Who Are You, Who Am I, and Where Are We Going: Sustained Empathic Immersion in the Opening Phase of Psychoanalytic Treatment

Richard Geist, Ed.D.

There is a striking dearth of general, postmodern articles on the beginning phase of analytic treatment, and none that focus on how a particular analytic couple initially cocreates that risky, emerging therapeutic dialogue that will partially determine whether patient and analyst can reorganize their experience in ways that facilitate mutual growth and healing. In an effort to correct the lack of attention to this neglected but important phase of treatment, this article offers a way of listening and responding in the opening phase that is rooted in an unwavering empathic stance. It attempts to (a) define 3 overlapping modes of empathy and how they interweave as treatment commences; (b) explain why it is in the best interests of the patient and the analyst to remain immersed in an empathic stance during the opening phase; and (c) suggest how remaining in an empathic stance enables the analyst to use his or her subjectivity and authenticity in the service of the patient's growth. Using verbatim clinical material to illuminate how the analyst's initial, sustained, empathic inquiry (mediated through the analyst's own subjectivity) informs our understanding of the analytic endeavor, it delineates a clinical sensibility and theoretical-philosophical orientation that facilitates new patients remaining in and deepening the treatment.

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There is a striking dearth of general, postmodern articles on the beginning phase of analytic treatment and none that focuses on how a particular analytic couple initially cocreates that risky, emerging therapeutic dialogue that will partially determine whether patient and analyst can reorganize their experience in ways that facilitate mutual growth and healing.

No period of treatment is fraught with such a vacillating admixture of anxiety, hope, concern, optimism, skepticism, suspicion, confidence, and risk than the beginning phase of psychoanalysis or intensive psychoanalytic therapy. It is, after all, the beginning of an unnatural relational encounter between two strangers, and a tenuous slipping and sliding toward the cocreation of something new and usually unpredictable. The analyst is offering the patient himself as a subjective medium that facilitates the resumption of thwarted development in a way that can indelibly affect the patient’s life, although many patients do not really know this yet. The patient, also unknown to her, is offering the analyst a means to fulfill wishes, (selfobject) needs, and fantasies, however much they remain unarticulated, that have a profound influence on the analyst’s experience of himself as a vital, creative, useful clinician and person. What the patient wants from the analyst is ambiguous at best and depends on the state of her self; it may also change fluidly in the beginning of treatment according to the fluctuating state of the analyst’s self and his resulting receptivity to the patient. What each wants and needs from the other may also change concurrently with the rendering and concealing that underlies each participant’s intersubjective capacity for risk at the beginning of treatment. Neither participant is sure what will happen in the treatment, how deep it will take them, and where it will take them.

1For a review of the literature, see Lichtenberg and Auchincloss (1989). Lichtenberg’s review includes a summary of Anna Ornstein’s belief that the opening phase is characterized by “the patient’s efforts to seek or to ‘locate’ the analyst—to assess his emotional availability and to define his limitations.” But as far as I know, this is the only self-psychological comment on the opening phase. It is fascinating that in the 20 years Progress in Self Psychology has been published, it contains not a single article on the beginning phase of treatment. Jacobs (1991) has published one of the few clinical articles on beginning treatment and edited one of the few books on the topic (Jacobs and Rothstein, 1990).

2The beginning phase of treatment is defined simply as that time period before the transfersences “click in” (Kohut, 1984, p. 178) and become more stable.

3The case material in this article describes a male clinician and a female patient, and therefore I refer to the analyst as “he” and the patient as “she.”

Sustained Empathic Immersion

I first became interested in the intricacies and subtle nuances of this initial stage of treatment as a result of consulting with numerous patients whose first attempt(s) at treatment had failed. As a relational self psychologist committed to prolonged empathic immersion in my patients’ world, my own world, and the inevitable impact of our respective subjectivities on each other from the initial consultation onward, I began to realize over the years that there were commonalities in how I listened and responded within the beginning, cocreated ambience that allowed some of these patients to remain in treatment with me in their second and third attempts at analytic work while being unable to prevent others from repeating with me their failed experience with previous clinicians. These commonalities appear to have equal application to the beginning of any analytic treatment. In an effort to offer a way of listening and responding in the early stage of treatment that is rooted in an unwavering empathic stance, I attempt the following: (a) to define three disparate, but overlapping, modes of empathy and how they interweave as treatment commences; (b) explain why it is in the best interests of the patient and analyst to remain immersed in this empathic stance during the opening phase; and (c) suggest how remaining in an empathic stance enables the analyst to use his subjectivity and authenticity in the service of the patient’s growth. Although this article will not be a systematic discussion of empathy, I use verbatim clinical material to illuminate how the analyst’s initial, sustained, empathic immersion, mediated through his own subjectivity, informs our understanding of the analytic endeavor in the service of helping the patient evoke hope that the analyst can be “usable for cohesion, strengthening, and growth of the self” (Bacal, 1990, p. 62). In this way I hope to delineate a clinical sensibility and theoretical–philosophical orientation that facilitates new patients’ remaining in and deepening the treatment.

Clinical Vignette: First Interview

I begin with a clinical vignette from early in my career, just after Kohut (1977) published Restoration of the Self and just at the time when I was abandoning my traditional training and beginning to experiment with Kohut’s then-revolutionary concepts of empathic immersion and selfobject transferences. The patient was a 22-year-old woman who, in response to my asking how I could be of help, began by telling me that she had, in her words, “failed several therapies, and I really don’t have much hope for
this one either.” Ignoring my wondering about her lack of hope, Jennifer proceeded to tell me she was considering treatment because she felt depressed, although she quickly added that others were pushing her to return to some form of treatment because of her “recreational heroin use.” During this first meeting, Jennifer, with very little emotion and no prompting from me, almost robotically explained that she grew up with an alcoholic father who was overly seductive and used her as a special confidant when he felt needy. He was physically abusive to her mother, sister, and brother when he was drunk, but he never physically or sexually abused Jennifer. She described her mother as empty, depressed, and aloof, wallowing in self-pity over her marriage and her inability to fulfill any of her professional dreams and too depleted to respond to any of Jennifer’s needs. “I guess you could say,” Jennifer offered, “that I brought myself up, but didn’t do a very good job of it.” Jennifer alluded to her previous therapies as not being very helpful because “no one understood me; I felt used by them.” She was either unable or unwilling to elaborate. There was an exasperated “please, Mother, I’d rather do it myself quality” to her communications, reflecting her self-parenting, and an angry “I dare you to try to help me” message lurking behind her well-controlled affect. Although she had a waif-like, raggedy appearance, my initial reaction to her crystallized into the image of a mollusk-like creature—as if she had this hard calcareous shell with softness underneath. For a number of reasons, which will become clear in the discussion of this case, I felt both challenged by her and drawn to helping her. It seemed clear (I thought to both of us) that the tendrils of a connection were present. At the end of the hour in which she rarely allowed me to speak, I told her that I felt as though I should say or do something but sensed she just wanted me to listen for now. She grudgingly agreed and scheduled an appointment for two days later.

In the interim, I discussed the case with my supervisor, who was adamant that if I didn’t get at her underlying anger, she wouldn’t last in this treatment either. I disagreed with him, boldly at the time, suggesting that her rage was merely reactive to the lack of attunement she had felt all her life and that to tap into her anger rather than her feeling misunderstood (especially given that misunderstanding would be re-created in treatment) would, in fact, push her away. I further suggested to him that because her parents were consistently unable to respond to her feelings, she probably perceived feelings in general as destructive and in need of being split off—thus, her mollusk-like quality. At the time, we agreed to disagree.

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SECOND INTERVIEW

The second interview began unexpectedly with Jennifer telling me how she had returned to her empty home the day between appointments and “just exploded. I got angry, I never get angry like that. I kicked a chair and broke it and then shot up some heroin. I don’t know why all that happened, but the drug was sure fun.” I told her that being so out of control must have been very frightening. Jennifer said, “I never get angry, I don’t have any right to be angry.” “No right to be angry?” I asked. “I just don’t, that’s all. I’m not going to talk about it.” From here the interview proceeded along traditional lines because I was unsure exactly how to implement a self-psychological stance and felt the oppressive weight of a supervisor looking over my shoulder:

Dick: Which chair did you kick?
Jennifer: Just an old one.
Dick: An old one, who sits in it?
Jennifer: I’m the only one who sits in it. I never thought of that, what difference does it make? I wasn’t angry at myself, and besides I really wanted to kick a more expensive one, but I didn’t because I’d have felt too guilty.
Dick: Who sits in the one you wanted to kick?
Jennifer: It’s my mother’s. So what?
Dick: Well, it’s just a hunch, but I wondered if maybe you were angry at your mother, but for some reason couldn’t express it…
Jennifer: So you mean I got angry at myself instead? Well I’m not angry at my mother, I have no reason to be.
Dick: Why don’t you tell me a little more about your relationship with your mother.
Jennifer: [There was another prolonged description of how her parents were too preoccupied with their own unmet emotional needs to remain attuned to her for more than brief periods. Her father, she said again, used her for his own needs, taking her to business parties and often preferring to dance with her than her mother. Her mother was too depressed to notice or care. They just left me feeling empty.]
Dick: So that’s what you meant when you said last time that you had to bring yourself up.
Jennifer: Yeah, but I’ve never gotten angry about it before. I could hurt someone.
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Dick: You must feel the anger is very powerful sometimes.
Jennifer: I like the house empty. [She begins to fidget.] I think you're right, maybe I am angry, but I don't feel it.
Dick: How do you feel when you don't feel angry?
Jennifer: I don't know, depressed, I guess. Yeah, depressed. You know if there had been people at home, I wouldn't have gotten angry, I would have gotten depressed. It's just when I'm alone that I can get angry. [The hour ended with us scheduling another appointment in two days.]

I left the hour feeling as though I had let Jennifer down in a profound way. Although satisfying my supervisor's theoretical biases, I felt pulled out of an empathic stance to the point of using the patient as an extension of his theory. It was as though I knew that we were supposed to confirm some theoretical reality that encapsulated the relationship between anger and depression as well as the value of that insight for the patient. Indeed, my supervisor was elated with the interview—that she could understand so quickly the relationship between anger and depression—whereas Jennifer, as I had anticipated, abandoned treatment. My efforts to contact her met with silence, and her parents could not convince her to return to treatment.

Eighteen Months Later

About 18 months later, Jennifer called and asked to see me. At this point, I had felt so empowered by self psychology's new paradigm and the dramatic differences I observed in my patients' responses that I was thrilled to have a chance to understand what had happened a year and a half earlier. I am sure this enthusiasm also conveyed to Jennifer a sense of hopefulness. Jennifer told me that she decided to return because her increasing "shooting up of heroin" was frightening her, as was her increasing depression. "What prompted me to call," she said, "was that I repeated the incident I told you about last year before I split. I went home from college to an empty house and smashed a large mirror that belonged to my mother, and then I shot up some heroin." She spent a long time giving me the details of exactly what she did.

Dick: How scary for you.
Jennifer: It was scary; I hadn't been that angry since I saw you last year or whenever it was. But I don't have any right to be angry.

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Dick: No right to be angry? [This was beginning to sound all too familiar.]
Jennifer: Here we go again. I told you last year, I'm not going to talk about it.
Dick: It feels like I'm trying to get you to talk about something you don't want to or just can't put into words right now?
Jennifer: That's exactly right.
Dick: What's it like for you when I make that kind of mistake?
Jennifer: It's just like my mother when she intrudes on my privacy for her own needs. I get furious, but I don't tell her. I just split.
Dick: Guess that's where I screwed up last year when you split.
Jennifer: You did screw up, but your recognizing it gives me a little hope. [There was a brief silence and then she asked.>] Have you ever felt hopeless?
Dick: Not to the same extent as I think you have, but enough to begin to understand it.
Jennifer: Sometimes I don't even feel hopeless, which is worse. If you feel hopeless, you can think there is hope, but if you can't even feel hopeless, all you can do is kill yourself.
Dick: You mean if you can't feel hopeless, there's not even a you there to feel hopeless about.
Jennifer: Most of the time there is no me.
Dick: So we'll have to find ways to protect you until there is a you.
Jennifer: [She smiled for the first time.] Good luck. [Brief silence.] You seem different this time around. What's changed in you?
Dick: I knew the way I was trained to do treatment didn't work, so yes, your perception is accurate. I've been changing how I work so that it fits with who I am.
Jennifer: This isn't going to be easy you know, and in the meantime I could kill myself.
Dick: I know, I'm worried about that. I was thinking whether you needed to be in a hospital, but that doesn't feel right to me either. What do you think?
Jennifer: If I were in a hospital right now, I would kill myself. It would mean that there was no me, but maybe at some point if I need to. I'll let you know.
Dick: OK. But what worries me is how you'll let me know. Eighteen months ago when we met, there was this "please, Mother, I'd rather do it myself" quality to you that I know all to well. I know how protective it feels.
Jennifer: It is. How do you think I've survived this far?
Dick: It is healthy you’ve been able to rely on it—doing it yourself. So I guess we’ll just have to struggle with the other side of it.
Jennifer: You mean what happens when it breaks down?
Dick: Yes, it’s such a successful and seductive way of protecting ourselves, I think we don’t even know when it's beginning to break down.
Jennifer: It broke down when my anger exploded.
Dick: When it breaks down it really de-stabilizes things, doesn’t it?
Jennifer: How often do you think we should meet?
Dick: How’s three times a week sound for now?
Jennifer: OK.

She then cited several lines of poetry, which unfortunately I did not write down, although I remember wondering if it were mere coincidence that I was also a passionate reader of poetry.

In the beginning of treatment, the analyst has only a sketchy model of the patient’s experiential world and how his own self-state may be influencing that world. The fact that enactments tend to occur when the patient does not expect the analyst, or the analyst is unable, to tune into her self-state (Stolorow et al., 1987) means that the beginning of treatment can be difficult at best and may lead to a forced and unnatural dyadic fit, or, at worst, result in a compliant therapeutic relationship in which the analytic endeavor proceeds on a superficial level during which the treatment never deepens. Jennifer was the first of many patients I subsequently treated where a change in the analyst’s listening and responding sensibilities altered the course of the treatment. Before delineating how self-psychological and intersubjective system theory can make an invaluable contribution to how the analyst listens and responds through his own subjectivity in the beginning stages of treatment, a few words about empathic immersion are necessary.

Teicholz (2006) has suggested that “any joint endeavor between patient and analyst—if it is to be therapeutically successful—will involve an implicit striving toward mutual empathy, regardless of what other qualities of engagement are called forth” (p. 55). But a definition of empathy, despite the plethora of articles on the topic, remains somewhat elusive. Kohut (1959, pp. 207-208) originally defined empathy as vicarious introspection. In other words, he proposed that empathy was a methodological tool for collecting data whereby the analyst sensed in himself various affective states, moods, and thoughts that the patient was experiencing. If the analyst’s internal experiences accurately reflect those of the patient, we accumulate important data that help inform us not only about the patient’s experience but also about how we might intervene to facilitate the treatment within what is always a unique dyadic relationship. In addition, Kohut suggested that in the context of empathic understanding—when one feels deeply understood by another—empathy forms one of the most powerful emotional bonds between two individuals. So empathy, from a self-psychological perspective, came to have multiple meanings—a methodological tool for collecting data, an emotional bond, and a guide for informing our interventions. Ultimately, Kohut (1984) defined empathy as feeling and thinking our way into a patient’s experiential states and discerning the world from inside the patient’s perspective. Bacal (1997) recognized, however, that all empathy is not the same. Empathy is qualitatively different depending on the “psychical distance” that both patient and analyst experience from each other as a contextual couple. Modifying Bacal’s ideas slightly, I suggest that empathy embraces three broad, overlapping listening perspectives.

Vicarious Introspection

The first mode of empathy is vicarious introspection as originally defined by Kohut (1959). From this perspective, we sense in ourselves the feeling states of the analysand and therefore come to know some of the hopes, motivations, fears, self-states, and expectations that she is feeling. Using vicarious introspection, we may experience what the analysand experiences in a variety of ways: through our own cognitive associations, which at first may seem far removed from the patient; through sensing our more
direct affective states; and through images that may conjure up feelings or thoughts that reflect the patient's or our own concretized self-state. For example, when I told Jennifer initially that feeling so out of control must have been frightening, I was groping for a more universal understanding of what might have been her experience, a way to feel and think my way closer to her subjective experience. At other times, we use more specific affective introspection. During the second initial interview with Jennifer, I found myself picturing the dovetails on a dresser drawer and the side that would not fit together properly. Because I was a furniture maker on the side, this image was highly idiosyncratic for me, but clearly conveyed my sense of the lack of empathic fit she and I were experiencing when I was following my supervisor's advice to pursue Jennifer's anger. Because hand cutting dovetails used to frustrate me, it also conveyed my frustrated self-state—the feeling of having profoundly let her down during the interview and no doubt the negative impact of my frustration on her ability to mobilize hope for the treatment.

Vicarious introspection, although clearly involving affect, often has a slightly more observational, cognitive feel, noticeable under three conditions: when employed at the beginning of an analysis, at times in the treatment when the analyst and patient seem more distant from each other, or when there is an emerging dissonance in the couple's relationship. I believe that the analyst's tendency, before the development of the therapies, is to understand and cognitively make meaning out of the patient's associations. In my experience, analysts rely on vicarious introspection when we are less sure of our understanding of the patient or when we are coming to know new aspects of the patient.

Empathic Resonance

The second mode of empathy, empathic resonance, experientially feels more immediate in our understanding of the patient and often occurs without awareness of our associations. We react unsensitively to the patient's associations and do not recognize the rationale for our responses until we look back and analyze their context. There is also more of a mutual feel to this mode of interaction, a free-floating, easy give-and-take

with qualities of spontaneity, humor, metaphor, creativity, and authenticity that reflect what Kohut (1984) characterized as opening up mutual pathways of empathy between patient and analyst. In this modality, the analyst tends to ask fewer questions of the patient, and when they are asked, an answer is not expected—both partners realize that it is the ambient playfulness and meditation surrounding the question that proves to be illuminating. It is a mutual act of giving and receiving in which when one partner gives, the other feels eager to reach out and fumble to unwrap the ribbons in which the communicated emotions are packaged. It is this mode of empathy that I suggest Kohut (1981, 1984) had in mind when, in his final article and book, he acknowledged that empathy could indeed be curative (1984, p. 78). Because this type of empathy tends to occur sporadically in the opening phase and more consistently later in analysis, an example from the middle phase of Jennifer's treatment conveys the essence of this mutual empathic resonance. It was toward the end of the hour, and Jennifer, by then a graduate student in American literature with a strong interest in poetry, asked:

Jennifer: Do you remember the first time you rode a bike without training wheels?
Dick: How could I forget. The person who was supposed to catch me screwed up, like here sometimes I guess, except we've managed to recover and do it differently. Kind of exciting but scary.

Jennifer: Yeah, it reminds me of that game where you fall backwards and you're supposed to trust someone to catch you. I could never play it til now.
Dick: "Safe upon the solid rock, the ugly houses stand; Come and see my shining castle built upon the sand."

Jennifer: Edna St. Vincent Millay, right?
Dick: Yes, one of my favorite poets.

Jennifer: So now that I can fall backwards, where do we go from here?
Dick: I don't know, but based on our past experience, I am very certain we'll find our way.

Jennifer: I may just take the lead one of these days—ride the bike without you. Then what will you do?
Dick: You're wondering if I'll be excited for you and also still be there to catch you if you fall?
Jennifer: You got it. But surprisingly I think you will.
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otherwise. When I rang the doorbell, Jennifer answered, and I felt immutably frozen for several seconds, although it felt like much longer. There she stood, blood dripping from her half-banded wrist, a glass of wine in her other hand, and dressed in a black see-through negligee, which I knew her father had inappropriately given to her as a 22nd birthday present. “Would you like a drink before we go to the hospital?” she inquired in what I experienced as a cold and fragmented (stilted) tone. My frozen bodily sensation and slight disorientation gave me an immediate clue to her emotional state. I broke the ice, so to speak, and said, “I’ll pass on the drink, and now that I’ve seen you with all your defenses stripped away, I think you should get dressed so we can go put you back together.” Her expression changed, and she looked surprisingly whole again, went upstairs and put on her jeans and a sweatshirt. During our subdued 10-minute drive to the hospital, although it’s hard to articulate what is ineffable, I believe we both experienced an emotional closeness that derives from feeling understood when totally exposed. At one point, she said softly, “I suppose we should talk about this.” I told her we definitely should talk about this—and figure out how we both contributed to it. I would tell the emergency-room doctor to send her home in the morning, and I’d see her at our regular time tomorrow. But tonight, I told her, I was just glad she was alive. As I left her at the hospital, Jennifer hugged me good-bye, the only time in the treatment that she needed that physical contact.

The Importance of Remaining in an Empathic Stance

In the context of these overlapping modes of empathy, I am suggesting that it is in the patient’s and the analyst’s best interest to remain immersed in an empathic stance. In other words, rather than shifting between experience-near and experience-distant listening perspectives (Lichtenberg, 1984; Fosshage, 1995, 1997) or different theoretical vantage points, the analyst can playfully and experimentally shift between empathic modes of listening to gain an in-depth understanding of both the patient’s and his own idiosyncratic contributions to the specific (Bacal, 1997; Bacal and Herzog, 2003) analytic couple’s emerging needs and relationship. Many clinicians (Aron, 1991; Hoffman, 1992; Slavin and Kriegman, 1992, 1998; Fosshage, 1997) have argued that, by remaining in an unwavering empathic stance, we sacrifice both our understanding of how the patient’s emotional convictions

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She then looked at the clock, took the lead by ending the hour herself (a first), and said, “See you Thursday,” a move that not only heralded a shift away from an intense idealizing transference toward a mirroring transference, but also a step toward a successful and, for both of us, bittersweet termination a year later.

In this brief interchange, there was no conscious thinking on my part of how to respond. The interaction just flowed spontaneously, subjectively, playfully, and authentically, all guided by my unconscious empathic immersion in Jennifer’s world and hers in mine. Or, to put it intersubjectively, it was a mutual living in the space we both created.

Somatic Empathy

Third is somatic empathy, which connects analyst and patient through the experience of physical feelings that reflect a visceral communication, often tapping into what Orange (1995) referred to as an emotional memory that occurred previously to our capacity for symbolization and is outside the realm of verbal expression. In my experience, these memories often take the form of enacted communications that circumvent the analyst’s defenses in very subtle and circuitous ways and are felt physically. I frequently experienced these visceral reactions with Jennifer in the beginning phase of treatment when she became acutely suicidal. During the first six months of treatment, I learned to differentiate between a sinking feeling in the pit of my stomach, which always communicated a suicidal feeling without intended action, and a percussive drumming in my chest when she actually intended to harm herself. My most intense physical reaction with her occurred three months into treatment. Knowing their daughter was suicidal, Jennifer’s parents had gone away for the weekend and promised to return on Sunday evening. They telephoned Jennifer late Sunday night saying they had decided to stay for a few more days. She promptly found a razor blade and slit her wrist, then looked up my home telephone number and called me. “I just slashed my wrist and I need you to take me to the hospital,” a voice on the other end of the phone demanded, with no other identifying remarks. The pounding in my chest, however, made it clear who was calling. After obtaining directions to her house, I drove directly there, wondering why I was doing this and what the two of us were enacting and realizing that anyone I consulted about this case would tell me I should have called the police. But the pounding in my chest told me
shape her relational patterns and obviate the patient's need to experience the analyst's distinct subjectivity. But these authors ignore several important reasons to remain immersed in an empathic stance.

First, sustained empathic immersion, in my experience, creates a much more powerful bond between patient and therapist than does experience-distant listening. The creation of this empathic bond during the opening phase of treatment is necessary for both patient and analyst to strengthen their respective sense of self, for it is the increased self-cohesiveness that allows both participants a mutual receptivity to reintegrating split-off affective states and a mutual opening of "questions that had felt too dangerous or inaccessible earlier" (Orange, 2002, p. 694). It is in the opening up of these dangerous questions through our empathic immersion that the patient's organizing patterns are highlighted (as will be seen when we return to the interview with Jennifer).

For example, I could have, from a more experience-distant perspective, viewed Jennifer's suicide attempt and her call to me as seductive or controlling (some would even say an attempt at projective identification), and from the outside looking in, it was indeed both. But neither Jennifer nor I primarily experienced it that way; given her subjective reality, she needed me to see her stripped of all her defenses; she needed my help to restabilize her sense of self. Otherwise there would not have been such a dramatic transformation of her self-state when I interpretatively reflected on this need. Without using my somatic empathy, I believe this need would have totally eluded me and pushed us into a confrontational interaction that (in addition to leading to an unnecessary hospitalization) would have once again destroyed the treatment in its incipient phase, or at least prevented it from moving forward.

As a result of remaining in an empathic stance, Jennifer and I managed some weeks later to understand the suicidal enactment. She was able to explain that my reaction to the inappropriateness of her father giving her the diaphanous black negligee, which she had angrily told me about, was not strong enough. Although unarticulated, she wanted me to be outraged and confront her father, not just strongly agree that it was inappropriate. When I didn't, she felt an overwhelming urge to force me to bear witness to its inappropriateness. The two of us, then, understood how my failure to respond strongly enough not only disrupted her idealization of me in the present but resonated strongly with how she felt when her mother failed to protect her in the face of her father's overly seductive behavior, which led to a shaming, fragmented self-state that evoked suicidal feelings.6

Second, as I have written elsewhere (Geist, 1989 p. 9), remaining in the shifting sands of empathic immersion facilitates the patient's feeling deeply understood and thus fosters the capacity to experience a self/object failure within the context of a relationship—a necessary capacity, I believe, for therapeutic change. In every analytic dyad, selfobject failures will occur; there is no such thing as perfect empathy. But to utilize these failures to restore her connection with the analyst, the patient must first be able to experience them as empathic failures. Otherwise the patient's emptiness, loss, disappointment, anger, fragmentation, or lowered self-esteem are almost instantaneously split off or repressed (or both) and become unavailable to use in the service of restoring a connection with the analyst. Instead, what we observe is an almost immediate substitution of a defensive structure—in this case a "please, Mother, I'd rather do it myself" stance. We saw a stark example of this when Jennifer left treatment after her first attempt to connect with me failed. In contrast, what motivated Jennifer to understand her part of the suicidal enactment and both our contributions to it ("I suppose we should talk about this") was that when she felt understood, she had the capacity to experience empathic failures without splitting off her feelings. The capacity to experience empathic failure can only come about, however, in the context of an empathic bond, as when Jennifer felt deeply understood and connected in those moments, while standing in front of me at the door, she felt physically and emotionally exposed. What is important to understand and what is often overlooked in discussions of empathy is that disrupted connections to the analyst can only be restored if the patient first actually experiences the failures. Such failures, however, can only be experienced in a reliable and consistently empathic environment.

Third, remaining in an empathic stance enables the analyst to become acutely attuned to the multiplicity of his own internal states as they relate to a specific patient. Critics of the use of prolonged empathic

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6 It was only later that we also understood how the sexualization inherent in this enactment expressed a hope, in the only way Jennifer knew how, that I would be able to provide her with a "needed psychological structure" (Kohut, 1977, pp. 217-218). Although there were obvious elements of a repetitive transference in this enactment, it was the recognition of the forward edge transference—the hopefulness (Tolpin, 2003) that seemed to facilitate her self-cohesiveness.
immersion have argued that empathy is a technique that is both unnatural and a technical maneuver for hiding the analyst's self and that it must be complemented by the visible expression of the therapist's reality (Ehrenberg, 1992; Fošhage, 1995; Slavin and Kriegman, 1998). In addition, Friedman (1992) believes that "the analyst is frustrating his own natural thinking style to...come close to the patient" (p. 276). As the clinical examples in this article illustrate, however, prolonged empathic immersion is not a technical maneuver; it is better defined as an analytic sensibility that helps to inform the analyst how to respond to the patient. These responses include the analyst's inevitable expression of his or her subjectivity and authenticity.

One of the analyst's tasks in the beginning of any treatment is to experiment, play with, and come to know his different modes of empathic immersion evoked in the specific fit with a particular patient. I am suggesting an active role for the therapist. In my experience, this active role neither frustrates his thinking style nor, as Friedman suggested, "discomforts himself," rather, it encourages (often silently) exploration of his many alternatives for feeling and thinking his way into the patient's life. For example, he may discover which methods work best for him, which methods the patient evokes, how he responds to and feels understood by, and how these differing ways of collecting data inform him not only about his patient's subjectivity but about his own subjectivity as well. Finally, the analyst may discover which aspects of his subjectivity can be authentically expressed in the service of what Bacal (1985) termed optimal responsiveness.

For example, when I empathized with Jennifer's "please, Mother, I'd rather do it myself" stance and chose to let her know that I was quite familiar with the successful and seductive nature of that defensive structure or organizing pattern, I was choosing to reveal a part of myself in the service of my empathic understanding of what she needed at that moment. It was neither disconcerting nor self-sacrificing, nor was it a strategy for hiding myself. On the contrary, it was personally an imaginative and intriguing invitation to play with my own subjectivity, although in the service of Jennifer's needs. As I tested out that form of relating, it helped me become more attuned to what in Jennifer pulled for that particular response. In fact, it helped me to become acutely aware of how easy it would be, given the impact of her past history, to reenact with her the revelation of too much of myself so that she might once again perceive me (similar to her father) as using her as a confidant for my own needs. As one becomes more adept at shifting between empathic modalities, the analyst can, where one modality is not working, learn to shift listening perspectives easily and deliberately from vicarious introspection to empathic resonance to somatic attunement while maintaining a continuous, active empathic immersion in the patient's life.

Finally, sustained empathic immersion obviates an often overlooked dissociative element that creeps into our interaction with patients when we alternate between experience-near and experience-distant stances or between theoretical models to inform our responses. For example, when we "evaluate" a new patient, there is a natural tendency to isolate those self-reflective capacities that seem extraneous to our urge for an intellectual understanding and meaning that lends some credence to the illusory belief that we actually know what we're doing at the beginning.7

Of course, we know that analysts are trained to be self-aware and self-reflective. As we initially engage with patients, however, I believe there is a tendency to be less self-reflective than after the treatment is underway. Why should this be so? Just as the analyst must feel empathically connected to the analyst to strengthen her sense of self enough to reintegrate split-off affective states and resume development, so the analyst must also have a relational connection with the patient to hold him through the patient's pain. In the beginning of treatment, the self-object relationship lacks the solidity to provide such a holding environment for the analyst, so we are inclined to shift into an experience-distant mode—to be held by our theories, understanding of symptoms, interviewing techniques, and images of our mentors. This isolation of our self-reflective capacities, however adaptive in an evolutionary sense, more often contributes at the beginning of treatment to the kind of meddlesome intellectual inquiry demonstrated in my original consultation with Jennifer. When I initially met Jennifer and pursued the underlying connection between her anger and her depression, my attunement to my own feelings and empathic capacity was markedly diminished—especially when I pursued her angry feelings after she told me that she was not going to talk about them. Instead of using my empathic capacities, I relied on a shift to

7In its extreme form, we see these dissociations at work in case conferences where consultants, instead of relying on their own empathic capacities, use their theories and the patient's history and symptoms to generate hypotheses and paint a diagnostic picture of the patient. Such assessments often differ starkly from the therapist's or analyst's perceptions of the patient because the clinician has over time been more empathically immersed in the patient's world.
experience-distant theories (or my supervisor’s theories) as a Procrustean frame in which to fit her pathology. It is this subtle dissociative process that lends such an objective reality-based truth and “God’s eye view” philosophy, to use Stolorow’s phrase, to much traditional treatment. Dissociations, even healthy ones, generally disrupt the mutual and multifaceted meanings and nuances that are ephemerally present, and this can potentially emerge in a dyadic context as we let ourselves empathize with, and be with, the patient in the initial stages of treatment. Where we are able to maintain an empathic immersion in the patient’s world, we also cannot help but maintain a similar immersion in our own world, thus paying careful attention to how our own organizing patterns are affecting the patient and influencing our understanding of the patient.

**Enabling Functions of Empathy in the Beginning of Treatment**

My experience suggests that sustained empathic immersion in the patient’s world in the beginning phase of treatment contributes, more dramatically than Kohut (1977, 1984) emphasized, to an analytic sensibility—a certain way of seeing, hearing, and experiencing things—that idiosyncratically structures the remaining treatment. And although adamantly rejecting the idea that we should assume any preformed stance vis-à-vis the patient that would alter the unique development of every analysis, it seems important to recognize aspects of this initial analytic sensibility (or qualities of engagement) that may enhance the ability of the analytic couple to work meaningfully and deeply together. These qualities of engagement, which I will discuss in a subsequent paper, include the following: the capacity for mutual empathy; creating metaphors as a medium for communication, engaging the thread around which selfobject transferences will evolve; becoming familiar with the empathic modalities that will best help us to understand a particular patient; and beginning to understand how best to use our subjectivity in the treatment. In an effort to illuminate how consistent empathic immersion from the very beginning of treatment helps us understand these qualities, however, I want to

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return to the interview with Jennifer and consider it again, this time in its intersubjective context, illuminating the impact of my subjectivity on the analytic process.

**Jennifer: A Second Look at the Beginning of Treatment**

In Jennifer’s first attempt at treatment, notice my response to her story of kicking a chair, breaking it, and then shooting up some heroin. I told her that being so out of control must have been frightening, in retrospect probably a partially accurate but somewhat cognitive and distancing statement that she ignored. In the second encounter 18 months later, I responded much more emotionally—“How scary for you,” because, unencumbered by my theories, I relied on a vague fright within myself as I experienced the smashing of a mirroring presence rather than the external curiosity about her heroin use. Jennifer immediately confirmed my comment. At that moment, unlike in our first session, Jennifer felt understood, the first step in a developing capacity for mutual empathy. Equally important, however, was the fact that she was offering me mirroring confirmation of my affective response, increasing slightly my own confidence in my initial capacity to understand her.

Jennifer then associated to her anger 18 months earlier, to me a healthy sign of self-continuity indicating the emergence of what Marian Tolpin (2003) labeled the forward edge transference. In other words, Jennifer had the capacity to feel continuous over time if she felt understood, and indeed her self-continuity increased my own sense of connectedness with our last encounter. I started to reflect on this healthy self-state when she interrupted me with her “no right to be angry” feeling. “No right to be angry?” I queried, as I felt myself pulled out of the empathic stance by her sudden shift in affect. That’s when I felt “this is beginning to sound all too familiar,” a self-corrective antidote to my leaving the empathic stance. This time around, however, Jennifer could actually experience the empathic failure and was coldly critical of my repeated failure to understand her.

Her sentient reaction vicariously rekindled several affectively laden empathic failures in my own analysis, simultaneously rekindling childhood memories of family members encouraging me to retell daily events that I had no desire to share—an uncomfortable sense of being put on the spot, as it were. This vicarious introspection led me to acknowledge my error: “It feels
like I’m trying to get you to talk about something you don’t want to or just can’t put into words right now.” The minor rupture was repaired, confirmed by her strongly emphasized “That’s exactly right,” which evoked in me an efficacious feeling that once again we were resonating with each other. My empathy shifted to a different level, and I asked spontaneously what it was like for her when I made that kind of mistake, thus combining her subjective reality with my own subjective feelings about our encounter 18 months earlier. Jennifer replied, “It’s just like my mother when she intrudes on my privacy for her own needs. I get furious, but I don’t tell her. I just split.” Her comments reminded me both of how initially I had used her in the service of my own theoretical needs, and my own proclivity to “doing it myself” when feeling vulnerable. This feeling of essential alikeness motivated me to convey how my having “screwed up” last time led her to “split.” Jennifer immediately acknowledged that my willingness to own my contribution to her process of splitting gave her hope. The hour deepened. She then asked her first question: “Have you ever felt hopeless?” I experienced the question as the first hint of an idealizing transference, much like a child might ask a parent to share some of her growing-up war stories as a way of connecting with or borrowing the parent’s strength and power. There was also, I thought, the underlying hope that we shared enough of an essential alikeness (twinship) to sustain her. To not answer her question would be to quash the embryonic risk inherent in the expression of idealizing and twinship needs. So I answered Jennifer authentically. My answer did not emanate from an other-centered listening stance, but from an empathic immersion in Jennifer’s subjective attempt to connect with me.

As a result, the hour deepened again, and Jennifer acknowledged her suicidal feelings. In response, I felt a visceral sensation in my stomach. This woman could kill herself. Did she need to be in a hospital? It was not about anger. I was experiencing her as if she had very little self. This visceral feeling would be a clue to both her suicidal feelings and her inability to feel hopeless for the first several years of treatment, even when she hesitated to articulate her experience. Similarly, my experiencing that somatic clue affected and informed the way I then interacted with her, emphasizing her shaky sense of self. I also felt surprisingly more relaxed. I knew how to deal with self-disorders, so I fantasized and felt momentarily hopeful. My relaxed state seemed to allow for her affectively subdued, sad statement: “Most of the time there is no me.” I then spontaneously welcomed an idealizing transference and offered her some hope by indicating that we would find ways to protect her until she felt more cohesive. She smiled for the first time in the hour and said, “Good luck.” During the brief silence that followed, I experienced her hopelessness as healthy and more promising than not being able to feel hopeless at all.

As Jennifer felt more understood, she expressed some understanding of me, noticing that I seemed different this time around and expressing curiosity about what had changed in me. In addition to being touched by the sudden mutuality of the empathy, which pulled me closer to her, I felt more certain that questions and answers were the theme around which an idealizing transference would revolve. There would not be much about me she didn’t notice and allow to affect her responses, but I also knew her history pulled for a hypersensitivity to parental needs. Her tuning into my change encouraged me to share once again my subjectivity in the service of confirming her accurate perception (an important developmental aspect of her self). My “realness” enabled Jennifer to warn me that she could indeed kill herself and, on a deeper level, to ask whether I could tolerate working with someone who could kill herself. If she took the risk of mutual engagement, would I take an equal risk? We discussed hospitalization, and both of us decided to work on an outpatient basis with Jennifer indicating that she would let me know if she needed to be in the hospital. My thoughts drifted to 18 months earlier when she suddenly left treatment or, more accurately, chose not to begin; and I empathized with her “please, Mother, I’d rather do it myself” stance because, as mentioned previously, to some degree we shared this defensive structure. There was a partially healthy, partially archaic, twinship inherent in that style. I believed that the only way we would survive this treatment’s difficult periods was if we developed a solid twinship connection to buffer and cushion the anticipated disruptions. (From an other-centered approach, I could easily have experienced her defensive structure as pushing me away.) I acknowledged being worried about how she would let me know and shared with her my firsthand understanding of the healthy and not-so-healthy nature of the defensive structure we shared. This decision emerged from my empathic understanding of her need for twinship. As if to tell me that our relationship had potential for replacing the defensive structure, however, she asked how often I thought we should meet. After settling on a routine, she then cited a couple of lines of poetry, which became a dominant metaphor that served to strengthen a twinship bond that functioned as a structural underpinning of the treatment.
The Use of the Analyst's Subjectivity

What I have attempted to demonstrate in the interview with Jennifer is that not only is empathy a method for understanding the patient, it is a method for understanding ourselves and the impact of our personality, history, and subjective on the patient and her subsequent response to us. The beginning of treatment offers us an opportunity to play with and comprehend which modes of empathy work best with a particular patient and how our authenticity and subjectivity can best be used in the service of the patient's growth. Understanding the patient's experiences through our own subjective experience (Orange, 1994, p. 180) is perhaps the best definition of empathy. The use of my visceral empathy, both the sensations in my stomach and in my chest, evolved in the beginning phase of treatment with Jennifer and proved to be an important clue not only to her feeling states but also to my own emotional reactions to her suicidal ideation. The subjective meaning of my own first analytic experience also influenced how and when I shared my perspective with her, and her response to those revelations furthered my understanding of its helpfulness or intrusiveness. My use of vicarious introspection, for example, seemed to occur much more often when there was a subtle, growing aloofness between us, a helpful clue that I could harness to explore what about my behavior influenced Jennifer's wish to step back from the relationship. Much experimentation was required before we settled into an easy give-and-take in the last few years of the analysis. But it is just this experimentation that helps us to avoid reductionism (Orange, 2003, p. 481). Without the self-allowed freedom to observe and experiment with how I was empathizing with Jennifer at the beginning, I don't believe we would ever have achieved the sort of rhythmic fit that allowed both of us to change enough to make it to the middle phase of treatment.

Conclusion

The two initial phases of Jennifer's treatment offer us an unusual opportunity to experience and understand how disparate listening perspectives educe in the same person essentially different patients at the beginning of a therapeutic journey. The second phase of Jennifer's treatment succeeded because she and I were able to establish a mutual empathic tie rather than depend solely on a unilateral investigation of her experience. This mutual tie then enabled the emergence of sustaining selfobject transferences that allowed Jennifer to risk expanding her ossified emotional convictions and reorganize and strengthen her sense of self. What I am really arguing in this article is that empathy as here defined, because it offers us little gyroscopes to steady and adjust the sometimes-dizzying tilt of the intersubjective fit as we begin each new therapeutic journey, encourages the analytic couple from the very beginning to engage with a playfulness, insight, and experiential openness that can set the stage for a truly deep and meaningful treatment. Empathy can never be perfect, and, contrary to Kohut's belief, it can never be neutral, but it remains our most fruitfully imperfect way of understanding our patients' self-states and needs in the opening phase of analysis as well as throughout the treatment.

REFERENCES


Sustained Empathic Immersion

Existe una sorprendente escasez de artículos en la literatura postmoderna sobre la fase inicial del tratamiento analítico, y ninguno que se centre en cómo la pareja analítica inicialmente co-crea el emergente y arriesgado diálogo que en parte va a determinar si el paciente y el analista pueden reorganizar su experiencia de manera que facilite su crecimiento mutuo y la curación. Con el objetivo de corregir esta falta de atención a esta fase del tratamiento, tan importante y tan olvidada, este artículo propone una manera de escuchar y de responder en la fase inicial que se basa en una firme posición empática. La intención del artículo es: 1/ definir tres modos de empatía que se sobreponen y cómo se entrelazan a medida que el tratamiento empeza; 2/ explicar la razón por la que lo mejor para paciente y analista es permanecer inmersos en una posición empática durante la fase inicial; y 3/ sugerir cómo al permanecer en una posición empática posibilita que el analista pueda usar su subjetividad y autenticidad al servicio del crecimiento del paciente. Al usar una transcripción literal del material clínico para iluminar cómo la investigación empática continuada por parte del analista (a través de la subjetividad del analista) muestra nuestra comprensión de la labor analítica, se define una sensibilidad clínica y una orientación teórica/filosófica que facilita que los nuevos pacientes permanezcan y profundicen en el tratamiento.

Le très petit nombre d’articles généraux, postmodernes sur la phase du début du traitement analytique est particulièrement frappant. De plus, aucun ne porte attention à la manière avec laquelle un couple analytique participe à la co-création de ce dialogue thérapeutique émergent et risqué, laquelle va déterminer en partie si le patient et l’analyste parviendront à réorganiser leur expérience de manière à faciliter la croissance et la guérison mutuelle. Dans un effort pour corriger cette absence d’attention à cette phase négligée mais combien importante du traitement, cet article propose une manière d’écouter et de répondre dans la phase d’amorces qui prend racine dans une position empathique soutenue. L’auteur tente: 1) de définir trois modalités d’empathie qui se recoupent et comment elles s’entremêlent pendant le début du traitement; 2) d’expliquer pourquoi le meilleur intérêt du patient et de l’analyste requiert qu’ils restent immergés dans une posture empathique durant la phase d’amorces; et 3) de suggérer comment le fait de rester dans une posture empathique permet à l’analyste d’utiliser sa subjectivité et son authenticité au service de la croissance du patient. En utilisant du matériel clinique textuel pour éclairer comment l’exploration empathique soutenue initiale de l’analyste (par l’intermédiaire de sa propre subjectivité) influence notre compréhension de l’entreprise analytique, l’auteur décrit une sensibilité clinique et une orientation théorique/philosophique qui facilitent que de nouveaux patients puissent rester en et approfondir le traitement.

C’est une imposante quantité d’articles postmodernes sur les fases iniciales del tratamiento analítico, pero ninguno de ellos se concentra en cómo una cierta particularidad aporta analítica co-crea desde el inicio aquel sutil diálogo terapéutico que emerge gradualmente que determinará parcialmente si el paciente y el analista potenciarán reorganizar las esperanzas en modalidad que resulta facilitativa para la mutua crecida y para la curación. Entendiendo la necesidad de corregir la nuestra mancanza de atención hacia esta fase transcursada de no menos importante del tratamiento, este artículo ofrece una modalidad de asunto y de respuesta en
Treatment of a Severely Depressed, Suicidal Patient: A Self Psychological Perspective

David S. MacIsaac, Ph. D.

This article explores the challenge of treating severely depressed, suicidal patients, with a discussion of the self psychological approach in the treatment of a male patient in his early 20s who was suicidally depressed. With the focus on in-depth empathic immersion as essential to understanding depression, I demonstrate how the treatment unfolds by detailing the moment-to-moment empathic approach with the patient, the countertransference reactions that breached the empathic bond that was forming, and the management of the inevitable disruptions and repairs of the developing self-object transference. My primary contribution is to demonstrate in my clinical work how my patient’s feelings of worthlessness and self-loathing, which accounted for his depression, were sought after to maintain needed sensation states that can be considered addictive in nature. Furthermore, I argue that this need goes beyond the loss of a cohesive self as a consequence of the loss of the self-object experience, as is commonly understood in self psychology.

Treatment of the severely depressed, suicidal patient can challenge the personal mettle and professional confidence of the most highly trained and exceptionally skilled analyst. Bouts of intense despair, despondency, suicidal threats, and even attempts on the part of a depressed patient during treatment can shake a therapist’s theoretical and clinical certainty. As a consequence, many analysts may choose not to treat patients because they these doubt their own personal efficacy and question their analytic approach.

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Special thanks to Crayton Rowe, MSW, for his customarily generous and invaluable suggestions.