Consequences of “Empathy”: Rereading Kohut's (1959) “Examination of the Relationship Between Mode of Observation and Theory”

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The 50 years since Kohut's classic 1959 paper “Introspection, Empathy, and Psychoanalysis” have witnessed widespread changes in psychoanalytic theory and practice. In particular, the emergence of what has become known as “Relational Psychoanalysis” has attracted the attention of many “second-generation” self psychologists. In my own city, a leading local self psychological professional organization devoted their 2000 annual conference, at members' request, to a day with a prominent Relational theorist. And this organization is devoting much of the 2002-2003 programming year to the issue of clarifying the distinction between relational psychoanalysis and a "relational" self psychology. This distinction has become increasingly relevant to self psychologists seeking to move from a "one-body" approach to treatment toward a

Encouragement for my thinking and support for my writing has been consistently provided by Howard Bacal, William Coburn, Bruce Herzog, and Martin Livingston.
“two-body,” “relational,” theory of reciprocal engagement, but one that retains Kohut's innovations in regard to such issues as consistent vicarious introspection, the paradigm of “repeated relationships” (Stern, 1994, p. 318), and the nature of aggression. A reconsideration of Kohut's seminal paper provides both a starting point for thinking about clinical process and a touchstone for self psychologists seeking to locate themselves in the contemporary landscape of psychoanalytic thinking.

The richness and depth of Kohut's presentation preclude addressing its entire substance in the space of a single paper. I will focus here on explicating Kohut's first section, “An Examination of the Relationship Between Mode of Observation and Theory” (pp. 205-212). This section embodies: (1) Kohut's crucial assertion that "we designate phenomena … as psychological if our mode of observation includes … [vicarious introspection] as an essential constituent (p. 209) and (2) his operational description of “vicarious introspection” as the means by which we come to an understanding and explanation of the patient's introspective reports and external behavior. In its time, it was a radical step away from the conventions of Kohut's own analytic milieu. In addition, the implications of Kohut's operational framework for practice, some of which I will illustrate below, bear restatement and elaboration as a means of delineating a distinctively self psychological sensibility toward thinking about and working with patients.

The Relationship Between Mode of Observation and Theory

Kohut begins by delimiting the psychological field as the domain of a person's “thoughts, wishes, feelings, and fantasies.”

The inner world [of another person] cannot be observed with the aid of our sensory organs. Our thoughts, wishes, feelings, and fantasies cannot be seen, smelled, heard, or touched. They have no existence in physical space, and yet they are real, and we can observe them as they occur in time: through introspection on ourselves, and through empathy (i.e., vicarious introspection) in others [pp. 205-206].

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1 I have chosen, for purposes of clarity, to replace empathy, even in direct quotes, with vicarious introspection to emphasize that, in the 1959 paper, Kohut is referring to empathy as a mode of observation rather than as a form of relating or a source of therapeutic action.
Kohut asserts that “the only fruitful definition [of such psychological phenomena] is operational”—that is, the nature of psychological phenomena is delimited through the means by which we apprehend it.

We speak of physical phenomena when the essential ingredient of our observational methods include our senses, we speak of psychological phenomena when the essential ingredient of our observation is introspection [by the patient] and [vicarious] empathy [by the analyst]

Kohut then describes the crucial aspects of the operation of gathering psychoanalytic data. He tells us what we are to observe: that is, what the patient can report, through acts of introspection, about his or her “thoughts, wishes, feelings, and fantasies.” Yet, even by the article’s second paragraph, the terms of observation Kohut sets out, as regards the observing analyst, are more restrictive than they seem at first glance. In particular, the analyst's inner world also includes “thoughts, wishes, feelings, and fantasies.” But for psychoanalysis, as Kohut “operationally” defines it, only those of the analyst's thoughts, wishes, feelings, and fantasies arrived at through vicarious introspection fall within the psychoanalytic domain.

Over the next four pages (pp. 206-209), Kohut delimits which aspects of the analyst's inner world are included within and which are excluded from “vicarious introspection.” He speaks of vicarious introspection, not “in the narrow sense of an actual operation that is taking place at a particular time,” but “in the widest sense of an attitude of the observer [the analyst] toward the phenomena under investigation” [i.e. the patient's inner world]

A colleague of some renown who ... was extremely small in stature received a call [for] a consultation.... [At] the arranged time the new patient arrived.... About to enter the waiting room to greet him, the analyst suddenly stopped at the threshold and, momentarily, stood transfixed. There in front of him was a Paul Bunyan of a figure, fully six feet, eight inches in height, weighing perhaps 260 pounds, and wearing cowboy boots and a ten gallon hat. For several more seconds

2 Mark Gehrie provided the second rendition of the “Paul Bunyan” anecdote.
the analyst looked at him in silence. Then, with a shrug of his shoulders and a resigned gesture, he motioned toward his office. “Come on in, anyway,” he said [p. 289].

Jacobs goes on to comment, “This opening phrase … highlights the well-known yet sometimes overlooked fact that from the very outset of treatment, transferences are activated in the analyst as well as the patient” (pp. 289-290; emphasis added). Thus far, Jacobs presents what we can imagine to be the analyst's instantaneous introspection of his own “thoughts, wishes, feelings, and fantasies.” Kohut explicitly asks us to go further; the analyst's introspection must be vicarious, that is:

Only when we think ourselves into his place ... by vicarious introspection, begin to feel his unusual size as if it were our own and thus revive [our own] inner experiences in which we had been unusual or conspicuous, only then do we begin to appreciate the meaning of that the unusual size may have for this person and only then have we observed a psychological fact [pp. 207-208; emphasis added].

The point here is that Kohut's notion of “the total attitude of the observer” (p. 206) places the priority of observation on the patient's experience. We consult our own inner experiences in an attempt to evoke, within ourselves, in Evelyn Schwaber's (1979) classic phrase, “how it feels to be the subject, rather than the target” (p. 472; emphasis added) of the patient's subjectivity (i.e., of the patient's ideation, affect, and impulses). The second rendition of this anecdote makes just that point. Mark Gehrie (2001) insists:

It was not a story about the impact in the analyst! The point was precisely about “the priority of orientation on the patient's experience,” and in this instance the analyst's ability to use that in the construction of an empathic response: i.e., I see you are disappointed in how small I am, how could I possibly be of help to you, but despite it all, “Come in anyway.” [The analyst's] response demonstrated his empathically-derived understanding of the patient's disappointment in the analyst's appearance, as if his small stature would limit his ability to help such a large and imposing person [pp. 2-3].

“Scrutiny” as an Alternative to Vicarious Introspection

Continuing Kohut's (1959) delimitation of what is “psychoanalytic,” we note that the analyst's “thoughts” may well include the process of scrutiny as “the major tool of psychoanalytic observation”
(p. 209; emphasis added), which Kohut rejects in favor of “vicarious introspection.”

Here we must consider the objection which may be raised by some that the major tool of psychoanalytic observation is not introspection but scrutiny by the analyst of a certain kind of behavior of the patient: free association [p. 209; emphasis added].

In both cases, scrutiny and vicarious introspection, the patient is providing the same material: “introspective self-observation ... to which the analyst is witness” (p. 209). Kohut suggests that the “analyst's ability to maintain a level scrutiny” (Friedman, 1997, p. 35) is seen as the major component of analytic work by traditional analysts. The contemporary vitality of this stance—suspicious anticipation of irregularities—is borne out by Michael Franz Basch (1995): “I asked the candidate, 'What were you thinking during the patient's silence?’ ‘I wondered what he was trying to get away with,' my student replied” (p. 367). In contrast, Kohut implies that analysts should avoid such scrutiny. But he does not explicitly define scrutiny.

The etymological derivation of the word scrutiny itself provides unexpected help to our understanding. The Concise Oxford Dictionary (1960, p. 1116) begins a list of related entries with the term scrutin (italicized to indicate that it is a French word), referring to a method by which a citizen votes for representatives of a smaller or larger electoral district. “Scrutineer” is then “a person examining ballot papers for irregularities” (emphasis added). “Scrutiny” is a “critical gaze, close investigation, examination into details ... when suspicion of irregularity makes it desirable” (emphasis added). The analyst's “scrutiny” then goes beyond close examination of the patient's presentation and extends to anticipation and suspicion of irregularities. Lawrence Friedman (1997) comments that analysts

welcome what the patient is saying, but we think he's revealing it in order to conceal something more important.... Justified or not, the profession's response to ... Kohut was surely influenced by the fear that [he was] diluting a fundamental, adversarial attitude [p. 30; emphasis added].

This critique of Kohut's influence persists because, in contrast to “a fundamental, adversarial attitude,” vicarious introspection demands that we suspend such suspicions and “think ourselves into [the patient's] place” (pp. 207-208; emphasis added).

Contrary to a popular stereotype, this does not mean that Kohut calls upon the analyst to think only the same thoughts as the patient.
In both cases, scrutiny and vicarious introspection, “the psychological insights of the analyst are frequently ahead of the analysand's comprehension of himself” (p. 209). Yet, for Kohut, the analyst reaches this position, ahead of the patient, by a process, not of scrutiny, but as “the result of the trained introspective skill [of] the analyst used in the extension of introspection (vicarious introspection)” (p. 209; emphasis added). Vicarious introspection, as an attitude of the observer, reflects an attempt to establish a resonance with, rather than to get at what is behind, the patient's material.

**Taking Analytic Material in a “Straight” Manner**

Jule Miller's (1985) description of supervision with Kohut between 1978 and 1981 highlights this contrast between scrutiny and vicarious introspection. (Kohut may or may not have given the same supervision in the late 1950s, but what Miller describes is clearly implicit in the 1959 paper.) Miller's rendition is valuable in that it highlights Kohut's concept of the analytic space and task.

Miller's patient had mistakenly arrived an hour early for his session and seen someone else in the waiting room, leading to a state of anxiety and dislocation. In reaction, the patient felt, and acted on, an impulse to visit a nearby bookstore to look at homoerotic material. Miller interpreted to the patient that the sense of dislocation had led to the seeking out of the homosexual stimulation in an attempt to restore self-cohesion. But Miller, coming from what he himself describes as “a more traditional analytic climate” (1985, p. 16) also scrutinized the patient's report and found a disavowed “irregularity” with which he confronted the patient. “I added, however, he had set up the situation by coming an hour early (he was well aware of the time) and then had reacted, in part, blaming me as if I had deserted him and been involved in causing his dislocation” (p. 15). Kohut's supervision and Miller's response is worth quoting at length, including interpolated references to Kohut's ideas on vicarious introspection versus scrutiny.

Kohut disagreed with my interpretation that the patient had arranged the incident. He said that although it might be correct, he felt it was an unnecessarily complicated initial formulation. He enunciated a basic principle: one should take analytic material first in a “straight” manner, as if it means what it seems to mean…. Kohut felt the tendency of analysts to look first for a hidden meaning [to scrutinize—to anticipate irregularities] was a mistake. In this specific instance he added that he would have been inclined [vicarious introspection as an attitude] to believe that the patient was eager to see me. [This might reflect a way in
which Kohut, through vicarious introspection, connected with his own memories and feelings of being a child eager to see his father. Like a young child, eager to see his father, he had come early to the session. Once he opened the door and found the other patient sitting there, the sequence was much as I had described it, but the patient's motivation should be regarded first as one of an intense, childlike wish rather than an attempt to “set up” a situation of disappointment. Interpretation should be directed primarily along those lines [pp. 15-16; emphasis added].

Miller notes, “This was a strange conception to me, since I came from a more traditional analytic climate” (p. 16). In this instance, Miller apparently saw the patient as having “set up” the situation in order to reenact a theme of early disappointments and fulfill a forbidden aggressive wish by “blaming” the analyst in the present, while disavowing the roots in the past of the disappointment and anger. Miller (1985) continues:

Following my consultation with Kohut, the patient again brought up the incident, which he considered of “extraordinary importance.” This time I was able to modify my interpretive understanding. I emphasized his strong wish to see me and his coming early as an expression of that wish, rather than as an attempt to “set up” a frustration. He was visibly relieved at this second formulation, and it was followed by a flood of material, including the comment that it felt much more right to him than what I had said previously, which he had acknowledged made intellectual sense but which he could not feel. Kohut was correct in stating that I had underestimated the importance and the intensity of the patient's wish to see me at this particular time in the analysis [pp. 15-16; emphasis added].

Miller's realization involves an explicit reconfiguration away from the scrutiny of hidden, forbidden wishes and toward the vicarious introspection of “analytic material first in a ‘straight’ manner, as if it means what it seems to mean” (p. 5). Further, this shift does not demand the assertion of “empathy” as a mode of interaction or as a source of therapeutic action, although these issues demand their own study. Instead, it flows directly from Kohut's (1959) substitution of consistent vicarious introspection for the various forms of scrutiny.

3 See the discussion of the paradigm of “repeated relationships” in Stern (1994, p. 318).
4 Compare to Tansey (1992), a contemporary relational analyst, who writes that the patient's motivation comprises “not only a desire for positive change but also powerful unconscious elements of self-sabotage and self-fulfilling prophecy” (p. 311; emphasis added).
The Analyst's Subjectivity and the “Decisive Observation”

Returning to the 1959 text, in a passage that seems to have been overlooked by both sympathetic and critical commentators, Kohut addresses the question of that part of the analyst's own subjectivity that reflects him- or herself, rather than the patient. He writes that “introspection and [vicarious introspection],” despite being “essential constituents of observation, are often … amalgamated with other methods of observation” (p. 209). These “other methods” presumably reflect the analyst's thoughts, wishes, feelings, and fantasies that make up the analyst's subjectivity. Not only this, but the analyst's subjectivity frequently contradicts that of the patient. This is especially the case when the patient asserts that he has sustained unprovoked injury at the hands of some third party or of the analyst him- or herself. Kohut's comment recognizes that it is untenable to picture that analyst as being in such synchronization with the patient that such contradictions between the two subjectivities fail to arise.

Nor do Kohut's comments demand that all divergences of view between analyst and patient are the result of countertransference interference.5 The operational issue that arises is the clinical handling of such contradictions. That is, whatever these other methods may inform the analyst, the “decisive observational act, however, is [vicariously introspective]” (pp. 209-210). That is, the decisive observation, which determines whether the analyst stays silent or if he or she comments on what is said, comes from the viewpoint of “how it feels to be the subject rather than the target of the patient's needs and demands” (Schwaber, 1979, p. 472). In this context, the issue of countertransference interference arises when the analyst stops short of a stance of vicarious introspection and interprets the contradiction of his or her own renditions of the situation as the patient's “distortion” or “resistance” (see Bacal and Thomson, 1998; Ornstein, 1998).

Paul Ornstein (1998) has recently offered an example that will help to illustrate how a clinician operationalizes Kohut's theoretical approach. I chose Ornstein's example because (1) his historical and theoretical proximity to Kohut identifies him as a leading exponent of the central tenets of self psychology and (2) his examples provide clarity and accessibility. Ornstein describes a situation, common in both contemporary literature and clinical discussions, of the analyst being devalued for a perceived inability to recognize and tolerate the depths of

5 For a discussion of instances in which such divergences do represent a countertransference interference, see Bacal and Thomson (1998).
the patient's affect. The patient, Mr. T,

*complained during one of his Friday sessions that he experienced his childhood as if he had lived in a dungeon.... He expressed these thoughts at a time when he was already beginning to free himself from the consequences of those experiences. I was therefore surprised that he compared his childhood to living in a dungeon. In his Monday session, Mr. T complained bitterly and accused me of having disrupted his efforts at experiencing himself once again in his childhood dungeon. He believed that I could not tolerate his experiences and ... [that I] asked him for his reflections, instead of remaining with his experiences and accompanying him in his descent into his dungeon [Part II].*

Ornstein's (1998) own experience, drawn on direct, rather than vicarious, introspection differed in essentials from the one ascribed to him by the patient: “Although I was astonished at this new image of his childhood on Friday, I thought I was able to ... accompany him and resonate with his affects. *I did not experience the task [as] painful or repulsive*" (Part II, emphasis added). Ornstein's response to this discrepancy is distinctively self psychological. His own direct introspection contradicts the patient's rendition of his analytic behavior and of his underlying intentions. But Ornstein's “decisive observational act, however, is [from the viewpoint of vicarious introspection]” (Kohut, 1959, pp. 209-210).

*Nevertheless, this is how he pictured the reasons for my interference with his efforts. I then responded by saying that, I could well understand his embittered complaints, if he experienced me as not accompanying him on his descent into his dungeon and actually obstructing his descent [Ornstein, 1998, Part II; emphasis added].*

The patient paused and then became self-reflective. He noted that it seemed to him that Ornstein had failed to accompany him on the descent. Then he added: “Perhaps it was my anxiety that you would not accompany me that created in me the feeling that you did not remain with me. I know, I am very sensitive on this score” (Part II).

Ornstein explains his clinical stance in a manner directly reminiscent of Miller's (1985) report of Kohut as a supervisor, insisting, “one should take analytic material first in a ‘straight’ manner, as if it means what it seems to mean” (p. 15). In Ornstein's (1998) words: “Even if this image [i.e., the patient's rendition that is at odds with the analyst's experience] is over drawn it is important to accept it, to understand it, ...
rather than view it and interpret it as a distorted perception, by insisting that I had, indeed, accompanied him" (Part II; emphasis added). Ornstein responds to the difference between the patient's perceptions and his own by consistently focusing “on the patient's inner reality (on his subjective experience)” (Part I), a stance directly derived from Kohut's insistence that the “decisive observational act” (1959, p. 209) is obtained through vicarious introspection.

**Self Psychology and “Relational Psychoanalysis”**

Ornstein's stance and response represent a Kohutian sensibility, derived directly from the “Empathy” paper. The value of reconsidering “empathy” arises in juxtaposing this stance with the ways an analyst representing other traditional and contemporary orientations might view this clinical passage. The present purpose is not to demonstrate the superiority of self psychological theory or practice over those other orientations. Instead, it is to delineate differences in approach, but with the caveats inherent in all such comparisons. That is, any attempt to generalize about the approach of any given “school” in psychoanalysis is bound to provoke the protest that the ideas of some writer or writers within that school are being overlooked. What is more, the specific clinical choices of any particular practitioner, made on a pragmatic or theoretical basis, defy any such generalization. As a result, the comparisons that follow are inevitably “illustrative … rather than evidentiary in their nature” (Cooper, 1996, p. 897). And, like any such comparisons, they should be measured against the reader's experience in reading the literature, in working with patients, and in his or her own discussions about theory and practice.

These comparisons usually begin by noting Stephen Mitchell's (1988) three-part division of psychoanalytic frameworks, which has been widely cited and followed in contemporary literature. The first division, the traditional analytic orientation, is described as a “drive-conflict” model. This model portrays the patient as a closed system, and the analyst as an objective, external observer, for whom “nothing is more characteristic … than [an] inclination to see through everything” (Friedman, 1997, p. 30). For many of these analysts, the disparity of the patient's and the analyst's renditions of Mr. T's Friday session would be taken as the starting point for an approach that presumesthe patient's transferenceally derived distortion of the analyst's behavior and intentions. It is this “fundamental, adversarial attitude” (Friedman, 1997, p. 30) that was likely in Kohut's
mind when he “enunciated a basic principle: one should take analytic material first in a ‘straight’ manner, as if it means what it seems to mean” (Miller, 1985, p. 15). The specific technical response based on the drive-conflict model could include, on a pragmatic basis, a temporary restraint from confronting the patient with this disparity. But the ultimate goal would remain the resolution, through consistent interpretation, of what was presumed to be the patient's distortion.

For contemporary self psychologists the most relevant comparison of Kohut's stance is with Mitchell's (1988) second division, the “relational conflict” models. In this context, no survey could do justice to the variety of theory and practice that has emerged as “Relational Psychoanalysis.” But Relationally oriented writers seeking a synthesis of ideas note two common features that would suggest a clinical direction diverging from Ornstein's self psychological approach. The first of these addresses the role of repetition in clinical process. Irwin Hirsch (1994) describes the “model of clinical action,” preferred by Mitchell, the preeminent relational theorist:

Problems in living are a function of adhesion to the loved ones of the past, an inability to separate from the familiar and the familial.... It reflects an active striving to maintain old attachments.... In this context, patients in analysis are viewed as both striving for new and richer experience while also looking to repeat internalized old patterns, which most define one's sense of self [p. 181; emphasis added].

From this paradigm of “repeated relationships” (Stern, 1994, p. 318), which has been widely adopted in contemporary relational approaches, Ornstein’s response would be portrayed as having missed an important aspect of the interchange, that is, the patient's looking to “repeat the old and bad experience” of a “familiar” interchange with a “depriving or harmful internalized figure” (Hirsch, 1994, pp. 181-182; emphasis added).

The second feature that appears common to relational conflict models—interpretation of the countertransference—is a technical corollary to this paradigm of “repeated relationships.” This paradigm (Stern, 1994) focuses on the patient's tendency to organize his or her current experience of the analyst (and analytic relationship) in terms of familiar pathogenic relationship patterns from the past and (via projective identification) unconsciously to elicit the analyst's unwitting participation in these old interactional scenarios.... Theorists who emphasize the repeated relationship tend also to emphasize the role of interpretation ... particularly interpretation of the transference-countertransference enactments [p. 318].
Elaborating the technical implications of this model, Michael Tansey (1992) writes:

Although the relational-conflict analyst remains deeply interested in the patient's views and makes every effort to understand how they may be “plausible,” he is not reflexively called on to subjugate what may be his own dissonant experience in an effort to see things from “within” the patient's perspective; quite the contrary, it is often by paying closer attention to his own, at times highly discordant, responses to the patient that the analyst may eventually come to gain a clearer and deeper appreciation of what is happening in the patient's shoes [p. 312, emphasis added].

And the thrust of the relational model of therapeutic action suggests that confrontation of the patient, whose motivation comprises “not only a desire for positive change but also powerful unconscious elements of self-sabotage and self-fulfilling prophecy” (Tansey, 1992, p. 311; emphasis added), would be an inevitable and crucial aspect of the treatment. While allowing for individual differences among relationally oriented analysts, this viewpoint stands in clear contrast to Kohut's supervision of Miller (1985): “The patient's motivation should be regarded first as one of an intense, childlike wish rather than an attempt to set up a situation of disappointment.” (p. 6), as well as to Ornstein's (1998) proviso: “Even if this image [of the patient's rendition that is at odds with the analyst's experience] is overdrawn it is important to accept it, understand it” (Part II; emphasis added).

**Self Psychology and the “Developmental Tilt”**

In considering the continuing value of “empathy” to contemporary self psychology, Mitchell's (1988) third division, that of “developmental arrest” or “developmental tilt” models, seems less instructive. These terms have gained currency in the literature as shorthand for references to aspects of Kohut's or Winnicott's ideas that focus on maintaining relatedness, rather than recognizing

6 While the patient's experience is seen as “plausible” (see Gill, 1983), rather than inherently distorted, in this model, which remains within Stern's (1994) relational paradigm of repeated relationships (p. 318), the patient remains rendered as the *initiator* of the analyst's response. Irwin Hoffman (1983) writes “Because the analyst is human, he is likely to have in his repertoire a blueprint for approximately the emotional response that the patient's transference dictates and that response is likely to be elicited, whether consciously or unconsciously. Ideally this response serves as a key—perhaps the best key the analyst has—to the nature of the interpersonal scene that the patient is driven by transference to create” (p. 413; emphasis added)
“relational conflict” (Hirsch, 1994, p. 181). For example, Steven Cooper and David Levit (1998) write, “Each of these [British Kleinian and American Interpersonal] models actually differs in some ways from the ‘developmental tilt’ (Mitchell, 1988) models of Kohut and Winnicott, which emphasize more the need of the analyst to meet certain aspects of the patient’s experience of impingement and deprivation” (pp. 606-697; emphasis added). Yet their article includes no explication of the phrase “to meet certain aspects of the patient's experience,” apparently a reference to what Barry Protter (1988) describes as “a developmental tilt ... which insists on seeing the analyst as playing a remediating or restorative role” (p. 512; emphasis added). Nor do Cooper and Levit (1998) refer to the ongoing controversy in self psychology over this exact issue.7 Such references to “developmental arrest” and “developmental tilt” models function as proxies for references to Kohut and/or Winnicott, whose approaches are associated with “corrective emotional experience” (Frank, 1992, p. 74); “treatment [consisting] more of caretaking than what many of us know as psychoanalysis” (Hirsch, 1994, p. 180); “the tendency to portray the patient as passive, detached and victimized ... which I have characterized as the ‘Sleeping Beauty’ model” (Mitchell, 1984, p. 492); and “models [that] allow the analyst to gratify the patient in the context of addressing early deprivations and tend to play out patient's and analyst's fantasies of a magical cure”8 (Slochower, 1991, p. 710).

One value of reconsidering “Empathy” is to begin to disentangle Kohut's ideas from this condensed amalgam of Kohut and Winnicott, which obscures the specific distinctions of the theory and practice that each developed. Ornstein (1991) reminds us that Kohut began with: “the psychoanalytic exploration of patients with narcissistic personality disturbances and ... the study of the working through of these (then called narcissistic) transferences” (p. 188). The fruits of this study (Ornstein, 1991) was Kohut's recognition that these patients'

- expectations, needs, demands, and fantasies centered around two main issues.... First, the patients expressed their need for someone to serve as an echo, and for affirmation, approval, admiration, and the bolstering of their self-esteem.... This “mirror transference,” once

7 See also footnote 12. Cooper and Levit (1998) include Winnicott, but not Kohut, among their references; Protter (1988) includes Kohut, but not Winnicott, among his.

8 While Slochower (1994) goes on to critique Mitchell's portrayal of this aspect of Winnicott, she describes a characterization of “developmental tilt” or “developmental arrest” models (that is, Kohut and Winnicott) that has gained widespread acceptance, especially in formal and informal case discussions.
established ... served as the necessary “psychic glue.” ... The second cluster of experiences, which Kohut called an “idealizing transference” is expressed by the need of some patients to attach themselves to the analyst by putting him on a pedestal.... These expectations and needs, when experienced as having been met, also lend the patient a modicum of cohesiveness and vitality as well as inner calm [pp. 188-189].

Kohut explicitly legitimized the patient's need for “psychic glue” in life and in treatment. And many writers have noted that “because the self psychologist is ‘tuned more sharply to how it feels to be the subject rather than the target of the patient's needs and demands’ (Schwaber, 1979, p. 472), there is a more collaborative and less adversarial quality to the therapeutic process than that which is informed by the more traditional analytic perspectives” (Bacal, 1995, p. 355). Yet this is not the result of seeking to offer “a new atmosphere for conducting analysis, [nor] a special sort of humanity or kindness, but simply (and profoundly) a new theory” (Goldberg, 1985, p. 63). Rereading “Empathy” as “the actual beginning ... of Kohut's [theory] of the self and its disorders” (Ornstein, 1993, p. 5) then helps self psychologists to locate ourselves in contemporary theory and practice, not by external characterizations (and sometimes misattributed stereotypes), but on self psychological terms.

Vicarious Introspection Within the “Widening Scope” of Treatment

The relevance of “empathy” to contemporary self psychology does not end at that point. We usually envision the content of vicarious introspection as the patient's subjectivity—the combination of ideation, impulse and affect the patient brings to us. But there is another level of the patient's experience, that is, the state—cohesive or fragmented; vital or depleted; realistically confident, grandiose, or mortified—of the patient's underlying self system. This self-stabilization9 determines and supports the patient's capacity for the psychological functions required to participate in an analytic process. In many instances, we can count on a degree of underlying self-stabilization sufficient to allow us to focus, for the most part, on vicarious introspection of the patient's subjectivity. But with some patients (perhaps with all patients, some of the time), it seems that the two levels do not move concurrently. Vicarious introspection and interpretation of the patient's ideation, impulse, and affect does not seem to provide the consistent self-stabilization required for self-reflective inquiry

9 “The subjective perception of the self as ‘stabilized’ is the opposite of feeling prone to [disintegration, depletion, and grandiosity or mortification] and the term I will use for that combination of support, enhancement, and comfort of the self that describes a self-selfobject experience” (Lenoff, 1998, p. 148).
and exploration.

For example, Gehrie (1993) writes of Ms. B, a patient with a traumatic history of abandonments by mother and sexual abuse by father and brothers.... The empathic grasp of this patient's subjective world ... precipitates anxiety that is characteristic of her continual state of partial fragmentation—a chronic traumatic state—which is mitigated only by the fantasy that the analyst will become her lover, and she will not experience this as intrusive and damaging, as with sexuality in real life ... [and] has led to a mixed result, in which she experiences the available mirroring and understanding as always inadequate because they do not lead to the act of sexual intimacy, and therefore, for her, are essentially rejecting in quality [pp. 1086-1087].

Even in clinical situations less dramatic than that of Ms. B, we encounter patients for whom “the available mirroring and understanding,” because they do not fulfill the equivalent of Ms. B's fantasy of intimacy with the analyst,10 are “always inadequate” (p. 1086).

In these situations in which patients seem stalled in treatment or even deteriorating, clinicians are called upon to push at or go beyond the conventional practice of the orientation in which they were trained. Some writers have suggested that a form of pragmatic clinical eclecticism (as opposed to theory-building) is inevitable and itself the “normal science”11 of psychoanalytic practice. Charles Spezzano notes Mitchell's claim “that mixing models of mind and development produces unstable hybrids” (Spezzano, 1998, p. 384), yet quotes Mitchell as going on to write that:

10 Bacal (1995) describes these fantasies, which are frequently difficult or impossible to fulfill in clinical work, as “phantasy selfobjects.” “Selfobject experiences may be substantively fueled by the patient's creative imagination, that is, by the elaboration of conscious or unconscious phantasy. This is often a significant component of the patient's hope that the therapist will respond in ways that will meet his or her basic psychological needs, perhaps for the first time. When phantasy plays a predominant part in the patient's sense of the selfobject, we may speak of a phantasy selfobject. In this situation, the therapeutic relationship is particularly vulnerable to the therapist's potentially disruptive responses” (p. 362; see also Lenoff, 1998).
11 This approach, in Mayer's (1996) view, provokes “echoes of what Kuhn and others have described as the pursuit of normal science. Inconsistent or contradictory observations are assimilated by making plenty of room for anomalies, such that an original and overarching paradigm can be retained, while it stretches to incorporate as many new observations as possible” (pp. 173-174; emphasis added).
To claim that model mixing is conceptually unstable and costly says nothing about how analysts use psychoanalytic theory in the consulting room [where] an analyst may use concepts from many different authors, but reset those concepts within an implicit, unarticulated, but generally consistent metapsychological framework of his own design. Similarly, the fact that some clinicians draw on different models for understanding and treating different kinds of patients, or the same patient at different times, says nothing about whether these various models fit meaningfully together in any logical sense [Mitchell, 1988, p. 60].

Similarly, Joseph Sandler (1983) proposes that analysts develop “private theories”:

*With increasing clinical experience the analyst, as he grows more competent, will preconsciously (descriptively speaking, unconsciously) construct a whole variety of theoretical segments ... which have the quality of being available in reserve, so to speak, to be called upon whenever necessary. That they may contradict one another is no problem [p. 38].*

Elizabeth Lloyd Mayer (1996) writes that Sandler regards such private theories as an adaptive response to the useful but constraining nature of our public theory; thus he is able to argue that contradictions between private and public theory can and do “coexist happily” in the minds of analysts, as long as they remain unconscious (or preconscious) [p. 172].

Some clinicians are comfortable to work within this pragmatic eclecticism and practice effectively and ethically. Other clinicians feel more of a need for a theoretical and clinical anchor, even as they conduct treatment with patients for whom therapeutic engagement “rests on [access to and] alteration of emotional patterns of experience which may not be accessible by ordinary analytic means” (Gehrie, 1993, p. 1092). Mayer (1996), however, asserts that the problem goes beyond this individual need:

*Contradictions between private and public theories [do not] coexist as happily as Sandler suggests.... As time goes on, many analysts start to feel less and less like “real” analysts doing “real” analysis.... Those analysts develop an increasing and often uncomfortable sense that much of how they think they help their patients doesn't fit with the model of analytic technique to which they in principle adhere.... A variety of consequences can follow—ranging from an insistent muddiness of thinking which is required to prevent contradictory ideas from*
encountering each other, to severe and disturbing lapses in conscience [pp. 172-173].

Mayer (1996) documents her concern with an uncommon case example in which a colleague's disjunction between his public and private theories led to a lapse in professional discipline sufficient to allow a sexual involvement with his patient (pp. 175-180). What is much more common is concern about "muddiness of thinking which is required to prevent contradictory ideas from encountering each other," and what it means to be a "real" self psychologist doing "real" self psychological treatment.

Gehrie (1993) frames the problem well:

While our initial diagnostic impressions and treatment recommendations are often incorrect, our treatment goals are adjustable with changes in understanding. Adjustments in our goals should be reflected in adjustments in technique, and eventually a picture of our justifiable expectations are likely to emerge [p. 1085; emphasis added].

While Gehrie (1993) himself differentiates sharply between psychoanalysis and psychotherapy (pp. 1084-1085), he addresses the issue of technical flexibility within a self psychological perspective in a manner that transcends the analysis/therapy controversy. And prominent among the sources he cites to support the call for flexibility in goals and technique is empathy:

Particularly in the case of patients with traumata at early, presymbolic and/or preverbal levels, interpretations couched in symbolic, verbal terms will be less likely to be affectively understood and used by the patient.... Under these conditions, interpretations often rely on alternative modes of communication, which are created by the analyst out of his own personal repertoire,12 and subject only to his own personal and ethical limits. Kohut's (1959) definition of psychoanalysis as that field defined by the acquisition of empathic and introspective data also suggests that “whither the analysand goeth, so must the analyst go,” if contact based on empathy is to be maintained [p. 1097; emphasis added].

“Empathy” reminds us that it is by consistent vicarious introspection with the patient's underlying self-state that we can frame our clinical responses. Our evaluation of those responses will remain the same self-psychological criteria that Ornstein (1990) has outlined: “how well the analyst will be able to understand the patient's communications, how well he/she will be able to get this understanding across (verbally and
nonverbally), and finally how well this will enhance the patient's deepening self-explorations by making him/her feel understood” (p. 479).

In this way, empathy rewards our rereading and reconsideration by serving as a touchstone, allowing clinicians to adapt Kohut's innovations to the specific needs of their own work and patients, while remaining within distinctively self-psychological sensibility.

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12 Gehrie (2001) also differentiates sharply “as central to how we understand our work,” between “empathy as a mode of observation [as opposed to] its definition as a form of response or a mode of relating…. [I]t is one thing to use empathy to understand, and therefore be able to help the patient to understand what he or she may be experiencing, and another thing altogether to use empathy as a basis for then providing for the patient what they believe they require or desire from you” (pp. 1-2) In fairness, my own use of the quote may well be read as implying a wider continuum of “alternative modes of communication” than Gehrie himself had in mind. But I believe that Gehrie's description remains relevant to this discussion because of the centrality with which he places empathy in the consideration of this highly controversial issue. The wider recognition of such centrality of empathy as the “the actual beginning … of Kohut's later systematic study of the self and its disorders” (Ornstein, 1993, p. 5) might help focus the exploration of this issue among self psychologists. The authors included in Bacal's 1998 edited volume and Lenoff (1998), among others, make a case for the validity and self psychological provenance of a continuum of clinical responses embodying “optimal responsiveness” or “optimal provision” (Lindon, 1994)
References


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