feeling of depression, but a typical empty, drained feeling. The self-esteem drained out of his preconscious self-concept that he was beginning to try to acquire in an independent move. The important thing is he felt no anger then at the father whom he had always idealized and in whom he had never seen any shortcomings. He never went back to hear that speaker again, even though he was at that college for a number of years.

So you see the difference between what is happening yesterday and today, as it were, in the analysis. These are not issues that make or break
an analysis. This is only a tiny detail among thousands of others. If I had not found my way back yesterday, it would not have destroyed the analysis, for nothing can destroy this analysis anymore. But if one makes nothing but mistakes, that is a different story. This is an example of feeling oneself into another person. And it becomes somewhat more difficult when indeed the kind of mentality is of another type. This person too, as in the patient we were describing, comes to me and tells me about his particular research. He has very interesting research ideas which are very difficult for me to understand. They involve a great deal of mathematics and physics, which are not at my disposal, but it is not so much that. It has something to do with the whole mental setup being different. And yet I have to find my way in allowing him to be different, and not trying to be in his field what I am in my field. It does not fit the field, and it does not fit his personality.