To the Graduate Council:

I am submitting herewith a dissertation written by Barbara L. Taylor entitled "Psychotherapists' Experiences of Empathy: A Phenomenological Inquiry". I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Dr. Howard R. Pollio, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Associate Vice Chancellor and
Dean of The Graduate School

PSYCHOTHERAPISTS' EXPERIENCES OF EMPATHY: A PHENOMENOLOGICAL INQUIRY

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Barbara L. Taylor

May, 1995

DEDICATION

This work is dedicated to my parents,

with whom I had my first empathic experiences

and to

my patients

who continue to teach me about empathy

ACKNOWLEDGMENTS

I am most grateful for the assistance of many people in seeing this work to its completion. I am thankful for the continued presence of my chair, Howard R. Pollio, particularly for his encouraging me to study a topic that is both meaningful and relevant to my clinical work. I am pleased that I have the assistance of three other committee members who contributed in varied ways to this project and to my overall education: Len Handler who opened my eyes to a more creative and meaningful assessment process that is person-focused rather than formulaic; Ron Hopson whose strong personal spirit and focus on relatedness and experience in therapy are my companions in clinical work, and Kathleen Bohstedt who reminds me there is much outside my domain that can contribute both to my professional work and to my personal growth.

While a dissertation is often a solitary endeavor, the Phenomenology Group in the Department of Psychology has been a constant source of sustenance throughout this graduate program. During this project, the considered reflections of group members have been important components in the phenomenological process.

I have also been accompanied throughout this process by the ten articulate psychologists who allowed me inside some of their clinical work. I am most grateful for their curiosity and candor.

As I near the completion of my formal education I am aware of the many

who have helped me along the way. My parents instilled in me a love of learning and have continued to support my educational endeavors. Wellesley College and her professors revealed to me the importance of a community of scholars. Social work graduate school helped me articulate my values and priorities. In this program I have endeavored to remain true to these foundations while embracing the field of psychology, with all that it has to offer in understanding the human adventure. For this I am also grateful to Howard Pollio, who has embodied many educational "virtues". As Buber said,

> But what is it then which is meant here by educating -- by drawing out and drawing upward? No content of an utterance, but the speaking voice; no instructing, but the glance, the movement, the being-there of those teaching when they are inspired by the educational task. Relationship educates, provided that it is a genuine educational relationship. (Martin Buber (1967) A Believing Humanism: My Testament)

This program has also been enlivened by many professors and supervisors and I am appreciative of their input. I am keenly aware of the significance of several fellow students: most especially to Dr. Susan M. Flynn, with whom I shared classes and questions, coffee and conviviality. How empty all those classes and years would have been without her. Dr. Jean Hunt assists me in my phenomenology venture and stretches my frame; I am proud to have her as a friend. Dr. Carol Grant continues to share important clinical and personal questions. Dr. Jane Tillman and I have shared some "good ideas", both conceptual and concrete, as well as a great deal of essential laughter. The internship class in Boston was a support and breath of fresh, warm air during

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ABSTRACT

Psychotherapists' experiences of empathy with their patients were explored in order to understand the characteristics and the meanings of such experiences. Phenomenological interviews were conducted with ten seasoned psychologists from the East Tennessee - Western North Carolina area. They were asked to describe in detail experiences of empathy from their clinical work. Phenomenological analysis of these interview texts rendered four major interrelated themes: letting go, connecting, being responsible and responsive, and danger. Letting go was perceived as a change in mode of experiencing -- from doing to being. It involved letting go of the tethers to the everyday personal world as well as customary personal and professional processes, particularly the "need to know". Connecting was characterized as a resonance to the patient and involves connecting to patient's experience and connecting to one's own experiences, while the points of interpersonal connection are affective. Moments of connection were described as attaining an understanding of the meaning of the patient's experience. Being responsible and responsive allude to the context of therapy and imply a movement towards a positive end that will further the therapeutic work. It ushers in another shift from a more receptive mode to an active one. It means to be useful and provide understanding. Danger and risk are part of the empathic experience. Therapists are asked to go to places of pain and trust they will return. Therapists were aware that the

perception of danger and safety promotes or hinders empathic experiences. They realized that the danger to themselves can be on a personal or professional level. Throughout the empathic experience therapists also were aware of the patient's experience of these four components as well as as well as the empathic experience as a whole. The implications for clinical education and practice were discussed.

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CHAPTER I

INTRODUCTION

"Look at that tree."
"I do look at it, morning, noon and night."
"Have you begun to see it?"
(Sarton)

This study presents an existential-phenomenological approach to understanding the experience of empathy as it is lived by therapists in their work with patients. A series of interviews conducted with seasoned therapists explores in depth the experiences these participants had with the phenomenon, and narrative text was derived from each transcribed interview. These texts were then thematically analyzed using a hermeneutic-phenomenological technique to arrive at a general structure of the experience of empathy in the therapeutic encounter. A model illustrates both the gestalt of the experience as well as the relationship of individual aspects to the whole of the experience. The intention of this investigation is to illuminate a meaningful element of the therapeutic endeavor from the point of view of the therapist. A clearer understanding of the complex process of empathy in psychotherapy is the result.

In the past, research into the intricacies of psychotherapy have been investigated primarily from the point of view of an outside observer or from the point of view of the other therapeutic partner, the patient. Most attempts to capture the therapist's experience either have been personally anecdotal or theoretical and experience-distant. This study offers an alternative. Shared themes are allowed to emerge across participant narratives and the limitations of former attempts are transcended in a rigorous exploration that utilizes comprehensive experience-near descriptions across multiple participant therapists.

A selective review of relevant literature begins in this chapter. The importance of empathy in the psychotherapeutic venture is demonstrated in the results obtained from past research on psychotherapy. A review of the psychoanalytic literature with respect to the importance of empathy as well as ideas about what is constitutive of this phenomenon are offered. The psychoanalytic theoretical frame is presented because it is this perspective that has offered continuing interest in and debate about the nature and role of empathy in psychotherapy. Presenting the therapist as a person whose experience is valuable as a source of knowledge that can be elicited in a systematic and thorough manner is a departure from past investigations focusing on patient experience. Thus we trace the changing views regarding the nature of the therapeutic relationship in psychoanalysis and the therapist's place in that relationship. Additionally, a previous phenomenological study on the experience

of really feeling understood will be reviewed and compared to results of the present study.

Because phenomenological methods differ from traditional approaches to psychological research, this methodology is discussed in detail in Chapter II. Procedures specific to the present study also are presented.

Chapter III presents results of this study as a thematic structure that emerged during hermeneutic analysis of interview texts. A description of the emergent themes and subthemes is presented, as is a discussion of the manner in which they interact.

Chapter IV relates these findings to previous writings in both theoretical and empirical domains. A discussion of the implications of the results in terms of the practice of psychotherapy and the educational process are offered.

Psychotherapy Research

Comprehensive investigations into the process of psychotherapy began after World War II. Within a decade the topics of study evolved from whether or not psychotherapy was effective to delineating specific aspects of patient, therapist, and situational variables and the effect these interactions had on therapy outcomes. An examination of the literature reveals that the term "empathy" as used to describe a therapist characteristic often appeared as an essential ingredient in effective psychotherapy.

Empathy became a primary construct of client-centered therapy when it emerged as a major variable in the psychotherapy research from Rogers' group at the University of Chicago in the 1950's and at the University of Wisconsin in the 1960's. As early as 1954 Rogers and Dymond talked about the "psychological climate" created by therapists to facilitate patient growth and progress toward self-actualization. A prominent feature of this "climate" was the therapist's attempt to understand the feelings and communications of the patient, and to convey this understanding to the patient. This attempt was seen as an ongoing aspect of therapy. In a well-known paper in 1957, Rogers discussed his view of the necessary and sufficient conditions for constructive change in psychotherapy. Of his six conditions, two involve empathy;

> The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
> The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (Rogers, 1957, p. 96)

Rogers defines empathy as the ability to "sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (Rogers, 1957, p.99). By the "as if" quality he means to sense the client's feelings without one's own feelings getting bound up in it. The usefulness of this ability depends on the second aspect of empathy; the therapist's ability to communicate understanding to the client. Rogers noted that when the therapist understands the inner world of the client he not only can move around in it freely, he can also

communicate to the client both an understanding of what is "clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware" (p.99). Rogers does not explicate the process by which the latter occurs.

Rogers and his group continued to formulate an empirically-based view of empathy. They later pointed out that "accurate empathy" consists of both perceptive and communicative facets. The technique constitutes far more than being attentive to the content; the inner personal meaning of the client's experience also must be grasped. Empathic understanding only has value if brought into the living relationship of the client and therapist. As a response in the moment, this communicative aspect helps the client get closer to himself. Contact with his inner experience is maintained, extended, and perhaps deepened in the process (Rogers and Truax, 1967). Rogers and Truax also observed that at times an intent towards understanding is valuable, in and of itself. The therapist's attempts to understand, communicate to the patient that feelings and experiences are worth understanding. Results of a study (Kiesler, Mathieu, and Klein, 1967) in Wisconsin suggest that sustained accurate empathy in a treatment situation allowed schizophrenic patients to sustain experiential involvement. Therapist empathy and client experience are associated with the client's positive personality change and favorable therapeutic outcome.

In further research, Truax and Carkhuff (1967) demonstrated the importance of "matching" the intensity of the patient, through vocal tone, content or other non-verbal channels. They also noted the importance of specificity of response. This specificity or concreteness both ensures emotional proximity and promotes accurate empathy by making the response available to immediate feedback from the patient. Misunderstandings are thereby resolved in the moment, and the likelihood of the therapist remaining "with" the patient is increased (Truax and Carkhuff, 1967).

Cartwright and Lerner (1963), also from Rogers' research group, investigated therapy outcomes related to the therapist's empathy and the patient's need to change. They found that, in successful cases, therapists adjusted their conceptions or understanding of the patients to be more in line with their patients' self view. The therapist's ability to understand a patient's self-conception at the end of therapy was positively correlated with good outcome in therapy (Cartwright and Lerner, 1963).

Differences in sex were a factor in trying to account for what makes empathy easy or hard for therapists. Therapists had difficulty understanding opposite sex patients early in treatment, although such difficulties were resolved over time. Same sex patients who improved were seen by therapists as much like themselves early in treatment. (Cartwright and Lerner, 1963).

Rausch and Bordin (1957), operating out of what they termed an eclectic perspective that included psychoanalytically informed views, investigated

warmth in the therapy process. They found warmth to be a complex aspect of the therapist's relationship to the patient, with three components: commitment, effort to understand, and spontaneity. "Effort to understand" is described as similar to Rogers' construct of empathy, although without using the term. Rausch and Bordin recognized that efforts to understand produce the first major emotional tie between therapist and patient. Their emphasis on the word "effort" indicates active involvement with the patient as helping to build rapport. Like Rogers, they underscored the importance of communicating such efforts to understand. "Failure in the beginning to give positive indications of effort to understand may mitigate against the formation of any working relationship" (Rausch and Bordin, 1957, p. 361). Efforts to understand are to be directed toward the patient, not toward theory.

> It involves rather an ill-understood process of entering into the patient's contextual world. ... The problem of how it occurs, both in therapy and in other relationships, remains an important and unsolved problem for psychology. (Rausch and Bordin, 1957, p. 360-361)

Further work on those characteristics of therapists thought to affect empathic ability stress the importance of both personal and experiential factors. Bergin and Solomon (1963) discovered a negative correlation between empathy ratings and personal disturbance of the therapist, while a positive correlation between empathy ratings and personality strength and stability were found.

In an early review of psychotherapy research, Bergin (1966) notes that what Rogers and his group refer to as empathy is quite like good or moderate

interpretation in psychoanalytic writing. "It is related to productive patient self-exploration. It consists of responding to clients' affect just below the surface and labeling, identifying or emphasizing it" (p.125).

Two major empirical research projects related to empathy in psychotherapy were begun in the 1950's through the Menninger Foundation. One investigation by Holt and Luborsky focused on the process of selecting psychiatric residents, and attempted to isolate factors predictive of positive outcome in the residency program. Empathy was considered one of the personal factors related to "orientation to others". It was defined as the "ability to take the role of the other in imagination, to understand, or to 'resonate to' another's feelings or viewpoints" (Holt and Luborsky, 1958, p.144). Empathy also was a significant factor, following intelligence and clarity of thought, in predicting successful completion of residency.

The Menninger Foundation's Psychotherapy Research Project was begun in the 1950's and continued through the 1960's. The final report was issued in 1972. Many studies investigated factors in the therapy, in the therapist and in the patient's life situation that interact with patient variables. One such study examined characteristics of the therapist that lead to positive change in therapy by examining the "good hour" in therapy. Therapist variables found to be most differentiating were skill, empathy, unconditional positive regard, security and maturity, and warmth. (Auerbach and Luborsky, 1968)

Luborsky continued to investigate outcome and process factors in the Penn Psychotherapy Project . In presenting cumulative findings from this project, the authors (Luborsky, Crits-Christoph, Mintz, and Auerbach, 1988) note that the second most curative factor is the therapist's ability to understand and respond. This factor is described as an interactive feedback sequence consisting of three phases: listening, understanding and responding. Listening is described as unreflective while understanding is described as reflective and occurring when "the therapist listens for how the patient experiences the neurotic suffering of the moment." (p.153) During this phase, recurring themes are noted and the therapist's "responding" should point to the essence of the main recurring theme or part thereof. The second facet of the understanding is used to provide helpful interventions that are adequate responses to the patient's communications.

Taking their series of studies into account as well as those of other researchers, Luborsky et al. observed that empathy continues to appear as a significant factor. They note that it adds muscle to a finding if it appears in different studies utilizing different methods. [Empathy] "deserves a place in the theory of therapeutic change as well as further research to understand the basis for its contribution" (Luborsky, et al., 1988, p.304).

In another project investigating the therapist's contribution to the treatment process, Strupp (1960) found high empathy ratings to be positively correlated with positive patient prognosis. When therapists who had been

analyzed were compared to non-analyzed therapists, higher levels of empathy were noted in the analyzed group. Analysis mitigated attitude, in that a therapist who had been analyzed was better able to be empathic regardless of his conscious attitude (positive or negative) toward the patient. Later results of the Vanderbilt Psychotherapy Project also include a discussion of empathy and its role in psychotherapy. The authors note that one of the therapist's main tools is empathic listening so as to

> understand the inner world of the other person. ... Frequently underestimated is the degree to which the therapist's presence and empathic listening constitute the most powerful source of help and support one human being can provide to another. (Strupp and Binder, 1984, p.41)

Strupp's concept of empathy also includes a discussion of transference and countertransference in the lived relationship. Countertransference is viewed as a form of interpersonal empathy; the therapist, open to the world of the patient, becomes part of that world and then works himself out of it. Empathy is described as a "trial identification with portions of the patient's inner world" (Strupp and Binder, 1984, p.149). Thus, Strupp views empathy as a necessary tool in psychotherapy.

In reviewing what a practitioner can learn from research on psychotherapy, Strupp notes the importance of the empathic climate. He is clear in his assertion that "research has sharply etched the overriding significance of the interpersonal relationship between patient and therapist as the vehicle for therapeutic change" (Strupp, 1989, p.723). It is his view that psychological

problems result from cumulative effects of interpersonal relationships. On the basis of this assumption, an empathic therapist offers a different sort of experience to the patient; one that can be profoundly corrective.

Psychoanalytic Theory

The only reference to empathy in Freud's writings occurs not in his major papers on technique but in a paper on group psychology. In this paper he noted that empathy "plays the largest part in our understanding of what is inherently foreign to our ego in other people" (Freud, 1922, p.40). While he proceeded to state that this process has great significance for our intellectual lives, he left it to his followers to elucidate what empathy means in the context of psychoanalysis: how it is accomplished and how it fits into therapeutic work.

Fliess (1942) attempted to do this in an early paper. In this work he related empathy to the psychological aptitude of the analyst and viewed it as a prerequisite for training rather than as a result of training. This aptitude depends "essentially on [the therapist's] ability to put himself in the latter's place, to step into his shoes, and to obtain in this way an inside knowledge that is almost first-hand" (Fliess, 1942, p.213). He then refuted himself by describing the process not as one of projection (putting oneself into the other's shoes) but as a trial identification whereby one introjects the other into himself, "for it is in the analyst's mind that everything has to occur" (Fliess, 1942, p.214).

The introjection is transient, and the analysts projects the introject back onto the other person. Fliess states that it is through this use of empathy that the analyst comes to understand transference conflicts presented by the patient. Such conflicts pass through the analyst and "have temporarily to become intrapsychic conflicts in the [analyst]" (Fliess, 1942, p.215). He describes the process as occurring in four phases. In the first the analyst becomes the object of striving; next the analyst identifies with the patient, the subject of the striving. In the third phase he becomes the subject, and in he fourth he projects the striving back to the patient. But now he has had the experience himself and can truly understand the patient. He has the "emotional basis for the interpretation" (Fliess, 1942, p.215): thus, empathy leads to interpretation.

Fliess noted that during the fourth phase the material must be projected back without any "admixtures" of the analyst, uncontaminated by the instinctual strivings of the analyst that might distort the picture. In order for this to be possible, Fliess postulates that the analyst acquires a "work ego" wherein the id is severely restricted while the superego is intensely gratified. Flies uses this to explain the analyst's detachment from his own psychic content, but admits that the state of theory cannot explain how all this comes about.

Perhaps the most well-known paper to highlight the importance of empathy in the domain of psychoanalysis was Kohut's paper of 1959. In it he discusses introspection and empathy as the two tools of observation available to analysts. While other methods may be used, the final act is either introspection

or empathy, which he coined "vicarious introspection". Analysts are concerned with the inner, psychological world of the patient. This world is real but has no existence in physical space. Therefore we know it not from employing methods used in understanding the outer world, but by these different methods. Through introspection we come to understand our inner selves and through empathy we come to know the world of others. Only through empathy can we come to know the meaning of the physical fact of another's experience. Though we may observe a physical experience in another, we can only know the personal, psychological meaning of that experience for the other through empathy. He concedes that every branch of science has its limits, and these are determined by the limits of its modes of observations. The limits of psychoanalysis are given by the limits of potentials in introspection and empathy (Kohut, 1959).

Greenson's (1960) paper describes empathy as an "emotional knowing" -- a special mode of perceiving. He views empathy as an automatic process, observed only in reflection after the fact. Like Fliess, he underscores the temporary nature of sharing the feelings of another. He notes that one partakes of the quality but not the quantity of the feelings. Rather than postulate a "work ego" as did Fliess, Greenson talks about a shift or split in ego functioning. By this he means that the analyst must have the ability to shift from being observer to participant and subsequently, be able to return to the role of observer. He must have the ability to be both detached and involved and move fluidly between these two positions. Greenson points out that there are special problems that

some analysts have in this process: Some are inhibited and eschew real involvement, fearful of experiencing the affects or impulses of the patient; others, uncontrolled, become too involved and cannot pull back to the observer's position (Greenson, 1960).

These incapacities are viewed as countertransference problems. They refer to what Fliess hinted at when he spoke of the analyst reprojecting without "admixtures". Greenson clearly states that inhibited analysts are fearful of their own countertransference reactions, and, therefore, do not permit themselves to become involved. Undercontrolled analysts give in to countertransference reactions and act on them rather than using them in the analytic work of understanding the other. The analyst needs a secure sense of identity such that he can let go in a controlled and reversible regression of ego functions (Greenson, 1960).

Greenson adds a new dimension to the description of empathy when he talks about the "aha" experience the analyst has when the process of empathy leads to further or new understandings of the patient. This experience is described as an "involuntary and pleasant sensation of suddenly grasping and understanding something hitherto obscure" (Greenson, 1960, p.422). He introduces the concept of a "working model" of the patient, which is built slowly over time, and includes both physical and psychological attributes. It is not identical with the patient because it contains the analyst's expectations and anticipations for the patient as well as his theoretical knowledge and clinical

experience. During the empathic process, Greenson as analyst brings this model to the forefront of his mind and listens "through" this model; that is, listens according to the patient's ways of listening. The successful empathic experience either changes or adds something new to the working model, which is a dynamic one. Greenson also points to the importance of the analyst remaining aware of the differentiation of patient, model and self.

Successful empathy depends on the patient as well. Greenson points out that the patient must be ready to be empathically understood. The empathic capacity of the analyst is limited or expanded by the receptivity of the patient. Some patients do not want to be understood for a variety of reasons, such as fear of being destroyed or rejected.

In an early paper Loewald (1960) expanded the concept of the experience of empathy by bringing in the dimensions of time and direction. The empathic relationship between analyst and patient is likened to the relationship between an empathic mother and her child. An empathic mother understands her child's present level of development yet at the same time looks ahead to the future. Loewald speaks of the neutrality needed by the parent who has the "ability to follow and at the same time be ahead of the child's development" (Loewald, 1960, p. 20). This is similar to what Greenson called the expectations and anticipations of the therapist toward the patient, part of the working model. Loewald emphasizes the importance of the analyst being able to shift in the relationship to the patient. The patient's manifest level of development is always

shifting, thus the analyst must also shift, although "always from the viewpoint of potential growth, that is, from the viewpoint of the future" (Loewald, 1960, p. 20). The analyst reveals himself as someone

> who can feel with the patient what the patient experiences and how he experiences it, and who understands it as something more than it has been for the patient. It is something more, not necessarily in content but more in organization and significance, ... [toward] which the individual is striving. (Loewald, 1960, p.26)

In a later paper Loewald (1970) described the analyst's empathy as involving a suspension of the subject-object split. This facet of the experience differentiates empathy from sympathy. This suspension, while present in all empathic encounters in psychoanalysis, is more necessary when trying to work with patients whose level of development centers around less differentiated phases. The analyst must be willing to operate on these levels for more sustained periods. A lack of empathic understanding and an unwillingness to act at this level will be perceived as a severe disruption and/or annihilation (Loewald, 1970).

Two different kinds of empathy were delineated by French (1970): "direct empathy" and "empathic understanding". Direct empathy involves the direct perception of what another person is consciously feeling at the moment and can be checked for veracity by asking the other what he feels. Empathic understanding is concerned with feelings that are not conscious. Such experiences seek an understanding that goes far beyond the moment at hand. They seek to understand the relationship between many events and experiences

by inference and by bringing to bear all that one knows of a person. Veracity is checked by observing the person's subsequent behavior and by remaining open to new evidence that either confirms or denies the most current understanding. After all, interpretation of behavior is only a hypothesis, and a hypothesis can change over time.

French's hypothesis is quite similar to the working model postulated by Greenson (1960). The motive for empathic thinking, as French states it, extends beyond understanding and communicating that understanding but to influencing as well. Not only is the analyst's current understanding of the person influenced, but the interpretation that flows from that understanding influences the patient.

French describes the empathic experience structurally as a split in the analyst's ego. One part remains in resonance with the patient while another part remains detached and "understands" by observing not the patient but the part of himself that is in resonance with the patient. One might say that in this manner the analyst introspects part of his own ego, or as Kohut (1959) would frame it, he introspects vicariously.

Shapiro's (1974) contribution to the literature on empathy concerns itself with defensive aspects of the analyst that can result in distortions of the knowledge gained from empathy. Since empathy involves both perceptual and cognitive aspects, distortions can appear in either part:

> The possibility of projection of our own affective reactions should be considered lest, on our certainty, we err. It is too easy to use the rationalization of 'much clinical experience' to bolster this certainty when

> tolerance of doubts and watchful waiting may be the better path. (Shapiro, 1974, p.22)

To aid in keeping perception free of distortion he advocates increased self-knowledge. He also states that good judgment involves accurate relation to reality and is aided by sustaining an optimal distance from the patient.

Focusing on the interplay between affective and cognitive components of empathy, Beres and Arlow (1974) suggest that affect experienced by the analyst should be viewed as a signal that announces a momentary identification with the patient and possibly the emergence of an unconscious fantasy shared by both parties. A shift from the affective state to a cognitive state ensues, allowing clues furnished by the empathic feeling to mingle with judgment and intuition to produce understanding. An interpretation that communicates this understanding to the patient follows. Of the many observations available to the analyst, empathic experience selects the most meaningful one for the patient in the moment.

Following his assertion in 1959 that empathy and introspection are the observational tools of psychoanalysis, Kohut (1977, 1980, 1984) further refined and expanded the role of empathy in the psychoanalytic process. His stance, that empathy is the analyst's primary tool, was discussed above; further theorizing led him to believe that empathy must also hold a more dominant role in analysis. In this view, empathy becomes the reason for the patient's problem in the first place. Insufficient empathic experiences in early childhood lead to

adult psychopathology. Kohut also viewed empathic experiences in therapy as a major curative factor in successful psychotherapy. His view that inevitable empathic breaks and the subsequent repair of these breaks are essential to the forward developmental movement of the patient in a successful therapy. Empathy also was seen as the ultimate goal of treatment, i.e., through the repeated sequence of break and repair, the patient would be able to act towards others with what Kohut called "mature empathy". Thus, in Kohut's thinking, initially seen as an observational tool of the analyst, empathy grew to become a central part of his theorizing about the etiology of psychopathology, the treatment of that psychopathology, and the goal of that treatment.

Kohut separated out two major kinds of psychopathology, those that arise from unsatisfactory solutions to conflicts between psychological structures that are essentially intact (traditional neuroses stemming from problems in the resolution of the Oedipus complex) and those that arise from defective structures (hitherto called prestructural pathology) which result in major deficits in the self that regulates such psychological activities as ambitions, skills and ideals. This pathology is viewed as the result of the patient being repeatedly exposed in childhood to severely disturbed empathic responses from the parents. For this latter class of patients, the goal of analysis becomes a newly developed ability in the patient to evoke and sustain empathic resonance with mature selfobjects and to be able to be adequately sustained by them. For persons with this type of "self pathology", successful analysis would end reliance

on relationships with archaic selfobjects that reflect a need for merger, perfect mirroring, or archaic idealization (Kohut, 1984).

To reach this goal of mature empathy, Kohut visualized the basic therapeutic unit as being one of understanding and explaining. Archaic needs are activated in the patient repeatedly during therapy. Inevitable failure of the analyst as selfobject results in frustration (optimal frustration) of this need and a break in the patient-analyst relationship. A reestablishment of a bond of empathy (via an initial recognition of the break, followed by repair through understanding the original need and sequlae from the perceived break) then substitutes for the direct gratification of the need. By repetition of this sequence throughout the course of therapy, minute internalizations of psychic structure occur (transmuting internalizations). Over time, such internalizations allow the patient to move beyond a relationship in which he leans on the analyst as an external selfobject. Initially the patient borrows the analyst's functions through gross and unstable identifications. A gradual and relative independence from the analyst occurs with subsequent recognition of the analyst as an independent center of initiative (Kohut, 1977, 1984).

Kohut talks repeatedly of the need for the analyst's empathic immersion in the inner psychological life of the patient (Kohut, 1980). He states that the patient has the right to expect above average empathic responsiveness from his analyst (Kohut, 1977). By the end of his career Kohut believed that the

understanding component far outweighs the explaining component in significance for therapeutic growth (Kohut, 1984).

Contributions to the literature on empathy also derive from the Stone Center for Developmental Services and Studies; a group that seeks to understand and articulate women's patterns of development. Members of this Center have contributed to the development of a literature concerning the relational approach to psychological understanding (Jordan, Kaplan, Miller, Stivey, and Surrey, 1991). They view empathy as a complex and advanced interactive experience. In their writings, this view is contrasted with what they thought was a prevailing mind-set regarding empathy: that it is a regressive merger that represents a loss of mature functioning. In their theorizing they, too, struggle to address the issue of how affective and cognitive components interplay. They view the affective components as serving to enhance feelings of connectedness to another through the capacity to take in the experience of the other. The cognitive components function to retain a firm sense of self as well as an ability to make decisions and take action on the basis of that sense of self. In this model there is no either/or situation of merger or separation. Neither is there a temporal sequence of merger followed by separation. Both connectedness and differentiation coexist simultaneously in the same experience referred to as empathy (Kaplan, 1981, 1991).

Burke and Tansey (1989), in an attempt to bridge the intrapsychic and interpersonal divisions within the psychoanalytic domain, use the language of

both in their discussion of empathy. For these writers empathy is a unitary sequence of interpersonal communication between therapist and patient that is transmitted in words as well as in actions, on both conscious and unconscious levels. Fulfilling what they consider to be an insufficient recognition of the way the patient affects the therapist in the empathic encounter, they postulate a relationship between empathy and projective identification. To this end, they suggest that the process of projective identification as communications emanating from the patient are always present in the therapist's empathic contact. Both parties are involved in this process, the patient as the initiator and the therapist as the recipient of the identification. When a patient engages in projective identification there is always potential for the therapist to achieve empathy. Such potential may or may not be realized, depending on the therapist's own processing of the interactional communications coming from the other. Thus the authors focus on the broadly defined countertransference aspects of the interaction as being the pivotal experience that can facilitate or impede the flow to an empathic outcome. Successful outcome (achievement of empathy) depends on the therapist's

> capacity to entertain various trial identification [and] is correlated with his tolerance for what may be difficult self-experiences. ... A corollary of this important relationship is that the therapist's degree of conscious awareness of his internal state at any point in the processing sequence depends largely on his capacity to tolerate the image of self that is aroused by the interactional communication from the patient. (Tansey and Burke, 1989, p. 68)

They conceive of this mutual process of projective identification and introjective identification to an empathic outcome as consecutive operations that "offers the patient the opportunity, through the corrective object relationship, to strengthen ego integration by the introjection of a more tolerant view of negative self-representations" (Tansey and Burke, 1989, p.198).

The Therapeutic Relationship and the Role of the Therapist

Theoreticians and practitioners who consider themselves "psychoanalytic" in orientation often seek to validate their concepts and behaviors by reference to the actual words of Freud. Eschewing the idea that any text can be interpreted in a multiplicity of ways, each author quotes Freud so as to lend authenticity and authority to whatever position is developed. Such an appeal would seem to be straightforward and sensible were it not for the fact that Freud does not present a unified nor tight theory. The dynamic nature of human thought is no better captured than in the evolution of Freud's own ideas. Lacking a final word, then, psychoanalytic thought has had the freedom to develop from that beginning core as branches from a sturdy trunk. Each branch claims allegiance to Freud but all have grown in directions different from one another.

One of the concepts that has both evolved and been the source of divisiveness is the nature of the therapeutic relationship. To trace this evolution we turn first to Freud's (1912, 1913, 1914) papers on technique. In his recommendations to psychoanalysts he speaks first of the complementary role of

patient and analyst. The patient in analysis is instructed not to select but to communicate anything that occurs. This is the sine qua non of free association, i.e., that process by which the dominance of the secondary processes is loosened and material from the unconscious is allowed to flow. The analyst's instructions are to become a receptive counterpart to this by not selecting anything in particular, and thereby maintaining an "evenly suspended attention". Freud warns that if the analyst concentrates his attention he will select some things and obscure others, and whatever he selects will be more related to the analyst's own expectations and inclinations. The analyst will therefore find only what he already knows. He exhorts the analyst to meet the patient with an open mind free from presuppositions, thereby allowing himself to be taken by surprise by any new turn. In this way the analyst turns "his own unconscious like a receptive organ towards the transmitting unconscious of the patient" (Freud, 1912/1958, p.115).

A further instruction is offered that speaks to the role of the analyst. Freud advises the psychoanalyst to be as a

> surgeon who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible. ... The justification for requiring this emotional coldness in the analyst is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his own emotional life and for patient the largest amount of help that we can give him to-day. (Freud, 1912/1958, p.115)

Another metaphor for the analyst's role developed in this paper is that of the analyst as mirror. Freud says that the "doctor should be opaque to his

patients and, like a mirror, should show them nothing but what is shown to him" (Freud, 1912/19958, p.118). The context in which this is offered is a reference to the tendency of young analysts to

> carry the patient along with them and lift him over the barriers of his own narrow personality [by] affording him a glimpse of [the analyst's] own mental defects and conflicts and by giving him intimate information about [the analyst's] own life. (Freud, 1912/1958, p.117)

Freud asserts this action verges on suggestion and must be avoided because it mitigates against the uncovering of the unconscious, the ultimate aim.

In Freud's second paper on technique he concentrates on the beginning phases of treatment: the evaluation, arrangements of time and money, use of the couch, and instructions regarding free association. He also discusses the significance and ubiquity of both resistance and transference. Analysis of the resistance helps to usher in the transference. In this paper, Freud talks of transference in a particular way, as a positive rapport between analyst and patient.

> If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment and link the doctor up with one of the imagoes of the people by whom he was accustomed to be treated with affection. Freud, 1913/1958, p.139)

In the third paper the roles of transference and resistance are elaborated as Freud discusses the evolution of technique. While Freud began with an emphasis on catharsis, he later advocated hypnosis as a primary technique. He finally settled on free association and a focus on the resistance to remembering.

But by this time Freud had given up the idea of the patient remembering a particular moment and began to study whatever was present to the patient's mind. As the focus shifted from remembering the past and its repressions, more importance was placed on the actions in the present. The patient acts out whatever is repressed; he repeats it without knowing it. The transference is a part of the repeating, a "playground" for the compulsion to repeat. This repetition is rendered "harmless, and indeed useful, by giving it the right to assert itself in a definite field" (Freud, 1914/1958, p.154). The neurosis now exists in the relationship between the patient and the analyst. This "transference neurosis" is amenable to treatment. After all, "one cannot overcome an enemy who is absent or not within range" (Freud, 1914/1958, p.152).

The importance of these papers lies in the way Freud conceptualized special properties of the relationship between the analyst and the patient. Communication is essentially a one-way street, with the patient verbalizing whatever comes to mind and by so doing reveals his unconscious. The analyst acts a receiver who hears without prejudice or personal filter the unconscious of the patient. At the same time he is to remain cold and aloof, opaque as to his own personality and as a mirror to the other. Interpretation of resistances and of the transference lead to the patient becoming conscious of heretofore unconscious processes. Freud views the relationship in terms of topographical features (unconscious, preconscious, conscious), although he also sees the

relationship as representing structural components of the patient (id, ego, superego).

Neurosis is seen as a compromise, distressing and painful though it may be, between unacceptable id impulses and demands of the real world mediated by the ego. Because neurotic symptoms are a compromise and repressions are incomplete, anxiety flourishes. Freud also added the function of the superego which punishes via guilt. The pain of neurosis is due to the presence of anxiety and guilt. In this view, transference takes on another significance: what is essentially an intrapsychic problem is worked out in the interpersonal sphere of the analytic relationship. The analyst is on one hand the object of the id impulses and on the other hand an auxiliary or substitute superego (Strachey, 1934), and the role of interpretation is to provide a break in the neurotic vicious cycle. Through the work of interpretation the ego becomes "wider" and the conflict is somewhat reconciled to the ego; hence there is only a little gratification and only a little sublimation. Over time the ego becomes more tolerant of the id's libidinal trends and the superego becomes more relaxed and less punitive. Strachey (1934) points out that success is dependent on the patient's reliable reality testing that can recognize the unreal, the archaic, and infantile aspects of the transference relationship.

Ferenczi and Rank (1925/1986) elucidated technical and therapeutic facets of psychoanalysis. By stressing the repeating aspects of the transference, they focused on giving "the patient the opportunity to 'experience'

these wishes intensely for the first time, in order...to place him in a position of attaining an adjustment to reality" (Ferenczi and Rank, 1925/1986, p.10). The emphasis on experience was heretical to Freud, but Ferenczi and Rank thought that knowledge is not everything and that understanding is not the same as experiencing. Therefore they exposed

> the patient a second time to his infantile trauma by offering his unsatisfied Oedipus libido, which had displaced itself neurotically upon inadequate objects, the actual old object. The discharge of libidinal excitation represents for the unconscious of the patient a satisfaction which he is not able to find elsewhere in his life. (Ferenczi and Rank, 1925/1986, p.21)

The analyst is the parental imago on which the patient can live out his libido. This is not a permanent offer, and the aim is for the patient to give up a part of his infantile libido by realizing that fulfillment is contrary to his adult ego ideal. In their emphasis on direct perception and experience, Ferenczi and Rank re-emphasized the role of abreaction, not in reawakening memory but in relation to the analyst, who takes the place of the patient's whole heterogeneous environment. The role of the analyst was seen as active, in opposition to the passive stance required by Freud. Ferenczi, however, was adamant that psychoanalysis not be merely an intellectual experience, but an emotional one as well.

In his later years, Ferenczi began practicing what was termed the "relaxation technique". It was in an important way diametrically opposed to Freud's accepted technique. Rather than building tension in the therapy, this

method sought to reduce tension in order to create a psychological atmosphere in which the patient would feel free to experience what was ego-alien to him (Alexander and Selesnick, 1966). Thompson (1964) postulates that the new technique originated in Ferenczi's ideas of the parent-child relationship.

> Ferenczi reasoned: if the analytic situation is a repetition through the transference of the childhood situation, the same things must be important in analysis - - the patient must need to be loved and accepted by the analyst; he must also need sincerity from the analyst. (Thompson, 1964,.p.77)

The main points of the new relaxation technique were sincerity toward the patient, acceptance of the patient, and emotional reliving.

Ferenczi's continual experimentation took him further away from the Freudian orthodoxy. Ever the optimist, he thought that if a particular approach was unsuccessful it was not because the patient was unanalyzable but because he had yet to find the appropriate approach (Thompson, 1964). He felt compelled to change his method according to the problem encountered.

These essential points of the techniques of Freud and Ferenczi are presented in order to elucidate the beginnings of two different lines of psychoanalysis. Considering Freud's work as a basic frame, the two lines split into what can be called a one-person psychology of the Freudians and a two-person psychology rooted in Ferenczi's work. Increasingly, Ferenczi came to view psychopathology as having its foundation in early relationships. Consequently, successful treatment is contingent on different experiences with relationships and the therapeutic relationship offers an important opportunity for

the patient to experience a corrective emotional experience. (Alexander and French, 1946)

Broadly speaking, there was increasing recognition that the analyst's personality plays a part in the therapy. This led to a greater emphasis placed on the analyst becoming as self-aware as possible through his own analysis. There was also a tendency for greater activity on the part of the analyst. Thompson (1950) states that this resulted from accumulated experiences in therapy such that the analyst could point to certain aspects of experience over others. The analyst is no longer neutral, nor would such a person be desirable (Alexander and French, 1946).

Perhaps the largest leap in evolving ideas about the therapeutic relationship occurred as a result of field theory being incorporated into psychoanalytic theory. Sullivan (1965) speaks of the totality of the person and the situation:

> Everything that lives, does so in communal existence with its medium, its environment. ... There is no such thing as an organism living *out* of its medium. Neither is it possible for us at any time to differentiate completely the organism from its environment. The two are indissoluably mixed, regardless of the degree of organized integrity that the organism may possess. (p.12)

For human beings, this communal existence occurs in an environment of other people, institutions and traditions. To understand another, one must understand how the individual functions as a person among other people and within the

larger social and institutional communities. Psychopathology is disordered personal relations.

For Sullivan "each person in any two-person relationship is involved as a portion of an interpersonal field (not a separate entity) in processes which affect and are affected by the field" (Sullivan, 1953, p.6). His view of the therapeutic relationship, then, is one in which there is a complex and dynamic interchange between two people who are being changed by the experiences of the relationship. It becomes imperative that the analyst understand the activity of his own participation in the relationship. Self-understanding is a necessary condition of effective therapy.

Later developments of the relational school of psychoanalysis combine the theories of interpersonal psychoanalysis, the object relations theories, and certain aspects of self psychology and existential psychology. They, too, see pathology as emerging from disturbance in early relationships which the child then takes to build an interpersonal world. "Psychopathology is repeated because it provides the organizational glue that holds the self together" (Mitchell, 1988). From this perspective the analyst is embedded in the relational matrix of the patient; it is a prerequisite.

> Unless the analyst affectively enters the patient's relational matrix or, rather, discovers himself within it - unless the analyst is in some sense charmed by the patient's entreaties, shaped by the patient's projections, antagonized and frustrated by the patient's defenses - the treatment is never fully engaged, and a certain depth within the analytic experience is lost. (Mitchell, 1988, p.293)

Such a view of the therapeutic relationship leads to a different set of questions one can ask concerning therapeutic process and relationship. While it is clearly important to understand the patient's experience in the therapeutic relationship, it is also important to ask what the therapist experiences as he lives in this relational matrix, this field of mutual influence.

The Experience of Really Feeling Understood

While studies that remain experience-near as they explore the patient's experience of empathy in the therapy relationship are non-existent, one study did examine a related topic in a general, non-patient sample. In a phenomenological investigation of the experience of "really feeling understood" Van Kaam (1959), received written protocols from 365 high school seniors and college students. In this study, participants were asked to describe in detail how they felt when they thought they were being really understood by someone.

Van Kaam arrived at the following necessary constituents of the experience:

- perceiving signs of understanding from a person
- perceiving that a person co-experiences what things mean to the participant
- perceiving that the person accepts the participant
- feeling satisfaction
- feeling initially relief
- feeling initially relief from experiential loneliness
- feeling safe in the relationship with the person understanding
- feeling safe experiential communion with the person understanding
- feeling safe experiential communion with that which the person understanding is perceived to represent.

Using these constituents, he formed a composite description of the experience of empathy:

> The experience of really feeling understood is a perceptual-emotional Gestalt: A subject, perceiving that a person co-experiences what things mean to the subject and accepts him, feels, initially, relief from experiential loneliness, and, gradually, safe experiential communion with that person and with that which the subject perceives this person to represent. (Van Kaam, 1959, p.69)

While the experience elucidated here is generic, and not confined to the therapeutic endeavor, it does provide some idea as to what an empathic experience may feel like to the patient involved in a therapeutic relationship. As such it can be used as a complement to the study presented in the present work.

CHAPTER II

METHOD: THE PHENOMENOLOGICAL APPROACH TO RESEARCH IN PSYCHOLOGY

> Perhaps, then, the best way of investigating the nature of man is to ask him. (Schultz, 1969)

The nature of any research question reflects a specific attitude towards human beings as well as a system of values and meanings about humankind. Likewise, implicit in any methodology are attitudes and beliefs about what it is to be a human being. Both research questions and their methods of inquiry lead toward specific aspects of reality and, together, form a coherent unity of purpose. Choice of method is of vital importance in carrying through to an answer that appropriately fits one's question. To understand the experience of empathy as lived by therapists in their relationships with their patients directs us to a methodology uniquely qualified to accomplish this; that is, to the method of phenomenological psychology. The ways in which phenomenological methods differ from more traditional psychological approaches point to its appropriateness as the method for this research project.

Traditional and phenomenological methods lead to different kinds of knowledge. Traditional approaches to psychological data have been borrowed from the realm of natural science. As such, they are interested in objective prediction and theoretical understanding whereas phenomenology seeks first-person description. Dilthey (1894/1976) talked about two domains of knowledge: natural science contemplates events that are caused and require explanation whereas human science is concerned with acts that are intended and personally meaningful. In human studies, we "deal with living connections of reality experienced in the mind" (p.89). Whereas in natural science an objective vantage point is assumed, in human science it is simply not possible: "Adequate understanding requires participation in the world" (Shapiro, 1986, p. 172).

Similarly, Schutz (1967) insisted on the differences between the kinds of reality studied by natural and social scientists. In natural science, the scientist need not be concerned about preconceptions of the subjects of the study. Such subjects are not expected to interpret themselves nor the contexts in which they find themselves, and knowledge derives from the scientist alone. In the case of social science, the subjects of study are persons situated in a social world. They are aware of their "biographical situations" and have conceptions of the world in which they live and of themselves in that world. Their overt actions are only a part of their existence; they come to any study of any phenomenon with preconceptions and preinterpretations. Thus, the task presented to the social

scientist is to understand the ways in which human beings interpret their experiences in and of the world.

Two significant and related philosophical tenets influence the methodology of phenomenology . One is the primacy of human experience; phenomenology seeks to describe the world of human experience as well as the phenomena of consciousness. Husserl called this a return to the study of things as they appear. A second tenet concerns the unity of being-in-the-world as expressed by Heidegger's term *Dasein*. Any significant understanding of humankind is possible only by seeing the human being in relation to his or her setting. This setting is one of space, time, and others; thus human existence can be disclosed only in cultural, historical, and social contexts of which it is a part.

Acceptance of these tenets must lead the would-be researcher away from traditional views of science, knowledge and methodology. Experience reveals a first-order knowledge whereas traditional science is second-order expression - - that is, of concepts, rationale and explanation. The return to experience is a return to the preobjective origin of constituted thought; that is, to those experiences which gives rise to thought. Lingis (1980) speaks of "moments of evidence", of simple seeing. "...Thought begins with them and builds on them, [and] they are the authority for thought" (Lingis, 1980, p.55).

Herein lies the first of many seeming paradoxes. Experience is pre-reflective. How, then, may we say that we return to the things themselves when

it is through reflection that we make that return? Phenomenology answers this in two ways: first, it tells of the interconnectedness of prereflective and reflective modes of being. If experience is spontaneous primary awareness, it is only through reflection that one comes to be able to describe it clearly and fully. In reflection is revealed the meaning of the experience for the being whose experience is at issue. Human beings make sense of the world and their part in it. "Such organization [as the data of experience] attain is given by the nature of the experience itself and is comprehended only upon reflective consideration at a later time." (Lyons, 1963) There is a givenness of reflection as a major mode of understanding.

> When I begin to reflect my reflection bears upon an unreflective experience; moreover my reflection cannot be unaware of itself as an event, and so it appears to itself in the light of a truly creative act, of a changed structure of consciousness, and yet it has to recognize, as having priority over its own operations, the world which is given to the subject because the subject is given to himself. The real has to be described, not constructed or formed. (Merleau-Ponty, 1962, p.x)

Secondly, phenomenology specifies the nature of the return to experience; it is to be as presuppositionless as possible. Researchers are advised to enter into "moments of evidence" without hypotheses or prior concepts. With a naiveté and openness to phenomena we become what Merleau-Ponty calls "perceptual beginners." Observation is directed to the whole field of possible experiences of the phenomenon. Although consciousness is always consciousness of something, it is this "knowledge of something" that must be set aside so that we might disclose the world in all its

possibilities -- a world that exists prior to our reflection of it. Such an abeyance of prior knowledge is called the phenomenological reduction in Husserl's philosophy. Through the procedures of the reduction, phenomenologists enlarge and deepen their range of experience with the phenomenon. The reduction allows what Eugen Fink, Husserl's assistant, called "wonder in the face of the world".

> Reflection does not withdraw from the world, ... it steps back to watch the forms of transcendence fly up like sparks from a fire; it slackens the intentional threads which attach us to the world and thus brings them to our notice... (Merleau-Ponty, 1962, p. xiii)

Merleau-Ponty brings us to another paradox: namely, the impossibility of a complete reduction. A human being is both of the world and in the world and cannot sever his or her ties to that world. The attempt at reduction then becomes an attempt to make explicit the ties that connect us to the world such that all possibilities of experience may emerge before us. We become aware of "intentional threads" that bind us to the world, and use them in understanding the phenomenon before us.

This brings us to the second and related tenet of phenomenology: human existence is only and always a being-in-the-world. Humanness is unknowable outside its contexts. Such a position contributes to the impossibility of a complete reduction. As beings-in-the-world, researchers are aware that they cannot make themselves or their topics acontexual. Accepting the contextual

nature of their work, they must take the appropriate attitude and stance; in this case, that of the phenomenological psychology.

Acknowledging *Being* as *Being-in-the-world* also leads phenomenologists to a unique point of view regarding subjectivity and objectivity. Subsequent to the Cartesian split of mind and body, scientists found themselves forced to choose as their domain one or another side of the split. Traditional science and positivistic psychologies were interested in things and processes, of measurements and evidence of facts. A human may be considered a thing like all other things, and, therefore, can be treated as we treat other "things" in the world. Thus the methodology of natural science could be embraced by psychology construed as natural science. Within this stance, objectivity was viewed as good, subjectivity as bad. There is an objective world of reality that can be known by applying the strict methods of natural science. Perhaps the best symbol of this approach is the statue of Justitia who, with eyes covered holds the sword and the balance of justice. Justice is to remain abstracted from human existence, and delivered without regard for the person (Straus, 1966). Therefore Justitia wears the blindfold. Analogously, in psychological research traditional researchers are asked to renounce all personal interest in their studies and this is accomplished by a collection of procedures and devices meant to distance the researchers from the humanness of the individuals studied, i.e., their "subjects". At the same time, the subject is also to be

distanced from the world of everyday reality and brought into a controllable environment - - the laboratory.

In recognition of the difficulty of stripping humans of the very stuff which differentiates them from other objects of the world; namely, that we give personal meaning to the experiences of our lives, rationalist and idealist thinkers reacted by concentrating on the other side of the split. They emphasized human subjectivity, and, in so doing, tended to deny any reality of the world as external fact having its own organization and structure. For this view, the human being is a creator/discoverer of meaning in the world, and meaning, described and articulated, has ascendancy over the reality of things. Such a position, unfortunately, leads to solipsism or to a transcendence to the ideal.

The existential-phenomenological acceptance of humanity's situatedness aims at embracing these two extremes; to say that human beings and world co-constitute each other does more than recognize the importance of both subject and object - - it attests to their unity and indissolubility. It heals the Cartesian split by recognizing that a human being is tangibly in the world and imaginatively in reflective understanding of that world.

Husserl recognized that experience is always an experience of something. What he called intentionality is this directional shape of experience. "Every experiencing has its reference or direction towards what is experienced, and, contrarily, every experienced phenomenon refers to or reflects a mode of experiencing to which it is present." (Ihde, 1986, p. 42-43) There is an

experiencer who is experiencing that which is experienced. In the freshness of experience, the experiencer is not aware of his own experiencing. Only afterwards, in reflection, can he separate out different aspects of the unity that is experience. When experience is viewed in this way, terms like subject and object lose their practical significance.

> Knowledge does not become non-objective because it does not refer to the object in the natural scientific sense. Conversely, it is logically forbidden to speak of a 'subjective concept of the truth' and of merely subjective knowledge, when actually what we have is 'knowledge of something subjectively considered true'. Knowledge of the subjective, knowledge of the subjectively grounded, does not in the least subjectivize this knowledge, which is and remains a knowledge of a second kind: namely ascertainment of what can be known in respect to the subject and the subjective grasping of the phenomenon. This is the 'object', and the knowledge that refers to it remains objective. (Funke, 1987, p.127)

This attempt at resolving the subject/object split also affects the nature and range of phenomena to be considered. Phenomenology is equally comfortable investigating what others would call "internal" or "external" experience. Internal experience affects our ways of being with others and in our world. "Our subjective experiences are subjective to ourselves and are also in inescapable ways objectively real to other people." (Guntrip, 1971, p.ix) Unlike positivists, who must limit themselves to tangible things and relativists who, although comfortable with internal events, focus only on inevitable individual differences, existential phenomenology seeks to describe common human experiences. Although different people verbalize experiences in different ways,

the "description of common experiences by people of extremely different types are found to have a common consistency" (Guntrip, 1971, p.6).

Existential-phenomenological psychology attempts to disclose the lived structure of human experience and behavior considered as a totality. This goal is to be accomplished on the basis of descriptions obtained by way of reflection. The "data" may be collected in various ways (thought samples, written narratives, cued recall, etc.), but commonly consist of detailed dialogic interviews in which the researcher is considered a vital participant in the process. Healing the subject/object split extends to the research situation. The "subjects" of the research project are not viewed as passive objects whose behavioral responses to an experimental situation are viewed from afar by a disinterested observer, but as participants engaged in a dynamic flow of conversation focusing on a phenomenon of mutual interest.

Prior to data collection the phenomenological researcher engages in a process that recognizes the meanings and intentions he or she brings to the phenomenon. By positioning oneself as a participant in a "bracketing interview", the researcher seeks to become aware of the "intentional threads" he or she brought to the work. The researcher's study of the phenomenon as it is viewed by other specific orientations is also noted as part of the acknowledgment of preconceptions of the phenomenon. Awareness of these intentions assists the researcher in becoming open to the phenomenon as it unfolds in the process of

data collection and analysis, and in recognizing the situatedness of the study both for the participant and the researcher.

The researcher tries to leave behind "fetishization of the world" (Funke, 1987), thereby becoming open to another's view. To accomplish this, the researcher must leave the present to return via reflection to the context of his or her participants. Phenomena "always have their sense within an assigned context, but they also retain that sense only there" (Funke, 1987, p.131); therefore, it is to that context that the researcher must go with the help of the participant.

The phenomenological interview celebrates the dynamic nature of human relationships. There is a lived relationship between the participant/experiencer and the investigator, both of whom are interested in the phenomenon under discussion. The word "interview" comes from the French, meaning "to see each other" or "to see together". Engaged in a dialogue, both participants enter into a critical reflection on experience - - both the experience of the phenomenon in the past as well as the experience of it in the evolving interview in the present. "Dialogue not only allows the speaker to describe experience, it also requires him or her to clarify its meaning to an involved other and, perhaps, even to realize it for the first time during the conversation itself" (Pollio, 1995, Chap 2). During the interview, changes in awareness occur which then affect an understanding of the phenomenon by both participants. Two people influence each other, and the phenomenon emerges by way of the dialogue. The

phenomenological interview is neither highly structured nor lacking in structure. Kvale (1983) noted several characteristics of the interview that underscore its phenomenological aspects: it is focused; it is experience-oriented not person-oriented; it attempts to describe on both implicit and explicit levels; it is specific and detailed and ambiguity is pursued to discover whether it is a function of communication or of the phenomenon; and whether the phenomenon changes over time.

A dialogic interview method was chosen for the present study because of the richness of data provided by such a process. It was thought to afford an opportunity to clarify and more fully comprehend participants' meanings. Through dialogue with a given participant, ambiguity can be diminished and confusion resolved. The researcher's reflection brought back to the participant during the interview allows for immediate confirmation or disconfirmation of understanding. Thus it serves as a self-correcting device for the researcher and mitigates the impact of leading questions. Since all questions lead, and questions are a vital and substantive part of an interview, it is not the goal of phenomenological interviewing to eliminate questions but to consider different types of questions and their influence on dialogically situated answers. In addition, the interviewer can guide the participant away from abstracting about experience and back to the experiences themselves. The aim is not technical objectivity but reflective intersubjectivity in action as both participants attempt to elucidate the structure and meaning of a specific human experience.

"Interpersonal disparity is analogous to binocular disparity; it gives depth. Disagreement then occurs in and only in communication about the 'same thing' and therefore operates within the horizon of mutually verifiable truth" (Wertz, 1986, p.192).

Each participant in a study offers a unique perspective on the phenomenon.

> He is not a pure gaze on being any more than I am, because his views and my own are in advance inserted into a system of partial perspectives referring to one and the same world where our views intersect. (Merleau-Ponty, 1964, p.82)

To disclose the "same world where our views intersect", and to reveal their commonalities of experience, is the aim of phenomenological analysis. The process begun in the interview itself as an oral dialectic is subsequently expanded during the analysis of interviews as text. Transcribed interviews are analyzed in various phases and on different levels, in a new dialectic of discovery and clarification leading to a continuing understanding of the phenomenon. The researcher, as co-creator of the text he or she interprets, enters a process of reflection with the text as had been previously experienced with participants during the interviews.

Beginning with detailed individual descriptions, the researcher then moves to what is a wider and more abstractly generalized description by elucidating common themes. Trying to describe the essence of a phenomenon, the researcher looks for those aspects that remain constant over the variations

in the specific examples offered by the interview participants. The movement which at first seems linear, from individual to general and from concrete to abstract, is found to be more of a spiral by virtue of continual reference back to the text. Themes are checked against individual instances for convergence or divergence.

Accuracy depends not only on constant reference back to the texts, but also on attention to all permutations of the phenomenon. In this way, phenomenological reduction extends to the analysis. The researcher remains open to the phenomenon as it appears in the interview texts and this means considering both the presences and absences of possibilities as they appear in the texts. What emerges across texts are the essential features; that is, those features that are necessary and sufficient characteristics of experience.

> When we make these analyses, we realize that what we are disclosing has to be the way that is. We have given ourselves not only to the structure we describe, but also the inability of the structure to be other than it is. (Sokolowski, 1985, p.18)

Phenomenological descriptions and understanding attempt to reflect with fidelity the underlying character of the phenomenon. As Husserl said,

> If we find here something flowing, then we simply must form the idea of flow; if we find something vague, the idea of vagueness; if we are able in certain spheres to find only typical difference, then we must form the concepts of type. (Husserl, 1980, p.127)

While an essential structure is the desired result, the researcher must be attentive to divergences and distinctions among the data. Inconsistencies are as important as similarities in revealing an underlying thematic structure.

The meaning of experience emerges and is transformed from everyday understanding to psychological understanding, by using the language appropriate to a phenomenologically informed psychology. The final step in any analysis is a synthesis of themes recovered from the interviews into an integrated general psychological structure of experience. As such, it is more than a list of elements and must at once embrace the whole gestalt of the experience while implicitly attending to major facets of the experience. Thus, the researcher works first in relation to participants and later in relation to the texts to grasp some aspects of the experience on which all might agree.

As Giorgi (1986) notes, the descriptive and explanatory sciences each have different goals. In the former, one strives for understanding in a context of discovery, using human experience as data. In the latter, facticity is sought in a context of verification, using scores or other measures of behavior. Two such different types of research activities obviously lead to differing ways of construing reliability and validity. Rather than asking whether the instrument does a good job of measuring the construct and if it measures what it intends to measure, existential-phenomenological researchers address validity and reliability from a broader stance. They ask whether the findings and conclusions can "be trusted and used as the basis for actions and policy decisions" (Polkinghorne, 1989, p.57). Confidence in the accuracy of the research is attained if the following questions can be satisfactorily answered:

1. Are interviews conducted such that participants are able to disclose their experiences in a full and detailed manner that will yield sufficiently rich data from which results can be drawn? "The aim of descriptive science is to try to be exhaustive with respect to the given and to learn from it." (Giorgi, 1986, p.163)

2. Does the researcher lead the participant or allow the participant to unfold the experience of the phenomenon in the course of the interview? To understand one's own presuppositions regarding an experience, the researcher is interviewed regarding personal experience with the phenomenon prior to interviewing participants. In addition, an interpretive research group assists the primary researcher in attending to presuppositions both at the time of the "bracketing interview" and, later, as they review transcripts together.

3. Are descriptions of individual experiences faithful to transcribed interviews? The self-correcting aspects of the phenomenological interview mentioned above help to ensure this. In addition, the researcher returns to the participants post interview to share with them the provisional conclusions reached from their interview data.

4. Are the emergent themes consistent with both the data and the research question? Since any text can be interpreted in a variety of ways, the phenomenologist is interested in "whether the interpretation is consistent with the aims of the study, can be directly supported by reference to participant descriptions, and provides insight into the phenomenon being investigated". (Thompson, Locander, and Pollio, 1990, p.347) The use of an interpretive

research group throughout the thematizing process is designed to provide the researcher with ongoing feedback as well as additional perspectives from which to view data..

Once all of these concerns have been taken into account, it becomes possible to describe a general thematic structure designed to capture a particular human experience. The structure attained, however, is considered as neither a final description nor as an ultimate truth, but as a "temporally shaded experienceability" (Funke, 1987). The life-world of any phenomenon is larger and richer than any research project can capture, whether that project is phenomenological or otherwise. Therefore the description cannot be completely exhaustive, but needs to be an accurate reflection of the totality of the phenomenon as it has emerged from the experiences of participants. From an existential-phenomenological perspective, the researcher is ever appreciative of the situatedness of human experience, and thus the researcher must remain open to the phenomenon in such a way as to reflect both continuity and change.

The Present Study

Any phenomenological interview begins with a question designed to elicit the experience of the phenomenon under study. It sets the field of inquiry and allows participants to move freely in that field. The question asked of participants should be sufficiently broad to invite them to reflect on a class of

experiences, but it should make no attempt to delineate further the possible description of that class.

While phenomenological psychology research can investigate experiences from mundane to extraordinary, this study investigates an experience that is common to most human beings as well as one experienced in the more specific context of psychotherapy. It is also a topic extensively written about in the psychotherapy and psychoanalytic literature. Therefore, the opening research question needs to be free of suppositions brought from that literature. It should be broad enough to allow the participants to define the phenomenon as they live it with their patients. The question should recognize that it is not "empathy" that is being studied, but the "experience of empathy with patients in the psychotherapy situation". Consequently the phrasing should generate specific examples.

The present study reflects my ongoing interest in the therapeutic process and in the therapeutic relationship, fueled by clinical experiences and a dissatisfaction with limitations in a body of literature that focuses on the importance of empathy while it defines it in experience-distant conceptual terms. In consideration of these limitations, the following question was developed: "Can you think of some times when you have felt or been empathic with your patients and can you tell me about one or two of those times?"

The inclusion of the verb phrase "felt or been empathic" was designed to limit restrictions on the nature of the empathic experience. The question does

not assert that empathic experience is one of feeling, thought, attitude, or action, but may be any or all of these. It sets the field as the world of the therapy session. Because empathy is also a human experience not limited to the therapeutic situation alone, the question used to open the present set of dialogues was designed to allow the respondent to speak to similarities or differences between everyday empathy in the world and empathy in the world of therapy. At the same time, it was phrased in such a way as not to necessitate such a distinction.

In order to determine what sort of situations the present question might be expected to provoke, it was tested in a preliminary interview conducted by the researcher with another psychologist as a voluntary participant. This interview was held in the presence of the larger membership of the University of Tennessee Phenomenological Psychology Research Group. In this context, the researcher could elicit feedback from the group regarding the phenomenon under investigation as well as the technique of the interviewer. Such a "trial run" is an invaluable tool, for, in this case, it assured the researcher that the question was adequate for the purposes intended. The interview also elucidated the differences between clinical interviews that are person-focused and phenomenological interviews that are phenomenon-focused.

Method

Once the question was settled on, a bracketing interview was conducted by a member of the research laboratory with the researcher as participant. The purpose of this interview is to highlight the researcher's experience with and reflections on the phenomenon in question. Appreciation of one's personal and theoretical biases allows the researcher to become aware of presuppositions that could influence the study. When these are clarified, greater openness to others' experiences of the phenomenon is possible, and it becomes easier to avoid questions that will simply lead to a confirmation of one's own experiences. Analysis of this interview occurred in the phenomenological psychology research group. The following themes emerged from the text of this interview: empathy as connection in a relationship, empathic experience as a struggle leading to a further understanding of the patient, an awareness of barriers to empathy, emanating from the patient and/or from the self, and empathy as both an embodied and intellectual experience.

Participants

Participants in the present study were selected from the psychology community of East Tennessee and Western North Carolina. Potential participants were located through the local Yellow Pages or through minimal acquaintance with the researcher. All participants were solicited via letter and/or telephone call. Selection was dependent on the participant having attained a

doctoral level degree in clinical, counseling, or educational psychology and on having been actively involved in clinical practice for a minimum of five years post-degree. Seasoned therapists were sought in order to tap experiences of those who live daily in the world of therapy. The final participant list also was dependent on a balanced gender representation. In addition, some attempt was made to select participants who received their educations from a variety of institutions, although no attempt was made to limit participants to a specific theoretical background. It should be noted, however, that the final participant list heavily favors a psychoanalytic perspective.

Of the twelve psychologists approached, ten met the criteria and agreed to participate. Five were female, five were male and they ranged in age from 39 through 59 years. All ten had received Ph.D.'s and had been in practice for from ten to thirty years. The participants received their doctoral degrees from six different institutions of higher education. All participants described their major current clinical situations as private practice, and several reported having a diversified practice that includes institutional work and/or consultation.

Interviews

Interviews were conducted at the convenience of participants. Nine interviews took place in participants' offices; one in a therapy room at the UT Psychological Clinic. All were audio-taped and subsequently transcribed by the researcher. Each initial interview began with a discussion of the informed

consent process (see Appendix for specific copy of the consent form) and the assent of the participant to the present interview.

The interview followed an unstructured format beginning with the same opening question: "Can you think of some times when you have felt or been empathic with your patients and can you tell me about one or two of those times?" Further questions were asked to promote clarification or expansion of a particular aspect of the participant's experience. The researcher also guided participants back to a more experience-near description when they seemed to move to an abstract description of the phenomenon. Attempts also were made during the interview to summarize the interview and to ask for feedback from the participant as to the "accuracy" of the description.

Following transcription of the interviews, synopses were written for all ten interviews. Participants were sent both the verbatim transcripts and the synopsis to review for reaction and comment. During a second interview, these synopses were discussed and a second consent form outlining the parameters for using quotations was obtained (see Appendix for a copy of this form). Each participant received a copy of his or her interview and synopsis; the researcher also furnished a final copy of the dissertation to each participant.

Thematic Analysis

Thematic analysis seeks to disclose the essential structure of an experience. During this process major constituents of the experience emerge as

do relationships between the constituents comprising the totality of the experience. The first phase of the present analysis consisted of an attempt to grasp the whole of each interview. Since the researcher was the transcriber, this process began in the transcription phase. A sense of the participant's unique experience with the phenomenon was reached by an immersion in the interview text, and the product of this process was a synopsis of the interview. The synopsis was intended to capture the essence of the participant's interview by condensing and highlighting significant statements of his or her experience, across the examples the participant offered. These synopses were reviewed by the participants to ensure fidelity to the participants' experiences.

At this point, four complete and two partial interviews were brought to the Phenomenological Psychology Group for collaborative interpretation. Using the group at this stage of the research functioned both as a means of opening the researcher to the many possibilities and of avoiding her reaching premature or narrowly conceived conclusions. At these sessions, the texts in their entirety were presented, with all pauses and idiosyncratic utterances left intact. Thus, the interview unfolded for the group in the same way as it unfolded in the original dialogue, or as close to that as possible given differences between the written and the spoken word.. Typically the researcher read the part of the participant and another group member read the researcher's part of the dialogue. In this type of group interpretation, at any point members can stop to discuss a word, phrase, or idea from the text. (For a further description of this process, see

Thompson, Locander, and Pollio, 1989) Attempts are made to remain at the level of the lived experience of participants rather than to refer to some theory or to the personal experience of group members. There was also an attempt to remain phenomenon-focused, as opposed to becoming entangled in an analysis of the participant. The researcher and the group began to see patterns emerge, both within and across the texts.

The researcher then began a wider phase of the analysis. Returning to each text in turn, significant statements regarding the experience of empathy in therapy were drawn from the text and grouped in a preliminary attempt to arrive at common aspects of the experience. Verbatim quotes were utilized throughout this process. Tentative thematic groups were reached, and quotes checked in their original contexts, to ensure that the meaning of the grouped quotes fit the meaning of participants. While a sense of themes emerged at this point, premature attempts to name and thereby fix the themes were avoided. At this point, the researcher simply asked: do these statements seem to fit together?

Each group of statements was then considered in relation to a new question: in what way are these statements alike? Tentative names were then given to the various groups of statements, always attempting to retain wording of the texts. Nine groups emerged at this level of interpretation. At this point, another condensation was attempted on the basis of the following overriding question: Are these preliminary themes sufficiently different from each other, or

are they different aspects of a broader theme? An answer to this question led to the collapse of the original nine themes into five, more inclusive themes.

These five themes were then analyzed in terms of the various subthemes that emerged. An attempt was made to understand the relationship of each subtheme to the larger theme and to each other. As facets of a geometric solid are unique but related significantly to the whole of the object, so each of the subthemes are singular but stand in relation to each other in special ways to complete the richness of the theme.

At this point in the analysis, the laboratory group became involved once more. During this phase individual statements were again read in order to understand the ways in which the major themes related to one another. Experience is an indivisible whole as it is lived; therefore, statements almost always contain reference to more than one theme. Although a single theme may be figural, all others act as ground, and all are required to complete the experience just as each facet is required to complete the geometric object.. Four of the themes were found to relate directly to each other, with the fifth relating to only three of them. Further reflection led to the realization that this fifth theme is actually located outside the experience of empathy proper; it is the consequence of empathic experience. During empathic experience, it reveals itself as another aspect of one of the four major themes. Thus, the final structure consisted of four major themes. The discussion that follows in the next chapter will explicate

these four themes of the empathic experience as well as the consequences of empathic experiences.

In a final check to ensure accuracy of the structure, the four major themes were considered in relation to each other and in conjunction with their subthemes. Referral back to the original interview texts revealed that some subthemes seemed to have been misnamed and when renamed, were found to belong to another theme.

In this manner statements and themes were once more viewed against the context of the larger texts from which they were taken. This is a fundamental part of the process of hermeneutic interpretation of texts. The movement is a spiraling between the texts via significant statements to the thematic level and back again to the texts for reference and confirmation. Thus the thematic structure that emerges is directly referable to the interview texts, and, when possible, bears the words from the texts.

The thematic structure to be described in the next chapter is meant to be a "necessary and sufficient" structure, encompassing significant elements from the various texts while not implying more than is supported by those texts. The structure is such that all themes relate to one another in a complex interweaving that elucidates the rich tapestry of the interview texts. As in a tapestry, the themes, as threads, are woven into the background threads of the warp. While these warp threads are not visible when looking at the tapestry, their unseen presence provides the important framework on which the weft threads are

woven; therefore, the warp threads affect each weft thread. In this study, the context of the therapy relationship must be viewed as the warp on which all four themes emerged as figure.

CHAPTER III

RESULTS

> Draw bamboos for ten years, become a bamboo, then forget all about bamboos when you are drawing. (Duthuit)

Before proceeding to describe the results of the study, it is important to remind the reader of the intentions that guided this work. First is an ongoing interest in the process of psychotherapy and salient aspects of therapeutic work. Second is an interest in understanding and explicating therapists' experiences as important aspects of that process. Accordingly, the question this work sought to answer was: what are therapists aware of during empathic experiences with patients? To this end, participant therapists were asked to describe in detail experiences in therapy in which they felt empathic with their patients.

The hermeneutic method of interpretation involves a process of movement back and forth between the parts and the whole of a corpus of data. The movement is best characterized as a spiral since each step brings the researcher to a new level of understanding the data. The results of the data are

presented in a manner that seeks to respect both the parts and the whole of the experience.

Just as a human is a "being-in-the-world", experiences are embedded in varied contexts that color each experience and each experience, in turn, influences its context. An important context in this study is the world of therapy as it is embodied in therapeutic relationships. The word "therapy" originates in the Greek word *therapeuo* which means "wait on" or "cure" and the Greek word *therapeia,* meaning "healing". With therapy as a ground, therefore, there is an explicit purpose or direction to experience, and that is towards healing. The therapist is the partner in the relationship who "waits on" the other for the purpose of the latter's achieving a healing or cure. The patient (from the Latin *patiens* meaning "suffer") seeks an ameliorative change in some aspect of being, leading to an abatement of suffering. Both partners stand in similar relation to their common purpose of healing while they stand each to each other in different ways according to their roles. This is the larger context in which present experiences of empathy took place.

Thematic Structure of Psychotherapists' Experiences of Empathy

The hermeneutic analysis of the ten interview texts disclosed a structure consisting of four major themes. Taken together these themes comprise the essential aspects of therapists' experiences of empathy with their patients.

These themes are:

- Letting Go
- Connecting
- Being Responsible and Responsive
- Danger

A pictorial representation of the experience is found in Figure 1 on the following page. This figure is intended to present both parts and whole. The circle represents the unity, or gestalt, of the entire experience. The four points on the circle represent each major theme as experientially distinct parts of that whole. The lines connecting the themes are meant to represent relatedness between thematic aspects.

The four major aspects of therapists' experiences of empathy are all present in the seamless lived experience, and influence each other equally. Not all are figural, however, at one time, during experience or reflection. Thus a single aspect might be more figural for a participant during the interview. Other aspects, though present, might occur in a less highlighted form. In other interview protocols, a pair or trio of themes might be salient. In addition, many passages contain references to more than one theme. In this presentation we will acquaint the reader with the themes not only as distinct entities, but also as pairs and triads of relationships, and as aspects of a complete experience.

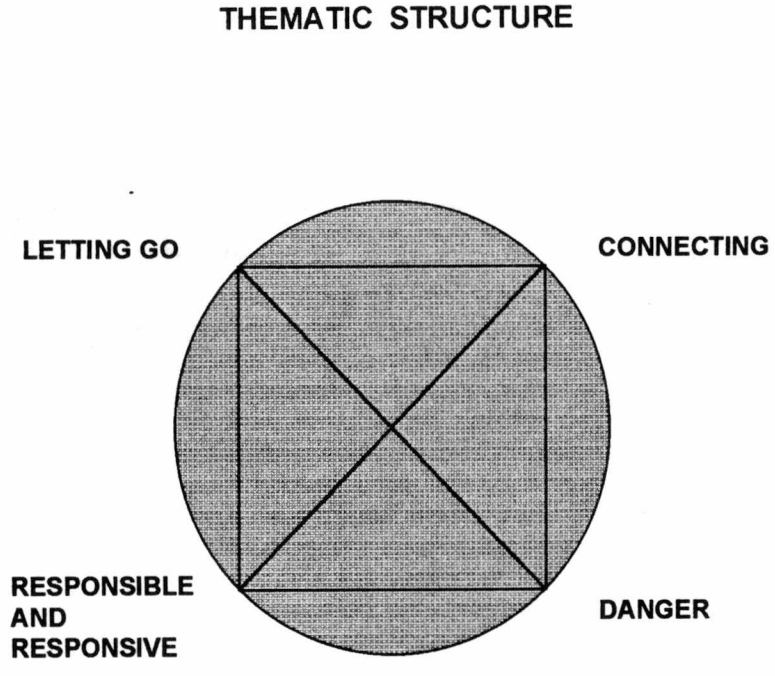

Figure 1. Thematic Structure of Psychotherapists' Experiences of Empathy

Letting Go

An integral aspect of the empathic experience was described as a process of letting go. It was experienced by the participants as a "being" rather than a "doing" that involved a basic change in the mode of experiencing. Participants described this shift as a letting go of self, a "hanging up" of self, or an emptying of self. In this change of being participants reported a sense of allowing the relaxation of customary processes which ushered in a receptivity to whatever might come. It was often portrayed in spatial terms: opening up a wider space or more room; putting things to the periphery to open up a space; suspending the protective barrier. In the presentness of their experience participants noted a feeling of authenticity that resulted from letting go. The therapist was aware of being honest, real, fundamental and alive. The experience was characterized as one of quietness and peace.

Participants used words like dissolving, suspending, opening, leaving, shifting, defocusing, and detaching to describe this shift in mode of experiencing. Letting go happens on several levels: global living or world, the demands of everyday life, assumptions about the other, and on down to the level of therapist as therapist.

> "It's as if I've put everything of my own concerns and needs of the moment, preoccupations and all the things I might think about, they all move to the periphery and I gather myself together to make a container for whatever's going to be put there." [F-01]

> "But the threshold thing I'm talking about is sort of like, I let go of as much structure as I'm capable of letting go of. And stuff starts happening. And it's invariably fascinating to me. The demands of everyday life recede.

> The kind of global living recedes. ... Letting myself not know what's going on." [M-01]
>
> "I will try to open a larger place in myself. Sometimes I'll even try to dissolve at that moment all my preconceptions about the person, and try to re-hear them or re-experience them in a fresh way." [M-02]
>
> "Aaaa, [letting go of] ego, letting go of having to have the answers, having to have it figured out, having to have it analyzed. Letting go of having to say just the right thing at just the right time. Letting go of my desires, or how I would like another person to perceive me." [M-05]

The experience of letting go involves a different kind of experience that the participants described as being "open to life", or "holding self in readiness". Another participant characterized it as allowing

> "more space for authentic self or selves to be present. .... That creates a special kind of space for people". [M-05]

At the same time there was an awareness of the fragility of that experience, since it is sometimes both difficult to attain and then to maintain. Participants sometimes expressed this experience in terms of barriers; there are things in the therapist that can get in the way. Letting go is not always easy to accomplish. When there is interference, either at the personal or the therapist level, effort is needed to discern the nature of the interference. This special notice can lead to letting it go.

> "Inquire into myself first: can I discern any barrier, any resistance I'm having inside of me to some aspect of this person? ... I identified inside myself two - we can call them countertransference interruptions or counterresistances that interfered with my, with the smooth flow of empathy. ... That self-awareness dissolved the barrier to my being empathic with her." [M-02]

> "I was there to hear her process, and that I could later journal, sort out, or deal with whatever her issues were stirring up in myself. But it was often a conscious thing that I was saying to myself, 'OK, later. Be here' ." [F-05]

> "Suspending any assumption I know what's going on. I don't know what's going on. And having that be fine. That's part of what's hard. I don't know what's going on, OK? I'm powerless. I can't understand. ... Letting myself not know what's going on. I'm trusting that some bigger version of me will offer comment." [M-01]

While is was clear that the participants were most aware of self during this aspect of empathic experience, they also commented on the necessary participation of the other. The patient must be willing to engage in the process. When this does not occur, "how futile it feels, and how, what a deadening experience it can be". [F-01] Another participant talked about the need for the patient to "tolerate your getting into that [trance state], may even at some dim level of awareness realize that you need to get into that". [M-03] He talked, somewhat ironically, of the letting go as a letting go of the demands of interpersonal responsiveness in the moment. "I have to leave them to get to them". [M-03] The patients have to be able to tolerate that.

A sense of being alive was articulated by several participants. One called it being

> "willing to be alive, being open to life, in whatever form it presents itself, in terms of the people I see." [F-05]

> "It feels more alive in the sense of not trying to engineer myself to be some way, to be therapeutic. It's like it feels more alive in the sense that I'm more and more and more able to let whatever emerges emerge." [M-01]

Participants also articulated situations that ushered in the change in mode of experiencing that is called "letting go". One mentioned that this is how he tries to start each session with a patient. Another noticed that when he begins to feel out of sync with the patient he takes that as a cue that he is not understanding something and tries to shift to a different mode of reception. A third situation was highlighted by a participant as he described the importance of healing any breaks in empathy that occur during the normal course of therapy. In each case, the therapist makes a choice to let go in order to be present for the patient.

Connecting

This aspect of the empathic experience is rich and complex. Participants spoke of connecting to the other in general, human ways as well as in specific situations of listening to the other. Being connected is experienced as connection to the self as well as to the other through affective experiences. Moments of connection occur at specific points in time when understanding is reached. But experiences of connection also have enduring aspects. The participants worked to grasp the nature of the connection. This discussion often revolved around issues of consciousness and boundaries.

Because we are, as Sullivan says, more simply human than otherwise, most participants felt connections with their patients on a very basic level. Human life entails certain similarities that make available points of connection.

> "I think of empathy as the commonality that we all have as human beings, struggling with our lives in whatever way we choose. And so I rarely see a patient that I don't have some empathy with. It may not be because I've lived through that specific event or that specific situation, but because they're human and I have respect for their humanity, their courage, their means to face what they're facing." [F-05]

> "What I think also happens is that there are experiences, for instance, that people have, that are fairly common across everybody's spectrum of experience of life. And that's what I'm talking about with these sort of developmental stages that I personally have gone through. I know what they're like." [M-04]

Another participant looked for the commonality across his practice experience and uncovered a theme that relates in an ironic way to the experience of being connected as human beings.

> "... 10,000 clinical hours, and what does that mean? What have I learned from that? And I don't know yet; I don't know what I've learned. But one thing that came out was about isolation. How isolated people; if there's one thing, one common theme throughout all this work with folks, is about isolation, how isolated people are. How alone that people are in this world. The absence of connection in the world, even families and couples and how isolated they are." [M-05]

When illustrating empathic experiences with patients, participants described connecting as a complex series of events. Connections to the patient and to the self occur through the affect generated in the therapist by the patient's narration. Sometimes the affect is shared in the moment, but not always. Again, the experience was described in spatial terms, as therapists grappled with the nature of the connection. One termed it "being in the same place at the same time".

One participant spoke of the necessity for the patient to be connected to personal experiences as an essential component to the connection shared between therapist and patient.

> "And what I have seen is that depends on the emotional intensity that they have brought to it. Now if they're just talking about something and they're still pretty removed from it, there's still not really a connection there. ... You can have someone talking endlessly about all kinds of experiences, and they're not connected with that body, so there's not much that happens." [F-03]

The therapist's connection to the patient is an analog to the patient's experience. Therapists experience this as a resonance. It was not easy to describe.

> "As though, you know, something had, there had been some connection. That there was just this sense of resonance." [F-03]

> "She stores something in me, and my psyche keeps right on working with it. I'm going on making pie or doing dinner or whatever, but she stores something in me and we both know that we both carry it. We both have it. And we both have the faith that we'll work on it together. That it will go on being a shared experience until it is resolved." [F-01]

> "It was as if it had happened to me. It hadn't. But because there was a level in which we were, I guess, connected, when she talked about [it] there was a certain sense of commonality of experience that really wasn't." [M-04]

> "It's sort of an instant experience of being you and then it moves on". [F-02]

The struggle to describe connecting in the empathic experience seemed to touch on an important question: whose experience is it - - mine, yours, or ours? This lead to an inquiry into the subject of boundaries.

> "I think that the soul of it is to maybe be boundaryless." [F-02]

"...me and the person, and for awhile it's the person. There's some alteration of boundaries. ... It's not a forgetting in the sense that you forgot something, but there's a blurring of, of yourself and the other's self. Your head, as the patient would talk about something, describing experience, it's like it's your experience. Then you're back in some sort of interpersonal mode. [M-03]

"I don't think I really took on her own pain. But I felt, I experienced her pain and it echoed into my own pain, that life can be so cruel." [F-05]

"It's like I let myself find a configuration within myself that seems at least an approximation of what he seems to be living. It's not, this isn't conscious. [M-01]

Yet another participant asserted that empathic connection is, for her, both conscious and with clear boundaries.

"The experience of empathy is a conscious awareness. ... With empathy I don't think you get lost. ... The person, they are talking about their own experience, and you know, in thinking about it, you are thinking about them as well as informing yourself from your own experience. ... With empathy there is a clarity. ... With empathy I think of empathy as a kind of attunement where it's very clear. Everyone's very clear on whose it is, and who's having feelings, which probably in some ways both of you are, or maybe one person is and the other is being able to talk about it. So there's something...about empathy, I think, where a boundary isn't lost. It's like you, you're still differentiated. [F-04]

Perhaps the difficulty participants had in answering their question of whose experience it is, comes from the fact that it is simply not the most important question when talking about empathic experience. At the moment of connection it is the connection that is significant, not the people doing the connecting. The two people as separate individuals recede into the background and the place of connection is figural. The area between, the shared affective space present in this meeting of experience, provides the keystone. The word

"resonance", that several participants used to describe this aspect of empathy, works well since to resound means "to produce echoes; go on sounding; fill the place with sound; to prolong with vibration or reflection". Connection fills the space between and the echoes that vibrate reflect both persons involved in the connection. The space between is figural in being connected as it is in resonance.

Therapists viewed accessing one's own experiences as essential to connecting with the other. Self-connection enlivens the connection between the therapeutic partners and underscores the importance of person-to-person aspects of being connected.

> "All we have is what we are and the accumulation of all we've ever been and all everyone else has ever meant to us. That's all we've got to work with." [F-01]

> "And all of a sudden, I had this real sense of empathy for the family, and understanding for the family about what they were going through, ... I could experience it in myself, and it gave me a ground to talk about with this adolescent girl. Somehow, even though I had used the words before, it somehow felt new. ... So that was again, was a moment of empathy that was, it was informed by my own experience, and then I was able to bring that and be in touch with what the person was feeling. ... I think before I had an intellectual understanding of [it]. I had read stuff, and so from things I had read, I realized that one would expect these kinds of feelings and thought and I would talk about that. I think what shifted was I then had an understanding that was more a real experience for myself, and perhaps not so distant or clinical for the girl. I'm not sure what had shifted, but I knew once I had gone through it some, she and I could talk about it and I could use those words, and she could ... embrace them." [F-04]

Connecting involves emotions. The therapist uses the emotions he or she feels to apprehend the experience of the other.

"I think it is, at some level, some kind of communication that deals with emotions, picking up. And a sense of being in some resonance with someone you're working with. I'm trying to, trying to be. I guess I'm trying to do two things: both keep a part of me available to what, to some outside view and then part of me very tuned in or even available for whatever's coming from the patient in that. Whatever's coming emotionally. [F-03]

"Like I'll be listening to someone and I'll find myself in a fragmented state. And every time I talk to this person I find myself disorganized. That's kind of this. I think of that as a kind of empathic access to what's going on with this person." [M-01]

Using one's own experiences gives one access through shared feelings.

"And I think that's, now that I've had that experience myself and I know the affective components of having that experience, of being a parent, and now I can much, that I can easily understand in a feeling-type way as well as just intellectually what these parents are talking about..."[M-04]

Using one's own personal experience to forge the connection between therapist and patient is experienced as qualitatively different from using clinical or theoretical knowledge.

"...I can understand that and I can reflect that, but I think it's kind of a, kind of a sort of a, maybe *hollow* empathy. Sort of a brain empathy without having the real experience of what it's like to be a parent who's trying to give their child up to the world. ... Before I could *see* what it was like to be a parent, to give up a child to the world. Now I can *feel* what that's like. And with that I think I'm a lot more help. ... To me it's more genuine." [M-04]

"So it was, yeah, all of a sudden it allowed me to understand in a genuine way, in a real way, what that experience was like." [F-04]

Clearly, not all therapists have had all of the experiences their patients talk about. Connections are made on the basis of other kinds of experiences as

well, through feelings and thoughts that are generated in the therapist which serve to illuminate the meaning of another's experience.

> "Often when I hear of empathy and hear people speak against it or for it, it's experiencing exactly what the other person or coming close to experiencing the same thing. But I think that that is empathy, too: to be open to hearing another person's meaning, another person's experience, another person's story, from their perspective." [F-05]

> "And so, even though, you know, nothing like what happened to her happened to me, as far as the traumatic abuse is concerned, there is some place where she and I have had similar experiences, and I think that level of relatedness to her, based on those, what *are* similarities. ... And I think there are some commonalities in her way of being in life that are similar to certain parts of me. Even though what happened to her didn't happen to me, some of the ways she's put together are similar. And I think in our early work together in forming a therapeutic relationship I was able to identify what those were, and then when she began talking about being abused, ... it was as if that had happened to me. It hadn't. But because there was a level in which we were, I guess, connected, when she talked about that having happened to her, there was a certain sense of a commonality that really wasn't." [M-04]

> "In fact, I think that we have to somehow. We do our best to try and get there even if we haven't had the experience. For example, if a therapist hasn't been sexually abused and she is with a patient who has, some of that's going to be missing. It's not going to be easily available, at the level that the patient has knowledge of what that's like. That's what I mean. A therapist, yeah, a therapist has to work at getting it, OK. Because I know what I do - it just got murky again - umm, I do work on understanding that at the most primitive levels that I can. And I know when someone does have experience that I have access to in my own life, it's a whole lot easier. I don't have to do as much work. I know much more quickly something about that experience and something about the feelings. Not that they're going to match up totally, but there's just a whole lot more rich tapestry of information that creates like a whole, w-h-o-l-e, that I can draw on. And when that's not all there I have to do more work to, to - it's not just be in touch with - to let myself be open to something. It may be painful, I don't know, just something that will begin to give me more information to fill out some of that. If I have a patient who's in an arena that I don't have experience with, then I have some other kinds of knowledge about . I think I have to look at being able to resonate and connect with them at those levels. Of that experience, or

> something about that. ... I pull whatever there is and stretch that. Whatever experience I can use." [F-03]

One participant described being with a disorganized patient who was rambling in an incoherent manner about family moves in his childhood. As the therapist was listening he found himself thinking about something seemingly different. He was able to use his internal experience that was not like his patient's in specific content but was similar to it on a meaning level.

> "And I had a thought in there. And I saw him and his relationship, this sort of just. I started thinking about [my son] and his relationship to our neighbor. He's a man in his seventy's, and I thought, 'When he sees him, [my son] lights up, and he lights up when he sees [my son]'. Those two have a much closer relationship than I have with this man. I was thinking, I had this thought about 'What happens when he dies? What will [my son] feel like? How can I ever explain it to him?' OK? And I said, 'What am I doing thinking about this?' That was the information from within where I sort of inadvertently slid to that said, 'Wait a minute - this is about loss!' " [M-01]

At times the affective state of the therapist is parallel to the patient, while at other times it is not. When it is not, the therapist is often aware of a deficit in the patient and the therapist finds himself feeling or doing what the patient cannot or will not.

> "So I think the empathy is I start to feel the deficit and so some of what I've learned in response to that state, to counterbalance it, to evolve out of it. I probably start to do what I did to evolve out of that particular deficit for myself - in his presence." [M-01]

Sometimes the point of affective connection is not even recognized at the time. One participant knew a connection had been made but did not have a sense of the basis for it until he reflected on the experience during the interview.

"Yeah, something just clicked with me about that whole thing, maybe, but, what was it, that he saw himself as unlovable? ... And what just occurred to me when I was saying 'I don't know how', and 'I've never had that experience', but I think I know what it's like to feel unlovable. I know I've experienced that; I know that feeling. I hadn't thought that before, but maybe that's, you know, maybe that's why I could identify with him now." [M-05]

Connecting is not simply sharing an experience. It goes further. It is not the experience alone that is sought, but rather the meaning of the experience. The moment of connection is described as the instant of achieving an understanding of the meaning of the experience.

"I'm more inclined to view empathy as a knowing. there are feelings associated with it. But, for me, empathy is a means of knowledge. It's a way to know something. ...I'm not sure [the feelings] are primary. They're never not there. But I don't know what I would say, for me that's not the primary aspect of the experience. There is something that occurs inside, where I experience, 'Damn, that's what this is about!' " [M-03]

"And I, when she was talking, that experience, that memory came to mind, and all of a sudden it was very clear to me what she was talking about." [F-04]

"I'm paying attention to whatever emerges and whatever might end up bracketing this whole thing and it often happens suddenly. And sometimes it just sort of gradually emerges into my conscious awareness and, 'Oh, that's what's going on!' " [M-01]

While there are specific moments of connection and understanding, there also seem to be enduring aspects. Understanding within relationship moves forward in time.

"Yeah, there's an ongoing aliveness of the other person inside of me, so it's easy, session to session, to just kind of pick up where we left off. It's somehow there, just stored inside of me." [F-01]

Sometimes understanding moves forward in time and a different level of understanding is reached later. One participant talked about understanding the patient's experience with her and only later realizing further implications of the experience. "Not until after I got out of that mold." [M-03] During the session he had understood her experience from her perspective. Afterwards he could see it from a different perspective and understand it in a different way.

Being Responsible and Responsive

This theme speaks to the special nature of the therapeutic encounter and the differing roles of therapist and patient. This is not to say that responsibility and responsiveness to the other is present only in therapeutic relationships, but special responsibilities inherent in therapy color the empathic experience in specific and unique ways. Being responsible and responsive is a way in which the therapist is there in the experience with and for the other. This aspect of experience speaks to the therapist's role as one who is useful and who provides understanding that can lead to change for the patient. Being responsible is perceived as a way to reach an understanding ("I don't know how else to understand people" [M-03]) and this propels the therapist into the empathic experience. At the same time the understanding must be used for the amelioration of the patient's suffering ("But it was very important because it helped me understand what to do with the boy, how to help the boy." [F-04]).

The necessity to be responsible through responding pulls the therapist out of the receptive mode and into a more active mode.

A general sense of movement or direction of the experience is focal rather than an awareness of just how the experience will be helpful. Being responsible intimates movement towards positive outcome and a trust that this will occur. This outcome is uncertain although reflections of the experience revealed specific ways in which empathic experiences moved the therapy forward. Participants felt it important to recount just how the empathic experience affected the patient, the therapist, and / or the work, even though these consequences were not part of the experience proper. For the present set of therapists, these outcomes represent the completion of the direction of the experience.

Being responsible means having to go with the patient to places that are often painful: places where the other has been, places where the other is in the moment, and places in the self that echo the other's place.

> "It makes a difference to have someone else present, feeling some of the pain, and that that's the difference. That's the difference that makes the difference. It's not talking about it, it's beginning to find out that it's possible to detoxify these experiences." [F-03]

Being responsible is being useful to the other. The therapist responds to the other by applying clinical skills to the new understanding of the person in his or her life and by giving this understanding to the patient in some way, whether concretely, verbally, or in terms of relating to the person in a different and more helpful way. Being useful occasions another shift from passive receptivity that

was characteristic of letting go to a more active, responsive mode. Responding means answering. The participants reported needing to go beyond understanding; to take the understanding and do something with it. This action is the answer to the patient's communication of experience.

> "And my attempt was then to take the empathic experience I was having and to provide some understanding, some intellectual handle, as I call it, for the particular patient." [M-04]
>
> "And that's really exciting. 'I know how to lead you, help lead you out of this. I know how to help you heal' ." [F-02]
>
> "I mean I can resonate all I want to somebody's situation, but if I don't, clinically or intellectually, with the gifts I have as a clinician, help them structure their lives, become self-safe, come to treatment regularly, pay your bills,...take care of your children. If I don't also tend the real life stuff, I'm useless to them." [F-01]

For one participant being responsible meant that empathy in therapy is different than empathy with a friend. She articulated these differences as not letting the affective engagement take her over and prevent her from doing her job.

> "They're doing a lot of active inner work, umm, and I feel like a ringmaster and I'm very busy when they're inside. Part of what I'm busy doing is feeling what I think they're feeling. But I'm also very busy doing other things: trying to figure out where they're going and what they're doing and where to take, where to help them go. Umm, and when it's over, there's a sort of 'hhhhuh', like you've run a mile doing these things. But I don't sit with that person while I'm doing it and feel - I mean I do but I don't. There's a, I'd call 'distance'. That's one of the things I'm doing but I'm doing other things, too. I'm doing cognitive things and I'm also responsible for guiding them through this."
> "I think empathy as therapist might have to be different. You just couldn't, you just couldn't do it! I think you can feel it some place but there almost has to be a piece of plexiglass someplace where you know it's going on, where you say to yourself, like situations where you say to yourself, 'I know this is really awful, but I can't think about it right now because I've

really got to do this, and this and this and this and this'. And then I can fall apart later, or can sit down and cry later, but right now I've got to umm 'help this mother get her bleeding child to the emergency room'. Or whatever."

"I think it's a level, an intensity that I'm talking about that you just cannot join them in feeling what they feel or you would drown with them, be perfectly useless to them."

"It's a paradox, because it's more finely [tuned], I let it out but I don't respond to it in the same way. My affect doesn't, I don't let the affect go the way I do in a friendship. ... When I'm in my therapist role I do something different. Then I, I, - just for the sake of communication, let's say I turn off, I turn off the e - I don't turn off the empathy. I turn off the affective, the affective engagement with my empathy when I'm in this room, so that I can also be a strategist, and a rescuer. There are so many things I don't have, umm, you know somebody's, if you're drowning in the river I can't stand there and feel for you. I can have horror and probably have, while I'm trying to rescue you, have all the empathy for you, but I've got to help you!"

"I don't have to lead people out of the jungle socially. If you're sad about something, I can be sad with you. I don't have to do anything about it - other than as your friend."

"And I think friends count on one another to do something but it's different. Mostly I think as a friend I need to be there for you, be with you, to care about you, but I don't have an additional layer, 'Now *do* something to help me with this. *Do* something, to change this, yeah." [F-02]

Going beyond the understanding to responding takes various forms. One participant spoke of a need to assess her patients strengths as a way of furthering her understanding but with the direction towards change.

"I think some people see empathy as being so empathetic that you don't challenge them; you let them off the hook. And I don't think that way at all. Because also one of the things I'm trying to gauge is the person's strength. What strength is there, how much can I challenge, how much can they be held accountable for, as opposed to just understanding. I guess one of the things I do is see the healer inside of them, and I'm constantly, what I'm trying to do is to contact that healer. ... And sometimes I think of it as trying to catch the thread. Like when you're trying to thread a needle and you're trying to get that thread. And I'm constantly trying to catch that thread in that person that's committed to healing, not just to therapy, and they're different." [F-05]

Another aspect of being responsible involves knowing the limits of one's responsibility during the therapeutic relationship and in the empathic encounter. Sometimes this means letting go of one's own perspective.

> "I think that's one of the hardest things is to allow them to make choices that from my perspective really look terribly destructive. It's my responsibility to point out what I see, but it's not my life; it's their life. All of us being human, all of us making choices. Struggling with our lives the best we can. It comes out of a basic respect." [F-05]

> "I am not responsible *for* them. I'm responsible *to* them, in a lot of different ways. But their work is their work; their process is their process. I don't want to rob them of the responsibility and ownership of that. It's my responsibility to them to help them, to facilitate that in the kind of ways we do that." [M-05]

One participant was aware of another aspect of being responsible and responsive that related to the empathic experience. When there is a break in empathy, the therapist is responsible for reparation and the renewal of empathic relationship.

> "They almost always have a tremendous need for the rupture to be healed, and for receiving help in healing the rupture. And so when the therapist does that, and the therapist, always, in my opinion, needs to take the major initiative in healing it, that itself is an empathic response to a very basic need of the person." [M-02]

Danger

Empathic experiences were perceived by this set of participants as threatening to their personal safety; they endanger the therapists. It is in the face of such danger that therapists proceed. They were aware that both partners engaged in empathic experiences are at risk; both are vulnerable. Both

partners have the choice to enter the experience or not, and to proceed or not. Both partners must feel some measure of trust in order to proceed into or within the experience. On some level each partner must trust that the experience will be worth the risk.

Proceeding in the face of danger was articulated by several participants.

> "I guess some of it is knowing I can go to places and be OK. That I go to places with patients and either return or I'm OK, or am not damaged, or it's sure lucky" [F-03]

> "I survived another one. There really is some coherence. [Survived] another getting lost. I let myself get lost on purpose. ... Going to get lost. Trust that I'll find myself." [M-01]

> " 'You just meet them, meet them and you take them in.' And she says, 'And you're never damaged by them'. And it's true, I'm never damaged by them. Umm, I'm enriched by them and they always feel, umm, like a gift of sorts. Because I have, I'll have for the moment or however long it lives inside of me, the experience of someone else's internal richness, umm, and that's not always pleasant. I mean it's not always pretty or comfortable." [F-01]

> "If I'm willing to be empathic, I will experience a lot of pain. I'll experience a lot more range of emotions." [F-05]

Throughout the experience choice is involved. Participants talked about their involvement as choice and articulated both sides of that choice, i.e., whether or not to be in the empathic experience.

> "I have a choice. I don't have to go there and if I can't, then it's not going to do either of us any good. I have to be able to go there and stand whatever it is that is there. And I don't know how to describe that." [F-03]

> "And that's a struggle; I'll go in and out of it. I can't stay there. And with this particular one, I don't know that I can get to [my patient's] experience until I get beyond my own. My own imagining what it would feel like." [M-03]

"Now I've sat with people before and refused to take in what they've offered me. ... I cannot bear this. I can't bear it, literally bear it about in my body and my psyche. It's too disturbing to me. I need to understand it, I need to understand what we need to do to protect you and me from this." [F-01]

"Sometimes patients will do something to knock you out of it. Typically, when you're sailing along listening, experiencing and then they come up with a question. You have to do a double take, and then you have to switch gears completely to answer the question, because it doesn't flow from whatever's happening. I run into that once in awhile. More intriguing is ways that I will knock myself out of that state. And those become laborious hours. Laborious in the sense of either trying to get back into the state and you don't quite understand why, or you know very well why you don't want to get back into that state, because the material is unpleasant, uncomfortable, threatening, or whatever." [M-03]

Various circumstances occur to make the empathic experience safe enough for the therapist to proceed into dangerous territory. The participants mentioned several conditions that make empathic experiences "safe enough", both in general and specific situations.

"I now have a sense of having enough experience that I know I will not get there and stay there. I'll come back. There's not so many defenses and so much anxiety, perhaps that's what it is, in the way of trying to make a connection with that person and myself in whatever, whatever the information, conflict, whatever that is that's often too horrific to deal with." [F-03]

"That's where I have a commitment to my own therapy, always. To continue to grow, to continue to work on my own life. And also to be very available to people I see, in terms of empathy. But I think if you do the one without the other, it can be very dangerous." [F-05]

"And before she would come I just dreaded our sessions, not because I didn't like her, but because of what this child was suffering! It was really hard, really hard to see her. There wasn't any distance. This was fresh, so it was hard. The horror and the suffering were fresh, and it was almost impossible [to have distance]. I don't think I could be a therapist if I couldn't keep distance." [F-02]

"It's more than just talking to people, listening to people, or processing what people are saying. It's dealing with what it touches inside of me. It uses me up. It uses some of my availability, my empathic energy. It uses some of it up. And if you use enough of it up across a day, and I'm pooped! ... There's got to be some kind of empathic rationing that has to go on here. Because if you experience empathy on an ongoing basis with people that you see, there's not enough empathy to go around. I mean there's enough pseudo-empathy to go around, but there's not enough real, genuine empathy that requires the sort of personal energy to invest in each of these." [M-04]

"My partner and I, ... we're similar in a lot of ways. I think we have a lot of empathy for each other. ... It's made a tremendous difference to know that all those things we're not supposed to feel and, it's been OK to act out with each other in appropriate ways, kind of keep each other sane. To say the things we can't say to anyone else about this work, and have that accepted. It's been a tremendous gift. It has been a kind of empathy with a colleague, with a close colleague. Where you can have that experience of saying whatever and it's all understood by the other. ... And if I can do that with him, two or three times a day we can connect for five minutes or whatever and unload what I need to unload and have that accepted and affirmed by the other. ... It really makes a difference with my work with folks that I don't carry that in, you know, to sessions with people. Not as much. I know it's really helped me, I believe, to be much more available and present when I need to be, when I want to be present with folks. I hadn't thought about it in that way, but that's probably a real key for me, as I think about it now, in being empathic, to be receiving empathy from my colleague." [M-05]

While therapists were keenly aware of the issue of danger for themselves and talked at will about them, they were also aware that struggles around this issue occurred in their patients as well. Not only were they aware that the patient had to trust enough to take the risk, but that the patient also had to know that the therapist would survive the experience. Sometimes participants reported an awareness of such experiences not being allowed by the patient, and of why that was so.

"But I don't know as she would ever have been able to go into the depth of that experience had it not been a group that she trusted, and that she knew she could face whatever. She would have done it much more in pieces, but she just plunged in such a dramatic way. And it was that courage that kept me there." [F-05]

"That creates a special kind of space for people. ... It's a freeing kind of experience; I know it is for me. It's OK to say, you know, experience what, I mean, you know what gets shared in these rooms! All the secrets. ... How really a difficult thing that really is for folks to expose [themselves], to really say that. Sounds real simple. Boy, it's not. And to have that accepted and not judged, or to have someone not try to fix that and say, 'Oh, you shouldn't feel that way', or 'Why's that?' But just to have that accepted. ...Have that be all right. ... It's not an easy thing to do, to really have that empathized with." [M-05]

"I think that's the key issue with many clients or patients. If they don't think you can survive, they won't go there. Because in many ways, they'll try to protect the therapist. And I think they pick up very quickly, about whether you're willing to go into the depths with them." [F-05]

"If they are able to sustain not looking at me, can tolerate that, then I'm free to go where I go. Now with people who see you face-to-face, I believe there are some who can tolerate you getting into that. And there are others who can't tolerate that. If you've got to respond to eye contact constantly, there's no way you can get into that state. There's a demand for interpersonal responsiveness." [M-03]

Interrelationships Between and Among Themes

While the above descriptions of each of the four major themes were intended to highlight each theme individually, it is clear that many passages contained reference to more that one theme. This state of affairs would seem to illustrate the seamless nature of human experience, since lived experience invariably contains all the essentials aspects of the experience while only in

reflection are we able to divide it into separate facets or components. Even on reflection this is at times difficult to accomplish, and four themes in combination were characteristic of therapists' descriptions of their empathic experiences. To consider interrelationships among these themes invites us to understand the experience further.

The experience of letting go stands in relation to connecting in a temporal manner. Participants' accounts help us understand that letting go can lead to connection and was experienced as preceding it in time. Letting go opens up the possibility that connection will occur, although it is no guarantee of connection. Through the process of letting go, the therapist becomes present to himself as a person and to the other as a person. Their histories and experiences provide the space where they can connect one with the other. In connection, the therapist must continue to be present to the other while allowing presentness to self to lead to connection.

The theme of letting go has a somewhat paradoxical relationship to the theme of being responsible and responsive. To be responsible in the long run one must be able to let go of responsibility in the short run. On the one hand, empathic experiences fill the need of the therapist to know, to understand and the need of the patient to be known and understood. But to get to that understanding, the therapist must suspend the assumption of knowledge, let go of the need to know or be "in the know", so that he may take in the experience that will lead to "real" knowledge, that is, authentic.

> "Letting myself not know what's going on. But that's sort of undoing the training. I'm supposed to know what's going on. Pff." [M-01]

This relationship between the two themes presents the dual role of the therapist during the empathic experience. On the one hand the therapist is involved in a person-to-person encounter and participants talked about authenticity and feeling real. When one "let's go" in the manner therapists suggested, one is left with oneself as a person being present with another person, being touched by another's humanity in the here and now. There is some sense of a levelness and correspondence between the two people. Both are in the moment of empathic experiences more as human beings than therapist and patient.

> "to be present and in an honest way. ... to be present with the parts of yourself ... I mean all the parts. I just know that if I'm going to be with someone, I have to really be there. It has to be *me*. It's me as a therapist, but it's still me. It's me, basically, as a person. It doesn't go away. You can't fake it. You can't pretend that, to be there, and folks know that. Well, we all know that. We know, the patients, the people who know no one's been there. They certainly know when, they certainly can tell. They may not always be able to tell you that you really are there, but they sure do know." [F-03]

At the same time, being responsible means that one's humanity and personhood is *there-for-the-other*. While both people are present, person-to-person, the therapist remains there *for* the patient. The mutuality of personhood is in the service of the patient. Consequently, while letting go leads to mutuality of humanity, being responsible means non-mutuality of relationship. In a mutual relationship both partners would expect the experience to be reciprocal. It is the

nature of the larger therapy context that mutual empathic experiences rarely occur. But being present as a person and being responsible as a therapist are not experienced as mutually exclusive categories. Both are present in the experience of empathy. Being responsible as a therapist retains an overall intentionality of experience as well as of the larger endeavor: being there in the moment as a human being with another human being, but for the other.

> "I think of the therapy hour...being a time and a place where you really can be authentic, certainly. Experience it as that. These rooms, these rooms here are to be that kind of space and place where a different experience of time and of relationship. And so certainly I think it's really incumbent on me to 'be there'. It's certainly my intent. As I think I was sharing earlier, I think that one thing I'm learning, that as much as that is my intent, I value that, it's my goal to try to live that out, I think it's still difficult. I think it's still, I have walls. And certainly there need to be some walls, appropriate boundaries. My personal life is not what this therapy hour is about for that person, and defining those boundaries appropriately. It's not about self-disclosing my own journey all the time, and that kind of stuff. And I don't think that's necessary to be authentic. It's really not so much in what we say. I really think there's something almost kind of mysterious about it, really being present." [M-05]

This recognition of non-mutuality affects the experience of danger. This, in part, leads to a sense of isolation therapists reported feeling in their work. The therapist's sense of personal safety may be affected by spending so much time involved in intensely personal but non-mutual relationships. The therapist's sense of danger in turn affects the patient.

> "How dangerous a trap it is, particularly for private practitioners, that tend to be more [isolated]. It is isolating." [M-05]

The triad of letting go, connecting and being responsible and responsive brings together the being there (present), the being with (connected) and the

being for (responsible). At this moment the therapist can pull together the here and now experience (both one's own and the patient's) with knowledge of the patient and situation, as well as clinical and theoretical framework. This allows the therapist to move from a sharing of the other's experience to an understanding of the meaning of that experience and a responding to that meaning. It means tending to different levels simultaneously.

> "I'm paying attention to what we're talking about but I'm also being receptive to whatever emerges and whatever bigger might end up bracketing this whole thing." [M-01]

The relationship of being present to danger entails the therapist feeling comfortable enough with himself to allow another's experience to touch his own in such a basic and raw manner. This speaks to the suspension of intrapsychic and interpersonal defenses to be open to all the parts of self that the other will touch.

> "But when I work with a patient like this, my own ongoing issues and emotions, I really have to be crackerjack on top of them." [F-01]

> "And I think that's it - to struggle with one's own defenses, to be present and in an honest way. I think that's what it means. Because you have to be present with the parts of yourself - I guess this is it - that are sadistic, and primitive, and helpless, and fragile. I mean all the parts. You have to stand yourself." ... "I now have a sense of having enough experience that I know I will not get there and stay there. I'll come back. There's not so many defenses and so much anxiety, perhaps that's what it is, in the way of trying to make a connection with that person and myself in whatever, whatever the information, conflict, whatever that is that's often too horrific to deal with." [F-03]

> "I think it's also the willingness to have, to not protect myself. Empathy is willingness not to, to be able to be willing to experience whatever it is I experience and to deal with it outright. Because I think that it might be

easier to be more objective, in that you don't have to deal with as much of your own feelings later, or your own problems. [F-05]

Being responsible and responsive also means that the therapist must be careful how his own experience is used in connecting to another. The therapist is at risk in both domains, as a person and as a therapist. On the personal level the therapist will be asked to experience whatever suffering the patient brings. Normal responses and defensive barriers must be relaxed in order to experience empathically such suffering. This is the risk of personal suffering. The ability to be a therapist is contingent on the ability to do this. On the other hand, if she does not take the risk, her ability to meet the professional task will be compromised. This is a professional risk. Other risks may leave the therapist unable to be responsible in his responses. One participant illustrated this in terms of overidentifying with a patient that can make a situation more dangerous.

"I've seen other therapists end up not holding the line as far as keeping appropriate boundaries and such, and that they get in trouble with the patient. ... You can't overidentify empathically with the patients so that you are kind of operating at the same level they are, and you can be of no help to them." [M-04]

Using one's own experience to reach the patient's experience acts as an advantage, but it can also make hearing and understanding the other more difficult.

"But never adulterated, hopefully, with my stuff. And it's terribly important in the use of empathy, I think, that one be aware of one's own empathic tools, and where one's own issues are with all this all the time, with any given patient." [F-01]

"A woman began to tell her life story and there were so many commonalities that it was very important for me to back off from that, just

to be really, really sure I was listening to her life and not getting my own tangled up in it." [F-05]

Sometimes being responsible means staying connected to the patient even when it feels too dangerous. At such times the safety of the patient and potential advantages to the patient override personal concerns. The therapist is aware of the need to stay connected to the patient, particularly when the patient is re-experiencing a painful and terrifying situation.

> "I work with them to either stay connected with me: eye contact and aware of my presence, aware of where they are, anchored in this real world. And as they talk about the experiences then we can live through it, with them being aware of connection to me and me reminding them and me keeping checking. And, and my sense is I have to be real connected to them. And sort of tenaciously so. ... And what I'm real aware of is how important it is for me to stay connected and not distance emotionally, which gets tempting. One way of thinking about it,... me being connected with myself and them being connected with themselves, a part of this also, the self that they're trying to retrieve that was cut off." [F-03]

> "But the pain was just excruciating, that I was experiencing. In terms of staying present to her. ... For me to have pulled out of that pain, my pain, when she was so willing to go into her own, would have been unforgivable, for me. ...would have been abandonment. I just really could not do that. although I really wanted to. There's no question in my mind that my impulse was to just jump up and run out of the room screaming. It was so horrible." [F-05]

There is an awareness to empathic experiences that, if all four aspects, letting go, connecting, being responsible and responsive, and danger are manifested in the situation, there will be a "rightness" to the experience: it will be perceived as correct. Under this circumstance, the therapist will be able to maintain both personal and therapeutic ways of being with the patient, and thereby gain an accurate understanding of the patient even as both risk the

dangers of the encounter. For therapists, positive outcome is "proof "that the empathic experience was correct. Accurate empathy involves remaining present to the patient's level of understanding. The therapist may reach several levels of understanding, but responses need be close to the level of the patient's understanding. Too far ahead (or too deep, or too simplistic) and the therapist will not "be there". The patient will then experience distance rather than connection.

> "I would then, if she had said, 'Oh, no, that's not it at all', it would probably not be empathy. ... It only, it makes me feel it's only empathy if it's right. Or you might, the therapist might still have checked in on it. Knows something's going on but at the point they say it, it might be too soon for the patient. The patient may be denying it, or having to avoid it. Sometimes that happens to me where the person talks about that - again, I know through clinical experience - most probably means 'x'. But at that point I question the patient about that, they say, 'No, no.' It doesn't mean I change my mind about what I believe; it means I probably mistimed something that may, in fact, develop later. ... It's both a timing and a correctness." [F-04]

Consequences of Empathic Experience

While the results of empathic experiences lie outside the experience itself, participants were clear about what such results entail. Their words conveyed the strong directedness of the experience: empathic experiences serve clear and definite ends that affect the larger therapeutic endeavor, thereby living beyond the moments of the experience. Such ends substantiate the usefulness of empathy as a therapeutic process and confirm that the experiences are, indeed, worth the risks. Something changes, in a positive way.

Participants spoke of several consequences of empathy: changes to the patient, to the therapist, and / or to the problem. The first, and perhaps most obvious outcome is that the patient feels understood. This is often but not always accomplished by the therapist having shared verbally with the patient his new understanding. The patient feels heard.

> "That was, to me, the hallmark of empathy. He felt understood. But he didn't feel judged. He didn't feel I was critical. He felt understood." [F-04]

Sometimes nothing is communicated verbally, but both partners seem to be aware a change has taken place.

> "You know, as I said, I'm not aware of, you know, if it had to do with something we were talking about in that moment during the session. It's just like something shifted; it just shifted. I felt that it was communicated somehow and he seemed to receive it and felt and sort of acknowledged that. ... It was just coming across." [M-05]

Something changes in the relationship as a result of empathic experiences. The participants talked about the patients feeling more trust, in the process of therapy and in the therapist. The therapists credited the patient's feeling of being connected with this increased trust and greater relaxation in the therapy.

> "When somebody really feels fully understood by a person that is important to them they relax. Psychologically, physiologically. You can see it in a person's musculature: where they were tense before, they're at ease. They even move closer physically. It's a natural, I think, biologically rooted human response to empathic connectedness." [M-02]

> "I'm realizing that I'm talking about what seems to be some turning points as a result of empathy. I don't think that empathy has to result in any sort of major turning point. Some are more mundane, more day-to-day. ... that don't seem particularly remarkable, but because I was somehow able

to understand what the person was talking about, they felt a great relief just at that moment." [F-04]

This increased trust and feeling of being safer enables the patient to stay in the area of the experience or to broaden the experience in some way. Feeling understood and affirmed, whether verbally communicated or otherwise, opens up the area in a new way.

> "I used my own words; she hadn't used the word. I then came a name to it, and she then could talk about the experience in all sorts of ways. ... So it allowed her to feel heard and understood and get to talk about the need in a broader sense, that's been troubling her. ... It opened up all kinds of things to work on." [F-04]

> "And he, by virtue of that, recognizing that by virtue of having someone make some effort, offer some gesture of comprehension to him, was able to be with himself more quietly and receptively. And not get so scared by his own internal chemistry. That sort of happened to him. And he was able to talk about some more concrete memories. ... Realizing how it had marked his life, because that's him, and it's better to be that, without being frightened of it, fleeing and fending it off." [M-01]

> "A person's willingness to look at their own woundedness and to turn that into an asset as opposed to a deficit." [F-05]

At times it is the problem itself that is changed; detoxified, if you will. A place of great pain becomes a safer place because of being connected to the therapist. As one participant noted, she is "being asked not only to bear it but to make it more bearable for the other." [F-01] Another participant shared how she thinks it becomes more bearable:

> "To be connected with another person while they're in a place that's very difficult, that often changes it - that it's a place one can go and come out of. Isn't stuck there. ... There is a difference with them, that they've not had to go someplace by themselves for awhile. Something different has happened, and it makes going to that place less frightening. ... To begin to find out it's possible to have more resources, in those places?" [F-03]

> "[I]t's my job to be very respectful of it, and to bring all that I am to bear, to help her make it better. To leave it in better shape than I found it." [F-01]

Sometimes the therapist is most aware that he is changed by the empathic experience. This change can be small or it can be one that shakes his idea of the person, the relationship and the therapeutic work. He may share this verbally in the moment with the patient or it may inform later interactions with the patient.

> "Having it revealed sometimes abruptly, in a way that can be jarring because it can shake how I think of myself, how I think of the relationship, how I think of what's going on." [M-01]

> "I knew something had changed and I knew, after that I had some sort of clear idea of what to talk to the boy about." [F-04]

> "Sometimes I don't say it. Sometimes I just operate a little differently. ... Sometimes the moment of insight is, 'I need to be quiet.' Sometimes the moment of insight is, 'Oh God, I need to talk or this person doesn't do it.' It's not necessary that I have to say, 'Oh, I'm just realizing what your talking about.' Sometimes you just need to do it." [M-01]

Empathic experiences transform both partners, in both small and significant ways. What may seem to be an innocuous statement to the therapist may have great meaning to the patient. One participant told of a patient who had left therapy and returned at a later date. The patient told the therapist about an empathic encounter many months before that had had a substantial positive impact on the patient. Just as the therapist may not communicate verbally in the moment of the empathic understanding, the patient may also remain non-verbal but be profoundly affected by the encounter.

Another enduring aspect of empathic experiences was articulated by a participant as she thought of the accumulation of experiences with her patients and how they live on inside her. This statement makes it clear that such experiences are worth the risk.

> "What patients give to me is the imprint of who they are, and I am eternally changed by it and enriched by it. It doesn't matter, really, the valence of the content. It can be incredibly frightening or it can be incredibly beautiful. It's the imprint that matters; the aliveness of the other person in the world and being in contact with another human being and the poignancy of their lives." [F-01]

CHAPTER IV

DISCUSSION

> We must study, respect and question what we want to know, instead of massacring it. We must assimilate ourselves to things and surrender ourselves to them; we must open our minds with docility to their influence, and steep ourselves in their spirit and their distinctive form, before we offer violence to them by dissecting them.
> (Amiel's journal, 1866)

Empathy is a universal human experience. It is one of the ways we as humans relate to our world and come to know that world, with world being that which is not us. Human beings are both separate from world and embedded in that world, and, therefore, always in relation to it. Human beings are unlike all other objects because we perceive them as experiencing beings like ourselves. How, then, do we come to know another experiencing being, given both its separateness from us and its likeness to us? Separateness informs us of the foreigness of the other person and challenges us to be open to difference and the unknown. Likeness gives us a familiarity and possible access to that person, but such familiarity can be a detriment to knowing the other as other and may

lead us to embrace in the other only what we already know in ourselves. Thus, likeness challenges us to set aside our comfortable, familiar selves and embrace newness and wonder as it emerges through the other's experiences. These two paradoxical aspects of the human other, difference and similarity, are important aspects of empathic experiences.

Buber (1957) was among the first to consider a similar paradox as he introduced a "twofold principle of human life" he called distance and relation. Distance is called "the primal setting at a distance" (p.97) and is a presupposition of the second, "entering into relation" (p.97). Setting something at a distance involves detaching it from oneself and recognizing it for what it is in its own particularity. This is possible only when the person can consider the other separate from his own needs and wants, thereby viewing the other as independent. Only when the other is independent can we have the possibility of standing in relation to him or her.

"Man can set at a distance without coming into real relation with what has been set at a distance" (Buber, 1957, p.100). Buber elsewhere (1923/1970) has called these I-It relationships, characterized by using and possessing. "Man sets things which he uses at a distance, he gives them into an independence in which function gains duration, he reduces and empowers them to be the bearers of the function" (Buber, 1957, p.101). I-It relationships exist between a person and either animals or things as well as between people.

The type of relation Buber refers to in "Distance and Relation" he calls I-Thou (or I-You). I-Thou relationships can also exist between a person and animate or inanimate objects or between people. This type of relationship allows the other to exist for itself and in its own uniqueness. The other is no longer viewed only as meeting one's needs and wants; that is, for functional utility. Only when separation and uniqueness of the other are recognized can a person enter into real relation with another as a like individual. Buber goes so far as to say that humans depend on I-Thou relationships to confirm their humanity. All humans want to be recognized and known, and it is through this process that they become selves to themselves and to others.

> The basis of man's life with man is two-fold, and it is one - the wish of every man to be confirmed as what he is, even as what he can become, by men; and the innate capacity in man to confirm his fellow men in this way. (Buber, 1957, p.102)

Buber (1957) designates the height of such relationships as "making present" and classifies such relationships as genuine meetings between people. Such relationships are dependent on the person's ability to imagine the real of another but go beyond this ability to imagine what another is experiencing. "Something of the character of what is imagined is joined to the act of imagining" (p.103). As an example of this process he describes

> that event in which I experience, let us say, the specific pain of another in such a way that I feel what is specific in it, not, therefore a general discomfort or state of suffering, but this particular pain as the pain of the other. This "making present" increases until it is a paradox in the soul when I and the other are embraced by a common living situation, and (let us say) the pain which I inflict upon him surges up in myself, revealing the abyss of the contradictoriness of life between man and man. At such a

> moment something can come into being which cannot be built up in any other way. (p. 103)

Buber states that at the moment of these experiences the other becomes a self for me, not "for" in the sense of for my benefit or utility, but "for" in the ontological sense, an acceptance of self and other as individual human beings. The experience is "complete only when the other knows that he is made present by me in his self and when this knowledge induces the process of his inmost self-becoming" (1957, p. 104). Growth of the self occurs in relation between persons: knowing "that one is made present in his own self by the other - together with the mutuality of acceptance, of affirmation and confirmation" (p. 104).

Buber finds such genuine meetings between people to be rare. Certainly such a genuine meeting has the possibility of describing the experience of empathy. Our participants described it as letting go and connecting. Letting go would seem to correspond to Buber's withdrawal of needs and wants. For the present set of participants this was a letting go of the tethers to the personal everyday world as well as to the preconceptions of knowing that emanate from the therapist's role. The person-to-person, "level" quality that issues from letting go allows both to enter into what Buber would call "real relation". Our participants described it as profound connection between two people; one that consisted of shared feelings and experiences. As such it allowed what one participant described as two people being in the same place at the same time.

Like Buber's "setting at a distance" opening up the possibility of entering an I-Thou relation, the experience of letting go opens the possibility of connecting but does not guarantee its occurrence.

Buber also points to the importance of the consequence of I-Thou relationships that corresponds to our participant's understanding of the consequences of empathic experience for the individual being empathized with. It affirms the person in his personhood. Van Kaam's (1959) study on the experience of really feeling understood shows us the ways in which a person feels affirmed. A person feels satisfaction, relief, safety and communion. These themes are echoed in our participants' experiences of their patients as feeling understood and acknowledged, safer, more relaxed and closer.

The experience of empathy as described above is an important one in the life of human beings. Our findings correspond well to the general view of empathic experience but differ in certain important ways. While empathic experiences are characterized by themes of letting go and connecting, those described as taking place in psychotherapy also included being responsible and being safe enough. These four themes taken together refer to the special setting of psychotherapy and this setting affects all the themes, thereby making empathic experiences in therapy somewhat different from their occurrence in other inter-human settings.

In psychotherapy, therapist and patient have common goals but enact different roles as they attempt to realize them. The therapist is expected to help alleviate suffering that the patient has endured. As one patient stated,

> The therapist is the only one to whom we dare expose painful feelings and conflicts as we seek his expert help in easing unhappiness. To stop what Freud called "internal bleeding". The therapist can help ease the pain or push us further into the miasma of mental misery. (Freeman, 1984, p.3)

Therapists quickly become aware of this fragile dichotomy: what does not help may injure the patient. They are aware of the vulnerability and risk incurred by the patient in coming to the therapeutic endeavor. Through this, therapists are aware of the responsibility inherent in the their own position in the relationship. It is this sense of responsibility for the therapy that infuses experiences in the therapeutic work, empathic experiences included.

While the research question asked participants to describe their experiences of empathy, the therapists reported being aware not only of their own experiences but of the experiences of their patients as well. Whether they were describing letting go, connecting or feeling endangered, they were acutely aware of the patient's location even as they spoke about themselves. Such awareness of other speaks both to the relational qualities of empathy and to the unique responsibility the therapist carries into the empathic experience.

Empathic experiences occurring in psychotherapy have considerations beyond those of everyday life. Because of the special situation of the therapy, in which the "mental misery" of the patient is always to be considered, the therapist

is aware of the conditions that promote or hinder empathic experiences. In our study, these conditions were called being safe enough in the face of danger. Being responsible means considering both the patient's experience of danger, the therapist's own experience of danger, and the present condition of safety in the relationship. Each of these aspects needs to be "safe enough" to reach empathic experiences in therapy.

Havens (1989) describes a safe place in therapy as one in which the patient can experiment with being himself. "A safe place where he would be free, recovering in this *protected freedom* (italics mine), what he might have lost, or creating something new." (p.17) The idea of *protected freedom* combines both the therapist's responsibility and the limits of that responsibility as described by our participants. It is the therapist's responsibility to create a protected space where the patient can be free to explore who he is, who he fears he is, who he wants to be, and who he can be - - in short, what the psychologist might call the many facets of self. At the same time, the therapist feels he or she ought not intrude on that exploration by taking excess responsibility for it. As Buber remarked, we can only become our human selves in a relationship wherein we feel unique and independent. Havens notes that what the therapist ought to do is similar to what Winnicott recommended to mothers: to let the child be alone in her presence: protected freedom.

While a therapist's responsibility is to create a safe space in general for the patient, Havens offers no formula by which to accomplish this. Each safe

place is as different as each patient and each relationship is different. Consideration of danger and safety in empathic experience is equally non-formulaic. Our participants offered no solutions; they were clear, however, when talking about becoming safe enough themselves in the risky business of empathic connections.

Understanding they are personally involved in experiences their patients offer them, therapists also are aware that they must take care of themselves in other ways and at other times in order to take care of the patient in the here-and-now of the therapy. Only when personal needs and wants are met can one be expected to lay them aside and both separate the other from those needs and wants and be present to, with and for that other.

They also are clear that while being endangered is a condition of empathic experience, becoming safer is a consequence of that experience. Empathy often has the effect of increasing both partners' feeling of safety in the relationship;

> Indeed, what is moving about our encounter with one another is this very element of suffering and danger which, appearing in the patient's life and suffered through with the therapist, moves us and the patient through a danger, not necessarily to safety but to some point beyond what had been. (Havens, 1993, p.4)

Being responsible means that the therapist not only is in the here-and-now with and for the patient but has faith in the future; that is, that the "point beyond", existing as a destiny, will be one that promotes the forward movement of the patient along the therapeutic journey. This seems to be the reason

therapists trust that the experience will be worth the danger for both partners. As Loewald (1960) suggested, the therapist understands the present level of the patient while looking to the patient's future. Being responsible is more than seeing what is; it is also imagining what might be.

Thus, time is present in the empathic experience. The experience originates in the past of the patient and is brought to the present by the patient, who remembers and reflects on that past even as he or she relives it in the present. The therapist connects to the other in the experience as present, and imagines a future. While the patient embodies past and present in the empathic experience, the therapist primarily embodies present and future. The two partners meet in the present connection of the empathic experience: the patient sharing his or her past with the therapist and the therapist connecting to his or her own past, while, at the same time, offering the patient some future, some point beyond.

Relationship of Empathic Experiences to Prior Conceptualizations of the Therapeutic Relationship and the Role of the Therapist

This study presents a view of the therapist's role that bears little resemblance to the metaphor of the surgeon described by Freud (1912/1958). The picture that emerges from the present descriptions of empathic experiences is not that of a cold, aloof, unfeeling person who protects his own emotions, but of a person fully engaged with another person, the patient. Protecting one's

emotions, as Freud recommended, would seem a barrier to empathic experience. Letting go and connecting mean being available to experience whatever the patient brings to the consulting room.

Descriptions of the process of letting go that allow the therapist to be present to the other have much in common with what Freud (1912/1958) recommended when he instructed the analyst to meet the patient with an open mind that allows the analyst to be taken by surprise. By maintaining an "evenly suspended attention", the analyst relaxes customary intellectual processes and allows the patient's "unconscious" to be received by the analyst's "unconscious", as Freud put it.

The complementarity between analyst and analysand is similar to the complementarity described by the participants in letting go and becoming present; presence, not absence.

> But it is most difficult to describe what substitutes for directing attention. Perhaps the phrase "pure presence" will do - an accompanying that does not stay too close, an interest that does not itself attempt to be interesting. ... The analyst should be surprised, that is, pure presence opens the way to surprise. Not thinking actively, not trying to explain or predict, makes it easier to hear the successive associations just as they are, still free of imputed meaning or connection, so that something unexpected, even unique, will not pass unheard because a prejudgment has excluded it. (Havens, 1989, p.23)

Letting go included the therapist's being able to "not know": to give up the stance that the therapist can, should, and always does know. Such a stance may be paradoxical: the therapeutic relationship, like any other, begins in an atmosphere where each person is unknown to the other. What is different is that

the therapist is expected to "know" things, to have education and experience to bring to this endeavor. But the person of the patient is unknown and only emerges over time. Categorical knowing, about psychology and psychopathology as well as about other therapeutic experiences, is augmented by personal knowing. Personal knowing is achieved primarily through empathic experiences that allow genuine meetings to unfold the reality of the patient for the therapist. The phrase "personal knowing" refers both to the knowledge the therapist gains about the patient as person and to the sense that the therapist attains this knowledge by involving his or her own person in the experience. This is what our participants referred to as real and genuine, as opposed to knowledge gained from training or experience.

Yet within this increased personal knowing, the patient remains the one less known. The process is incomplete, and by its incompleteness, always an ongoing project. The other remains other. The therapist is continually engaged in getting to the unknown by bringing openness and willingness-to-be-surprised into the relationship.

> It is all too easy to equate not-knowing with ignorance. This can lead therapists to seek refuge in an illusion that they understand. But if they can bear the strain of not-knowing, they can learn that their competence as therapists includes a capacity to tolerate feeling ignorant or incompetent, and a willingness to wait (and to carry on waiting) until something genuinely relevant and meaningful begins to emerge. Only in this way is it possible to avoid the risk of imposing upon the patient the self-deception of premature understanding, which achieves nothing except to defend the therapist from the discomfort of knowing that he does not know. (Casement, 1985, p.4)

Implicit in Freud's (1912/1958) instructions to analysts about how to conduct therapy is the idea that the unconscious of the two analytic partners will meet somewhere. While Freud does not describe this meeting, it is not too far-fetched to consider that it might be similar to our participants' descriptions of connecting. "The free passage of thoughts in the patient's speech and the therapist's mind occupies a space between the two; discoveries are not made by separate minds, but spring up in the common space." (Havens, 1989, p.25)

Freud's (1912/1958) metaphor of the analyst as mirror, opaque to the patient, presents us with an either/or situation that also did not appear in the present descriptions of the empathic experience in therapy. Freud directed analysts to be opaque. This he offered as a reaction to observing therapists who had shared intimate details with patients in attempts to help patients get beyond their barriers to health. Freud viewed these ways of being (opaque and personal) as opposite and exclusive: to be opaque is good, and to share is bad and to be avoided because of its suggestive properties. What emerged from our participants' descriptions was that, in experiences of empathy, one is neither opaque nor suggestive. The therapist is seen by the other.

> What is not always acknowledged is that patients also read the unconscious of the therapist, knowingly or unknowingly. Therapists can no longer claim to be the blank screen or unblemished mirror, first advocated by Freud, because they too are people and no person can be blank or unblemished. Every analyst and therapist communicates far more to the patient about himself than is usually realized. It is important to take this clinical fact into account. (Casement, 1985, p.3)

To paraphrase one participant, the patients know whether or not you have been there with them.

If therapists are not opaque, neither do they use their own experiences as models for correct behavior. Self-experiences are used to understand the other, not to force or move the other. One participant said that there was no need to tell the patient details about his personal life, precisely because he is genuine within the therapy:

> "I think that while it is almost always irrelevant to the treatment, the therapist's personal history, personal experience, details about the therapist's personal life. I virtually never get into that with patients. And patients virtually never ask me anything about my personal life. There's a reason for that. The reason why they don't and we almost never get into it is because in my dealings in the relationship with the patient, I endeavor to be as absolutely authentic and genuine and real as I know how to be. And I don't hold anything back interior to our relationship. Everything can be examined: everything I've said or done or felt, or that the patient has said or done or felt. And I hold myself to the same standard of honesty as I try to hold the patient, and I think if therapy cannot proceed, therapy can only proceed if the therapist is willing and able to endeavor to be as authentic as the patient is being encouraged to be. And if it's only going one way, wherever that one way is, you don't have real therapy happening." [M-02]

This passage elucidates the person-to-person nature of the therapeutic relationship that was described by participants in the present set of interviews. At the same time, our participants made it clear that they also were present as therapists. Freud led us to believe that the two positions are incompatible, whereas our participants viewed them as existing simultaneously in the experience of empathy. Indeed, they viewed both as necessary to empathic experiences in therapy.

Ferenczi and Rank's (1925/1986) position that psychoanalysis should be both an intellectual and emotional experience is borne out by our study. In empathic experience the intellectual and emotional stand in a special way towards each another. For the therapist, genuine knowing that is the hallmark of empathy issues from emotional connection. The empathic understanding lives in the therapist in a different way than a mere intellectual understanding; our participants called it more "real". Participants were clear in pointing this out as they spoke of their connections with the patients and of their connections to their own experiences. While Ferenczi was referring to the patient's experiences in therapy, our participants referred to experiences of both therapist and patient.

The view of relationship that emerges from our interviews is of a complex interaction wherein both people are affected by the experiences of their relationship. This is the view that Sullivan (1965) offered and is shared by the relational school of psychoanalysis (Mitchell, 1988). Sullivan's interpersonal field and the relational matrix spoken of by Mitchell refer to the complexity of the connection that therapists are aware of in empathic experiences. Connection is of patient to self in the past and now, of therapist to the patient in the present and to the self in the past. It is a person-to-person "between", where the therapist is both with and for the patient; for this reason the experience does not lose the ground given by the therapy relationship and objectives.

Relationship to Psychotherapy Research and Psychoanalytic Theory

Both theory and research point to the necessity of the therapist being as self-aware as possible. Freud described the need of analysis for those training to become analysts themselves, and today many training programs retain that requirement. Research shows that analyzed therapists attained higher levels of empathy (Strupp, 1960) and that such constructs as "personality stability" and "personality strength" positively correlate with empathy ratings (Bergin and Solomon, 1963). Our participants would agree (and one even made a point to talk about an ongoing personal commitment to personal therapy). Such work on one's own psychological health and understanding contributes positively to empathic experience in various ways. Becoming present to another means letting down defenses and eschewing normal interpersonal responses as well as letting go of the active role of therapist. Self-knowledge and acceptance of self would seem to help one feel safer even in the dangerous territory so often alluded to by our participants. To know that one has gone to the depths of one's own psyche and survived makes another's depths less frightening.

Self-work can increase the range of feelings that a therapist has access to when with another.

> Therapists do not have to remain limited to their own experiences, their own ways of being and feeling. It is possible that each person carries the potential to feel all feelings and to resonate to all experiences, however strange or alien these may be to their conscious selves; but whenever there are unresolved areas of repression or continued disavowal, there will continue to be degrees of feeling that remain deadened and unresponsive. The expanding of a therapist's range of empathic

> resonance is a major gain from analysis, and this needs to be a continuing process. (Casement, 1985, p.95)

One of our participants pointed to work with other cultural groups as an area that requires the therapist to open wider with respect to the range of feelings and experiences. Only then can the therapist be present to the other.

Self-knowledge and awareness also helps to differentiate self from other during the empathic experience, thereby ensuring that the therapist is there *with* and *for* the patient. As one participant put it, one has to remain on top of one's own issues regarding the experience the patient presents. If not, there is danger that a therapist's responses will contain what Fliess (1942) called "admixtures" from the therapist's issues that cause distortions in the empathic experience.

Along similar lines, Greenson (1960) pointed to two special problems therapists may have in the empathic process. Some therapists are inhibited and overcontrolled, avoiding real involvement with patients, and are fearful of the affects or impulses of the patient. Such therapists would have problems in the letting go that is required of empathic experiences. There are also therapists who are uncontrolled and become too involved. Such individuals would have trouble maintaining both being with and being for as they experience connection to their patients. For such therapists, being with may become more important than the being for, thereby compromising responsibility to the patient.

An area causing confusion and controversy in the literature is the part of the description of the empathic process that speaks to whose experience is

involved. The major views offered in Chapter I regarding this topic will be summarized here and compared to participants' descriptions.

- Rogers (1957): In empathy the therapist senses the patient's world as if it were one's own. The experience never loses this "as if" quality, in that one senses the other's feelings without one's own feelings getting bound up in it.

- Fliess (1942): The therapist introjects the other in a process of "trial identification". By "trial" he means transient. What the therapist gains is an "inside knowledge that is almost first-hand" (p.213), an emotional understanding of the patient.

- Greenson (1960): Empathy is the temporary sharing of the feelings of another. While the quality of the feelings are shared, the quantity is not. Greenson describes a split in ego functioning wherein the therapist may fluidly move from the position of detached observer to involved participant and back again.

- Loewald (1970): During empathy there is a suspension of the subject-object split in the psychic field.

- French (1970): In empathic experience there is a split in the therapist's ego - one part of the ego is with the patient, one part remains detached and understands by observing not the patient but the part of the therapist's own ego that is in resonance with the patient.

- Beres and Arlow (1974): Empathy is a momentary identification and affect is the signal to the therapist that identification has occurred.

- Jordan, Kaplan, Miller, Stivey, and Surrey [Stone Center] (1991): Affect in empathy enhances feelings of connectedness to the other. There is no sequence in empathic experience of a movement from merger to separation. Both connectedness and separation coexist simultaneously.

- Burke and Tansey (1989): Empathic experience begins in the process of projective identification. The patient projects and the therapist introjects. Such experiences become empathic when the therapist is able to enter trial identifications and tolerate the often difficult

experiences the patient presents. The therapist must also be aware of his own state throughout the process.

As the above writers provide varied ideas about the empathic process, so do our participants. The following are brief summaries of some participants' interviews with respect to this issue:

- My patient stores something in me and we both know that we both carry it. And I will give it back, a little changed, but hopefully not adulterated by my own stuff.

- There's a resonance or connection where I join the patient in a deep level. There's a congruence of being in the same place at the same time.

- I think maybe it's boundaryless. I know I am with them every inch of the way. There's an instant experience of being you and then it moves on. I feel the sadness, but put an arm around it, I guess, but not feel it the same way.

- There's an attunement where it's clear whose experience it is. You're still differentiated. And you know the experience is theirs. I don't think you get lost. There's a clarity.

- I don't think I took on her own pain but I felt, I experienced her pain and it echoed into my own pain. It's connection, making contact.

- It's like I let myself find a configuration within myself that seems at least an approximation of what he seems to be living.

- And you're there in it, in the patient's experience. It's me and the person, and for awhile it's just the person. There's an alteration of boundaries, a blurring of yourself and the other's self.

- I not only understood how he must be feeling, But I was experiencing some of that affect myself. And then I thought about it, what it meant. Because there was this level at which we were connected, when she talked about that having happened to her, there was a sense of commonality that wasn't.

- I know that feeling. Maybe that's why I could identify with him now. Sometimes I ask, "what must that be like?"

Given the varied perspectives offered by present participants and the prior literature, one might ask how to understand these seeming contradictory assertions. As Ghent (1992) suggests, paradox invites us to transcend the familiar. A new question emerges: how can there be both clarity to empathic experience and ambiguity of experience in the sense of joining at a deep level?

Edith Stein (1917/1989) may offer us a way of understanding both clarity and joining in empathic experiences. In her dissertation, On the Problem of Empathy, written over 75 years ago under the tutelage of Husserl, she considers the role of primordiality in empathy. By primordiality she means the presence of the object in the here-and-now. Using this as a basic tenet, Stein asserts that empathy is a situation that is primordial as present experience, but is not primordial in content. The experience originates in the other person; therefore, the content is primordial for that person. It issues live from that other person by way of re-experiencing the content that is remembered. For the other (in our case, the patient) it is primordial both in content and as present experience. The content is primordial for the patient because it lives in her or him as an aspect of the past. However, for the therapist it is not primordial in content. The content comes through the communication of the patient. It is, however, primordial in experience, because, as our participants noted, the therapist experiences the situation in the present as if it were his or her own.

> When it arises before me all at once, it faces me as an object (such as the sadness I "read in another's face"). But when I inquire into its implied tendencies (try to bring another's mood to clear givenness to myself), the content having pulled me into it, is no longer really an object. I am now no longer turned to the content but to the object of it, am at the subject of the content in the original subject's place. And only after successfully executed clarification, does the content again face me as an object. (Stein, 1917/1989, p.10)

There is clarity regarding the origin of the experience; it is in the other. There is a joining as both partners share a primordial experience in the moment of empathy.

What Stein does not account for is the circumstances that occur when both persons share the experience in the present, as our participants described. Stein asserts that when empathy is complete there is still a distinction between the one and the foreign "I". There is no oneness. "I am not one with the [other] but only 'at' him. I do not actually go through the motions but *quasi*. ... I feel led, accompanied" (Stein, 1917/1989, p. 17). It is the non-primordial origin of the experience that prevents oneness. Many of our participants experienced a oneness during empathic experience. Stein explains that there is no oneness in empathy, but empathy leads to a feeling of oneness. Our participants experienced the oneness but then it moved on. Being responsible moves the therapist beyond the oneness and towards a response.

Another struggle that some participants presented was understanding the difference between empathy and projective identification as lived experiences. The distinction Stein makes regarding the non-primordial content and the

primordial experience may help make these two experiences clearer. In projective identification the clarity of non-primordial content is missing. One thinks that the content originates in oneself and it feels primordial. One is unaware at that moment that the content arose in another.

The presence of both primordial experience and non-primordial content may be one way to resolve the paradox of clarity and ambiguity. But a further question remains: is the primordiality of the content affected if the therapist has experienced the patient's experience in his own life? The therapist may no longer feel that the experience originates in the other because the content is primordial in the lived past. We know from our participants that considerations do shift in this situation. When a therapist faces a patient whose experience or way of being in the world is very different from one's own, the challenge is to open wider in order to let in the more foreign, and therefore, perhaps more frightening experience. When one has endured the experience that the patient presents, however, the challenge is to guard against an "unholy connection" in which the therapist only understands those aspects of the experience already understood in oneself.

Implications for Clinical Education and Practice

Therapists and patients have many different kinds of experiences in therapy, and empathy is a significant one for both of them. For the therapist, it allows a personal knowledge of the patient's experience that can be secured in

no other way. For the patient it is an experience that allows him or her to feel closer to the therapist and more trusting of the therapeutic process. It may also detoxify the places of pain that they have endured for so long alone. Because results of this study present a more comprehensive understanding of therapists' lived experiences of empathy with their patients, they offer to the therapist, both rank beginner and seasoned professional, a clearer picture of what to many is an ineffable experience.

For the student, present results can prepare him or her to feel a wide variety of experiences as he or she enters the therapeutic endeavor. Patients must bring their suffering into therapy, and the therapist must participate to some degree in that suffering. Beginners feel off-balance as they enter into experiences of being connected with their patients; it may be frightening to feel what another is feeling. The student needs to be aware that the therapeutic process being entered will change not only the patient. Discovery of the other is accompanied by discovery of oneself, and transformation is common to both therapeutic partners.

The results also warn of possible pitfalls in experiencing accurate empathy. Often students are advised to enter therapy themselves, but without a clear idea of why this is necessary. Such advice is thus heard as judgmental. Present results point to some clear reasons why the therapist must know himself before he can presume to know another. One participant said that he could not

ask his patients to do what he could not do himself. Personal knowing of another should go hand-in-hand with personal knowledge of self.

While the beginning therapist may experience being in uncharted waters in the therapeutic work, all therapists are in uncharted waters. The experience of empathy teaches us that one aspect of therapy is to throw away the charts. To know and yet not know. We all need to be reminded of this.

Beginning therapists need to know as much as possible about empathy in order to prepare for these often powerful experiences. Perhaps the most unique finding from this study is the theme of "danger". Little in the literature has spoken to this issue, and an appreciation for this theme and its relationship to the other themes helps to clarify two common but rarely spoken of traps for therapists - - burn-out and loss of boundaries. The intensity of experiences in therapy can leave one drained or wanting more for oneself in the therapeutic work than is appropriate. Both conditions lead the therapist away from being *for* the patient.

Consequently, an ongoing problem in the field of psychotherapy is that of impaired professional colleagues. Open discussions with students and among seasoned therapists regarding issues of self-care as professionals could lead to mitigating the occurrence of full-blown impairment. As a community of professionals we are responsible for ourselves, but are only beginning to understand what we might do to help each other in impairment, let alone to head it off before it occurs. Our own fears and denial may leave us isolated from one

another rather than there for each other in a caring community. Opening discussion of these issues in graduate programs and local professional groups can lead the way to greater understanding of this phenomenon, with consideration of prevention as well as intervention. Making therapy a "safe place" for ourselves may help to make it a safer place for our patients.

Summation and Final Paradoxes

The structure of therapists' experiences of empathy is a rich tapestry of interwoven themes: letting go, connecting, being responsible and responding, and danger. Contingent on both participants' perceptions of enough safety in the face of danger, the therapist experiences an opening of self and a letting go of aspects of oneself that is experienced as a being rather than a doing. This allows for the possibility of connecting to the patient's experience and to parts of oneself, even as the patient connects to his own experiences. In this resonant chamber, alive with the shared experience, understanding arises, often abruptly, and meaning emerges from experience that allows the therapist to respond in a manner that moves the patient forward in the therapeutic endeavor.

Empathic experiences in therapy present us with several paradoxes that elucidate the themes:

- knowing / not knowing
- being a person / being a therapist
- letting go of self / connecting to self

- ambiguity / clarity
- danger / safety

While we might strain toward the resolution of paradoxes, we are reminded of Ghent's (1990) caution to avoid premature resolution that closes off possibilities and further learning. Instead paradoxes must be embraced to see what they might offer us. These themes and paradoxes hold keys to an important therapeutic experience, both in the moment of the empathic experience and in its enduring aspects. It is an experience that leads to transformation of both partners in the therapeutic endeavor.

With themes and subthemes as the threads of this rich experiential tapestry of empathy, it is difficult to see where one theme ends and another begins. All are interwoven and all are woven into the foundation. This unseen framework provides an anchor for each thread in the weaving and affects the structure of the entire work. Letting go, connecting, being responsible and responding, and danger are all touched by the meaning of the therapy relationship, and, in turn, the relationship is affected by the uncanny experiences of empathic connection.

Every exit is an entrance somewhere.
(Stoppard)

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APPENDIX

INFORMATION AND CONSENT FORM

I am a graduate student in clinical psychology at The University of Tennessee, Department of Psychology. I am now in the process of collecting data for my doctoral research, and I would like to ask your help as a participant in this work.

The purpose of this study is to obtain first-hand descriptions of experiences of empathy that therapists have had with their patients. While the term "empathy" has been written about extensively in the literature, the lived experience has not been described from the point of view of the therapist. As a result, I am interested in hearing about your personal experiences of this phenomenon as they have arisen in your professional work.

Your participation in this study, if you choose to volunteer, will involve two interviews. In the first interview, I will ask you about specific experiences of feeling empathic with your patients. This interview will be audiotaped and should take about one hour. At the time of the second interview I will ask you to review the transcript. I will present the preliminary findings and ask you whether they capture the essence of your experience. I will be interested in your co mm ents and suggestions.

All material obtained will be held in the strictest confidence. Audiotapes and transcripts will be coded by number and identifiable only through a master list that will be kept secured along with other ma terials collected. The master list will only be accessible to the researcher and will be destroyed along with the audiotapes at the completion of the project. Any identifying information about you or the patients you choose to discuss will be edited from the transcript. You will receive a copy of the transcript.

The risks involved in this study are minimal. You will choose the experiences you wish to discuss. You are free to withdraw from participation at any time without question. I hope you will find the topic an interesting one to think about and discuss.

If you have any questions at this time or at any point during the project, do not hesitate to contact me. You will be given a copy of this form to keep and I encourage you to contact me with any questions, concerns, or co mm ents about the project. Thank you for your interest and participation.

Barbara L. Taylor

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Department of Psychology
University of Tennessee
Knoxville, TN 37996
Telephone:
office: 974-6060
home: 995-2722

I have read the above information and consent form and agree to participate in this project.

_____ _____

Sign and Print name Date

_____ _____

Address Telephone #

INFORMATION AND CONSENT FORM II

At the time of our interview we discussed the possibility of my using all or part of the interview in my dissertation. I now want to ask your permission to print excerpts from the interview, the summary that I have developed and/or the verbatim transcript. I plan to use excerpts in the body of the text as specific examples of the way the participants have described their experiences. The purpose of including a verbatim transcript and a summary is to illustrate how the interviews were conducted and the steps involved in the analysis of the material.

I have provided you a copy of your transcribed interview and my summary of it. All names, dates, places, and other potentially indentifying information have been deleted. I would like you to check over the transcript and summary to ensure that they are accurate accounts of your experience and of our conversation, and that they do not leave out any important point you wish to make. Please feel free ito make any changes you want, to mark out sections you do not want me to include in any publications, and to add further comments. We can discusss these as well as any questions you may have.

I would like to remind you that no identifying information will be presented along with this material. I will not publish any part of the transcript or summary without your permission as given on this form. If you do consent I will include only what you havve approved for publication. If you decide to not have your transcript or summary published, please do not hesitate to refuse this option.

If you agree to my publishing the transcript and summary as they are, or after corrections and deletions, please sign below. A copy of this form will be given to you. Please do not hesitate to contact me if additional questions or concerns arise.

Thank you for your participation in this project. Your assistance has been invaluable and is greatly appreciated.

Barbara L. Taylor

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I have read the Information and Consent Form II and approve the publication of the verbatim transcript, excerpts, and/or summary of my interview in the form we have agreed upon.

_____ _____

Sign and Print Name Date

_____ _____

Address Telephone

PARTICIPANTS' DEMOGRAPHIC INFORMATION

Code #:

AGE:

SEX:

HIGHEST DEGREE AND YEAR EARNED:

EDUCATIONAL INSTITUTION:

NUMBER OF YEARS IN FIELD:

FULL TIME:

PART TIME:

CURRENT PRACTICE SITUATION:

BRIEFLY DESCRIBE YOUR THEORETICAL APPROACH TO TREATMENT:

INTERVIEW: Empathy Project
Participant F-O3
6/21/93

I: So, can you think of some times when you've felt or been empathic with your patients and can you tell me about one or two of those times?

P: O.K., Well, I realize, thinking about this interview, I began to realize that the times I've thought about being empathic I wanted to distinguish from having projective identification in me, because there are some similarities. I hadn't gotten to how far, how I make the distinction.

One of the times I can think of being empathic, I think, with a patient was in a inpatient setting with a woman who was extremely schizoid and withdrawn. I had been working with her over some time simply to try and engage her, say that there was someting worth engaging in the world. There were reasons for her not to do that, in her own background . And I can remember sitting with her as she was moving toward the real possibility of discharge and an outpatient sort of structure that we in the program had worked for. And it was different than other times I had sat with her, either trying to engage her, being very, very aware of her withdrawal. There was a sense of we were both in the room together even though there was some silence. And I remember thinking, "Gosh this feels very different. And it had a quality of being together and being, some resonance and it being O.K., not me trying to pull her withdrawing. As though, you know, something had, there had been some connection. There was just this sense of resonance with, that we were talking about what she had accomplished. There was some kind of looking back and talking about what she had accomplished, and I think some appreciation on both our parts of the work that she and I had done. I can just remember that feeling kind of good.

And empathy, for me, I haven't thought much about what it means, but I think it does mean some kind of awareness of what someone is feeling and being able to join them on a deep level. I'm not sure that's what it's supposed to be. That's an experience I had that seems to have been

I: What distinguished this experience from others you had with the woman was sort of a difference, it sounds like. You described yourself as trying to engage (P: To engage her, and her withdrawal.) her and her withdrawing.

P: At times she would tend to, well, it was in a hospital so, withdraw, sleep in her bed and I would be doing something to move out of that state rather than so much being with her in that state. (I: Um, h mm .) We were both sitting instead of her being in bed. That's one difference. It is, it's more a sense of my own experience with her, I mean, (I: Right, right.) I don't have, ...

I: What was that experience like for you?

P: Well, O.K., I'm trying to even think of the sensations, not very clear. Umm, I remember feeling peaceful about it, and feeling appreciative of her, appreciative of the work, and even of myself, in a sense, of being with her in the same space

rather than pushing and shoving or pulling or some kind of struggle with the engagement process. It was as though I could sit with her and be silent, and we could both be silent but it didn't mean that there was this incredible distance. I really did have a particular, I think sensation, and I'm trying to recapture that. Let's see. It felt fairly safe, let's see, those are all - I can't get to the sensations.

I: You mentioned peaceful.

P: O.K., it felt fairly peaceful and calm and a, that it was O.K. to sit and be. Sense of, I had a sense of her presence and mine rather than a distance. I just cannot (inaudible) sensations which is frustrating. There was, I guess, a lack of tension. I come up with things like a sense of congruence or resonance. It was pleasant. I enjoyed just sitting there peacefully, enjoyed the peaceful. Well, I don't know what was at that. But I do remember thinking, O.K., this is what, I want her to have some experience of, that it's possible to be with someone, not be intruded upon, not be really in a struggle with much, which had been true of me and her but was also true of her and the world. To be safe and O.K. for a few minutes. And it was just a few minutes. A couple of minutes, not a lot.

I: This was a time then when you were letting go of her in the sense that she was leaving the hospital, too. It must have been nice to have had that experience with her before she left (P: Yeah, it was) - for both of you.

P: I had a lot more hope. She's somebody who I saw as very likely to kill herself, and so I had hope of some chance that she would be able to connect with someone.

I: Do you think or sense that she was having a similar experience of hope?

P: That's my sense and I don't know. (I: Yeah.) I don't know if she, u mm , let's see, I'm trying to think of, She was sad. She wasn't as rigid as she sometimes is. Some facial expression. The atmosphere had been relatively friendly, and with some sadness that this was moving toward an end, this relationship we had. Was, let's see, I'm trying to think if she said anything. It was more facial expression and some (inaudible). I guess it felt to me like there had been a connection made, rather than there hadn't been one and been one more failure. And she was able, at least for that time not fight with it on the way out. Could be something like, "This worked out O.K."

I: So, in the history of your trying to go to get her, so to speak, out of her withdrawal, there was a lot of activity on your part to do that, and it sounds like a bit of a struggle, too, and that this experience was of a lack of struggle, lack of tension, and peacefulness, and a sense of oneness I think you mentioned also, that you were with her.

P: Yeah, the resonance, being in the same place at the same time. Which sounds real simple, but it's (P. laughs) (inaudible)

I: Also something you said made me think of a being instead of a doing.

P: Yeah, it really was in that realm, a being and being with, not doing.

I: So in the sense of connection you no longer had to be such a doer. That's interesting. (P: Um, hmm.) But also you, it was probably, because you were terminating, a time to pull back from being such a doer as well.

P: Well, that makes sense. I don't know that, I mean, the experience seems to have just been there. (I: Uh, huh.) And it, I can just remember thinking, "Oh, wow. This is really both nice and different and aware of something, and I wonder if she's having this experience." I mean, I, there really was a sense of, "Gosh, maybe it's possible for her to be with someone and for it to be 0.K. at times." And she's safe enough to be with. For me to be with her.

I: Tell me about that.

P: Uh, I don't know quite, 0.K., what comes to mind? That she, that I could stand to be with her, with whatever pain, with whatever, there aren't words. That the connection was safe, for me to be there, too. I suppose that's (Inaudible) There's a sense about empathy, or about whatever this is, that one lends vulnerable parts of oneself to another. No, that's not right. That you have to go to places that are frightening and painful, to be with someone. And whatever it was about her and my connection it was strong enough for us to both be wherever that was. (I: Um, hmm.) And I certainly know she's had very painful, frightening things in her life. A lot of the struggle of just being around someone like this. It's a real struggle. Not to withdraw, but to venture forth, so this was a sense of, "Oh, we're both sitting here and we can both be here. It's 0.K."

I: It's not just 0.K. for her, then, (P: Yeah.) to trust you with those difficult parts, but also it's safe for you. What makes it safe for you?

P: I don't know. Umm, ... I guess some of it is knowing I can go to places and be 0.K. That I go to places with patients and either return or I'm 0.K., or am not damaged, or it's sure lucky.

I: Right, well, you say you're thinking of other patients. (P: Yeah.) You can change sets if you want.

P: Yeah, I have another patient that I've been working with for a long, long, long time. And I think part of the work is us hanging in there doing something ( ) while she and I can make enough of a connection for her to feel like I can stand to be some of the places she has been. Her to feel that way and for me to feel like I can, too. Now I don't know if that's empathy. Does that sound like it?

I: Hmm, she has to feel that it's 0.K. (P: That I won't be destroyed.) that you won't be destroyed, yeah.

P: And she has been able to vocalize that. She doesn't think I can, that she isn't sure of what would happen to me if she told me some of the things she might tell me if she could trust the world or herself in it. And, and she's a patient, and this is where I started thinking about it's not empathy it's projection or or one of those words. (I, laughs) Because I've had the experience with her, I mean it's a very curious thing, of getting very, very sleepy during the sessions. And I would finally, you know and it wouldn't

I: So in the sense of connection you no longer had to be such a doer. That's interesting. (P: Um, hmm.) But also you, it was probably, because you were terminating, a time to pull back from being such a doer as well.

P: Well, that makes sense. I don't know that, I mean, the experience seems to have just been there. (I: Uh, huh.) And it, I can just remember thinking, "Oh, wow. This is really both nice and different and aware of something, and I wonder if she's having this experience". I mean, I, there really was a sense of, "Gosh, maybe it's possible for her to be with someone and for it to be 0.K. at times." And she's safe enough to be with. For me to be with her.

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I got some consultation and have been able to track that much better now and I have my hypotheses. And I get, I get sleepy, I get so I cannot stay awake. My eyes, I'm about to fall asleep, and it's hard to wake up. It's hard to concentrate. And when I get like that I talk to her about that. Because the framework is that her own withdrawal is somehow there. We're both struggling with it. There's an extraordinary withdrawal in her, withdrawal, distance. And that when we're dealing with it, in some way that I'm not always aware of it, that's what happens to me. And she sees it as, "Gee, I'm getting bored." And I've talked to her about it a number of times and I have learned that I talk about this. "Gee, you know, this is happening again. You know, that I think that it's this." And I've been able to track it some and it does appear when, umm , gosh I can't remember the specifics, but there's certain kinds of subjects we'll touch on when, you know, there'll be this moving away in some way, or there'll be something that triggers what I now think is some kind of withdrawal and I'll go capture it. I'm not even sure (inaudible) theoretical framework. I have learned that I can talk myself because I cannot contain it. I do act it out. Umm,

I: In the sense that your eyes will close?

P: Yeah, yeah, so I at least talk about it. I remove myself from the helplessness of it, and begin to provide some attempt at dealing with it.

I: To understand it.

P: But I don't know if (I: Does she?) that's empathy.

I: Does she respond to that, is she able to?

P: She, she, yeah. We talk about it, and she does say that she often has that feeling that she has, she stays tired a lot, talks about emptiness and numbness and is aware that she does withdraw. We can sometimes track it in the session. "Were you here and then did you go aw ay?" She can do some of that. She has more difficulty than lots of folks I see in the hospital tracking who say, "Yeah, I checked out but now I'm back." It's much harder for her to even acknowledge that she does do that.

I: Is it acknowledge or realize?

P: I think it's acknowledge, umm, I don't think it's realize. I think it's very, it's always frightening to her, telling me about herself, because she has the idea that if I get, well, that if I get too bored or too fed up or something, that I will leave, that I will (inaudible). That's both what she is expecting and is afraid of and I suspect it also is somewhat (inaudible) "No, that's what happens to everybody and it's going to happen here, too." So, it's not a simple thing. (I: No.) It's huge. So those are, as I came over here those are, when I talked to you and you said would I be interested in doing this, those are the two times I thought of. Those are what came to mind. I don't know if ... There is, I do think of empathy as a very, a deep, some sort of emotional connection. Sympathy is

where you say, "Gee, that's too bad." Empathy is some connection with whatever the experience is, I think. (I: Um, hmm.) And it's much more difficult.

I'm losing my connection here.

I: Difficult. Difficult, tell me about being difficult.

P: Well, it's not something I can make myself do. (I: Ah.) I can try to create the opportunity for it to happen, create the opportunity for me self to stay open to that, which I think it is, open to catching the experience from someone. I don't know if that's right. This all sounds wrong. Umm, and I guess I do realize that for me it is being able to catch and track something that is a projective identification or introjection or, ...

I: Well, in the case of the feeling sleepy, you said that, it sounds like one of the first realizations you had was that you realized it wasn't you who was sleepy. (P: Right.) You hadn't had lunch, you weren't, you hadn't slept poorly the night before, all those kind of things you do in your mental check list (P: Yeah,) and say, "Is this me?"

P: It was from the room, and it did take me awhile to begin to figure that out. "This isn't me, this is the patient. It's not even in the session." And to track when it would come up.

I: So in it's not being you, what was it? (P: O.K.) Where'd you place it?

P: Well I guess what I did with it is say, "O.K., this is coming from the patient." And I don't have, I don't have a way to put that into English. That's why I use these words like 'projective identification' 'cause I don't (inaudible). I don't know, I don't know, I think it is at some level some kind of communication that deals with, I don't know, emotions, picking up. And a sense of being in some resonance with someone you're working with. I'm trying to, trying to be . I guess I'm trying to do two things: both keep a part of me available to what, to some outside view and then part of me very tuned in or even available for whatever's coming from the patient in that. Whatever's coming emotionally.

I: So the sleepiness became not necessarily something she was experiencing but then something that you were sharing with her. (P: That was my take on it.) What you (inaudible) that she had given to you?

P: Yeah, it was like that. I remember when I got the consultation. The consultant I talked to talked about this sense of hopelessness and helplessness which is often true of this person. And my catching that, being overcome. That's not directly related to the sleepiness but is also a tangible way to feel, that you can't do anything, including even move. (I: yeah.) And she often describes herself that way, that she has to rest. There's sort of a helplessness.

I: It seems like if someone is feeling that sense of hopelessness that sleeping is a good way to check out for awhile, check out of this whole feeling. (P: Yeah.) I mean sleep can rejuvenate you.

P: Right, I hadn't thought about that, the sense of the death of the emptiness. And in this case it happened to me rather than to experience, hmm, so much emptiness. So, just kind of chewing away at it.

I: But to you it was a signal that something was going on that needed to be understood.

P: Yes, yeah. Understood and addressed. Partly, out of my own, "Gee, you don't know what's going on. I keep doing this. Out of a simply pragmatic, I've got to do something to get myself able either to use this or mobilize something. Because there was a lot of guilt, an awful lot,"Oh, I can't believe you' re doing this!"

I: These two examples you've given, I'm sensing one difference at least, between them is: in the first one it was O.K. to just be, be with the feeling of sharing the connection, almost enjoying that kind of moment of resonance. (P: Yeah.) But in the other case it wasn't. In fact it was almost a flag for action on your part.

P: Yeah, it has been. And I'm not sure she's feeling it at the same time I do - she's usually not. She isn't sleepy (I: Uh, huh.) at the time. It's not a sense of being with her. It is more of a sense of catching something. It happens sort of overcomes me, and struggling with it. That's why I was thinking of the difference, what is the difference between empathy and an introject. The latter makes more sense in terms of that.

I: Well, yeah, because in the second example, it's more like something she might want to get rid of (P: Yeah!) and therefore gives it to you, not as a gift of sharing so much as a "You can have this." Versus the first one which is much more a moment of sharing. The two of you held something in common together . (P: Yeah.) ... But they are hard to pick apart, in a sense.

P: I think they are physically. I'm not sure they are, theoretically, when you think about them. I'm trying to think of other times when I felt empathetic. These I'd see as fairly extreme of some arena - the arena that doesn't have language very easily - moods, sensations and what they mean, give meaning to. Physical sensations and trying to check out whatever they ( ) Was it the lunch I had? Like in Charles Dickens' Christmas - was it the soup or something Ebenezer Scrooge ate or was it Marley's ghost? O.K., maybe it's just indigestion. I guess I also, I'm trying to think about, there's another part of just empathy and maybe these are just explorations of the extremes of what is it, but I do think there is some capacity to, to talk with someone and increasingly try to understand some of what their world view looks like, along with the feelings. And then to then using that, begin to help make sense of that, whether over time or I guess for me the thing that is interesting is not so much the words, but all the other information one exchanges when one is face-to-face with another

person. And that empathy is, I don't know, but maybe some way of trying to take in all that other information. Filter it through, and somehow you come up with something like resonating with feelings. But I know it's very clearly not just sympathetic, because that can be very distancing, but the empathy for me has within it the idea of being with someone. In a way that can be conveyed to them. Now these examples don't necessarily ( )

I: So you can have the experience but not necessarily talk about it with the patient.
P: Well, I think I, yes, I think that's true. I think, yeah, but you can be empathetic but the whole experience is one in which you convey something with ideas, with communication levels so that the person has the opportunity and sense of being understood and heard, at all the levels, or most of the levels you can plug in with? I guess that's what I think.

I: You said it's not necessarily or only the words.

P: Yeah, I realize I'm using the idea of resonance here, which just comes out of the work and the training that I do. I'm not sure if they're exchangeable or not, or interchangeable. But that empathy for me does go down several levels. It may be with words, but it's the congruency of the whole message. I see it a lot in groups.

I: What are the other channels then? (P: Hmm?) What are some of the other channels - you're talking about different levels, or levels.

P: O.K. let's see. Well, certainly voice tone and posture and facial expression, and those at a very subtle level. Because what I see, and often, it often goes with a package of words that says, "This is what has happened to me. This is where I am. This is what I am talking about." Because what I see in groups is patients being empathetic with one another. (I: Um, hmm.) I think it's empathy. I know it's resonance. It's, there is a real possibility of connecting, this is not necessarily true of therapists, with the experience, at the level of experience. For example, people who have been sexually abused or have some experience of extreme violation or abandonment and all kinds of things that somebody talks about. And one of the things that can happen, I've seen people really connect with conveying that they understand, by facial expression. Often by words. But everything else says that, too. They're not just saying, "Oh, gee, I understand." The whole picture is there and it fits with the person and there's a sense of connection between the two people, that they don't have to really, they have to articulate what is going on, but there isn't so much, "Gee, do you really?" It's like, "Oh, yeah, you really do understand this." They may get that from a mirrored story. And maybe, now how is this distinguished from mirroring? I don't know, O.K., I don't know what the distinctions are.

I: You said that when you see the patients doing it with each other in group you made sort of an aside remark, "Therapists don't do this." (P: Well,) Can you tell me about what's distinguishing that?

P: What I was thinking is that - Oh, I don't know that therapists don't. In fact I think that we have to somehow, we do best to try and get there even if we haven't had the experience. For example, if a therapist hasn't been sexually

abused and she is with a patient who has, some of that's going to be missing. It's not going to be easily available, at the level that the patient has knowledge of what that's like. That's what I mean. A therapist, yeah, a therapist has to work at getting, O.K. 'Cause I know what I do, it just got murky again, umm, I do work on understanding that at the most primitive levels that I can. And I know when someone does have experience that I have access to in my own life it's a whole lot easier. I don't have to do as much work. I know much more quickly something about that experience and something about the feelings. Not that they're going to match up totally, but there's just a whole lot more rich tapestry of information that creates like a whol, w-h-o-l-e, that then I can draw on. And when that's not all there I have to do more work to, to, it's not just be in touch with, to let myself be open to something. It may be painful, I don't know, just something that will begin to give me more information to fill out some of that. If I have a patient who's in an arena that I don't have experience with then I have some other kinds of knowledge about. I think I have to look at being able to resonate and connect with them at those levels. Of that experience or something about that. And maybe, maybe it's better. I was going to say maybe it's better because then I have to use them as a guide instead of myself. I do think there's a back-and-forthness to it. It's a little like method acting: I figure I pull whatever there is and stretch that. Whatever experience I can use.

I: It's a back and forth.

P: Stretch it into "O.K., this may get into this more." Back and forth? Yeah, 'cause it's a very, yeah, it is back and forth. Because I stay aware, in some way, actually I don't know as I stay aware of it 'cause I just don't, I now have a sense of having enough experience that I know I will not get there and stay there. I'll come back. There's not so many defenses and so much anxiety, perhaps that's what it is, in the way of trying to make a connection with that person and myself in whatever, whatever the information, conflict, whatever that is that's often too horrific to deal with. 'Cause that's often what I'm doing. Working with people who don't have an easy time.

And I guess of empathy or some, something that's in that ball park as part of a tool that allows me and them to go, for two people to be someplace that's very hard for one person. So it's through the connection that's possible, to deal with the information in a different way. Less frightening.

I: So, in the sense of a patient, going back to the idea of damage, because you're saying a lot of these places that we should go and are asked to go are horrific. In the sense of not being damaged, then, that person wants you to be there, or needs you to be there, but needs you not to be there in the same way that she or he is there. (P: Yeah.) Not overwhelmed, because that's, in fact, what's happened to them.

P: Right. And they've been alone.

I: And they've been alone. So needs you to be with, but something else, too? Because if you were just with, you would be damaged.

P: Hmm, O.K., what comes to mind is 'with, with a way out'. With as a whole person, or with as a person. I'm not sure that's true. I think that one can be with another person. I don't know that it's the same as being alone with it.

I: So just by virtue of your having allowed yourself to go to that place it has changed.

P: I think that's true. And by having someone able to be connected with another person while they're in a place that's very difficult, umm, that often changes it.

I: But you also mentioned a way out.

P: Well, yeah, and I don't know that it's true. That it's a place one can go and come out of. Isn't stuck there. That whenever you think about it, that it doesn't have to come up ( )

I: Can you think of a time with a patient when that has happened? That you've gone to that kind of place?

P: Well, let's see, off-hand. Yeah, I guess in groups. Yeah. Umm, 0.K. I am aware that I don't let people go and basically dissociate if that's what they do. In groups I'm working with. I work to have someone, if they're tending to do that, I work with them to either stay connected with me: eye contact and aware of my presence, aware of where they are, anchored in this real world. And as they can talk about the experiences then we can live through it, with them being aware of connection to me and me reminding them and me keep checking (inaudible) And, and my sense is I have to be real connected to them. And sort of tenaciously so.

I: You have to keep going to make sure of the connection.

P: Yeah, yeah. And I, a certain amount of intensity to it. Not just sitting back and listening. It's a very involved connection, and sometimes they can talk about it, some things that have happened in their lives.

I: Is that a time when you feel like you're resonating with that experience with them?

P: I'm very aware of working on the connection. I think that, yeah, yeah, 'cause usually I'm really. There's something, some awareness of the fears, sometimes the pain and I'll have physical sensations of various, and a sense of how all alone you'd feel if we weren't together in this. And what I'm real aware of is how important it is for me to stay connected and not distance emotionally, which gets tempting. (I: Mmm, um, hmm.) To stay somehow emotionally connected and that they are connected. It's sort of like, one way of thinking about it, and it's certainly not original with me, me being connected with myself and them being connected with theirselves, a part of this also, the self that they're trying to retrieve that was cut off. And then there being a connection between us. Pretty much all at the same time, so my experience is: these are very brief and they are, so it's not like a long involved minutes on end. It's very brief, because that's (inaudible). But my experience is that there is a difference with them, that

they've not had to go somewhere by themselves for awhile. Something different has happened, and it makes the going to that place less frightening.

TAPE TURN

I: There's something of a shift for them. (P: Yeah.) Do you experience a shift as well?

P: I don't know. There's something, umm, there's a real sense of the profoundness of the connection, something like that. I don't know, I don't know if I can articulate it more than that, just a sense of, yeah, there's more awareness of how important these connections are. Usually feels good to me. Umm, O.K., that doesn't the same thing.

I: But you're also aware of working really hard.

P: Yeah, of not. My experience is most people who've been through things like this are making connection to it by themselves, so any, any, the presence of anyone else goes against the grain, so that's what then it feels like.

I: Say that again. I'm sorry.

P: O.K., we're talking about folks who have gone through some memory of, some kind of abuse. And, a, O.K. What I'm aware of is the importance of maintaining the connection, even at the expense of going back very far into the experience. I would have them not, stop the experience rather than stop the connection, because, for me it's more important that they maintain the connection and begin to find out it's possible to have more resources? in those places? (I: O.K.) And so I would, sometimes when someone's too far gone into some dissociative state I just try to pull them up. I don't always do that. But if it just looks like it's going to be something that, they're just retormenting themselves, then I work at getting them out of there.

I: Wasn't able to be useful to them (P: Oh, yeah.) or helpful to them?

P: No, it was just a, just a repeat. I'm trying to think, what was your question again?

I: The fact that you were working hard.

P: Yeah, that's what it is. 'Cause what I see myself doing is holding onto the belief that they can deal with something very painful, that it makes a difference to have someone else present, feeling some of the pain, and that that's the difference. That's the difference that makes the difference. It's not talking about it, it's beginning to find out that it's possible to detoxify these experiences, and that's a way of doing it. You can have more resources. You can have someone with you and it can start looking different. You don't have to face it alone, by yourself. You're an adult and there's another person here.

I: So, resources have changed on a number of levels: the fact that they're adult and have more resources, and (P: And that there's a person there.) and you're there. And that you're both 'there', but also you said that there's another part of you thinking about it at the same time, even though you're with them.

P: Yeah. I don't know how much I actually do that, I'm mostly just aware of being with them. Being, watching, well, I guess that would be the part, watching for eye contact, watching visual expression, trying to gauge how much they're still there rather than moving back into something else.

I: How do these kinds of intense experiences end? How do you get out of there?

P: Well, usually, there's not, they're not very long. I don't know. They just talk a little bit. It gets to be a bit more O.K. Whatever bit of work, it's been just sort of a few steps. It's been different for them, and that's what I want.

I: What's it like for you afterwards?

P: Well, it's, I feel successful, especially if I've been able to help them maintain a connection and notice, and I usually do, and if they can notice if there's a difference between going there by themselves, which they usually have all kinds of experiences with, and doing it this way where there's a sense of, you know, was there a sense that I was there or that you were there or that you weren't alone. Sometimes I ask them. And if there was, then was that different? And sometimes it's not for people. And what I have seen is that depends on the emotional intensity that they have brought to it. Now if they're just talking about something and they're still pretty removed from it, there's still not really a connection there.

I: They're not there.

P: Right. They're not there.

I: That's what you experienced: they have to be there, you have to be there, and you two. So, those are those kind of three connections (P: Yeah.) that you're talking about.

P: And then it doesn't do that. And you can have someone talking endlessly about all kinds of experiences, and they're not experiencing it. They're not, whatever body that happened to, they're not connected with that body, so there's not much that happens. And so I don't tend to

I: You talked about body, about sensations, and about places (P: Yeah [said equivocally] Yeah, that's right, that's pretty phenomenological, isn't it?) Very spatial terms. Yeah, that, too. But very, very kind of spatial terms (P: Yeah.) and body, like this is an experience for you in your body as well.

P: Yeah? Oh, boy, that's murky, too. I think that's probably true, probably true.

INTERRUPTION AT DOOR

P: Is this what you want? (I. laughs) I mean,

I: Yeah, I mean, I want what I get.

P: Right, I know, gosh, I've done some of these, and they're just

I: I think there's always a question, because if this were an easy topic then I probably wouldn't have to do this study (P. laughs) or feel the need to do this study.

P: You know, it's interesting to me, because empathy really does touch on lots of other things, like projective identification, like mirroring, and I didn't even realize that, like, and then sensations. Is empathy an intellectual and emotional discipline? Is it some kind of holding environment? Is it a focus? And you're right, I do probably, in my own metaphoric mind, think of people going places. I mean literally. You know, Dante's descending into hell is a perfect metaphor. But I do have some sense people go places: they go to their past, or they go, something triggers them and they're suddenly back, being beaten by their father, you know, under the stairs or something,

I: And you need to go there.

P: Well, I need to either get them back or go there. Yeah. I have a choice. I feel like I've got a choice. I don't have to go there, and if I can't, then it's not going to do either of us any good. I have be able to go there and stand whatever it is that is there. And I don't know how to describe that. I get better at it. But I still know it's pushing me. I think of people I've worked with who sure did push the limits. I think of a woman who - this is real confidential

I: Absolutely, yeah, it'll be anonymized.

P: who had been in a situation of having a psychotic break, and that injury. (inaudible) And it was just, sort of, an enormous nightmare. And this sort of struggle to be anywhere that close, dredges up, I don't know, one's own anger at one's various relatives, and how close, "'here but for the grace of God" I suppose. I just remember one staff (inaudible) and this was a very nice person. This was somebody who didn't deserve it, (inaudible), whatever that means, not that anyone does. But I mean it was much easier to identify with her, and say "God, this is too close to home:" And I think that's it - to struggle with one's own defenses, to be present and in an honest way. I think that's what it means. 'Cause you have to be present with the parts of yourself, I guess this is it, that are sadistic, and primitive, and helpless, and fragjle. I mean all the parts. You have to stand yourself.

I: So it's like, it's almost the equivalent of what you were talking about when you say you can hear people talk and talk and talk and talk about experiences but they're not feeling them at the moment, and the counterpart to that is your connection, your need to connect to that, those parts of yourself?

P: Yeah, maybe the parts you're capable of. Well, something, 'capable'? Yeah. Capable of these things happening to you, of doing them.

I: So that sort of addresses your connection to yourself?

P: Yeah, and how the defenses get in the way. Working and stretching, moving through, doing that with some, I don't know, ease. I just know that if I'm going to be with someone, I have to really be there. It has to be ME. It's me as a therapist, but it's still me. It's me, basically, as a person. It doesn't go away. You can't fake it. You can't pretend that, to be there, and folks know that. Well, we all know that. We know, the patients, the people who know no one's been there. They certainly know when, they certainly can tell. They may not always be able to tell you that you really are there, but they sure. I think that's true. Only (inaudible) some way communicate.

Well, Barbara, I hope some of that touched on it.

SYNOPSIS: Interview F-03

For this participant, the empathic experience with a patient is a deep emotional connection with the patient's experiences. At such times there is a sense of being together, being with, joining with the other. She has a sense both of the patient's presence and her own. Rather than experiencing distance, she feels connection and resonance with the patient, and a lack of tension between them. It occurs in the realm of being, not doing. One cannot make these experiences happen, but you can create the opportunity for them to occur.

Finding it important to differentiate empathy from projective identification, she realizes that in both instances, the therapist must be open to the communication of emotions from the other, cathching the experience of the other. While in the case of the former there is a sense of being together with, in the latter there is more of a sense that the patient is giving emotions away to the therapist.

Part of what empathy is, is trying to understand the world view of the other, along with the feelings. It is not a distancing phenomenon as sympathy is, and it often occurs on many levels. Communication may be through words but may also be through non-verbal levels. The patient needs to have the experience of having been heard or understood, whether or not there is formal verbal acknowledgement by either partner. She uses the word "resonance" to describe the congruence of the whole message along various levels.

As a therapist she must let herself be open to something that will begin to give her information that will add to her understanding of the other. She often must work at getting the other's experience, particularly if the patient's experience is very different from her own. She likens it to method acting, in that she pulls whatever there is from her own experience and stretches that as much as she can. In order to do this she must lessen her own defenses and anxiety so that she may connect to those parts of herself that can connect to the patient's often horrific experience. Presence to the experience must be honest and real, because the patient will know immediately if it is not genuine.

The idea of the "safety" of the therapist is important. The connection between the two must be strong in order to go to those frightening places. Both the patient and therapist must be assured that the therapist will survive. In these empathic experiences, two people must be some place that is hard for one person to be. The connection at the moment is what makes that possible. The therapist must be connected with herself and her own experiences, the patient must be connected with herself and be emotionally present to those experiences at that moment, and the therapist must work to remain connected with the patient.

What makes these experiences useful for the patient is that there is a difference. Rather than visiting these places by herself, which is horrifying, she has gone with another; therefore it is less frightening. For the participant, these experiences give her a sense of the profoundness of the connection, of how important such connections are. They are so important that if they are not present, she will discontinue the experience in order to preserve or retrieve the

connection. The experience of going to whatever place the patient must go only makes a difference for the patient in the presence of strong connections. The participant is aware that while she has a choice of whether to go to those places, is she cannot, it will do neither person any good.

VITA

Barbara L. Taylor was born in New Bedford, Massachusetts in 1950 and began her formal education in the New Bedford Public Schools. She graduated from high school there in 1968 and entered Wellesley College later that year. She attended the University of Chicago during her senior year of undergraduate studies and received a Bachelor of Arts degree in History of Art from Wellesley College in 1972. In 1974 she enrolled at the University of Illinois, Chicago Circle and earned a Master of Social Work, concentrating in clinical social work, in 1976. In 1988 she entered the University of Tennessee, Knoxville to study clinical psychology. Her pre-doctoral internship was completed at The Tufts University and Boston Department of Veterans Affairs Psychology Internship Consortium in 1994. In May, 1995 she received the degree of Doctor of Philosophy in Psychology from the University of Tennessee, Knoxville. She has been employed in the area of mental health services in both the public and private sectors.