Understanding the Patient's State of Mind: 
Affect Attunement and the Empathic-Introspective Stance

There is an enormous amount of activity going on, at a variety of levels (individual/system, intrapsychic/interpersonal, verbal/nonverbal, conscious/unconscious, to name a few) when therapist and patient work to make sense together. We focus in this chapter on the empathic-introspective stance and affect responsiveness because they are two, perhaps the two, necessary processes in effective psychotherapy. These two relational processes provide the underpinnings for the all-important therapeutic relationship. Furthermore, they are the building blocks of both subjectivity, as we will see, and of intersubjectivity. This chapter elaborates on these two fundamental processes of intersubjectivity theory: a mode of responsiveness—affect attunement, and a mode of listening—the empathic-introspective stance. In practice, the distinction is labored, as patients frequently experience affirmation simply when the therapist listens with an ear to what the patient is feeling about the story he is telling.

In theory and practice, important processes converge around
the phenomenon of two people seeking to understand the internal world of meaning and affective experience of one of them. Consider, for example, such questions as how one person can share the private experience of another, how one person uses her personal experience to make a connection with another, and what transpires between the two when an understanding connection is made and communicated. Any discussion along these lines quickly becomes complex and experience-distant. It is paradoxical that when we attempt to clarify and specify the processes that promote effective treatment, we often end up obscuring what seemed self-evident.

Although we use the terms empathic inquiry and empathic-introspective stance interchangeably, the empathic-introspective stance includes the therapist’s empathic inquiry both into the patient’s subjective world and into her own. Affect attunement refers to the therapist’s abilities to perceive correctly and respond meaningfully to various qualities of a patient’s subjectivity. We specifically avoid the use of the term empathy as it is burdened with a long and confusing history, which we discuss below. Of the two processes, the more encompassing is that of empathic inquiry, which includes comprehending a full range of contextual elements, such as the emotional, historical, behavioral, and cognitive aspects of the patient’s unfolding experience. In contrast, affect attunement straightforwardly describes what a therapist does or says in response to the patient’s emotional states. To borrow a metaphor from the world of radio communication, in the empathic-introspective mode, the therapist acts as receiver of signals or transmissions from the patient (and her own internal world). The therapist fine-tunes the signal in order to hear as clearly as possible the subjective affectate the patient is communicating. In a different mode, that of attuned responsiveness (particularly to affects), the therapist functions as transmitter of a signal to the patient as receiver.

Affect attunement and empathic inquiry are two-person processes. They materialize in the therapeutic dyad, an intersubjective field formed from the subjectivities of patient and therapist. Once again, the therapist’s subjectivity becomes both a source and a limiting factor for appreciating the subjectivity of our patients. To reiterate and elaborate some of our previous discussion, “subjectivity” refers to the sum of the personal internal experience of an individual, including much that is not conscious. Like the subject in a sentence, subjectivity is the totality of experience, action, emotion, and sensation, both conscious and unconscious, that an individual refers to when saying “I.” Subjectivity, however, cannot be separated from that which is intersubjective because “all selfhood—including enduring patterns of personality and pathology—develops and is maintained within, and as a function of, the interplay between subjectivities. . . . The principle components of subjectivity . . . are the organizing principles. . . . These principles, often unconscious, are the emotional conclusions a person has drawn from lifelong experience of the emotional environment, especially the complex mutual connections with early caregivers” (Orange et al. 1997, pp. 6–7).

Each element of the theory is inextricably connected to the other. Subjectivity consists, in part, of organizing principles, formed out of lived emotional experiences with childhood caregivers. The context for the creation of the organizations of experience is the intersubjective field of early childhood, primarily the subjectivity of the caregivers as they learn to understand and respond to the unique temperament and personality of their child. A key factor in the quality of that early context is the capacity of the caregivers to appreciate and respond in soothing and affirming ways to the emotional life of the child. Therefore, a child’s experience of being understood or not, especially when he contends with intense affects, is the intersubjective context (lived experience) out of which his subjectivity develops. There is no subjectivity without intersubjectivity. The critical features of the intersubjective field as it contributes to positive and stable subjectivity are those experiences that affirm, regulate, and
integrate affect for both members of the dyad. It is always a system of mutual influence, with the subjectivity of each member of the dyad continually and inevitably shaped by the other.

AFFECT RESPONSIVENESS IN INTERSUBJECTIVITY THEORY

A therapist’s sensitivity to affects is fundamental to the intersubjective approach to treatment for two reasons. First, as we have noted earlier, affectivity is considered the primary organizer of experience. The way we organize our experience and the principles we develop to make sense of that experience have emotion at their core. The templates formed around repeated or highly intense affective moments contribute to our development in various ways. As an example of the process, a vivacious single woman in her mid-30s became overwhelmed with anxiety whenever she participated in casual, flirtatious banter with men. For her, early experiences in which her father and older brother responded to her playful seductiveness with irritation and discomfort left her feeling bewildered and ashamed. As an adult, she believed that she was behaving inappropriately whenever she enjoyed the attention of men and responded to it. She made sense of the early affect of shame by constructing a view of herself as “silly and bad.” She fit subsequent exciting interactions into these organizing ideas about herself and was left with feelings of self-loathing.

Second, affect identification, regulation, and integration are fundamental to promoting in our patients a stable, cohesive, and continuous self-experience. To extend the previous example, this patient recognized her responses of shame and bewilderment and subsequently developed an appreciation of their original intersubjective context. That is, she accepted her childhood wishes to be seen as pretty and special and recognized the discomfort of her father and brother with her playfulness—key contextual features of her early lived experience. Over time, as she understood herself and felt herself understood, her intense anxiety subsided. These transformations of affect are essential to the creation of new organizations of experience, an important goal of treatment from an intersubjective perspective. Clearly, the therapist’s developing capacity for affect attunement is critical to becoming an effective clinician.

Humans are distinguished from other species in part by their capacity for abstract thought. This stunning intellectual capacity often overshadows the vitally important emotional underpinnings of our evolutionary adaptation and our psychological life. Any attempt to discuss effective treatment practices must address the phenomenon of affect. As Nancy McWilliams (1999) straightforwardly asserts, “For therapists, attention to affect has never been a choice. Patients fill our offices with their feelings” (p. 105). When emotions cannot readily be observed, therapists note, wonder, and explore their apparent absence. The therapist’s personal emotional experience of working with a particular patient, in general, and at particular moments in treatment, provides essential clinical information. More than any other single factor, affective understanding grounds and guides effective treatment.

Our emphasis on affect attunement in the practice of psychotherapy places us at the center of cross-currents of contemporary psychological theory and research. Interest and debate associated with the role of affective experience in treatment extends beyond psychodynamic practice. Neuropsychologists (Grigsby and Stevens 2000, Schore 1994), cognitive theorists (Ekman 1984), process/experiential therapists (Gendlin 1996, Greenberg et al. 1999), trauma theorists (Krystal 1988), and infant researchers (Emde 1983, Tronick 1989), among many others, recognize the pivotal role played by emotions in personality development. From our theoretical perspective, affects serve as the substrate of organizations of experience. Therefore, recognizing, exploring,
and integrating affects become fundamental to creating new organizations of experience.

If patients become emotional in the consulting room or appear numb to their emotions, we as therapists are contributing to their experience. “Affectivity is something that from birth onward is regulated or misregulated, within an ongoing intersubjective field” (Stolorow et al. 1999, p. 382). Inevitably, then, affective experience will be an important component of the intersubjective field created in the context of psychotherapy. In treatment, affect, or a significant lack of it, points the way to personal meaning and reveals in-the-moment processes within the intersubjective context—what is happening between therapist and patient. Therapists working from the perspective of intersubjectivity theory line up with generations of psychotherapists of many persuasions who have considered affect the “gold” of a treatment hour (Lichtenberg et al. 1992), invaluable in identifying and understanding a patient’s deeper experiences of both their formative early life and the immediate therapeutic relationship.

In the evolution of psychoanalytic ideas, and for intersubjectivity theory in particular, affects have replaced drives as the central motivational construct. As we integrate findings from infant research, neuropsychology, and ethology, we find convergence around the centrality of affect for making sense of personal experience. Much has been written about emotion, and theories of emotion include evolutionary, psychophysiological, neurological, and psychodynamic constructs, each deriving from a particular scientific tradition (Plutchik 1980). However, an extensive exploration of these theories is beyond the scope of this book. For our purpose—to enhance the capacity of therapists to notice and respond to their patients’ affect—we offer a brief overview of generally agreed upon ideas.

Tomkins (1962, 1965), Plutchik (1962, 1980), and Izard (1971, 1977) identified several primary inborn affects of infants. Roughly, these can be grouped as either positive or negative. According to Izard’s (1971) typology, they are interest-excitement, excitement-joy, surprise-startle, fear-terror, distress-anguish, anger-rage, contempt, disgust, and shame-humiliation. Tomkins (1962) proposed the emotional categories of interest, surprise, joy, anguish, fear, disgust, and rage. So, from two basic emotional states, distress and contentment, the fundamental affects appear spontaneously in newborns. As development proceeds, the subtlety and variety of responses increase, giving nuance and texture to our emotional life.

The hard-wired, observable emotions identified by Tomkins and others appear to be responses to either internal or environmental stimuli. When physically uncomfortable, as in the cases of hunger, pain, or exhaustion, distress-anguish, fear, or a related negative affect may register. When the infant whimpers or screams, an attentive adult moves into action to relieve the discomfort. Alternatively, the social smile, contented gurgling, and expressions of absorbed interest of infants stimulate siblings, parents, and the casual observer spontaneously to engage with them. Clearly, affective signals are vital for an infant’s survival and optimal development. In addition, they guide the efforts of caregivers to soothe or stimulate the child. In the process, when all goes well, caregivers and baby create ways of relating in which each of them feels effective and cared for.

Lichtenberg (1989) and Lichtenberg and colleagues (1992, 1996) link the biology of affects with psychological motivation; they posit five interconnected motivational systems, each with characteristic affects that function across the life span: (1) the need for psychic regulation of physiological requirements, (2) the need for attachment-affiliation, (3) the need for exploration and assertion, (4) the need to react aversively through antagonism or withdrawal, and (5) the need for sensual enjoyment and sexual excitement.

During infancy, each system contributes to self-regulation in mutually regulatory interactions with caregivers. . . . The
“self” develops as an independent center for initiating, organizing, and integrating motivation. The sense of self arises from experiencing that initiating, organizing, and integrating. Experiencing has an active (agent) and passive (receptor) mode. . . . The vitality of the motivational experience will depend initially on the manner in which affect-laden exchanges unfold between infants and their caregivers. . . . Lived experience is about how we human beings consciously and unconsciously seek to fulfill our needs and desires by searching in potential events for affects that signal for us that experiential fulfillment. [Lichtenberg 1989, pp. 1–2]

Lived experience, affects, needs, and motivation operate interdependently. So, for example, Lichtenberg and colleagues (1996) suggest that affective experiences associated with the attachment-affiliation motivational system include “affection, trust, love, contentment, generosity, pride, respect, courage, optimism, and moral goodness. . . . To the sugar of these feelings, the spice of moments of anger, doubt, envy, jealousy, fear, shame, and guilt intensify an attachment experience” (p. 128). Patterns emerge from lived experiences that color attachments throughout life. In a similar way, individuals form characteristic combinations of affects that influence how they go about meeting their needs in all areas. The feelings associated with activities such as assertion, ambition, or sensual pleasure derive from early lived experience and they recur repeatedly in many contexts. By attending to affects, we are alert to what needs patients may be revealing and to their characteristic ways of organizing around these needs.

Affects, then, arise in the body either to signal and/or to amplify internal experience or in response to external circumstances. They alert us to what is happening and guide us to satisfaction of our needs. From the beginning, they are powerful constituents of our subjective and relational lives. Emde (1988a,b) has described a very similar scheme based on what he considers the biological preparedness of the affective core of self. He concludes that subjective affective experience, expressed and regulated in the caregiving context has “adaptive function in facilitating self-development—that is, in sustaining and enlarging working models of the three dynamic aspects of the self system: (a) the experience of self, (b) the experience of the other (e.g., attachment figure), and (c) the experience of self with other or ‘we’” (1988a, p. 37). These aspects of what he refers to as the self system are inextricably joined. Our organizations of experience (in Emde’s vocabulary, our working models of ourselves) form at the interface of affect expression in the caregiving surround. In other work, Emde and Sorce (1985) cite the emotional availability of the caregiver as a primary factor in the levels of pleasure, calm, and curiosity of infants. Orange (1995) makes the case that similar emotional availability is an intersubjective quality in the treatment of adults. She characterizes such availability as a readiness to attune and respond to the patient’s emotional expressions in an atmosphere of safety.

Infant studies and theories of affect provide for clinicians a topographical map of how to understand the emotional expressions of our patients—not a street map with each boulevard, lane, and landmark designated; not a trail map, with one well-trodden path clearly marked. The preceding ideas on affect reflect not a universal developmental perspective with milestones unfolding in sequence, but rather a contextual, dynamic view of development. They are offered here to provide therapists with some sense of how emotional expression relates to the intersubjective world of the patient. Just as the relational world of the young child gives rise to emotions and shapes their appearance and fate, a therapeutic relationship offers the possibility for recontextualizing needs for attachment and assertion, for example. The dimension of affective expression in the context of a different lived experience in treatment allows for the transformation of core organizing principles. Is the patient offering us a glimpse of an accomplishment with pride and appropriate exhibitionism at the
core? Or do we sense fear in the lack of anything to say? We don’t know the meaning of our patients’ emotions without exploring them together. However, we set the stage for the work of making sense of the affect by being available to notice it and by our conviction that it is important. For us, it is the thread we follow to find what is personally meaningful to our patient.

As Emde (1988a) states, “Because our affective core touches upon these aspects of experience which are most important to us as individuals, because it organizes both meaning and motivation, it also allows us to get in touch with the uniqueness of our own (and others) experience. . . . It is the emotional availability of the caregiver in infancy which seems to be the most central growth-promoting feature of the early rearing experience” (p. 32). We recognize that what originates in infancy within the caregiving surround does not correspond literally to the therapeutic dyad. Patients are not infants and therapists are not parents. However, our ability as therapists to recognize and even to share the affective experiences of patients is profoundly important to growth and change in treatment.

Stolorow and Stolorow (1987) focus in depth on the nature and quality of responsiveness to patient’s affective states in treatment. Regarding a developing sense of self, the authors point to the relationship between the integration into self-experience of “affect states involving pride, expansiveness, efficacy, and pleasurable excitement [and] the consolidation of self-esteem and self-confident ambition” (p. 68). In contrast, “early experiences of oneness with idealized sources of strength, security, and calm, . . . indicate the central role of soothing, comforting responses from caregivers in the integration of affect states involving anxiety, vulnerability, and distress” (p. 68). They link what is needed from the caregiver with the specific positive or negative affective state of the infant. To develop ambition and positive self-regard, caregivers must accept and affirm a child’s early efforts to learn, to do, and to show. To support the capacity to tolerate and modulate affect, caregivers soothe children when they are upset. By a short and direct leap, we infer that a therapist’s capacity to identify correctly a patient’s affective expression bears directly on the nature of her response. The accuracy with which the therapist understands the emotional experiences of her patient and her own emotional availability in affirming or soothing them contribute much to the patient’s improvement. (And, significantly impact the therapist, as well.)

Infant and caregiver and patient and therapist form dynamic dyads operating as self- and interactive regulation systems (Beebe and Lachmann 1998). What is being regulated is affect arousal for each member of the dyad. The implications for understanding treatment processes are enormous, and we deal with them extensively in subsequent chapters. However, in our present discussion we note that, as a system, whatever feelings or behaviors an individual expresses is a function of the operation of the system, not the exclusive domain of either individual. As mentioned above, Emde (1988a) identifies three aspects of the self system: the experience of self, the experience of other, and the experience of self-with-other. We extend his schema to the dyad. That is, wherever in the self system a person’s (subject’s) attention is focused (whether on self, other, or self-with-other), what is felt and experienced is inextricably related to the dyadic system. Any feature of one member of the pair can be understood fully only in terms of how each is simultaneously experiencing self-arousal and emotional regulation within the dyadic context.

Beebe and Lachmann (1996) identify affect as central to each of their “three principles of salience in the organization of the patient-analyst interaction” (p. 7). The principles are metaphors derived from infant research that the authors consider applicable to adult treatment. They are (1) ongoing regulation, (2) disruption and repair, and (3) heightened affective moments. The authors consider heightened affective moments to be jointly constructed by both participants. An expectation of how the interaction will go is transformed for both analyst and
patient. Simultaneously, the patient’s state is dramatically transformed. These moments can be integrative, thereby altering the transference. The therapeutic action of heightened affective moments is mediated through state transformations that potentially usher in opportunities for expanded self-regulatory range and altered patterns of mutual regulation. [p. 7]

In the language of intersubjectivity theory, since experience is organized around affect, experiences of affect in treatment provide opportunities for new organizations to form, as well as for growth in the areas of self-regulation and sharing of affect states.

We wish to extend the discussion of shared affective moments beyond mutual influence and mutual regulation. In terms of our discussion of affective expression within an interpersonal world, we understand intersubjective influence and regulation to be operating at birth. Later, at the age of 7 to 9 months, infants develop a capacity to recognize shared affective experience (Stern 1985). When an infant expresses emotion and that expression is mirrored or matched by a caregiver, the infant can notice that the other is experiencing the same subjective state. Stern gives the following example:

A ten-month-old girl finally gets a piece in a jigsaw puzzle. She looks toward her mother, throws her head up in the air, and with a forceful arm flap raises herself partly off the ground in a flurry of exuberance. The mother says “YES, thata girl.” The “YES” is intoned with much stress. It has an explosive rise that echoes the girl’s fling of gesture and posture. [p. 141]

Stern describes this state as interaffectivity, an intersubjective experience that includes recognition of shared experience. So, not only is mutual influence continually operating in the service of regulating the arousal and behavior of each member of the dyad, but also sometimes the two subjectivities share a common emotional experience (interaffectivity). This can happen when either of the pair notices some demonstration of emotion and does something that the first one recognizes as a match. These are clearly powerful moments. Infant researchers will have more to tell us about the meaning of these preverbal experiences. Such shared moments probably represent the point at which empathic inquiry has informed the response of the onlooker. In a complementary way, the one whose affect inspired the response feels noticed and understood. The combined result is a shared experience that certainly contributes to formation of a bond between the two.

A final instance of how affect contributes to a core organization of experience in early childhood is that of attachment. As an infant matures and becomes mobile, an attachment to a particular caregiver ensures his proximity to someone who will anticipate his needs, recognize his distress, and protect or soothe him. At other times, the attentive caregiver may facilitate exploration or provide appropriate stimulation. When the child is excited, curious or feeling bold, the attachment bond serves to keep him safe and allows learning and exploration to unfold without the inhibiting effects of anxiety, fear, or pain. At the same time, joy, excitement, and shared pleasure enhance learning and development. Clearly, the flux of affect states becomes a kind of rhythm on which the melody of maturation unfolds. In other words, affects are part of an infant’s subjective experience from the start of life and are the seeds around which patterns of organization form. They also provide the glue of attachment, in particular, and relationships, in general.

Given the centrality of affects in self- and relational experience it comes as no surprise that problems with affect can become psychological problems. If affective states are repeatedly experienced as extreme and not well modulated by the environment, we believe that infants develop self-protective adaptations in order to achieve a sense of physiological equilibrium. For example, the infant may look away and withdraw from interacting, may escalate
crying to a red-faced bawl, or may find his thumb to suck. The affect and whatever somatic signals accompany its onset, the behavioral adaptation to contain the affect, and, eventually, the meaning the episode comes to have for a child are all of a piece. Although explicit memories of specific very early experiences are not available to the adult who enters treatment, we are certain that intense (or inhibited) affects will be revealed in the treatment as central to each organization of experience and to understanding the worldview of our patients.

An alternative psychological problem to the one discussed above, modulating and containing affect, is the situation in which the patient’s affective experience appears empty, depleted, or undifferentiated. In some, the early, inborn emotions we described above seem to go underground. Those experiences of the developing child where strong affects must be disavowed or dissociated in order to maintain needed ties to caregivers are especially pathogenic. As adults, they appear to have little zest for life or not much feeling about anything or anyone. In these cases, the therapist will notice the absence of affect or difficulty in discriminating among affects or even the relationship between bodily sensations and affect states. We have more to say on the ways a therapist works with a patient to vitalize and differentiate affective experience in our subsequent discussion of selfobject functions provided by therapists. At this point we simply point out the importance of recognizing the nature of a patient’s affective expression as a significant element of the patient’s experience.

We list briefly, however, the ways that a therapist may respond to affective expression by a patient. First, she may recognize affect where the patient does not. The patient may not recognize that what he is feeling is a feeling or may not have words for the experience. By identifying and naming affects and helping the patient differentiate them, she is facilitating self-delineation. Second, a therapist may need to match or affirm proud or expansive affects in order to solidify a capacity for joy and pleasure in the sense of self. Third, by noticing, tolerating, containing, and modulating negative affects such as fear, sadness, or anger, the therapist can facilitate their integration into the sense of self. These efforts support increased cohesion and consolidation of self-experience. Clearly, articulation, regulation, and integration of affective experience in our patients enhance their subjective world. As we have tried to describe, in the process the therapist both contributes to and is changed by the work.

We wish to highlight the difference between noticing affect and sharing an affective experience: the former is a clinical practice to be developed and refined with time and experience; the latter is an ideal that will sometimes materialize out of careful, disciplined attention to the subjectivity of our patients and at other times will come spontaneously.

**THE EMPATHIC-INTROSPECTIVE STANCE AND INTERSUBJECTIVITY THEORY**

*Empathy* is an often-used term but a poorly understood concept. Like other powerful human capacities, empathy is something we recognize but find difficult to explain. Theorists agree that “it” is probably an essential element of any successful treatment, and intersubjectivity theorists, when referring to the empathic-introspective investigatory stance, consider empathic listening to be a bridge to the subjectivity of the patient. As such, the affectively attuned responses of the therapist based on her empathic understanding make possible a special kind of subjective experience for the patient, one that includes feeling known and understood, and one that provides the basis for a new organization of experience.

In Chapter 1, we described the distinction made by Kohut (1959) and discussed by Stolorow (1994a) regarding empathy as an observational stance in contrast to an emotional bond. In an attempt to reduce confusion, Stolorow suggests that empathy and other related terms refer to the particularly psychoanalytic
method of gathering information on the subjectivity of the patient. For the connection between two people, the particular bond created through feeling understood, he offers the term “affective responsiveness” (p. 44). In this chapter we focus on the therapist’s attempts to enter the inner experience of the patient, that form of empathy referring to the mode of psychoanalytic investigation. We also identify the affective processes in the patient and the listening strategies of the therapist. In a subsequent chapter we develop more fully the idea of relationship in the context of intersubjectivity theory, and, thereby, address the other, more universal, understanding of empathy as a “powerful emotional bond between people” (Kohut 1982, p. 397).

Empathic inquiry refers to the therapist’s attempts to understand the internal world of the patient. While the traditional self-psychological stance was for the therapist to put herself into the patient’s experience, understanding the patient from the patient’s point of view, intersubjectivity theory recognizes that whatever the therapist sees in the patient’s experience is colored by her own lens. Therefore, while our work is patient-focused, we can never fully know the patient’s experience except as it is filtered through the subjectivity of the therapist.

Listening to the patient, understanding the context of the patient’s life experience, and reflecting that understanding to the patient constitute the essential aspects of empathic inquiry. As simple as it sounds, recognizing the perspective of the patient poses the biggest challenge to clinical work, in our opinion. Beyond this, to work intersubjectively means grasping the “inner pattern” of the patient’s life (Atwood and Stolorow 1993, p. 28) while maintaining our sense of our own subjectivity. “Grasping” another’s subjectivity is what is meant by empathic understanding.

Understanding formed out of empathic inquiry concerns what is near to the experience of the patient. Psychoanalytic theories include many complex concepts having to do with intrapsychic processes, particularly unconscious dynamics. As guiding principles for therapeutic technique, they can position the therapist far from the patient’s immediate experience. However, attuned affective responsiveness is measured by the way it connects to what rings true to the patient. To be experienced as attuned, a therapist’s response must feel right to the patient. So, ultimately, attuned responsiveness is what the patient experiences as attuned. We do not mean, however, that attuned responsiveness only connects with what the patient is aware of or has previously recognized. We mean simply that responses arising from the therapist’s grasp of the patient’s personal reality resonate emotionally and intellectually for the patient. The responses do not seem far-fetched, critical, or untrue. Rather, even if the articulation communicated by the therapist has never consciously occurred to the patient before, it seems genuinely to make sense.

An important corollary to empathic understanding and attuned responsiveness is that our theory of intersubjectivity does not dictate to us what the content or meaning of the patient’s experience is. Consequently, we assume nothing specific about why a patient acts in certain ways. Our theory only informs us, as we discussed in Chapter 1, that (1) humans are prewired to influence each other, (2) humans continually and inevitably organize their experience around frequently repeated patterns of interaction and associated affect states, (3) the vitality and solidity of one’s subjective sense of self significantly determine one’s level of functioning in virtually every area of life, and (4) the experiences of making sense together of one’s core organizing principles and of feeling understood provide the possibility for new organizations of experience. Based on these assumptions, we attempt to engage the patient’s experience to articulate our understanding of that experience to the patient.

We enter into a therapeutic dialogue oriented by three aspects of intersubjectivity theory: our assumptions, our attitudes, and our subjective experience. Our assumptions concern notions of mutual influence and the nature of human beings to organize experience. Our attitudes include the conviction that the patient
strives for health, that no predetermined meaning can be imposed on the patient's experience, and that we try to understand rather than fix the patient. Regarding our subjective experience, we have said that our capacity to enter into the worlds of our patients is limited by our own subjectivities. However, that very subjectivity is one significant source for understanding the other person. "Introspection" in the empathic-introspective stance refers to two processes: looking within ourselves for analogues or clues to what our patients are experiencing and attending to our contribution to the intersubjective field (Stolorow 1994b). We do this tentatively, fully aware that what we notice within are our affect, our associations, and our meaning formed at this moment in this particular intersubjective context. Thus, introspection allows us into the private worlds of our patients and ourselves.

To illustrate the nature of understanding developed from the empathic-introspective stance we offer a brief example. It is important to note that the patient's experience was not fully conscious for her, that the therapist's attempts at supporting and normalizing the patient's experience were not "warm" (what is popularly thought of as empathy), and, finally, that following up on the patient's emotions provided the key to understanding the patient's experience.

A woman in her early 40s, the stay-at-home mother of three school-aged children, talked intermittently in treatment about the parenting style of a close friend and her husband. She focused extensively on her friend's husband and his limitations as a father, his inability to understand his sons' behavior, and his blundering attempts to be a parent. The patient was unaware of the source of her fascination with this couple, particularly with the husband's rigid and harsh manner with his sons. The therapist's initial responses explored the connection between her friends' parenting and the patient's own experience as the child of similarly unresponsive caregiving. These interventions were based on a view of the patient's childhood relationship with her parents, whose style was not abusive, but distracted, uninterested, and rigidly moralistic. Despite the positive and supportive nature of the therapist's responses, the patient remained troubled and unsatisfied by them. The therapist's initial view that the meaning of the patient's fascination with her friends' parenting style had to do with her being the child of comparable parents did not match with the patient's subjectivity. Only when the therapist "got" that the patient feared her own inability to understand her children and her impulses to respond harshly and rigidly with them did the patient feel that both she and the therapist understood why she was so interested in her friends' parenting behaviors.

The therapist's nonjudgmental acknowledgment of the patient's fears became the basis for further work, including the patient's emotional reconnection to her isolated and barren relationship with her own parents. The therapist's ultimate understanding of the patient's sense of herself as a blundering and insensitive parent opened the treatment in a way that had been blocked previously.

To further elaborate the elusive concept of the empathic-introspective stance, we note a few cases of what empathic understanding is not. In general, from our supervisory work with students first embarking on the practice of psychotherapy, we notice their mistaken belief that empathy corresponds with any positive response to the patient. Students frequently preface their case presentations with a remark such as, "I really tried to empathize with what the patient was talking about," and then proceed to describe agreeing with the patient, dismissing the patient's worries, endorsing the patient's behavior, or a host of other affirming actions. These interventions suggest the confusion we noted earlier between what is popularly considered to be empathy and its technical meaning for psychotherapists working intersubjectively. To further clarify some of this confusion, we
address a few of the specific misconceptions about empathy that we encounter with supervisees.

The most common error is the confusion of sympathy with empathy. Sympathy represents the concordance of experience between two people—the feeling state in one is similar to that of the other. If I sympathize with another, I hurt for him based on how I would feel in that circumstance. Faced with similar events, our reactions coincide. However, responses derived from a stance of empathic listening are specifically based on a vicarious experience by one person of the emotional experience of another and of its meaning for that second person. We do not focus on what we would feel in a similar context but on how we sense the patient feels. The distinction is critical, as the cornerstone of psychotherapy from the intersubjective perspective, once again, privileges the subjective experience of the patient.

The crucial difference between empathy and sympathy is that empathy refers to a way of listening to the patient’s experience, and sympathy is a response from the therapist based on similarity of experience between patient and therapist. So, for example, hearing that a patient spent the weekend isolated in his study, working to meet a grant deadline, a therapist might respond, “You’re furious at losing an entire weekend to work!” Such a response, based on the limited information given, is as likely to derive from how the therapist might feel in a similar situation as from the patient’s actual experience. While we do advocate that the therapist articulate her tentatively held understanding of the patient’s affective experience, this must be done with an awareness of and appreciation for the fallibility of the therapist’s understanding. The point is not what the therapist thinks and feels but what the patient thinks and feels, and therapists, in order to facilitate exploration of the subjectivity of the patient, must be alert to the difference.

A second mistaken effort that derives from the notion of empathy as a way of responding results from a therapist’s intervening with a personal endorsement of the patient’s behavior.

While the patient may find such interventions gratifying or validating (or, ironically, gratuitous, hollow or demeaning) they are the value-laden opinions of the therapist and not the therapist’s understanding of the patient and its meaning for the patient. So, responding with “Good for you!” or “I’m proud of you!” or “That’s awful!” is not an understanding grounded in the empathic-introspective stance. Such interventions are not outside the range of appropriate interventions, but they do not necessarily represent responses based on accurate reading of the patient’s subjectivity. When appropriate, such interventions represent the therapist’s attempt to interrupt the patient’s self-pathologizing and to support the patient’s striving for health. The essence an empathic-introspective stance is not, as is so often believed, for the therapist to be accepting, nonjudgmental, or kind, however therapeutic such responses may be. Empathy refers to a way of understanding the patient’s experience, not the therapist’s response to that experience.

Responses formed out of empathic inquiry do not minimize or reframe the experience of the patient. Interventions designed to make a patient feel better by telling him that what he fears or believes is “catastrophizing” or “black and white thinking” are not necessarily attuned, even if they are descriptive. For example, one patient with intense anxiety in interpersonal situations consistently interpreted the occasional hurried brusqueness of her co-workers as signs of their (anticipated) rejection of her. No amount of reasoning or reality testing altered the patient’s conviction that she had finally been cast out by her peers. Only through repeated exploration of numerous instances of this experience did the patient and therapist come to make sense together of the patient’s view of herself as a burdensome annoyance with whom others inevitably get fed up. Because this organization of experience pervaded her subjectivity, a more realistic appraisal of the meaning of her co-worker’s intentions had no impact on the patient’s level of anxiety. Only when the therapist understood well enough how, as a child, the patient had
repeatedly felt that her overburdened and perfectionistic mother was frustrated with her age-appropriate needs and limitations, could the patient become less anxious in anticipation of going to work.

While subjectivity and objective reality are not mutually exclusive, the realm of experience available for observation and reflection in psychotherapy is that of personal meaning for a patient. The given of life—our gender, basic level of intelligence, early educational opportunities, ethnic heritage, or family configuration, to name a few—clearly have a reality that cannot be reduced to the subjective. However, the personal meaning created around such given is highly subjective and is grist for the psychotherapy mill. Focusing on how things really are is a wild goose chase for therapists and can leave patients feeling challenged, scolded, and misunderstood. Noting objective circumstances and the way they come to play in the treatment is highly important in therapeutic work when the patient wonders about them or when introduced with an ear to what the meaning is for the patient. From our perspective, when the therapist finds herself focusing on the realities of the patient’s life, some anxiety about helping or feeling competent or being evaluated may have become activated in the therapist.

An attractive Chinese woman in her 30s experienced almost delusional levels of fear over social relationships at work. Over many years of treatment and in scores of work and social situations, the patient described interactions in which she was sure that a casual look or statement meant that the other person was judging her as stupid, weird, or, worst of all, a pervert. The therapist believed that the patient’s observations amounted to projections of her own intolerable subjective judgments of herself. Whenever the therapist lapsed into trying to clarify what had objectively transpired in an interaction, the treatment inevitably veered toward misunderstanding and disruption. The patient felt that the therapist did not believe her and, ultimately, could not accept her as she was. When the therapist examined her own subjectivity regarding this recurrent scenario, she found that accepting as subjectively valid the patient’s paranoia felt to her as if she were colluding with the patient in a distortion of reality. The therapist valued highly her own capacity for reason and objectivity as a source of positive self-esteem. Only when the patient poignantly observed that the therapist appeared unwilling to accept the perversion within the patient did the overlapping and interplay of interacting subjectivities clarify for the therapist. The therapist wished to bypass or override the patient’s experience of feeling like a pervert by focusing attention on how she misconstrued what people were seeing and thinking about her. By failing to see the world as the patient saw it, the therapist paradoxically contributed to the patient’s feelings that her most private self-experience was offensive to everyone.

The following vignette concerns the treatment of a woman very much out of touch with her emotional core. Kim presented a challenge for her therapist because she showed determination and energy in attacking many problems that befall her. Kim’s attitude initially left the therapist bewildered about why she was not able to create a life that included the intimacy and satisfaction she claimed to want. The therapist watched and listened closely to the patient’s descriptions of her frustrations with co-workers and unsatisfying telephone conversations with family members. Over time, a picture of Kim’s early family life, including the quality of the atmosphere at home, took shape in the therapist’s mind. Repeatedly, the therapist looked within herself for emotional reactions to potential meanings of day-to-day events that Kim talked about in her sessions. Gradually, the therapist sensed the feelings of insignificance and inferiority at the heart of Kim’s organization of experience. An organizing principle of Kim’s
subjectivity was that she not display her emotions in order to preserve needed ties to others.

The patient, who seemed both too young and too old for her 36 years, tried to find a starting point for the session and began retelling a conversation with a friend from a few days earlier. It was a story of the patient’s friend whose daughter, at age 25, gave birth to a baby, prematurely, after a risky, complicated pregnancy. The baby died after one week. Both grandmother and mother made heroic efforts to comfort their daughters, with special concern that they not feel alone. At first the patient choked back her tears but gave up and let them flow freely. When the tears were spent, she looked at her therapist, as if to ask what it all meant. So they began to explore this powerful experience. Initially, she had no idea why she would be so moved by the story of maternal love and protectiveness. Her sadness and tears didn’t connect with any conscious memories or wishes or any sense of herself as identifying with one of the characters.

Sitting across from her, the choice of story and her tears made sense to the therapist. Her own brusque, competent mother believed that the way to launch her children in life was to make them tough, cynical survivors, and she responded to complaints of stomachaches and sore throats with, “It doesn’t hurt. You’ll be fine once you get to school.” And, in fact, the strategy of this patient’s Korean mother, who was determined that her children be successful Americans, accomplished just that. But the price was high, and two years ago, with a dawning awareness that her frenetic work pace and active social schedule camouflaged a life without deep intimacy or the prospect of a family, the patient entered treatment. That she cried openly was very different from her initial matter-of-fact, no nonsense, business-like attitude. As the therapist articulated her understanding of her story, the patient wept softly. She felt sad for herself at age 5, going off to school for the first time, unable to speak English, and knowing no one, sobbing while her mother walked resolutely away.

This vignette highlights a number of significant therapeutic tasks. For this patient, experiencing emotion and understanding its connection to both her early life and her current dissatisfactions has taken enormous effort. She is not a victim of physical or sexual abuse, and in most areas of her life she functions very well. However, her difficulties with emotions are at the core of her problems with intimacy.

SUMMARY

Therapy that is practiced from the stance of intersubjectivity theory weaves together an empathic listening stance and affect responsiveness to promote affect recognition, affect regulation, and affect integration in the patient. The more accepting we are of our own affects, the easier it is to engage with another in an emotionally intimate relationship.