The Centrality of Empathy in Psychoanalysis

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This article presents a condensed appraisal of Kohut's groundbreaking conception of the method and the boundaries of psychoanalysis, republished here with permission. Kohut reinstated Freud's original claim that empathy was the only way to enter the inner world of another and he extended and redefined its functions. Empathy not only permits a prolonged, sustained entry into the inner world of the patient, it also designates the boundaries of psychoanalysis as a pure psychology—in the sense that only what is accessible via empathy is psychoanalysis. A description of empathy and its functions are then presented in a more detailed fashion, and include a highly abbreviated clinical example. In this example, a prolonged theory-driven analysis ultimately gave way to a search for the patient's subjective experience and its understanding, leading to a therapeutically more effective analytic approach.

INTRODUCTORY REMARKS

This introduction is reprinted here for a wider professional audience to serve as a preface to the ensuing further consideration of the function of empathy in the clinical situation. Hopefully, this will spark that belated substantive debate Heinz Kohut wished for, when he first presented his ideas in 1957 and published them in 1959.

Kohut's (1959) essay, "Introspection, Empathy, and Psychoanalysis: An Examination of the Relationship Between Mode of Observation and Theory," presented at the 25th Anniversary Meeting of the Chicago Institute for Psychoanalysis in 1957, has become a classic. It was certainly the first nodal point in his contributions to psychoanalysis. It brought under a methodologic—epistemologic umbrella all that he had written before, and prefigured his subsequently developed self psychology (Ornstein, 1978, 1990). Kohut's scientific message is just as timely now as it was then. Perhaps this is what makes a landmark contribution into a classic. We can say without hesitation today that the message was, in many respects, revolutionary. It is conceivable that this was the main reason—if not the only one—why both his discussants at that
time and most psychoanalysts during the ensuing 25 years had failed to grasp the significance of Kohut’s essential contribution. Leading psychoanalysts Rudolph Lowenstein, Maxwell Gitelson, and Helen McLean were his official discussants. ¹ Lowenstein was sharply critical; Gitelson was friendly, but less critical; McLean was thoroughly approving—but according to Kohut they all missed his main point (Kohut, 1982). Franz Alexander, although not an official discussant, attacked the paper from the floor. That there was a wider disapproval on the national level is indicated by the fact that the *Journal of the American Psychoanalytic Association* was going to refuse (or had already refused) its publication, and only the powerful intercession of Gitelson averted the *Journal’s* inappropriate censorship (see also Kohut, 1982).

Why was this paper such an anathema to Alexander, to the other critics, and to the editorial board of the *Journal*? Why was it—as Kohut experienced it and as we can now clearly discern from surveying the ensuing literature (e.g., Brenner, 1968; see also Kohut’s previously unpublished reply, 1968²)—that, in spite of widespread citations of the essay subsequently, Kohut’s central message was not really understood? What did he say that was so unacceptable and at the same time, from our current perspective, revolutionary, that we now consider his essay a classic?

The following brief exposition should shed some light on these questions. Kohut was moved to rethink the psychoanalytic method and the boundaries of the field that constituted psychoanalysis. He was moved to do so because he was concerned, at that time, that biology on the one hand (mainly in Alexander’s work) and sociology on the other (mainly in Alexander’s and Hartmann’s work) were not clearly delineated from psychoanalysis proper; the introduction of psychobiologic and social-psychologic concepts and viewpoints foreign to psychoanalysis—such as the quasi-biologic drives; the quasi-biologic or sociologic dependence and other similar concepts—distorted the psychoanalytic view of the human condition, as well as the treatment process.³ Rather than using terms that portray pseudo-integration, and rather than mixing the methods of extrspection and introspection and thereby distorting the data, the appropriate approach would have required the correlation of the findings of biology and sociology with those of psychoanalysis. Thus, in his attempt to establish psychoanalysis as a pure psychology and spell out its method in relation to its theories, Kohut made three pivotal statements: (1) The first one had to do with the nature of reality (external vs. internal) as the psychoanalyst encountered it conceptually, as well as in practice; (2) the second one had to do with his recognition that the psychoanalyst’s observational method determined his findings and theories; and (3) the third had to do with his redefinition of the field of psychoanalysis—a redefinition that opened up psychoanalysis for further advances, which he himself was able to make. Kohut recognized, in line with postpositivist, avant garde thinking in other fields, that reality, as it exists in the external world, can never be known in its entirety. We can only know that aspect of reality that our method of observation (and instrumentation) can help us capture. Kohut (1982) grew up with this scientific outlook and had

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¹My relentless search for copies of his three formal discussants and for a possible summary of Alexander’s off-thecuff remarks remained fruitless. I obtained a copy of McLean’s discussion, which was found among her papers after her death. Her discussion attests to the fact that she praised Kohut’s contributions without reservations, but did not grasp its essential claims either. Kohut himself had no copies of these discussions among his papers.

²Kohut’s (1968) unpublished response to Brenner has since been included in Volume 3 of The Search for the Self (Ornstein, 1990).

³For more extensive comments, see Kohut (1981) and Ornstein and Ornstein (1994).
taken for granted that his professional colleagues shared this with him. He was quite surprised that this was not the case and that the discussants and critics engaged mainly in what for him was a nonissue. They argued about Kohut’s philosophical outlook on reality, rather than scrutinizing and discussing his claims regarding the inextricable relations between mode of observations and theory—which was his main topic, as announced in the subtitle—and the implications of these relationships for the field of psychoanalysis.

Kohut—as I see it—had in this treatise quietly undone the Cartesian dichotomy between psyche and soma with his operational approach—so quietly, in fact, that it almost went unnoticed and he had to reiterate it more extensively and more forcefully in 1981 (published in 1982). He did not do this by the frequently attempted, specious reintegration of soma and psyche in the form of the oxymoron: psychobiology. He did this by recognizing the inherent unity of psyche and soma, which we distinguish only (and separate into two fields) on the basis of the appropriate method we use for their respective study. He clearly stated that the appropriate method of studying external reality—in this instance, the human organism—is extrospection or vicarious extrospection.” This approach gives us the data that establish the field we call biology. In contrast, he claimed, that when we turn toward the study of inner psychic reality, the appropriate method of observation is scientific introspection (or vicarious introspection, i.e., empathy). This approach gives us the data that establish the field we call psychology (here psychoanalysis). These, then, are the two sides of the same coin. This recognition of the inseparable unity of psyche and soma on the one hand, and his clearly articulated operationalism on the other, led Kohut to consider introspection and empathy the essential ingredients of the method of psychoanalysis, even if other operational methods inevitably co-exist and contribute to our ability to enter imaginatively into the subjective, inner world of another human being. No other psychoanalytic psychology has placed the empathic observational vantage point so unequivocally into the center of its method of observation (Ornstein, 1979).4

It is of historical significance in this context that Freud (1921) unambiguously stated the essential function of empathy in human affairs, when he said: “A path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude at all towards another mental life” (p. 110). I read this to mean that there is no other way to enter the inner world of another as directly as via this innate capacity for empathy. Freud did not specify further what empathy meant in the clinical situation. He did not demonstrate in his case studies how to translate the use of empathy into the conduct of the analytic-therapeutic dialogue. In a detailed study of Freud’s (1905a) analysis of Dora, I demonstrated some years ago that Freud made no effort to make empathy-based contact with Dora’s inner experience, but relentlessly pursued his own agenda and thus essentially mistreated her and drew untenable conclusions from her treatment process (Freud, 1905a; Ornstein, 1993). It is significant, I believe, that Freud only spoke about empathy explicitly in his essays on “Jokes and Their Relation to the Unconscious” (1905b), in “Delusions and Dreams in Jensen’s Gradiva” (1907), and in “Beyond the Pleasure Principle,” (1920), that is, in his applied psychoanalytic essays. He did not mention empathy in connection in any of his case reports. In all of those reports, Freud used inferences from his theory-based notions of inner dynamics in the interpretive process.

Among the analysts in Freud’s circle, it was Ferenczi who was most interested in the curative process per se. He discovered that more was needed than the discovery of what was wrong in the

4The indented text was inserted in the previously published narrative.
patient's mind. It was necessary in the here and now of the treatment situation to offer patients a corrective experience to find a way to make up for what the patient did not acquire from the caretakers in infancy or childhood. Ferenczi acknowledged that his experiments with his approach of concretely supplying what patients needed and demanded was ultimately a failure—but at least he dared to experiment and, with unsparring honesty and self-criticism, entered into his diary what he did and how he failed in his efforts (Dupont, 1988). He did discover that tact—his word for empathy at that time—was a necessary part of the treatment process on the emotional level. Rachman (1997), as well as Aron and Harris (1993), presented a thorough appraisal of Ferenczi's clinical and theoretical contributions.

Kohut, having introduced his ideas (as discussed earlier), could make his main point: The method we use to study aspects of inner reality, our empathic observational vantage point, determines the nature of our data, our concepts and theoretical formulations. This is what he would have liked his discussants to focus on and debate seriously.

Kohut exemplified his meaning by examining some of those ambiguous foreign terms mentioned previously—the drives; dependence, as well as early mental organizations; endopsychic and interpersonal conflicts; and free will—to show what the introspective-empathic method reveals about them and how they, thus, become indigenous psychoanalytic theoretical constructs, rather than foreign bodies in psychoanalysis. In the careful analyses of these terms and the conditions they depict, Kohut searched for a further nonreducible primal psychological gestalt to determine the range and limitations of the introspective-empathic observational method. He illuminated the conceptual and clinical consequences of allowing the biological implications of these terms (such as drives and dependence) to infiltrate into psychoanalysis and thereby distort the psychoanalytic view of the nature of human beings (more explicitly discussed in Kohut, 1982; Ornstein and Ornstein, 1994). Simultaneously, he also delineated the psychological implications of these terms and demonstrated what might establish them as methodologically and epistemologically sound positions in psychoanalytic psychology. For example, the quasi-biological drives do not fit into psychoanalysis properly, according to Kohut, unless we redefine them as abstractions of innumerable “experiences of drivenness”—because only in this fashion are such drives accessible to the patient's direct introspection and the analyst's empathy (vicarious introspection), and thus constitute a psychological construct.

It is of particular historical interest in this essay that Kohut spells out one of the early precursors of his later core concept: the selfobject transference, without yet consciously recognizing its pivotal nature. This is what he (Kohut, 1959) says: “Here the analyst is not a screen for the projection of internal structure (transference) but the direct continuation of early reality that was too distant, too rejecting, or too unreliable to be transformed into solid psychic structure” (p. 471). The reader will be amply rewarded by open-mindedly reexamining with Kohut those concepts and mental states that he had subjected in his essay to his introspective-empathic scrutiny. What awaits the reader who takes the time and energy to redo the stepwise exploration presented by Kohut are these: (a) a better understanding of what exactly Kohut means by the introspective-empathic observational mode; (b) what exactly he means when he asserts that the same introspective-empathic method that determines the data also determines the theory, formulated on the basis of such data; (c) and just exactly the possible distortions of our view of the human condition that can develop if we are careless with the method (that is, if we mix data of extrospection with data of introspection or employ introspection to look at the external world, or extrospection to look at the inner world) and how this affects our treatment approach in the clinical setting (see also Kohut, 1982).
On the basis of all of the foregoing, Kohut redefined psychoanalysis as that aspect of inner reality that can be encompassed (or potentially encompassed) through introspection and empathy. Thus, Kohut has focused here on introspection and vicarious introspection (empathy) as the *definer* of the field of the data of psychoanalysis, as well as its *essential method of observation*. In other words, Kohut extended here the psychoanalytic domain over all subjective, inner experience that can be encompassed (or potentially encompassed) via introspection and empathy. It is the field of the patient’s directly introspected inner experience and the analyst’s empathic (vicariously introspected) method of its study that define psychoanalysis. Previous definitions included specific theories—such as, for instance, the Oedipus complex and the dynamically repressed unconscious—in the very definition itself. This presented obstacles to progress by tying the field to such specific theoretical constructs as if those were sacrosanct, untouchable, rather than leaving them open to change. One striking example of the impact of the new definition is Kohut’s own clinical and theoretical work on narcissistic personality and behavior disorders, where the Oedipus complex does not appear to play a primary pathogenic role.

It should now be obvious to the reader that Kohut’s trailblazing methodologic-epistemologic agenda threatened those who adhered to the leading paradigm of ego psychology. This threat was perceived, at least preconsciously, by the critics. I say preconsciously (rather than consciously), because, ironically, this contribution did not stop Kohut from becoming the President of the American Psychoanalytic Association a decade later and to serve several terms as Vice President of the International Psychoanalytic Association. The latency period between first setting his methodologic agenda in 1959 and the subsequent breakthrough in his creative work took nearly another decade. This breakthrough was prompted at first by the ever-widening gap between theory and practice in the 1960s, and sent him on a search for an “experience-near” theory.

For the fiftieth anniversary of the Chicago Institute and the Chicago Psychoanalytic Society, Kohut returned to the theme of his earlier essay (Kohut, 1982)—delivered by his son, Thomas A. Kohut, after his father’s death. In the new essay, his very last, Kohut revisited his work from the solid platform of his accomplishments in the interim. He revisited and further advanced his previous methodologic and epistemologic contributions, now substantially underpinning the value and validity of these early formulations with the empirical data of his life’s work.

Kohut’s classic 1959 essay on “Introspection, Empathy, and Psychoanalysis” was not only a direction-giving landmark in his own contributions, but it was also a significant one in the evolution of psychoanalysis itself. And as subsequent developments in self psychology demonstrate—whatever their ultimate merit, with lingering doubts by many—it is a contribution that brought psychoanalysis methodologically, epistemologically, and clinically into alignment with present-day, broad, philosophical trends in other fields.

It is without any doubt that reclaiming Freud’s 1921 recognition of empathy as the method of psychoanalysis, as well as positing empathy as the definer of the field, enabled Kohut to develop a new direction in psychoanalysis and leave us a systematic presentation of his discoveries and conceptualizations: his version of self psychology. The field has grown ever since his death in 1981, and is continually expanding its theory and clinical domain as its annual conferences and publications demonstrate. On account of the central role of empathy in theory-formation and in clinical practice, more needs to be said here about the clinical use of empathy.

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5 Five published books of collected papers, prior to the 20 annual *Progress in Self Psychology* volumes, now a quarterly *International Journal of Psychoanalytic Self Psychology* in its fifth year of publication, attest to this steady expansion.
ON THE FUNCTION OF EMPATHY IN THE CLINICAL SITUATION

The Greek word *empathein* means *indwelling*, designating an imaginative entry into the inner life of another (the German *Einfühlung* is a perfect translation for it). In our current usage, empathy is the act of *feeling* oneself and *thinking* oneself into the inner life of another, to understand, both emotionally and cognitively what the other thinks and feels. In fact, the philosophical conundrum of how we know of the existence of other minds is resolved, at least for some philosophers and some psychoanalysts. Thus, it is possible for us to know that other minds exist, via our capacity for empathy and to comprehend what others think and feel. Even if it is a biologically anchored innate capacity, for its further development the human capacity for empathy depends on the milieu the caretakers create for its enhancement or stifling. It is this biologically anchored and developmentally enhanced or thwarted empathic capacity that is then closely tied to the unfolding of the human personality and its manifold functioning.

The nature of empathy, its origin, and its development are, in contemporary psychoanalysis, still—or again—embroiled in controversy—along with how to conceive of its specific functions in the psychoanalytic treatment process. Recent criticisms of the centrality of empathy as a mode of observation in psychoanalysis have centered on the assertion that empathy belonged to a *one-person-psychology*, hence passé. I claim that empathy clearly belongs (and has always belonged) to a two-person-psychology—even if that recognition remained unarticulated, and the language in which empathy was generally discussed used the language of a one-person-psychology—operationally, without the patient acknowledging having felt understood, the analyst could not claim that he or she arrived at a valid understanding.

The question is often asked: Where does the insistence on the centrality of empathy locate other observational methods in the analyst’s listening process? As Kohut himself remarked, none of our other modes of listening to the patient’s communications should be thwarted, or excluded from our listening and observing. The data gained through any of the other usual channels of perception should be harnessed for the enhancement of our empathy-based entry into our patients’ inner world. But this still leaves the question of how empathy-based understanding is to be communicated to the patient in the two steps of the interpretive process: understanding and explaining (Ornstein and Ornstein, 1980, 1985). This should be a key question for us to ponder. Should analytic communication consistently be phrased from the patient’s subjective perspective? Or should it be presented by the analyst from the perspective of his or her understanding of the *psychodynamics* of the patient’s problems? Can, and should, both perspectives find a place in the analytic dialogue? If so, how should the decision be made, whether to interpret from the patient’s or from the analyst’s perspective? And what is the function of theory in analytic communications? The answer, in one word, is: to *guide* the analyst in his or her understanding and responsiveness.

I digress here briefly and explain why I do not include a detailed discussion on the nature of empathy, but restrict myself to an attempt to elucidate further only the *clinical function* of empathy. My reason for this is to do with the fact that neuroscientists in general, and neuropsychologists in particular, are busy these days with studying the possible neural substrate of empathy, connected with the mirror neurons and other preliminary neurobiological findings—and we can expect in decades ahead some significant progress in correlating the nature of empathy with its possible neural substrates. Such a correlation seems closer to realization, because neurobiologists now speak of the capacity for empathy-like phenomena in much of the animal kingdom, not only in our direct ancestors, the chimpanzees, but even in lower animals.
Be that as it may, this will not resolve the question I have raised about the function of empathy in the treatment process. One obvious reason for focusing on the function of empathy in human communication in general and therapeutic communication in particular, has to do with the problem of how to use the current and future findings in neuroscience in an analytic-interpretive dialogue that is embedded in empathy-based interpersonal communication.

In today’s manifold psychoanalytic theories, it is particularly important to be clear about which theory supports the empathy-based observations and responses, to make our choice for a guiding theory.

Taking up an empathy-based observational vantage point automatically alters the neutral analytic stance and tips the balance toward a relationship between members of the dyad, which then becomes the foundation of the treatment process. Still, our innate capacity for empathy alone is not sufficient for the development of a systematic treatment approach. We also need a theory of psychopathology and a clinical theory that is responsive to the dyadic nature of the interpretive process: empathy does not only offer us an observational vantage point, it also demands that the analyst’s responses be communicated in the empathic mode. In practice, this means that we communicate to the patient our understanding tentatively so that he or she can correct, reformulate or reject what we think we had understood. The essential recognition bears repetition: operationally, without the patient acknowledging having felt understood, the analyst could not claim that he or she arrived at a valid understanding. This empathy-based tentative mode of communication also familiarizes the patient with our own idiosyncratic way of listening. Hearing how his or her communications are being perceived creates a sense of safety and enhances trust in the analyst and in the analytic process. Most importantly, feeling understood (or, the analyst making the effort to understand) constitutes essential aspects of the curative process: empathy-based understanding evokes a feeling of being known, affirmed, recognized, and validated—in Kohut’s encompassing phrase: “mirrored.”

A CLINICAL ILLUSTRATION

A clinical vignette will illustrate two periods in a very difficult, five-times-a-week analysis with an envy-ridden patient, without appreciable progress during the first three years. According to the analyst’s own description (Gerhardt, 2009a, 2009b), well documented in the full report, she had pursued her theory-based interventions—in fact, she tried out several theories—with insufficient therapeutic impact. Then, instead of continuing with what one may call a theory-driven approach, in the fourth year she began to listen differently to her patient, which led to an empathy-based contact between analyst and patient (Ornstein, 2009a). The analyst herself discovered that this important shift in the way in which she now listened and responded evoked a significant change in the patient, as well. This not only humanized the analytic atmosphere, it refocused the analytic dialogue from dissecting the nature of the patient’s psychopathology regarding the “sense of lack” the patient experienced in herself, onto her experience within the analysis. It was the “sense of lack” that triggered her envy of the analyst (intensified by her episodic “envious attacks”). In the first three years, the analyst’s responses—as she was dissecting the patient’s envy—became a replay of the patient’s experiences with her mother. As the analyst’s listening perspective shifted and attention was focused on the patient’s experiences with her, the analysis took a new, productive direction.
The analyst gives a lively, evocative image in her description of her “40ish-year old patient, Ms. A., with a hostile dependent character overlaying a more primitive mode of functioning based on a terror of abandonment and narcissistic identifications with her objects.” The patient is “a daughter of a remote father and a highly regarded, artistic, extremely narcissistic mother.” We are introduced to Ms. A. with an extensive, admirably focused past history and clinical assessment of her psychopathology, which then becomes the target of analysis, from various theoretical perspectives, for the first three years. The analyst recognized the patient’s sense of lack—in my view the actual absence of caretaking responsiveness to legitimate needs—well documented in the patient’s history. But this idea did not take center stage until the fourth year of the analysis. In other words, it did not enter the analysis that the absence (the sense of lack) of needed experiences might be the reason that the patient was desperately clamoring for a belated acquisition of what she had never acquired in infancy and childhood: a sturdy self. To put it differently, the analytic interventions did not focus on what Ms. A. needed and wanted to achieve belatedly in the analysis—but only on what was wrong with her now.

The analyst (Gerhardt, 2009b), in her astute observations, mentions, “inevitable emotional deprivation . . . feelings of deficiency, . . . and wounded narcissism,” in her patient’s background. Then in passing, she also mentions “structural deficiency, “a not quite cohesive self,” a “barely cohesive self,” “wanting to be found beautiful,” “most special,” “archaic self states” (Gerhardt, 2009b, p. 284). But in the absence of a helpful theory, these significant remarks did not coalesce into a stable conceptual guide in the analysis. This illustrates that we need both the method of empathy to make our observations of the patient’s inner experience and a theory derived from empathic observation to guide us to an understanding of what we are dealing with, and how to translate that understanding into our communication with our patients.

Sample interchanges between patient and analyst from each period (the first three years and the fourth year) should here demonstrate the change in the analyst’s way of listening and responding. This highlights the later therapeutic impact of the altered interventions as a result of the analyst’s shift in her mode of listening and responding. And the analyst no longer appears to be hostage to the theories that did not seem to work before: the “decoding interpretations” (Ferro, 2002, p. 310).  

The analyst (Gerhardt, 2009b) gave a clear picture of how she responds initially to her patient’s enraged envy-outbursts: “The [envy] attacks were viewed against the backdrop of her feelings of anger-betrayal in the face of differences [experienced by the patient], or disruptions in [their] contact. These protests were initially viewed as a means of capsizing us as an analytic couple, or denying her dependency or the value of what I had to offer” (p. 284).

These and other, similar, responses seem to have laid bare only the inappropriateness (the pathological nature) of the patient’s demands in the analysis; demands that may well have been appropriate in their original, infantile, and childhood settings but were now perpetuated by her. As a consequence of such sessions, “A. might return the next day . . . either armed with accusations or collapsed into a state of hopeless despair” (Gerhardt, 2009b, p. 284)—leading the analyst to

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6 A designation introduced by Ferro (2002): The “intent [of these interpretations] is to make the assumed unconscious phantasy conscious” (p. 310, italics added). This is where the cat is buried! The paper presents a number of additional samples of these decoding interpretations, which reveal the reasons for the unhelpful analytic atmosphere and the so-called standard [?] interpretations some theories promulgate.
make decoding interpretations (Ferro, 2002), which locate Ms. A.'s difficulties in terms of her "personal intra-psychic dynamics, which puts the responsibility for change in the court of the patient" (Gerhardt, 2009b, p. 284, italics added). No wonder, then, that the analytic effort of the first three years could not become therapeutically effective.

It is highly instructive—and would, therefore, richly repay a study of Dr. Gerhardt's full essay—to learn about the details of how she came to recognize the need to reorient her listening perspective and no longer feeling hostage to the multiple theories she reached for, to inform her analytic approach to Ms. A. A condensed sample of this discovery, leading to the decisive shift that Dr. Gerhardt was able to make in response to the patient's ever more forceful demands to be heard, should now follow.

During the fourth year of the analysis, Dr. Gerhardt recognized that her decoding interpretations implied that the patient was causing her own problems and she should not feel the way she did. Because decoding interpretations are to deal with already "assumed" unconscious fantasies, there was no room for the deployment of the analyst's empathy and subjectivity in the treatment situation.

Here is an example of how Dr. Gerhardt finally discovered, during the fourth year of the analysis, the importance of her own subjectivity in how she viewed the nature of her own participation, and how this contributed to the manifestations of the patient's experience in the analysis. This discovery was a remarkable moment in this analysis, with far-reaching consequences. The shift from the analysis of envy, to the analysis of Ms. A., the person, is beautifully illustrated in one of Ms. A.'s dreams. I only quote (for the present purpose) a short final scene from this wish fulfillment dream:

It is the analyst's subjectivity (broadly encompassed) that makes each psychoanalytic treatment effort unique. Any commentator, therefore, has to reach some understanding from the clinical report of how the analyst deployed or withheld the participation of his or her subjectivity. It is also important to recognize how the analyst was [at some point] able to grasp the patient's subjective, inner experiences along with becoming aware of the inevitable interaction of their two subjectivities—co-determining what the patient experienced and was able to communicate in the analytic narrative" [Ornstein, 2009a, p. 310].

The patient's mother adopted a baby in Europe and sent it home, wrapped in a package. Ms. A. was worried that the baby would not survive. Another woman Ms. A. never saw before was at the house—and the baby does arrive in a package . . . the woman opened the package very carefully, unwrapped the baby and smiled at it, and the baby opened its eyes and came alive! It was a miracle! The baby is alive! Unbelievable. [Gerhardt, 2009b, p. 288]

Dr. Gerhardt remarked:

I marveled at my patient's unconscious which for a moment had cast me as a good maternal object who had valuable milk to offer—life, wisdom, a new beginning—someone to whom she was beginning to feel gratitude . . . rather than keeping me in the role of the tantalizing mother . . . or the secretly malignant mother wrapping her up in cellophane . . . After this dream Ms. A.'s envy and destructiveness seemed to diminish if only for a while. [Gerhardt, 2009b, p. 289]
One could hardly expect a better moment in the analytic experience, as presented. It is a remarkable response on the part of Ms. A. that the changed ambiance and altered focus of interpretations yielded such different results—even if at the moment perhaps only temporarily. Does this not underscore the anti-therapeutic impact of decoding interpretations?

CONCLUDING COMMENTS

Kohut’s reinstatement of empathy into its central position in psychoanalysis (both clinical and applied) was a momentous event for a more up-to-date psychoanalytic understanding of the human condition, and had become a method par excellence in the treatment process. In addition, for Kohut, empathy also delineated the field of psychoanalysis and demarcated it from biology on the one hand and sociology on the other. Thus, empathy and psychoanalysis (and all psychoanalytic psychotherapies) are inextricably intertwined. He added to this the requirement of a prolonged, sustained immersion of the analyst into the inner world of his or her patients—especially their transference experiences. This addition to the definition of a psychoanalytic empathy creates a particularly intense bond between analyst and patient.

Failures in attempting to integrate the many different contemporary psychoanalytic theories are related, among other things, to the different position and usage of empathy. Added to this are the difficulties created by the different meanings of the same terms used for different concepts in the various current theories (Ornstein, 2009b).

I included here the clinical example from Dr. Gerhardt’s essay because it offers a lesson for our time: How does one find the theory that could become a more reliable guide to support an empathy-based psychoanalytic approach in our pluralistic psychoanalytic world today?

REFERENCES


(1968), Introspection and empathy: Further thoughts on the role in psychoanalysis. Unpublished manuscript.


——— (2009b), On choosing a guiding-theory for treatment in a pluralistic psychoanalytic world: My personal journey. Unpublished manuscript. Presented at meeting of Atlanta Psychoanalytic Society, October, Atlanta, GA; Presented at meeting of Tel Aviv Institute for Contemporary Psychoanalysis, March 2010, Tel Aviv, Israel.

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