It is easy to clothe Imaginary Beings with our own Thoughts & Feelings; but to send ourselves out of ourselves, to think ourselves in to the Thoughts & Feelings of Beings in circumstances wholly & strangely different from our own ... and who has achieved it? Perhaps only Shakespere ... a great Poet must be implicitè if not explicitè, a profound Metaphysician. He may not have it in logical coherence, in his Brain & Tongue; but he must have it by Tact/for all sounds, & forms of human nature he must have the ear of a wild Arab listening to the silent Desart, the eye of a North American Indian tracing the footsteps of an Enemy upon the Leaves that strew the Forest; the Touch of a Blind Man feeling the face of a darling Child.

—SAMUEL T. COLERIDGE (1802)

Empathy, which we consider of focal significance in our work as psychotherapists, is something that is too easily taken for granted. We expect a good therapist to be empathic and we search for this quality in the candidates whom we select for training in psychoanalysis. Criteria indicating the presence of empathic tendencies, however, are hard to define, and the literature does not make clear whether this quality is a given or whether it represents something which can be developed through training and personal analysis. Disturbances of empathy, on the other hand, are easier to detect, and consequently more has been written and discussed about them; they are frequently introduced in connection with countertransference difficulties during supervised work with candidates. This communication will limit itself to discussion of the nature of empathy and its mode of operation.

With the exception of material dealing with problems candidates demonstrate during training, precise and documented data concerning empathic phenomena are difficult to find in the literature. There are many reasons for this. Because empathic communication is so fundamental to our work and constitutes a welcome, if unconscious, adjunct to our technical procedures, we do not tend to wonder as much as we should how such an interaction comes about. Furthermore, the phenomenon is an old and familiar one, known to us from our daily experience outside the therapeutic situation. It is only within the therapeutic situation, however, that we exercise with disciplined attention the necessary consistent self-observation which illuminates the vicissitudes of empathy. This part of our experience has an æsthetic quality and is one we tend to regard and mistakenly believe to be beyond the realm of scientific analysis. Hence, it is easy for us to think of empathy as part of the art of therapy, imbricated into a mystique which has come to envelop probing into the unconscious mind of man.

There is another, even more important factor that accounts for the scarcity of documented reports on empathy. Such documentation has to be self-revealing, especially about the personal response of the therapist to his patient's productions. Very few of us have the courage to expose for public scrutiny the record of our inner processes, as Freud did in The Interpretation of Dreams. It should be noted, also, that today the audience for such exposure is much larger, more sophisticated and highly skilled in the technique of psychoanalytic interpretation. Recording a few surface phenomena can be more revealing than they were in Freud's time.

The problem of how to enter into the mind of another person is an old and fundamental one. Freud (1915) spoke of the

1 A notable exception is a recent communication by Miller (1972) in which with rigorous honesty he reports his reactions to falling asleep while listening to a patient. He ascribes this to a manifestation of his countertransference, the result of the simultaneous appearance in the therapist and the patient of an analogous unconscious fantasy.
difficulty of apprehending the conscious workings of another's mind. He well knew that consciousness made us aware only of ourselves but that by identification could be extended by the ego to others. 'But', he wrote, 'even where the original inclination to identification has withstood criticism—that is, when the "others" are our fellow-men—the assumption of a consciousness in them rests upon an inference and cannot share the immediate certainty which we have of our own consciousness' (p. 169). If this, indeed, is the difficulty encountered in understanding the conscious functioning of other minds, how much more difficult then is the task of grasping unconscious processes in the minds of others. In this task empathy and intuition play a basic role. And, in turn, they are buttressed by the analyst's conscious knowledge of psychic functioning and psychopathology.

In his advice on therapeutic technique, Freud (1915[1914]) recommends that the beginning analyst should not be too concerned with trying to master the patient's data in a cognitive fashion. The correct interpretation, he suggests, comes into the analyst's mind in the form of a free association. What Freud was actually describing is the fact that we rely heavily on the process of intuition, that is, on the immediate knowing or learning something without the conscious use of reasoning. As in any form of creative scientific work, the vast stores of information available to the investigator are organized into meaningful configurations outside of the scope of consciousness, and the results of this process are later brought into relationship in a rational, disciplined, and cognitive fashion with the data of observation. This does not mean that every association which comes to the mind of the therapist during his work constitutes an accurate interpretation of the data presented to him (cf., A. Reich, 1961). Somewhere in the course of the introspective activity which the analyst exercises, he becomes aware of the end product of a highly complicated process which has been going on outside of the scope of consciousness. The awareness and the perception of this end product is the result of intuition; the validation of the interpretation thus presented to the consciousness of the therapist is a further process upon which the analyst must then embark.

In order to illustrate the problems surrounding the utilization of empathy in clinical interpretation, the following data from a therapeutic session are introduced. From this data, it was possible to reconstruct the nature of the underlying, unconscious fantasy, and to examine to some extent the process by which this reconstruction became possible.

**CLINICAL EXAMPLE**

On his return from the long Thanksgiving holiday a patient reported:

*I am not so sure that I am glad to be back in treatment even though I did not enjoy my visit with my mother and father in the Midwest. I feel I just have to be free. My visit home was depressing. My mother hasn't changed a bit. She is as bossy, manipulative, and aggressive as always. My poor father. He says nothing. At least in the summertime he could retreat to the garden and work with flowers. But my mother watches over him like a hawk—a vulture—she has such a sharp tongue and a cruel mouth. You know, each time I see my father now, he seems to be getting smaller and smaller. Pretty soon, he will disappear and there will be nothing left of him. She does that to people. I always felt that she was hovering over me, ready to swoop down on me. She has me intimidated, just like my wife. I don't feel like getting involved, but when you are married, there isn't much you can do about it.*

*I was furious this morning. When I came to get my car, I found that someone had parked in such a way that I was hemmed in. It took a long time and lots of work to get my car out. During the time I realized how anxious I was. The perspiration was pouring down the back of my neck.*

*I feel restrained by the city. I need the open, fresh air. I have to breathe. I have to stretch my legs. I'm sorry I gave up that house in the country. Next week, I am going up to Massachusetts to look around for property. I have to get away from...*
this city. I really can't afford to buy another house now, but at least I'll feel better if I can look.

If only business were better, I could maneuver more easily. I hate this feeling of being stuck in an office from nine until five. My friend Bob has the right idea. He arranged for retirement and now he's free to come and go as he pleases. He travels; no officers, no board of directors to answer to. I love my work, but I can't stand the restrictions it imposes on me. But I am ambitious, so what can you do?

At this point, the therapist called attention to the recurrence in the material of the theme of being trapped and confined. The patient continued:

I do get symptoms of claustrophobia from time to time. They are mild, just a slight anxiety. I begin to feel that perspiring feeling at the back of my neck, and begin to have a sense of restlessness. It happens when the elevator stops between floors or when a train gets stuck between stations. I begin to worry how I'll get out. You know, I have the same feeling about starting an affair with Mrs. X. She wants the affair, and I guess I want it too. Getting involved is easy. It's getting uninvolved that concerns me. How do you get out of an affair once you are in it?

I am really chicken. It's a wonder I ever was able to have relations at all and to get married. No wonder I didn't have any intercourse until I was in my twenties. My mother was always after me. 'Be careful about getting involved with girls—they will get you into trouble. They will be after you for your money. If you have sexual relations you can pick up a disease. Be careful when you go into public toilets. You can get an infection, etc., etc.' She made it all sound dangerous. You could get hurt from this, you could get hurt from that. It reminds me of the time I saw two dogs having intercourse. They were stuck together and couldn't separate. The male dog was yelping and screaming in pain. I don't know how old I was then, maybe five or six, perhaps seven, but I was definitely a child, and I was frightened.

By the time the therapist communicated to the patient the simple observation that he seemed to be concerned about being hemmed in or confined, he had already concluded that the patient was suffering to some degree from claustrophobia. At this point, the existence of claustrophobia could be deduced in a rational way from clues presented in the material of the session. Although the idea of being confined had appeared in a few similar or parallel expressions and the theme repeated several times, claustrophobia was a new element in the treatment. The experience of anxiety was a factor common in all the elements mentioned.

While the data in this case corresponded to a pattern recognizable from clinical experience and reported in the literature, it is hard to say to what extent the therapist was aware of the configurations and interrelationships of the data at the times he was perceiving them. More often than not, in such instances, most therapists appreciate only in retrospect the rich and subtle interconnection of the inner logic of the material. For the most part, but by no means exclusively, the data is conceptualized outside of awareness. First, it is intuited, and then, it is rationalized. (The term 'rationalized' is used here in its strict sense, not as a form of defense.)

But there was another idea that presented itself to the therapist's inner perception. This was the idea that the patient was under the influence of an unconscious fantasy in which his penis would be trapped or injured if it entered a vagina, originally his mother's. A corollary of this notion was that the patient fantasied his whole body as his penis, and it, too, would be subject to the same danger that threatened his penis in the preceding fantasy. Concerning this insight, there was much less evidence than for the conclusion regarding claustrophobia. Yet certain clues, more subtle ones it is true, could be identified. The factor of contiguity was important. The material conveying the sense of anxiety about being confined followed immediately upon a train of thoughts dealing with his fearsome mother and her destructive, hawklike beak.

While the factor of contiguity is suggestive, it is not definitive. It is true, however, that in claustrophobia fantasies which unconsciously equate the fear of enclosure with the vagina are common. In addition, there was the earlier knowledge of this patient's sexual inhibitions which accurately fit into the configuration of the data suggested by the second fantasy.
In this clinical vignette, it should be noted that beyond the cognitive organization of the data there was an immediate, noncognitive sharing with the patient of a fantasy of which he was still unaware—namely, the fantasy of a *vagina dentata*. There can be no doubt that at this point technical knowledge and training were very important in organizing the data in the analyst's mind and helped to facilitate in concrete terms the formulation of the underlying unconscious fantasy.

How is it possible for the therapist to select and collate out of the myriad of observations available to him those necessary elements that he organizes as his insight into the patient's unconscious mental processes? Beyond the rational activities that may operate either within or outside of the scope of consciousness, a further element must enter. This element we call empathy.

**IDENTIFICATION AND EMPATHY**

The dictionary defines empathy as the projection of one's own personality into the personality of another in order to understand him better. This is essentially the usage of the term to which Kohut (1959) subscribes when he considers empathy 'vicarious introspection'. Greenson (1960) speaks of empathy as a form of 'emotional knowing', the experiencing of another's feelings, a special mode of perceiving. He considers empathy primarily a preconscious phenomenon to be distinguished from sympathy because it does not contain the elements of condolence, agreement, or pity. Definitions of empathy often include concepts concerning the genetic origin of the phenomenon. Loewald (1970) assumes that emphatic communication tends to approximate the kind of deep, mutual empathy which we see in the mother-child relationship. Similarly, Burlingham (1967), H. Deutsch (1926) and others consider the infant's sensitive response to the mother's affective state as a manifestation of empathy. Perhaps the most extreme statement of this position is by Ferreira (1961) who sees empathy as rooted in the primary umbilical unity of the infant and the mother. A corollary of his view is the idea that empathy is primitive and archaic and gradually tapers off and decreases through the years. Such concepts which view empathy as recapitulating the early mother-child unity emphasize a merging of analyst and patient, of subject and object in the therapeutic interaction. Schafer (1968, p. 153) also speaks of infantile forms of empathy as being based on merging.

The literature contains many references to the importance of 'being with the patient' as a desirable technical approach. The fact is, for all its implication of human warmth, this may be detrimental to the therapeutic process. Brierley (1943) has made a useful distinction between thinking *with* the patient and thinking *about* the patient. Thinking with the patient is not necessarily empathy. Sometimes it may indicate countertransference, projection, or a degree of identification with the patient that implies merging and can be detrimental to therapeutic work. This point has been emphasized particularly by A. Reich (1960).

There is general agreement that identification is indeed involved in empathy, but this form of identification must be separated from other forms. Empathy may play a role in feelings of sympathy or pity, but it is not identical to these feelings. There are two distinguishing features to empathy: one, it is a transient identification; second, the empathizer preserves his separateness from the object. It is hard to say just when the individual develops the capacity for empathy, but evidence indicates that it is not present in infancy: the essential component of empathy, which is lacking in the infant, is the capacity to separate self from nonself. Stable self- and object representations or the state of object constancy are not established until later. In Mahler's (1968) terms, the infant has not completed the necessary process of separation-individuation. In addition, the capacity for empathy requires such functions as memory, thought, comprehension, and conceptualization. Only then can the cues that perception affords lead to empathy. Empathy consists of more than an immediate affective response; it requires considerable ego development. Accordingly, the capacity for empathy increases with age and experience, especially experiences of suffering.
While there is no question that the good mother empathizes with her infant, there is also a potential danger. Olden (1953) has described a pathological mother-child relationship which is essentially symbiotic and merging in nature and not empathic. When a child is hurt, for example, the empathic mother will react to his pain and anxiety but will maintain her separate existence as a mother; her identification with the child’s pain and anxiety is evoked, but it is transient and serves to mobilize behavior appropriate to the emergency. The nonempathic mother, on the other hand, may narcissistically withdraw from the situation or so completely identify with the child that she suffers along with him to the point where she shares the child’s helplessness. She merges with her child in identification; she suffers with the child and not about the child.

This is what Beres (1968a) emphasizes concerning the transient identification in empathy. Such identification implies only a temporary sense of oneness with the object, followed by a sense of separateness in order to appreciate that one has felt not only with the patient but about him. This point is important in evaluating the genetic precursors of the process of empathy mentioned above.

In general, narcissistic individuals have difficulty in empathizing because of their tendency to merge with the object for the purpose of narcissistic gratification and because of their inability to maintain a sense of separateness from the object. This is most apparent in the repetitive love relationships of certain narcissistic patients. They plunge into every relationship with great emotional intensity. To be separated from the lover gives rise to intense anxiety. They are totally submissive and will accept humiliation and even physical abuse. At the same time, they make demands on the lover for attention and are intolerably possessive. As self and object are one in their fantasy, the love object has no real existence and serves only as a prop. Such individuals merge with a lover in identification; there is no separateness of self from the other.

**SIGNAL AFFECT AND EMPATHY**

So far we have emphasized two ideas concerning empathy: first, the sense of transient identification and second, the complementary sense of separateness. Several authors (e.g., Greenson, 1960; Racker, 1958; Little, 1951) have emphasized the sharing of the patient’s affect in the process of empathy. The reaction of the empathizing therapist is a complex one, a mixture of affect and cognition. The affect experienced by the therapist we suggest is in the nature of a signal affect, a momentary identification with the patient which leads to the awareness, ‘This is what my patient may be feeling’. It does not necessarily follow that the mood of the therapist duplicates what the patient is experiencing (cf., A. Reich, 1960). The therapist need not be depressed when his patient is depressed, nor anxious when his patient is anxious. He knows what it feels like to be depressed or anxious, but after his momentary identification with the patient he avoids further participation in his affective state.

The affect which the therapist experiences may correspond precisely to the mood which the patient has sought to stimulate in him as, for example, the masochist who tries to evoke criticism and attack. Empathy in such instances consists of recognizing that this is precisely what the patient wishes to provoke in the analyst. The affect experienced is a signal affect alerting the therapist to the patient’s motivation and fantasy. If the therapist does not recognize this, then empathy has failed and countertransference takes over.

The technical implications of these observations were succinctly stated by Little (1951) when she said: ‘The analyst necessarily identifies with the patient, but there is for him an interval of time between himself and the experience which for the patient has the quality of immediacy—he knows it for past experience, while to the patient it is a present one. That makes it at that moment the patient’s experience, not his, and if the analyst is experiencing it as a present thing he is interfering with the patient’s growth and development’ (p. 35).

**FANTASY AND EMPATHY**
The therapist’s empathically sharing the patient’s affective state, an affect which we regard as a signal affect, leads to the question of the significance of the signal. Clinical observations suggest that the signal portends the emergence of an unconscious fantasy, and that the quality of the affect is appropriate to the nature of that fantasy. This was suggested in the preceding clinical vignette and the material which follows makes the same point. In addition, however, it demonstrates the instant communication of an unconscious fantasy shared in common between therapist and patient.

A middle-aged professional man tormented by feelings of guilt and depression, demonstrated a rather typical masochistic character formation. Much of his problem centered around an unresolved feminine attitude and erotic longing for an uncle who had served as a father surrogate during his early years.

The patient was the youngest of three children and the only boy. When he was two years old his father left the family in Europe and came to the United States. The family was not reunited until the patient was ten years old. During the absence of his father the patient’s uncle, his mother’s younger brother, played the role of father surrogate. Illusions of grandeur concerning the missing father were soon displaced onto the young uncle: to the little boy, he became an idol—he was strong, self-reliant, gay, and always helpful. When the time came for the family to join the father in the United States, the patient became depressed; he did not want to leave his uncle, with whom he had played and whose bed he had shared.

The patient found it difficult to reconcile himself to his father in the new country. He yearned for the uncle and tried to get his sisters to join him in saving money to bring the uncle to the United States, but the uncle had no intention of leaving Europe. The aggrandized image of his uncle from his childhood fell far short of reality. The uncle was a ne’er-do-well and lived primarily by his wits. However, this information, to which the patient was privy in his later years, had no effect upon the image of the uncle he retained. For example, when war broke out and the Nazis seized his home town, the patient was certain that his uncle would survive; his bravery and resourcefulness would see him through. In spite of the fact that no word had been heard from him for years, the patient was certain that his uncle must have outwitted the Nazis and found his way to Israel. Later, during his analysis, the patient went to Israel and learned his uncle’s fate: he had been shot the first day the Germans occupied the village because of some foolhardy and defiant gesture.

One day, the patient began the analytic session by saying:

Last night I had the following dream. I saw myself in a house with some cousin of mine in the country. It was not yet dark, but it was no longer light, and I seemed to be all alone in the house. My cousin was elsewhere; I could not see him. I called out ‘Peter’ and somebody, in a joking way, called back ‘Joey’.

The therapist heard no more than this of the patient’s material when suddenly he found himself having a vivid visual fantasy. He saw himself at a European airport, standing in the terminal. It was the kind of airport typical of many European cities: the passengers debark from the plane at some distance from the terminal and are brought in by bus. As the therapist was standing and waiting a bus approached the terminal. Among the passengers, he recognized his father who had been dead for a number of years. Many thoughts came into his mind about this fantasy. As a matter of fact, the last time he had seen his father alive had indeed been at an airport except that the circumstances had been reversed; his father was waiting for him at the airport in New York upon his return from a visit to Europe. The visit had included a sentimental journey. The therapist had made a trip to his father's native land, and had, in fact, gone out of his way to visit the city where his father had spent his youth. It suddenly came to him that he was in a twilight zone between life and death, in that in-between land where it is possible for the living and the dead to be reunited.

The therapist’s next thought was the patient’s dream. The patient had been in a house in the country; it was not yet dark, but it was no longer light. The patient, too, was in the twilight zone, and the therapist realized immediately that the names Peter and Joey, which occurred in the dream, were actually anglicized
forms of the names the patient and his uncle used to call each other. At this point, the therapist began to emerge from his intrusive visual fantasy and heard his patient speaking: 'Last night I was watching television. The show was "Twilight Zone" ...'.

It was not hard to interpret the patient's dream. It expressed the wish to be reunited with his uncle. The dream was based upon the unconscious fantasy of reunion in a twilight area where the living and dead find each other once again. The patient and the therapist both had the same 'dream' and, with no immediate associations to the manifest content, an unconscious fantasy of the therapist's congruent with that of the patient's appeared in his mind. Without the benefit of associations to the dream, and before the process of intuition could become operative, the therapist had grasped the meaning of the patient's dream and responded with his own version of the identical unconscious fantasy. In truth, the therapist had created his own unconscious fantasy before he had any conscious awareness of the meaning of the patient's dream.

Clearly, this empathic process by which the patient's fantasy stimulated the therapist's own had taken place entirely at an unconscious level. An identification between the two of them had been effected through this shared unconscious wish that led in turn to an almost identical fantasy in both their minds. What happened next, however, was a rupture of the sense of the momentary identification and the sudden awareness on the therapist's part that his inner experience, which seemed so personal and idiosyncratic, was in effect a commentary on the patient's material. The correct interpretation had come into the therapist's mind in the form of a fantasy. It then required a set of cognitive operations for him to be able to translate this fantasy into an interpretation. At this point, the identification was broken off and was replaced by an object relationship. Thinking and feeling with the patient was replaced, as Brierley (1943) and Beres (1968a) put it, by thinking about the patient.

**SHIFTING IDENTIFICATION IN EMPATHY**

Empathic understanding of the patient is much more complicated than simply the sharing of affects, presumably experienced by the patient at the time. Sometimes the process of identification in empathy goes through several phases and undergoes vicissitudes and transformations. This is illustrated in the following excerpt.

The main complaint of a patient in his middle thirties was pathological jealousy of one of his girlfriends. Although he had many transient love affairs, they did not seem to bother him. As the analysis proceeded, a pattern of hostile aggressiveness against women, expressed in these multiple affairs, became clear but the motive for this aggression was not clear. At least two possibilities had been suggested by the material but up until this time neither had seemed predominant. The first possibility was that the pattern of hostility toward women represented a displacement of his anger against his adulterous mother; the second was that this sadism was used as a defense against his masochistic, passive, feminine identification.

During one session the patient described a date with one of his girlfriends. It was a long and somewhat startling record of one provocative statement after another. He took advantage of every feeling of inferiority or sense of insecurity that the girl exhibited in order to put her on the defensive. As this was only their second date, the girl tried her best to make a favorable impression; with each fresh assault by the patient, she tried a new tack which she hoped would make her seem agreeable and friendly, all to no avail. At one point in the conversation the young lady mentioned the fact that as a result of strenuous efforts she had recently lost quite a bit of weight. 'You're still too plump', the patient said. The woman responded, 'Oh I have pictures of myself some months ago. I was much plumper then.' 'I don't believe it', the patient said, to which the woman responded, 'Would you like me to show you the pictures?', and she rose to fetch them.
At this point in the session, the therapist had a quasi-visual image of this hapless young woman. He felt terribly sorry for her, and could practically see her with a small, wistful, desperate smile on her lips, trying to do everything to please this man and yet feeling that nothing would be of any help. He indeed felt very sorry for her. If empathic feelings had been aroused, the therapist’s identification was completely with her and not with his patient.

The patient continued. He said, ‘I was amazed to think that she would really get up and fetch those pictures for me. How foolish can anyone get? Why would she take my cruelty the way she did?’ Beyond the triumph in the patient’s voice, the therapist detected a note of remorse, a feeling of how terrible it must be to be in this young woman’s position. At this point, the therapist had another empathic reaction, but with his patient. He recalled how, during his adolescence and on a few other occasions later in life, he had himself behaved in a similar way.

The therapist was struck by this two-phase experience of empathy; first, with the patient’s feminine victim, and then, with the patient himself, especially with that aspect of the patient’s productions which suggested an identification with his own victim. It made the therapist think immediately that the second possibility mentioned above—namely, that the patient’s behavior constituted an aggressive defense against his own feminine masochistic wishes—was probably the more important element in his unconscious fantasy life at this time. But this was as far as he could go in trying to reconstruct the unconscious wish at that time.

Material elucidating the nature of the unconscious wish was not long in coming. In the next session, the patient recollected some feelings of sensitivity about having called the therapist’s attention to the patient’s dress. He then reported that he had had a restless night. Before falling asleep he had a fantasy of being on the couch in the office, getting very angry and feeling that he did not want to listen to the therapist any more. In his fantasy he got up, pointed a finger at the therapist, and began to shout: ‘Now you listen here. There are some things that I want to tell you.’ After reporting this fantasy, the patient laughed and said, ‘I realize I had nothing to say. I don’t understand what I was so angry about.’

He then reported a dream of being both a pursuing and a pursued person. The dream culminated in a struggle with a man at the edge of a brown, muddy pit. He was being very aggressive toward his adversary and tried to hit him, but could not quite do it. He work from the dream in great fright, so much so that in regressive fashion he had to turn on the lights and go to the front door to make sure that it had been properly bolted to protect him against the possibility of intruders. His associations had to do with his fear that he might discover that he had homosexual trends, and with a number of recollections from his boyhood when he had placed himself in a sexually awkward and dangerous position with men; one of the men had fondled his buttocks.

This material confirmed the interpretation suggested by the therapist's double empathic response to the woman victim and to the patient, and, in effect, this double identification repeated the elaboration of the patient’s conflict—first, the awareness of his defensive need to assault the woman, and second, the emergence of his own masochistic feminine wish. This would seem to be a clinical validation of the point made by H. Deutsch (1926) that in empathy the analyst may identify not only with the patient but with his objects as well.

NONVERBAL COMMUNICATION AND EMPATHY

There are other derivatives of unconscious fantasy activity, some of which find expression in the form of nonverbal communication, especially motor activity. From our knowledge of gesticulation, mimicry, and the dance, we know how emotion can be transmitted through an identification by way of the emotion we see in action (cf., Fenichel, 1926). Jacobs (1973) has recently called attention to motor activity which analysts often engage in unconsciously during sessions. On investigation, he was able to determine that these constituted empathic responses to the patient’s unconscious mental activity. There are colleagues who seek to penetrate
the meaning of the patient’s associations by repeating certain gestures or hand movements which they have observed in the patient. In this way, they feel that they can enter into his mood more easily and better understand the nature of his conflicts.

In a paper on noverbal communication in psychoanalysis, Arlow (1969c) observed that certain specific configurations of the fingers as they appear in photographs or in works of art are, in effect, motor metaphors through which the musculature in action captures and conveys important affective states. Gombrich (1972) discussed this point in connection with artistic representation of symbolic images. F. Deutsch (1947), (1952) reported similar observations in his studies of the posture patients assume on the analytic couch.

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An example of empathy in nonverbal communication was reported by a patient. While in the kitchen his wife asked him to prepare the tuna fish for their son’s sandwich, pointing out that the boy whom they both dearly loved liked to have the tuna fish chopped in a certain way. As he was preparing the food according to his wife’s instructions, the patient was suddenly overwhelmed by a powerful feeling of the kind of affection that he felt his wife must have for their son. This emerged by way of his identification with her in the act of preparing the food. Through this identification he could understand not only her feelings but could be brought into closer awareness with his own very intense affectionate feelings of a maternal nature which he ordinarily warded off.

Also pertinent to this discussion is the analyst’s empathic responses to the patient’s silence, which may be an important clue to the mental content being suppressed or repressed during the periods of silence (Arlow, 1961). Blos, Jr. (1972) has also emphasized the communicative significance of the patient’s silence and the importance of the analyst’s feelings and reactions to the silent patient.

**RESISTANCE AND EMPATHY**

In addition to empathizing with the affective ideational and motor components of the patient’s fantasies and conflicts, the therapist must be able to empathize with the patient’s state of resistance. This has an important bearing on the timing and the wording of interpretation. Ferenczi (1928) emphasized this point when he stated that empathy is the precondition for tact. Ferenczi makes the further point that a proper empathic understanding and tact would dictate ‘when one should keep silent and await further associations and at what point the further maintenance of silence would result only in causing the patient useless suffering’.

Shapiro (1974) draws attention to variations in the capacity of a patient to empathize with others in his environment. There is, further, one aspect of empathy that is frequently overlooked.

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in the therapeutic setting: the lack of empathy of the patient as his present self with his past self—a kind of discontinuity of identity which is occasioned by conflict and narcissistic influences. By resolving unconscious conflicts, psychoanalysis enables a patient to see himself in a continuum from his early life and to accept and tolerate hitherto repudiated aspects of himself. One result of treatment is the enriched capacity of the patient to empathize with himself.

Another aspect of the problem of empathy is the capacity of the individual to empathize with others whose experiences and background differ markedly from his own. This point has been raised in connection with the analyst’s treatment of patients with different sex, race, social, and economic background. Except for the most extreme circumstances, the therapist, even as the artist, must have the capacity to empathize with the feelings and thoughts of others different from himself.

**PERCEPTION AND FANTASY IN EMPATHY**

In the clinical material cited above, we emphasized how the process of empathy reflects the awareness of
the affective tone enveloping an emerging unconscious wish or fantasy. In previous communications Arlow (1969a), (1969b) attempted to define the relationships between persistent unconscious fantasy and perception and reality testing. He emphasized the reciprocal effects that unconscious fantasy and the data of sensory registration have upon each other. Unconscious fantasy activity establishes the mental set against which the data of sensory registration are selectively perceived, inhibited, disregarded, or transformed. Conversely, the data of perception have the power to reactivate or facilitate the emergence of unconscious fantasy activity. Sensory registrations outside the realm of consciousness can also affect the emergence of unconscious fantasy, and conscious fantasy activity may facilitate, alter, transform, or repress the registered sensory impressions even before they achieve mental representation in consciousness.

Clinical material obtained in the treatment situation may be examined from the vantage point of these principles. The sensory input, the analyst's perceptions, consists of the patient's productions. A measure of the analyst's empathic capacity lies in his ability to be stimulated by the patient's unconscious fantasy when the analyst himself is not yet aware of the existence or the nature of the patient's unconscious fantasy.

The process described above is basic in psychoanalytic experience. It furnishes, as we know from Freud (1908 [1907]), Sachs (1942), Abraham (1935), Rank (1932), Kris (1952), Beres (1962), Arlow (1961b), and others, the fundamentals for the understanding of mythology, religion, group formation, and artistic experience from a psychoanalytic point of view. All of these shared experiences which hinge on the transmission of emotion have as one of their essential components the emergence of an unconscious fantasy that is shared in common (Sachs, 1942). In religious groups and in aesthetic experience, it is the leader or the poet who creates the frame of reference that evokes in his listeners, readers, or members of his audience unconscious fantasies which correspond to his own.

In previous studies on the analogy between aesthetic experience and the psychoanalytic experience, Beres (1957), (1968b) has demonstrated the parallel between the therapist and the patient on the one hand and the poet and the audience on the other. The devices which make poetry and enable the poet to transmit to others the emotion he experiences are the same ones which make the patient's material assume configurations that transmit meaning and emotion to the therapist, making empathy possible. Contiguity, repetition, symbolism, allusion, contrast, and, above all, metaphor (cf., Sharpe, 1935); (Arlow, 1969b) are the most important of these devices. In addition to the consciously experienced fantasies, what the poet presents to the audience are derivative expressions of fantasies of which he is completely unaware. These derivative expressions are congruent with the unconscious fantasies that members of the audience share in common with him. The universally shared early biological experiences of mankind form the basis of universal fantasies, facilitating empathic communication between person and person, and person and groups. Thus poet and audience respond to similar but not necessarily identical unconscious fantasies, though neither of them is aware of the infantile, instinctual fantasy roots of his emotions. Only the process of analysis can bring these fantasies into consciousness. The interaction between audience and poet, like the interaction between patient and therapist, is an empathic one based upon the communicability of unconscious fantasy. Psychotherapy and art both serve to place a distance between the individual and his unconscious conflicts, a distance from which he can contemplate with comfort derivatives of his unconscious fantasies. In art, for reasons of defense, the experience remains at the level of derivative expressions of unconscious fantasy. In analysis, on the other hand, one seeks to overcome the defenses and reconstruct the unconscious fantasies in order to alter their persistent intrusiveness and destructive effect on the individual's functioning.

**INTUITION AND EMPATHY**

There is an important relationship between intuition and empathy. Neither intuition nor empathy are
mystical phenomena based on some kind of innate capacity to comprehend or experience. When the therapist appears to arrive intuitively at an understanding of his patient he is actually becoming aware of the end product of a series of mental operations carried on outside the scope of consciousness. Intuition, however, differs from empathy. Empathy involves identification, although transient, with a mental activity of another person. Intuition does not involve identification; it is an immediate apprehension of an idea, a thought, or a fantasy. Empathy furnishes the clue which alerts the therapist to the emergence of the correct interpretation. The intuitive understanding of the therapist follows his empathic response.

The therapeutic situation requires that empathy and intuition go on to interpretation and insight; otherwise, we would have no more than a mutuality of experience—for the patient a transference experience and for the therapist a countertransference experience.

The final step in our discussion of empathy is the issue of validation. Greenson (1960) says that when the therapist’s associations precede or coincide with a patient’s, this confirms that the therapist is on the right track. While we agree with the statement, we would add that this phenomenon is suggestive but not necessarily confirmatory. Both the empathic and the intuitive responses which arise in the mind of the therapist have to be subjected to disciplined validation. The technical implications of these observations have been considered in detail by A. Reich (1960). Empathy is an essential tool in psychoanalytic work. It facilitates the emergence of intuition and leads by way of interpretation to insight.

**SUMMARY**

This communication considers the clinical and theoretical aspects of empathy, emphasizing the role of identification and the distinction between the self and the nonself. We have stressed how empathy is mediated by the communication of unconscious fantasy shared by the patient and the analyst. The cues for this communication are both verbal and nonverbal: they emanate from words, gestures, and behavior.

The empathic process which is central to the psychotherapeutic relationship between patient and therapist is also a basic element in all human interaction and finds its highest social expression in the shared æsthetic experience of the artist and his audience, as well as in religion and other group phenomena.

From the theoretical point of view it is necessary to consider the relation of empathy to identification, projection, and countertransference, as well as the distinction between self and objects.

Empathy serves as a signal affect and leads to intuition. These are not mystical, innate phenomena and demand disciplined clinical validation.

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