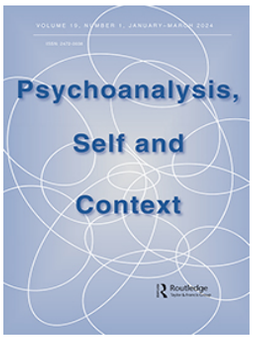

Psychoanalysis, Self and Context

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/hpsp21

Forms and transformations of empathy: Subtleties and complexities of empathic communication

Jill Gardner

To cite this article: Jill Gardner (2024) Forms and transformations of empathy: Subtleties and complexities of empathic communication, Psychoanalysis, Self and Context, 19:1, 80-93, DOI: 10.1080/24720038.2023.2266711

To link to this article: https://doi.org/10.1080/24720038.2023.2266711

PSYCHOANALYSIS, SELF AND CONTEXT
2024, VOL. 19, NO. 1, 80–93
https://doi.org/10.1080/24720038.2023.2266711

Routledge
Taylor & Francis Group

Forms and transformations of empathy: Subtleties and complexities of empathic communication

Jill Gardner, PhD

International Association for Psychoanalytic Self Psychology

ABSTRACT

The role of empathic understanding and responsiveness is central to therapies anchored in self psychology and intersubjectivity theory. The process of achieving and communicating empathic understanding, however, is complex and multiply determined. Understanding on a theoretical level the rationale for employing an empathic mode of observation and response does not necessarily mean that one knows how to do so effectively. To help bridge this gap between theory and practice, the author offers a series of concrete, experience-near suggestions or principles for enhancing empathic understanding and responsiveness. Starting with Kohut, several writers have stated their belief that empathic resonance is a skill that can be developed through training and learning. The author references these previous efforts and adds to them here by defining several choice points and subtleties of how we respond that can make empathic communication more effective. These suggestions emerged from the process of training and supervising mental health professionals in all disciplines and thus are presented as a resource not only for clinicians, but also for teachers and supervisors.

KEYWORDS

Empathic communication; forward edge; organizing principles; subjective experience; teaching empathy; supervision

My overall goal in this article is to link theory and practice about empathy in a concrete, experience-near way by describing some of the practical issues and choices that go into establishing effective empathic understanding and communication. Embarking on such a project, I think it's important first to answer two questions: 1) Why do we care so much about empathy anyway?; and 2) Why do we need yet another article about it? There are three different perspectives from which I'll address these questions and frame what follows.

First, the focus on empathy in self psychology and intersubjectivity theory rests on our particular understanding of development, psychopathology and therapeutic action. So at the outset I will summarize briefly our most relevant underlying theoretical assumptions about these topics in order to clarify the rationale for talking about empathy.

A second context has to do with the broad appeal and utility of these ideas. Although self psychology and intersubjectivity theory emerged originally from the work of psychoanalysts and psychoanalytic researchers, the concepts embodied in these theories have wide applicability to clinicians from all mental health disciplines and practicing in widely varied clinical settings. Our published case studies, however, tilt strongly towards examples of people in psychoanalysis or long-term, intensive psychoanalytic psychotherapy. Before entering full time private practice, I spent many years working in a hospital-based community mental

CONTACT Jill Gardner jrgardner@sbcglobal.net International Association for Psychoanalytic Self Psychology, 1572 Maple Ave., #604, Evanston, IL 60201

health center and teaching in a social work school, where people in the students' caseloads included some of the most psychologically, socially, economically, and environmentally challenged individuals. In these settings, I have seen how much a deep and effective empathic connection can make a profound difference in peoples lives, no matter how briefly offered. Many of the suggestions outlined below emerged from my experience supervising and training mental health professionals in these settings.[1]

This brings me to the third context for writing this article, namely, the challenge of translating theory into practice. As I'll describe below, formulating an empathic response involves a multitude of potential choices at any given moment and is infinitely more complex than any simple prescription to "just say what you hear." One can understand on a theoretical level the rationale for employing an empathic mode of observation and response, but that does not necessarily mean one knows how to do so effectively.

Nevertheless, there is broad consensus that empathic resonance is a skill that can be taught. Kohut (1984) stated that empathy is not a matter of endowment, but rather a product of training and learning. Basch (1988) similarly stated that he believed that empathy was not an inherent talent, but rather something that could be dissected, described, taught and learned. He outlined a five step process for reaching empathic understanding. Geist (2013) also took up the challenge of trying to be more explicit about how an analyst or therapist actually enters another's subjective world. Where Basch laid out a series of steps, Geist used the microprocess of a session to formulate and illustrate an intersubjective definition of empathy, emphasizing the mutuality of the process. Goldin (2023) further delineated the empathic process by describing empathy as a dynamic relational process that operates on a continuum from a "what" form of empathy to a "why" or storied form. Finally, Sucharov (2002), emphasizing the thorough embeddedness of empathic understanding in an intersubjective field, suggested that what we do involves less a matter of empathic immersion than what he calls an "empathic dance." These are just a few of the previous attempts to delineate how we create empathic responsiveness in the effort to enter the mind of another human being and promote a process of change. The present article strives to add to these efforts.

There is a vast literature on empathy, covering multiple dimensions, its relational meanings and construction, and the dynamics of how it mobilizes growth or "cures." My focus here, however, is narrowly on the concrete and experience-near translation of theory to practice when it comes to *communicating* empathic understanding. There are, similarly, multiple ways to describe and understand the components and process of change in therapy, most of which will also not be addressed here. Rather, I am focusing primarily on just one aspect of therapeutic action, i.e., how the effective communication of empathic understanding enables the identification, elaboration, and transformation of the patient's internal experience.

Theoretical underpinnings

As mentioned above, our focus on empathy rests on assumptions our theory makes about development, psychopathology and therapeutic action. So I'll start with a brief and highly

[1]More detailed reports of the use of self psychology theory in short term treatment can be found in Gardner (1991, 1999).

condensed summary of some of the basic assumptions that underlie self psychology and intersubjectivity theory, in order to offer a context for what follows.

In terms of development, we start with the idea that our experience, affects and sense of self are developed and organized (and later reorganized) in specific relational contexts. This means that our early experiences with our primary caregivers lead to ideas about how emotions and relationships work—what's allowed, what's not, what's rewarded, what's punished, and so forth. These ideas operate outside of our conscious awareness, but powerfully influence our experience and behavior. This patterning has gone by a lot of different names: organizing principles (Stolorow et al., 1987), working models (Bowlby, 1988), patterns of expectation (Beebe & Lachmann, 1988, 1994), emotional convictions (Orange, 1996), implicit relational knowing (BPCSG: Lyons-Ruth, 1999, Stern et al., 1998), or, more recently, attractor states (e.g., Magid et al., 2021; Thelen & Smith, 1994).

When there is a history of chronic misattunement, abuse or developmental trauma, people develop ways of trying to protect against retraumatization. If the environment doesn't lend itself to recognition and acceptance of what is authentically the child's internal experience (volitions, perceptions, etc.), the child will do whatever is necessary to protect the nascent self and the bond with their absolutely needed caregivers. These efforts are manifested in symptoms and defenses, which we understand as adaptations to vulnerability, although their function in these terms may not initially be obvious. When such a person comes into therapy, these adaptations become manifest in their relationship with us as continued attempts to protect the self through methods that have become firmly established for doing so.

A fair amount of therapy involves helping people become aware of and re-examine these implicit assumptions or organizing principles upon which they are conducting their lives. When needed, previous adaptations that are no longer relevant, required or useful need to be modified or transformed in the context of current realities in the patient's life. In therapy, we become a new partner in the patient's affective and relational experience. Through this relationship and a new and different experience with us, a door is opened to the possibility of change in these unconscious patterns.

So a major component of treatment, then, involves helping people become aware of and understand their internal experience, what's going on out of their awareness that interferes with them doing, feeling, or going after and achieving what they want. This includes affects, needs, adaptations, and organizing principles, all these things that may be driving people's experience and behavior without them realizing it, and much of which will be expressed via the transference, the relationship with us.

Of course people coming into therapy do not necessarily begin with this understanding that their own inner processes are playing a major role in creating the experiences that cause them such trouble. Often it is the behavior of others and external forces—whether the unfair boss or work demands, the bully husband, the defiant child or demanding parent—that are presented as the source of their problems, rather than the patient's reactions and response to these people. The unreflected meanings our patients make of their experience and their felt or automatic imperative to accommodate, or withdraw, or defy, or become invisible, and so forth constrain their options and paradoxically contribute to the very problems for which they are seeking relief. Much of our work involves bringing these automatic

patterns to light, where they can be reexamined. While subjective experience is always contextually and intersubjectively created, the potential for change resides in the patient recognizing and claiming ownership over the part that is internal. This is the part that has the potential to come under their own conscious control and thereby empower them to change their experience, their reactions and their lives.

All this is a very schematic, brief description, but hopefully it is enough to clarify why we put so much emphasis on illuminating and validating the patient's internal reality. But how do we do that, given that we don't have blood tests or scans for internal assumptions or subjective experience? This is where empathy comes in. There are two and only two ways to know about inner life: introspection is how we can know about our own internal experience; and empathy is how we can know about someone else's. This is why Kohut referred to empathy as vicarious introspection. For him, it was initially an observational stance, one of looking at the world through the eyes of the patient. At the end of his life, Kohut (1981) talked about empathy as therapeutic *per se;* and subsequently just about everyone else has emphasized the therapeutic impact of empathic responsiveness itself. So in our theory we focus on subjective experience, because that is the point of entry to the patient's inner life, and we focus on empathy because that is the *means* by which we gain access to that inner world.

Complexity of formulating an empathic response

What do we have to do to establish empathic contact with our patient? We could say, "Just say what you hear or understand, without adding, subtracting, or redirecting it." But already then we're going to be lost. If I want to go from New York to California and I'm told, "Just go west," I suppose I might eventually get there, but certainly not efficiently, and I'm likely to be clueless about where to turn next at many junctures. Also *how* should I say what I hear and which part of it? Is it better to use the patient's words or my own? Should I reflect feelings or behavior? Results or intentions? Events or reactions? Hopes or fears? Forward edge or trailing? These are all moment-by-moment decision points and choices. What about my tone of voice and non-verbal behavior? And complicating all of this is the fact that whatever we hear and potentially convey back to our patients is filtered through our own lenses and organizing principles. As Stolorow is fond of putting it, there is no immaculate perception. Our own history and organizing principles will impact both our expectations and our perceptions of what we've heard.

Since empathy *per se* is value neutral, we constantly make choices about how to use our empathic understanding to respond in ways that facilitate and advance the treatment process. So in what follows I'd like to offer some suggestions or possibilities regarding what to attend to or focus on in order to do the following: 1) achieve an accurate empathic understanding; 2) communicate that understanding in a way that enables the patient to *feel* deeply understood; 3) advance the therapeutic process by promoting the unfolding of the patient's interior life; and 4) provide a new relational experience. These are all among the central functions of empathy. I've organized my suggestions under 7 subheadings, illustrated with brief examples, and then followed by two additional vignettes that reflect a combination of the various interventions I've described.

1) Affect and underlying needs, wishes, or intentions

As I said earlier, our affective experience becomes organized and reorganized in specific relational contexts. For many of our patients the therapist's affective attunement provides a developmentally missing and corrective experience, which helps people both identify and feel the validity or legitimacy of their feelings. Kohut actually described the therapist's affective responsiveness as being at the heart of what is curative in treatment. So of course we naturally emphasize the patient's feelings, first and foremost, in our empathic reflections. But when in addition to reflecting reactive affects we also reflect the patient's underlying wishes, we belatedly legitimize selfobject needs that have been previously thwarted.

For example, with a patient who was upset with her family for being totally focused on their usual arguments with each other when they went out to dinner after her graduation rather than celebrating her achievement, the therapist not only reflected her hurt, disappointment and anger, but also said, "What you wanted was for them to be proud of you, to be able to set all that aside and pay attention to *you* for once, on your special day." To another patient whose AA sponsor gave her a lecture when she slipped and had a drink, the therapist said, "You felt criticized when you hoped for support." These kinds of responses not only help the patient feel deeply understood; they also help them undo the disavowal of needs that have been sequestered due to misattunement in the past. It is only when people feel the legitimacy of their needs that they can take actions to express and get them met. For the graduate, it was a response to her need for mirroring/affirmation; for the recovering alcoholic, a response to her need for idealized strength and guidance.

This also relates to fostering a sense of personal agency. Agency refers to the capacity to act effectively on ones own initiative, being in the driver's seat of ones own life. Hagman (2020) has written that promoting a sense of personal agency involves more than affect attunement. We also need to be empathic to the child as a center of initiative and action. Parents do this by naming and organizing the child's intentions. For example, sitting with a young child playing with blocks, a parent might say, "You're piling the blocks so high; you're making something very tall, maybe like a tower?" i.e., the parent is echoing not just how the experience feels (it's fun to play with blocks), but what the child is trying to *do*. I am suggesting that when we start to convey our empathic understanding to our patients, in addition to reflecting their affect there is therapeutic mileage to be gained from also listening for, naming, and affirming the patient's underlying needs, wishes, longings and/or intentions.

2) Focusing on what is present not absent

A child wants her mother to go with her into the therapist's office. Rather than saying "You're not willing to go into the office by yourself" or even "Why do you want your mother there?" it's more useful to say "You must have a (good) reason for wanting your mother there." In other words, we focus on what she is doing (wanting mother) rather than what she is not doing (going in alone). With someone who constantly jumps the gun, so to speak, reacting too quickly or impulsively, rather than suggesting, "You need to be more patient," we'd want to say, "It's hard to be patient." In other words, we stay with the patient's actual experience and say what we hear rather than doing something else, or trying to get them to do something else.

Another patient complained that his wife was constantly intruding on his zoom therapy sessions, which he didn't like or want. In a presumably well-meaning effort to legitimize the patient's desires, the therapist wanted to urge him to push back against his wife's intrusion into his treatment. But I'm suggesting that we would want instead to explore his *not* doing so; e.g., "I gather that even though you don't like it, you don't feel you can tell her to stop." This shifts the focus from his behavior to whatever internal experience is driving it. When we are using empathic responsiveness to connect with and elaborate internal experience, we need to focus on what is already present and available to the patient, aiming to expand *that* rather than directing the patient's attention elsewhere. This is what we mean when we talk about empathic immersion and staying experience near.

3) Specific meanings of word choice

What a word means to us may be very different from what the same word means to our patient. I say to my patient, "You don't feel entitled to have what you want." She says, "No, John (her husband) is entitled; it's more like I don't deserve it." To me, it feels pretty equivalent or synonymous to say someone doesn't feel entitled to something or doesn't feel they deserve it, but not to her. That did not make her feel understood. In the correction, she clarifies that she doesn't feel she deserves something different because she feels she has enabled his behavior, contributed to creating this situation by her passivity, and therefore forfeited her right to have what she wants, i.e., to deserve it.

The Ornsteins (Ornstein and Ornstein, 1985) also had a wonderful example of this in an early paper in which the therapist commented on how the patient's dream reflected how he had been rescued from a dangerous situation. The patient felt deeply hurt and misunderstood, because he felt he had *escaped* from the situation by dint of his own strength and resourcefulness. He wanted the therapist to appreciate this. Saying he was rescued made him feel instead that the therapist saw him as passive and dependent, rather than strong and resourceful.

It's also worth thinking about the way specific words carry an emotional punch. Two examples in English I've found particularly vivid and resonant for patients are the words "stranded" and "ambushed." Interestingly, each implies both an action by an outside force or person and an internal response to it, thereby condensing a great deal into just one word. Others reading this have probably found other specific words to be particularly powerful in capturing their patients' experiences.

Efforts at empathic immersion help us locate the right word or words to capture the patient's experience. But as we talk about the importance of what meanings specific words have for the patient, it is important to remember that we don't have to be, and often can't be, immediately right. We have to be flexible, meaning we have to let the patient correct us when we get it wrong. Only the patient can determine whether they feel understood and until someone feels we understand how it is for them, they can't make use of anything else we might say, no matter how "true" we might think it is.

4) External triggers, internal experience and sequence

People often describe their experience in terms of something they or someone else did and their reaction to it. In responding, it's helpful to emphasize or describe the internal

experience more than the external trigger. Consider these two statements: "They didn't believe you" vs. "You felt discounted by them." These describe the same event and seem to mean roughly the same thing, but one is talking about them, the other, and one about you, the patient. One describes behavior, the other describes affect.

A related point concerns the sequence in which we say things. People tend to elaborate from the place we end. So, when possible, it's helpful to emphasize and end with the part we hope to expand. Consider a situation where someone is at a bar with friends and then the others move on to the next bar without saying when or where. We could say, "You felt deserted when all the others left without you" or "When all the others left without you, you felt deserted." The sentences mean the same thing and even have exactly the same words, but the first may be more likely to evoke an elaboration of how the others left (their behavior), while the second pulls more for an elaboration of the deserted feelings, the internal experience. This distinction may sound like splitting hairs and less relevant in a short sentence like this, but can become more important when responding to a long description of an event and its impact on the patient.

5) Tone and other non-verbal aspects of our words

The same word can convey a wide range of different meanings depending on the tone with which it is uttered. If I say, in a flat voice, "That made you furious," the empathic impact is going to be a lot different than if I say, "That made you FURIOUS!" Our body posture, our sighs, our leaning in or back and other gestures all communicate aspects of understanding. Sometimes we convey our empathic response in ways that don't use or paraphrase the patient's words at all. In response to one patient who described to me someones outrageous and exasperating behavior, I blurted out, with considerable emphasis and no forethought, "Oh, for God's sake!" She stopped, let out a big sigh, and simply said, "Thank you," signaling clearly to me that she felt totally understood. I'm reminded here of Kohut's patient, with whom he simply synchronized his breathing to convey an empathic connection (Kohut, 1984). [2]

6) Intersubjective conjunction and disjunction

These terms refer to ways that the organizing patterns and defenses of the two people in the therapeutic dyad intersect and co-create particular outcomes. Both reflect the interaction of their separately organized subjective worlds. How *we* see the world may be similar or different from how our patient does. Those differences include not only our perceptions, but also our expectations, our reactions, our needs and values, and, importantly, our own defenses. As Atwood et al. (1989) have described, places where patient and therapist view the world the same way (i.e., intersubjective conjunctions) may be seen as reflections of objective reality rather than manifestations of the patient's personality. When a defensive solution is shared by patient and therapist, they note that it may escape analytic inquiry and/

[2]Descriptions of additional procedures by which other authors have described how non-verbal, bodily sensation and posture can facilitate empathic understanding and communication can be found in the work of Brothers and Sletvold (2022, 2023) and Nebbiosi and Federici (2022).

or put them at odds with each other. Such conjunctions may result in empathic ruptures/derailments or in mutual strengthening of resistance that may prolong the treatment.

Here's one of their examples, in brief. A patient complained about the impossibility of finding meaningful attachments because of the mechanization and depersonalization of modern life, a view of society that the therapist happened to share. So, seeing the patient's attitude as a reflection of objective reality rather than manifestations of his conflictual issues concerning intimacy and attachment, those issues were never explored. This example and several others can be found in the authors' article on impasses in psychoanalytic treatment (Atwood et al., 1989).

What we hear in our patients can be limited by what we can hear (or stand to hear) in ourselves. So these intersubjective conjunctions and disjunctions create potential impediments to empathic immersion and understanding. For this reason, accurate empathic understanding often necessitates that therapists become reflectively aware of the principles that govern our own internal experience.

In the decades since Atwood *et al* wrote about these ideas, the literature in self psychology and intersubjectivity theory has shifted towards an even more thoroughgoing emphasis on bidirectionality, mutual impact and co-creation of experience in the analytic relationship. While I do not further elaborate this focus in the present article, it is important to underscore how much these phenomena impact the process of empathic understanding. It is decisively important not only who the patient is, but who the listening therapist or analyst is. For those who seek a deeper understanding of this dimension of the process, a good place to start includes the articles mentioned earlier by Geist (2013) and Sucharov (2002), as well as Perlitz's (2022) work on mutual embeddedness.

7) Forward edge and trailing edge

One of the most important and useful concepts we have for guiding our empathic listening and response is the concept of the forward edge. This term came from Kohut, was described initially in an article by Jule Miller (1985), and then later elaborated by Marian Tolpin (2002) and others.

By way of definition, forward edge refers to transference and/or other expressions of thwarted but still remaining healthy, childhood, developmental needs. Trailing edge refers to transference and/or other expressions of repetitive patterns, negative expectations, and defensive strategies which have developed as a result of trauma, misattunement and empathic failure. So trailing edge comments address what the patient is trying to defend against, deny or ward off. Forward edge interpretations address the patent's strivings and hopes. Frank Lachmann (2016) noted that forward edge interpretations speak to "what the patient is trying to attain, retain or maintain through symptoms and behaviors that may look like pathology" to the observer, but actually reflect the patient's motivational strivings. (p. 501).

In describing the importance of this concept, Marian Tolpin emphasized that accepting whatever tendrils of healthy self there are and addressing that forward edge of health is what provides the motive force for resumed development in therapy. She also believed that an accurate understanding of the forward edge, as experienced in the treatment relationship, constituted the seeding of a new experience. This, of course, is very consistent with what

I said earlier about the therapist as a new affective partner, with whom new, co-created experiences can begin to transform the patient's expectations and internal world.

By way of example, Jule Miller, who was in supervision with Kohut, told him about a patient who Miller thought wanted to avoid his inner life by picking a fight with him. Kohut suggested instead commenting that picking fights was a way the man had kept himself from feeling empty over the years and making meaningful contact with the people important to him. It's a really nice example of how even in the context of what is undoubtedly a very problematic relational pattern of provoking others, this kind of understanding and comment on the healthy wish to make meaningful contact with others helps nurture that striving. It's what Marian Tolpin called "blowing on the embers." This not only sets the stage for the emergence of a more full blown selfobject transference, but, ultimately, helps him find less costly and more fulfilling ways of meaningful engagement with others.[3]

Here's another example, this one from the same paper on agency by Hagman (2020) I mentioned earlier. Hagman described a patient, David, who effectively shut him out during sessions by insisting on "doing his own analysis." A trailing edge interpretation might see this as resistance and defensive self-sufficiency. Hagman instead interpreted this as an attempt to avoid coercive intrusion by the therapist that would usurp his authentic experience, a feared repetition of his chronic history with his mother. So protecting and preserving his authentic sense of self was the forward edge here.

As I said above, when talking about what's present versus what's absent, it's important for us to place our emphasis on what our patients are striving to do rather than what they are trying to avoid and what is right, i.e., healthy, about their choices rather than what is wrong or pathological. Hagman's forward edge understanding and interpretation of David needing initially to shut him out not only enables his patient to feel understood in depth. It offers belated recognition and affirmation of his creative act of self-preservation. Importantly, this facilitates his dawning awareness of his own role in authoring the actions that now cause him great difficulty.

Because our patients generally start out with no awareness of these dynamics and phenomena, the things that on a deep level propel their behavior and inform and constrict their experience, it is imperative to stay initially with what is consciously available and not prematurely threaten what has been the patient's best or only way of protecting themselves. This is what empathic immersion and staying focused on the forward edge enables and leads us to do. When Hagman does this by restraining his own desire to interpret and allowing David to keep him shut out, he cultivates an environment of trust and safety, free of the threat of coercion or impingement. The goal is to enable David, and all such patients, eventually to see that their difficulties are not a product of external forces, but rather of internal choices made long ago that have become rigid and constraining. It is the sustained empathic immersion in our patients' internal worlds that allows us to bring about this result.[4]

[3]At the time Miller's article was published, homosexuality was still considered pathological and was included as a diagnosis in the DSM. There has been considerable criticism of Miller's understanding and treatment of homosexuality from our contemporary perspective. Nevertheless, I believe that much of his article remains valuable for its informative examples of how Kohut understood the concept of responding to the forward edge. For a contemporary perspective on the homoerotic aspects of Jule Miller's case, see Janna Sandmeyer (2019).

[4]An extended discussion of this case can be found in Gardner (2020).

Here's a last illustration, this one an example of how the concept of the forward edge reorients my empathic listening. At the end of a first session, my patient asks if he can pay in advance for his sessions. Some people don't like to write a check every week or get a big bill at the end of the month, so I tell him that would be fine. He writes a check and leaves it on my desk. After he leaves, I look at the check and see that it is for $5,000. I wonder various things: Is he trying to impress me?; compete with me?; counteract the humiliation of coming for help by being a big man and throwing his money around? But listening for the forward edge, when he returns I simply note the size of the check and invite his thoughts about it. It turns out that he was someone who had tried therapy many times in the past, but would always blow it off or drop out. The large check, covering many months of sessions, was a way of trying to secure a commitment from himself to stay in treatment.

What people do is nearly always in the service of protecting the self (their agency, vitality, autonomy) or protecting a bond with a needed other. Listening for these things with that orientation makes a profound difference in what we hear and how we respond. To find the forward edge it helps to start with the assumption that there is something right in what the patient is doing and to listen for how. When we see symptoms or seemingly dysfunctional behavior, it can help to ask ourselves the question, "To what problem is this behavior a solution?" (What could conceivably make *me* do what this person is doing?) Seeking the answer can help clarify internal dynamics and forward edge motivations. In my last example, the large check was an attempted solution to the problem of fleeing from therapy before giving it a chance to help.

Illustrative vignettes

To summarize, I've been describing under these various subheadings things that I see as relevant to enhancing effective empathic communication and responsiveness, all in the service of achieving our therapeutic aims—the resolution of presenting problems, resumed development, increased sense of agency, and so forth. I'd like to finish with two brief vignettes which capture many of the ideas I've described.

First vignette

My patient is 33, single, and longing to find a suitable marriage partner with whom she can settle down and build a life. She is having an intense affair with a man who lives a thousand miles away and is married with two young children, a family he has no interest in leaving. He is very jealous and possessive towards my patient, particularly grilling her if she pays any attention to other men. For the zillionth time we are discussing what draws her into and sustains this relationship. She says, "He challenges me, he probes and pushes me to say things I don't want to say, things that are hard. Like when I had dinner with Sam [a former boyfriend], he wanted to know if we had sex and he kept pushing. I told him it was none of his business. But he doesn't let up. It's hard for me to answer because I feel guilty, but he forces me to be honest. It's good for me. I can't hide from him."

At this point, I'm trying to keep my bearings, because what I feel like doing is screaming at her, "What are you talking about? This man is married and almost completely unavailable, yet he suggests that *you* are cheating if you hook up with an old boyfriend? And this is what you consider helping you grow by forcing you to look at yourself and be honest?" I feel like Dr. Phil and want to say, "Get real!"

But then I remember Kohut's (1984) famous dictum that the patient's rightness is likely to be more profound than his, so I refocus, give it another try and say to her, "There's something about being able to tell him things that are hard to say, that he won't like hearing —that feels very important to you." She replies, "Yes, all my life I've had to hide who I really am. I can never show my parents what's really going on. They would be so disappointed. But Jake just accepts me." I finally start to get it. "So it's in the way he accepts you *after* you've leveled with him about something he won't like that you finally feel you can be who you really are." She starts to cry (signaling we've hit an affective nerve) and says, "Yes, I feel like I've been hiding my whole life. It's the only place I can be honest." I reply, "It's such a relief to feel at last you can be yourself, not have to hide, and still feel worthwhile. Finally you can feel loveable and loved for who you are, rather than who you think others need you to be. That just feels so great." She cries harder.

Then she says, "I remember the first time I deliberately hid something from my parents. I lied to do it. It still haunts me." She then elaborated the incident in some detail and how it left her wracked with shame and guilt. The central importance of hiding, secrets, guilt and shame were coming into sharper relief and beginning to shed light on my patient's dynamics and struggles.

By reorienting myself to the importance of empathic immersion and the forward edge, I was able to transform my negative feelings into an empathic response which facilitated an unfolding clinical process. Following Kohut's dictum (that the patient is always right somehow, listen for it) made possible an empathic response which yielded an upsurge of affect, a confirming association/story, and an expansion of the thematic content so important to understanding the dynamics of what was keeping my patient in this ultimately unfulfilling affair. This vignette is an illustration of what I meant before when I said we are trying to use the empathic process to illuminate and promote an unfolding of the patient's internal experience.

Second vignette

This next vignette is from a supervision session with a therapist who comes for consultation on her private practice cases. I chose it because of the ways it illustrates a process and attitude I'm trying to convey.

My supervisee says, apologetically and somewhat shamefully, that she runs over the time with one of her patients and doesn't end the sessions on time. She says, "I know this is wrong, I shouldn't be doing it" in a way that feels to me almost like a little kid confessing that she got into the cookie jar and ate all the cookies, i.e. I'm bad.

So my first step is to create a different context and framework for looking at this, moving from condemnation to exploration, a process not that different from how we try to engage our patients. To create a safer space for her to explore the situation, I suggest that we shift from the idea that "you're doing something wrong" to the idea that "you're doing something for reasons you don't yet understand." In concert with what I described earlier as addressing what's present rather than absent, the focus is not on what she's *not* doing (ending on time), but on what she *is* doing (running overtime).

We proceed as follows: I ask if she generally runs over with patients. She says, "No." I say, "So there must be a reason for it with this person." She replies, "I feel I have to give the person more time." Why is that? She reports, "I withdraw towards the end of the session."

I ask if she could elaborate and I encourage her associations. She says, "This patient has very poor boundaries; I feel like I could get engulfed by her."

Continuing the exploration along these lines, the dynamics become more clear. It turns out the therapist gets more quiet and withdrawn about 10 minutes before the end of the session as a response to her experience of her patient as "too needy" (her words) and potentially engulfing. Eventually she realizes she's checked out and feels guilty about having withdrawn from her patient, and so she offers her extra time to compensate, which leads to running over time.

Like our patients, she doesn't start out knowing all this. She just comes in confessing that she's doing something wrong. She needs help to identify what's going on internally that's driving this behavior. What enables me to help her is my attitude, my way of thinking about things, by maintaining an empathic focus and searching for the positive (and initially hidden) function of her behavior. (Cf: what problem is this behavior a solution to?)

This requires an open minded, non-judgmental curiosity, as well as an initial tolerance for uncertainty and ambiguity, for not knowing. As my own mentor, Miriam Elson (*personal communication*), often said, "The tolerance for ambiguity is the hallmark of a professional." This becomes much easier when we hold a firm belief that empathy will enable us to find out what we (and they) don't yet know. Self psychology and intersubjectivity theory, especially concepts like empathic immersion and the forward edge, help us to understand and cultivate this kind of attitude.

Conclusion

These ideas about nuances of empathic communication help me to be effective and my hope is that writing about them will similarly help others be ever more effective in their own work. Empathic understanding and responsiveness aren't easy, automatic, or simple; but nothing is more powerful in revealing our patients' internal worlds, offering them a new experience, and helping them change their lives.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on Contributor

Jill Gardner, Ph.D. is a Clinical Psychologist in private practice in Chicago, Illinois. She has served on the Post-graduate Education Faculties of the Chicago Psychoanalytic Institute and the University of Chicago Crown Family School of Social Work, Policy and Practice. She is a member of the International Council of the International Association for Psychoanalytic Self Psychology and an Associate Editor of *Psychoanalysis, Self and Context.*

ORCID

Jill Gardner, PhD http://orcid.org/0000-0002-0086-1543

References

Atwood, G., Stolorow, R., & Trop, J. (1989). Impasses in psychoanalytic therapy: A royal road. *Contemporary Psychoanalysis*, *25*(4), 554–573. https://doi.org/10.1080/00107530.1989.10746320

Basch, M. (1988). *Understanding psychotherapy*. Basic Books.

Beebe, B., & Lachmann, F. (1988). Mother-infant mutual influence and precursors of psychic structure. In A. Goldberg (Ed.), *Progress in self psychology* (Vol. 3, pp. 3–26). Analytic Press.

Beebe, B., & Lachmann, F. (1994). Representation and internalization in infancy: Three principles of salience. *Psychoanalytic Psychology*, *11*(2), 127–165. https://doi.org/10.1037/h0079530

Bowlby, J. (1988). *A secure base*. Rutledge.

Brothers, D., & Sletvold, J. (2022). Talking bodies: A new vision of psychoanalysis. *Psychoanalytic Inquiry*, *42*(4), 289–302. https://doi.org/10.1080/07351690.2022.2059292

Brothers, D., & Sletvold, J. (2023). *A new vision of psychoanalytic theory, practice and supervision: Talking bodies*. Routledge.

Gardner, J. (1991). The application of self psychology to brief psychotherapy. *Psychoanalytic Psychology*, *8*, 477–500.

Gardner, J. (1999). Using self psychology in brief psychotherapy. In C.-P. in W. Borden (Ed.), *Psychoanalytic Social Work* (Vol. 6, pp. 43–85). New York: Haworth Press.

Gardner, J. (2020). Discussion of George 's "self-agency: Freedom and context in psychoanalysis. *Psychoanalysis, Self and Context*, *15*(1), 40–46.

Geist, R. A. (2013). How the empathic process heals: A microprocess perspective. *International Journal of Psychoanalytic Self Psychology*, *8*, 265–281. https://doi.org/10.1080/15551024.2013.800357

Goldin, D. (2023, October 20). *Empathy on a continuum* [Paper presentation]. 44th Annual Conference, International Association for Psychoanalytic Self Psychology, Chicago, IL.

Hagman, G. (2020). Self-agency: Freedom and context in psychoanalysis. *Psychoanalysis, Self and Context*, *15*(1), 33–39. https://doi.org/10.1080/24720038.2019.1652612

Kohut, H. (1981). On empathy. Chapter 17 in P. Ornstein (Ed.), *The search for the self: Selected writings of Heinz Kohut* (Vol. 4, pp. 525–535). International Universities Press.

Kohut, H. (1984). *How does analysis cure?* University of Chicago Press. https://doi.org/10.7208/chicago/9780226006147.001.0001

Lachmann, F. (2016). Credo. *Psychoanalytic Dialogues*, *26*(5), 499–512. https://doi.org/10.1080/10481885.2016.1214460

Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanalytic Inquiry*, *19*(4), 576–617. https://doi.org/10.1080/07351699909534267

Magid, B., Fosshage, J., & Shane, E. (2021). The emerging paradigm of relational self psychology: A historical perspective. *Psychoanalysis, Self and Context*, *16*(1), 1–23. https://doi.org/10.1080/24720038.2020.1856111

Miller, J. (1985). How Kohut actually worked. In A. Goldberg (Ed.), *Progress in self psychology* (Vol. 1, pp. 13–30). The Guildford Press.

Nebbiosi, G., & Federici, S. (2022). Miming and clinical psychoanalysis: Enhancing our intersubjective sensibility. *Psychoanalytic Inquiry*, *42*(4), 266–277. https://doi.org/10.1080/07351690.2022.2059285

Orange, D. (1996, October 18). *Reconceptualizing the clinical exchange*: F*rom the standpoint of intersubjectivity* [Paper presentation]. 19th Annual Conference on the Psychology of the Self, Washingto, DC. (unpublished).

Ornstein, P., & Ornstein, A. (1985). Clinical understanding and explaining: The empathic vantage point. In A. Goldberg (Ed.), *Progress in self psychology* (Vol. 1, pp. 43–61). The Guilford Press.

Perlitz, D. (2022). Mutual embeddedness: The foundation for a relational world. *Psychoanalysis, Self and Context*, *17*(1), 8–22. https://doi.org/10.1080/24720038.2021.1950158

Sandmeyer, J. (2019). Understanding homophobia in our forefathers: Rethinking how Kohut actually worked. *Psychoanalysis, Self and Context*, *14*(4), 376–392. https://doi.org/10.1080/24720038.2019.1592929

Stern, D., Sander, L., Nahum, J., Harriso, A., Lyons-Ruth, K., Morgan, A., Bruschweilerstern, N., & Tronick, E. (1998). Non-interpretive mechanisms in psychoanalytic therapy: The "something more" than interpretation. *International Journal of Psychoanalysis*, *79*, 903–921.

Stolorow, R., Brandchaft, B., & Atwood, G. (1987). *Psychoanalytic treatment: An intersubjective approach*. The Analytic Press.

Sucharov, M. (2002). Representation and the intrapsychic: Cartesian barriers to empathic contact. *Psychoanalytic Inquiry*, *22*(5), 686–707. https://doi.org/10.1080/07351692209349013

Thelen, E., & Smith, L. (1994). *A dynamic systems approach to the development of cognition and action*. The Analytic Press.

Tolpin, M. (2002). Doing Psychoanalysis of Normal Development: Forward Edge Transferences. In A. Goldberg (Ed.), *Progress in Self Psychology* (Vol. 18, pp. 167–190).