The Changing Face of the *Ideal* Therapist

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Dimensions of Empathic Therapy

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"Mirrors should reflect a little before throwing back images"

Jean Cocteau

Psychotherapy, in all its guises, has become a culturally sanctioned avenue for personal transformation. As such, the role of the psychotherapist is a relatively powerful one, both because it is invested with moral authority and because of the inherent healing potentials that psychotherapy carries. However, not all psychotherapies are created equal. A growing split is occurring as a managed care version of the medical model requires therapy to be short-term, diagnostically oriented, and manualized with prescribed techniques and goals. This form of "therapy" accommodates a technocratic bureaucracy where immediate costs are the "bottom line." It also appeals to our 'fix-it' mentality of medications, self-help books, and generic solutions to life problems. On the other side of the split, is an ever growing number of psychotherapists and counselors who believe that there is no substitute for an authentic relationship with a designated 'healer' entrusted with that responsibility, that unfolds over time. The following discussion is devoted to those involved in the ambiguous, dynamic process of change and growth. It is important to recognize that I speak from a particular perspective. This perspective, while limited, is what I know best. I am a psychoanalytic psychotherapist first, and second, a person who teaches clinical psychology graduate students theory and practice. These experiences inform my questions: what is our most current thinking about what is transformational in psychotherapy; what is curative in the "talking cure"? A related topic to explore is how the use of empathy fits in with the 'latest edition' of the effective therapist?

The quest to identify the "therapeutic action" has continued since Freud despite numerous research efforts, diverse accounts of therapies, and a wealth of theoretical ideas. Undoubtedly, this is because of the complex, multifaceted nature of healing and growth. These therapeutic factors may differ across patients and often vary within the course of any single therapy. Change is extremely difficult. As psychoanalyst Phillip Bromberg (1993) asks, why should people change, given the almost gravitational-

like pull of staying the same. Change is disorganizing and unfamiliar; it involves personal will, a hope for something better, trust, and opportunities in the world that may be beyond either participant's control. In the following chapter I examine how the empathic approach or empathic position has become an overarching construct in psychotherapy; a meta-discourse. While empathy appears to be foundational to a successful healing relationship, it is widely overused and misused. The tyranny of dogmatic empathy undermines the therapist's authenticity and spontaneity. It can serve as an avoidance of more profound contact by both the therapist and patient. Theoretical adherence to empathic constructs may stifle curiosity about relational qualities better described by other concepts. A case example is provided to illustrate some of the difficulties the therapist and client (patient) face in trying to forge an authentic, constructive relationship. Finally, I discuss how the concept of mutual recognition suggests that empathy is only *one response of many* that may catalyze a turning point in therapy.

THE CHANGING FACE OF THE IDEAL THERAPIST

One way to approach the question is to describe the changing picture of what a good enough therapist looks like over the 100 years since psychotherapy began. My account is highly selective and truncated. Within this context, we will see how empathy has been placed in a privileged position with regard to the therapist's approach. Contemporary accounts provide a balance to the emphasis on the therapist's function as an empathic mirror.

At the risk of oversimplifying Freud and the "classical" position of psychoanalysis, interpretation of unconscious conflicts and processes is seen as the work of the psychoanalyst and the basis for his authority (I will change pronouns later in the chapter to represent the analytic couple as both genders). These interpretations help the patient to understand and control her symptoms. Ultimately, she can make mature compromises rather than employ symptoms that unconsciously express infantile wishes and the defenses against them. Furthermore, the analyst is to remain neutral and detached; a blank screen to absorb the patient's transference. The analyst is himself "well analyzed" and thus purified of potentially interfering neuroses. His neutrality is supposed to guarantee that the patient's perceptions of the analyst are uninfluenced by the analyst's behavior and personality. Here the capable analyst can spot the patient's transference and analyze it, rather like a detached surgeon would cut out the offending tissue (Freud,1912; Renik, 1993). The analyst does this by listening in a unique way to the unconscious

narrative of the patient. In this way, Freud finds the passive complement to the active metaphor—he is both analyzing instrument and receptive listener. This is built around the idea of therapist as a seer of hidden meaning, like the prophet Teresias in the Greek mythology that Freud loved.

Within Freud's inner circle there were subversive challenges to this portrait. Most notably is Sandor Ferenczi's vision of the analyst's purpose. He believed that the cure came from the analyst's "love" for the patient and his ability to react in a truthful and open way. He made an effort to distinguish this from a giving in to the transference love demanded by the patient. He emphasized the tender, nurturing aspects of the analyst's love, identifying it as "sincere sympathy" and "maternal friendliness". Physical contact, in the form of touch, was used with some patients who had been sexually abused in the hopes of healing the trauma. (Homeke, 1999; Ferenczi, 1926). He further recognized that patients needed to analyze their therapist, as the therapist's conflicts were inevitably not fully resolved (another radical departure from Freud). He even experimented with "mutual analysis" whereby the patient and analyst would literally trade places! Ferenczi acknowledged the failure of this experiment, as he fell prey to becoming involved in friendships and romantic liaisons with some of his patients. In this way he sacrificed the integrity of the analyst's role for his interest in developing a more mutual relationship. However strange his technique of mutual analysis might strike us, it is only now that we acknowledge the truth of how reciprocity of healing is woven into a profound therapeutic relationship. Examples of these role reversals are found in recent popular movies about psychotherapy. We see how the insightful patient senses and attempts to heal the therapist's conflicts and wounds. In *Good Will Hunting,* the young patient (played by Matt Damon) will not begin to trust his therapist (Robin Williams), until Williams acknowledges his patient's observation that he is stuck in his love for his dead wife. In this way, both patient and therapist challenge one another to risk loving. This is also an aspect at play in the comedy, *Analyze This,* as the patient (Robert DeNiro) helps his analyst (Billy Crystal) confront, with comic irony, his oedipal rivalry with his successful psychiatrist father. Ferenczi's description of the analytic work begins to resemble the empathic approach. Ferenczi suggested that the analyst treat the patient with sympathy, genuineness, and a kind of maternal care that lay in sharp contrast to Freud's analyst-knows-best model.

Another portrait of the good-enough analyst that began to explore the value of emotional attunement and empathic resonance came from the object-relations group. Object-relations theory asserts the primacy of people's hunger for satisfying human contact over the drive for sexual and aggressive

instinctual gratification proposed by Freud. The British pediatrician and psychoanalyst W.D. Winnicott, championed the "care cure" over the "remedy cure". Winnicott s theory and accounts of his therapeutic style, indicate that he believed that the analyst should adapt to the patient's needs. In many ways, Winnicott drew parallels between his idea of the "good- enough" mother and the good analyst. The analyst was to provide a facilitating environment. This holding environment could include literal hand-holding as well as containment in the form of adjunct hospitalizations (without medications) for his more regressed and fragile patients. The analyst's "job" was to facilitate the patient's "true self" to emerge through spontaneous play that would occur if the patient perceived the analyst as safe and caring. While the patient and analyst worked on an intellectual understanding of her history and the impingements that lead to falling ill; much of the work was in the patient's creative use of the analytic relationship to provide a new way of relating with another and hence, a new of being.

Empathy, per se, becomes a cornerstone in psychoanalysis, with the work of Heinz Kohut and self-psychology. He asserted that the royal road to understanding was through empathic listening; defined as "vicarious introspection"(Kohut, 1959). Working with patients diagnosed with narcissistic disorders (alternatively called disorders of the self), Kohut became interested in representing patient's experience from their subjective point of view, rather than from a traditional "experience-distant" perspective that emphasized interpretation and diagnosis. The "experience-near" perspective, gained through empathic listening, helped patients to feel understood. Kohut demonstrated how faulty empathic responsiveness created deficits in self-structure. Analyst working from a self-psychology orientation tracked empathic failures and their impact on self-experience. Furthermore, self-structure is understood from a context of a "self-object" environment that can promote or weaken the self. Symptoms and experiences of fragmentation, emotional deadness, and weakness are all understood as resulting from assaults in the form of faulty self-object responsiveness. Kohut defined empathy, in the analytic situation, as the capacity to experience the patients inner life while remaining objective. While Kohut was ambivalent about the curative role of empathy in psychoanalysis, proponent have claimed that it is a reparative experience, leading to a sense of personality integration and cohesion. Thus empathy becomes essential, in self-psychology, as a mode of listening to patients, and as a relational quality needed throughout life, that can, if missing, devastate the development of the self.

Outside of these developments in psychoanalysis, the role of empathy in psychotherapy was

articulated in the late 50s and 60s through the work of Carl Rogers. Rogers created what amounted to a revolution with regard to making psychotherapy accessible to Americans. He took psychotherapy out of the medical model and into the realm of humanistic pursuits. His "client-centered" therapy markedly diverged from psychoanalysis in rejecting the role of interpretation and focusing on the here and now experience of the patient. In some ways, Rogers gave the patient the ultimate authority in the relationship. Unlike classical psychoanalysis where the analyst had the last word, the client determined the direction of the therapy and the accuracy of the insights gained. Rogers conceptualized his role as a "trusted companion" whose benign presence would facilitate the clients 'natural' abilities to grow and heal. Key to facilitation were the therapeutic triad of "accurate empathy", genuineness, and acceptance. If the therapist committed himself to developing these attitudes, the client would evolve in constructive ways. Empathic contact was to be achieved through the painstaking work of reflecting back what the client was feeling, thinking, and experiencing. For Rogers, empathy is in and of itself a tremendous healing force. He considered this to be the easiest of the three attitudes to teach, but a sorely neglected therapist skill (Rogers, 1980; Thorne, 1992). Like Kohut, Rogers was careful to emphasize that empathy must not turn into complete identification; the therapist must have a strong identity to not become frightened, overwhelmed, or lost in the client's subjective world.

While much has been made of the differences between Rogers's and Kohut's work, there are "striking parallels" between them (Kahn, 1985). These parallels include the therapist's ideal attitude, as well as constructs of how the therapy process works, and goals for outcome. Most salient is the emphasis on the therapist's immersion in the patient's subjective experience. The patient, through this process, feels understood, and on some level accepted and affirmed. Both theories attribute a variety of problems to a lack of empathy from significant others throughout development.

CRITIQUE OF THE "EMPATHIC APPROACH"

Due to the influence of Carl Rogers and Heinz Kohut, the empathic approach to therapy became a dominant force in clinical training, both in terms of theoretical models, and clinical techniques. The following considerations are offered in the spirit of restoring empathy to a more proportional place in psychotherapy. This is important because theoretical models intimately impact how we think and what we do as therapists. These models also influence patient's expectations. Empathy has become a catch all

term that is overused and misused. This complaint has been voiced by clinicians and researchers alike. Researchers find that the concept of empathy has so many divergent definitions that it lacks construct validity. The lack of agreement about what it is and how it works makes clinical research on the subject extremely problematic (Wispe, 1986). Even more relevant are critiques of empathy as it's used in the clinical situation. Ira Moses (1988), working from an analytic perspective, states, "Current theory and applications of empathic techniques, however, have become filled with illusions, fallacies and misapplications to the point that the concept is so overextended it lacks any special meaning and its use has become quite unconstrained." An apt illustration of how all manner of clinical interventions are called empathy can be found in an article by Jon Frederickson (1990). Frederickson presents a sensitive account of therapy with a man who becomes increasingly verbally abusive, shouting and swearing at the therapist. The therapist does his best to understand and explain the patient's outbursts. At one point he is pushed to a spontaneous reaction, when he stands up and yells at the patient to "shut up and stop yelling." Ironically the patient feels a profound sense of relief and tells him that this has been the most human contact they have ever had. Frederickson speculates that in these interactions where the patient was yelling, the patient has unconsciously, acted like his abusive father and put the analyst in the position of playing the patient as traumatized child. Thus he describes his reaction as an empathic intervention. While Frederickson's reasoning is plausible and informative, it seems that many issues get obscured by collapsing all that happened into an "empathic position." The patient does not immediately feel empathy and understanding; he feels relieved that he is dealing with a fellow human being who is capable of having spontaneous, expressive reactions. The therapist's deviation from his usual and customary position (the understanding, reflective therapist) results in a kind of profound recognition of the patient (Hoffman, 1998). It is, perhaps, because the therapist was willing to act outside the role of empathic therapist that a more mutually authentic relationship developed. This does not exclude the ways in which the therapist's expression of hatred could be considered empathic from a context of unconscious enactment.

Empathy is often integrated into clinical work as both a position and as a technique. Rogers identified "accurate empathy" as an essential part of psychotherapy. While he emphasized that empathy should be an attitude rather than a technical intervention, client-centered therapy is learned through the use of empathic statements. These statements are constructed from reflection techniques that mirror

as closely as possible the client's perceptions, feelings, and thoughts. These interventions often start out with something like "I think what you are saying is that . . .", or "I sense that you are feeling x." While some technique is useful and unavoidable, the consistent use of such reflections foreclose the therapist's creative thinking about other aspects of the experience. Not only is reflective thinking and inquiry limited, but it becomes unlikely that the therapist will act outside the role of empathic therapist. The therapist strains to make sure that he has captured what the client is experiencing. Both therapist spontaneity and authenticity become scarce commodities in such an exchange. I have personally listened to entire transcripts with student therapists where every intervention consisted of reflection statements, in an attempt to be empathic. While it would be nice to think that this kind of distortion of empathy is unique to beginners, it is not. Psychotherapists (of all persuasions) are guilty of hiding behind technical jargon; of not speaking in a sufficiently personal way (Schafer, 1974). Are we in danger of substituting one jargon for another? The stereotype of the blank screen analyst ("Hmm-mmm, and what do you think?") has been replaced by the therapist who hides behind empathy. Neither is willing to risk a fully authentic relationship where their subjectivity is openly expressed. Patients often sense this hiding in plain sight and may come to realize that this attitude serves the therapist's needs more than the patient's needs (Slavin,1994). This defensive use of empathy is comically portrayed in the movie, *Analyze This.* In one of the opening scenes, we see the therapist treat his patients in an apparently empathic manner; asking them how they feel and reflecting back to them their point of view. We then see a fantasy sequence where the therapist, portrayed by Billy Crystal, tells them what he is really thinking. Ironically, he is more expressive, less patronizing, and perhaps, more helpful in his unedited response. Of course, Crystal's dilemma is resolved when he meets the patient/mobster who challenges him to act in a way that is spontaneous, authentic, but disciplined. Ultimately, we see the therapist and patient involved in a dialogue. While this is directed at helping the patient, both change in the process.

The theologian Martin Buber articulated a similar concern many years ago. In a public debate with Rogers in 1957, Buber questioned the reciprocity of the relationship between therapist and client in Rogers client- centered therapy. A relationship not anchored in true reciprocity (where only the client's subjectivity is sanctioned) creates more self-centered individuals. It also creates dependency on the therapist for this kind of empathy (Thorne, 1992). While some of Buber's critique is a consideration in all forms of psychotherapy, I wish to deal with the troubling aspects that are specific to Roger's therapeutic

position. The salient issue at stake is that an empathic approach that lets the client take the lead and that assumes the client will grow in constructive ways seems to privilege the patient's authority. In this empathic approach, the patient's world is explored in depth, but the therapist must subordinate her subjectivity. Her perspective is valued only for its reflection of the client's perspective; for her mirroring function. Where is the therapist's person in all of this. She is somewhat restricted in her thinking and acting. She must not confront the patient with her differences.

With regard to psychoanalysis, the empathic approach, fostered by self-psychology, has developed many of these same problems. Stefano Bolognini (1997) objects to the way empathy is supposed to be used through force of will. He calls the degeneration of empathy "empathism." Empathism, in his view, consists of the problematic use of empathy as a forced analytic attitude and an over-identification with the client's perspective and feelings. This becomes a boundary problem, whereby the analyst does not give herself the psychological space to associate to the patient's material or to assume other positions in the countertransference. He is careful to point out that the dogmatic use of empathy is a distortion of Kohut's approach. Bolognini states that empathy should be a goal and not a technical stance. If we are lucky, we will gain some profound understanding of the patient's experience after long, hard work.

In a related critique, Hoffman (1998) discusses the damage we do by setting up empathy as an ideal therapist quality if, in fact, it is not a realistic, attainable goal. Furthermore, he argues that the therapist will do more harm than good if she is too concerned with playing the part of the "good object" and avoids doing anything that smacks of the "bad object" as construed by the patient. This is not a vote for an "anything goes" attitude. Furthermore, the therapist must not act in a way that violates the patient in any way. Thus, Hoffman conceptualizes the therapist's attitude as a dialectic between going "by the book" and a judicious throwing the book away. Empathy, in the form of empathic listening and reflecting the subjective world of the patient is part of what form the therapist took. The therapist must be able to step outside of her approach to act, think, and participate in ways that are emotionally involved and spontaneous. It is helpful for therapists (and patients) to have a theoretical model for this dialectic. All too often the therapist feels guilty for having acted in spontaneous ways (how many times do clinicians withhold information from a critical supervisor) which can spoil a perfectly therapeutic interaction. However, it is important to recognize that all therapist ideals, and any kind of intervention can be used in a distorted way. Therapy is hard work for both parties, and it is easy to fall back on formulaic ways of

engaging. However, it is particularly insidious when empathy is used in a clichéd, rote, or emotionally removed manner. After all, the true spirit of empathy is about feeling understood in a deeply meaningful and personal way. Empathy helps to ameliorate the inherent aloneness of human existence.

EMPATHY: A FORM OF RECOGNITION

Another relevant concept that is being developed in contemporary psychoanalytic literature, based on the ideas of the philosopher Hegel, is that of recognition and mutual recognition. Recognition from a valued other gives us our sense of who we are (Honneth, 1996). We see ourselves through the eyes of others. If parts of the self remain invisible through lack of acknowledgement then agency, power, and self-esteem are damaged. What is recognized is, of course, not necessarily some objective quality, but can arise out of creative and necessary illusions. When a mother sees her infant as perfect and beautiful, she selectively ignores some factors in favor of the loving illusion she is creating. The struggle for recognition begins within the family but is also fought at the level of the wider social order. We tend to construct social orders that recognize and privilege its members based on traits like gender, age, and ethnicity—with various constructive and destructive results. A key part of recognition is that it *always* involves mutuality. Jessica Benjamin (1990; 1999) calls this the "paradox of recognition." To be recognized, we must, in turn, recognize the others subjectivity. In recognizing each other's subjectivity we struggle with the inevitable clash of wills of two different subjectivities and with the potential for indifference that can occur in the intersubjective space. From a psychoanalytic standpoint, the psychotherapist is in a unique position to negotiate mutual recognition, because of her privileged place in the mental life of the patient. The therapist's recognition *may* take the form of an empathic response, whereby the therapist's understanding of the patient's experience is critical in allowing the patient to validate his experience. This may help the patient to solidify his sense of reality and trust in his own perceptions. However, the recognition can take other meanings and forms that fall outside the realm of empathy per se. The therapist may recognize some other aspect of the patient's subjectivity and agency that may even take the form of a protest. For example, a therapist may react to some irritating behavior of a patient that actually challenges him to take responsibility for his effect on the other. In this case, the therapist recognizes something that is hardly experienced as empathic, but yet helps the patient to register his potential to affect his therapist. In general, acts of recognition in therapy are often deviations from practice as usual

(Hoffman, 1998). The patient senses that the act of recognition is in fact, important because it lies in contrast to certain conventions or "rules of the game." When a psychoanalytic psychotherapist attends a patient's wedding, it acquires all the more value because it goes against the grain of the restrictions on meeting outside the consultation room. It is commonplace for people in long-term therapy to compare notes on this subject—exploring what the therapist has said or done that helps the patient to believe he is special in the eyes of the therapist. These proofs of love are poignant given the fact that this is a relationship that is paid for; a far cry from the unconditional love of a good childhood. Clinical examples of recognition range from overt acknowledgement of some aspect of the person to acts like adjusting the room temperature, sensing the patient's discomfort even before it is expressed. Again, some of these events may best be described as empathic while others are not.

A CASE IN POINT

The following case is offered to share my own struggles with empathy in psychotherapy. This therapy struck me as interesting because of some unique features whereby empathy was critically important to the patient, and at the same time his demand for empathy was often a way of avoiding the patient's difficulties accepting his own agency and thus, ultimately, contributing to his own disempowerment. Kevin was a 40-year-old research scientist of European heritage who began therapy with me to understand and ameliorate some extremely painful symptoms. The most prominent of these was his tendency to stare at other people or to look away. This caused him much anguish as he was constantly monitoring his eye contact. He felt that other people noticed his behavior and this made them uncomfortable. When I inquired how he knew that other people had observed this, he acknowledged that he did not receive direct feedback, he just "knew" that people noticed and felt it was odd. He seemed mildly irritated that I would question his conclusions. He revealed other bodily based symptoms. For example he sometimes felt as if his facial expression was fixed in a frown. Despite the ambiguity about the meaning of his symptoms, he was certain that they held at bay disturbing thoughts and feelings. He then went on to describe a number of significant "breakups" in his life that resulted in him losing people he had admired and loved. He appeared to want me to share his sense of outrage. These broken relationships often ended in an ugly scene where the other person abruptly terminated the relationship. One such situation, as I could reconstruct it, involved his dissertation advisor. He was supposed to be

working on his advisor's project in the laboratory. Kevin kept bringing him work that was not what they had agreed upon. The professor, Dr. B., kept asking him why he was working on it rather than the project they were being funded for. Kevin was mystified as to why Dr. B. wouldn't let him pursue his interest and thought that maybe it was caused by envy. He couldn't understand why such a kind and brilliant man would feel threatened by his discoveries. He instigated a series of discussions as to why he couldn't work the way he wanted to; that Dr. B. should see how his work was inspired by his mentoring and would be good for both of them. These discussions reached the point where Kevin was yelling at Dr. B. He refused to leave his office until they settled the matter. Dr. B. had a class to teach and ended up calling campus police asking them to escort Kevin out of his office. Kevin subsequently changed advisors and after many years, was able to finish. Similarly, relationship difficulties with his ex-wife (a school administrator), resulted in her complaining that she couldn't get any work done because Kevin was continually calling her at school wanting to talk about their problems. She also complained of being unfairly criticized. Their marriage ended, when his ex-wife moved to another state to further her education and get some "space." She also threatened to get a restraining order during their final days together. Previous therapy attempts ended in failure.

At the time Kevin came to see me he was preoccupied with his symptoms and with reviewing his losses. In every instance he felt he had humiliated himself and that they had failed to understand him correctly. He was aware that these situations were reminiscent of his relationship with his father. He described his father as a man who had become increasingly verbally abusive and paranoid to the point where he had lost a prominent position in business. The family suffered a downward spiral in social class status. He alienated his wife (Kevin's mother) who felt only disgust and contempt for him. His father, who he had once felt extremely close to, began to accuse Kevin of behaving in ways that had no basis in reality. For example, he would attack his son for not taking out the garbage after having just done so. These false accusations resulted in emotionally abusive onslaughts. Kevin would try to defend himself by "standing up" to his father rather than acting intimidated. This eventually lead to his father openly expressing his regret that Kevin was his son.

Now, I would like to shift the focus to what happened between us in those first few sessions. After Kevin had described his symptoms and given much of the above history, he shared with me his goals for treatment and told me how he thought I could best serve him in our work together. He told me that the

symptoms he had reported interfered with all aspects of his life. He had almost no social life (except for one friend who lived in another city) and had stopped dating for fear of further rejection. He felt that other people, including his chairperson at the college, where he was an assistant professor, felt uncomfortable around him. He spent an inordinate amount of energy trying to control his symptoms and his thinking about it often got in the way of his productivity. He was so afraid of appearing insubordinate to his senior colleagues and to the Dean, that he felt he had squelched himself to the point of feeling emasculated. In this eat-or-be-eaten world, he was prey. Kevin spoke about such domination and submission rather literally, using examples from the animal kingdom.

Kevin was very rigid and explicit about what I should or should not do to help him. Whenever I tried to explore with him an alternative way of looking at an interaction, he responded on a continuum between mild annoyance and rage. These negative reactions to my offering other "spins" on events often resulted in me feeling quite devalued. Further attempts at interpreting these attacks as "transference" or as him doing to me what was done to him by his father went nowhere fast. He seemed to only want empathy or silence, his own version of 'if you can't say anything nice, don't say it at all.' My fear was that his attempts to control me and his devaluations would result in the same old story—where I would throw him out, unable to tolerate his domination, or he would leave convinced of my incompetence.

According to Kohut, such narcissistically fragile patients need a prolonged period of empathic immersion. They need to be understood from an "experience-near" perspective before they are ever confronted, challenged, or interpreted. Self-psychology theory suggests that empathic failures should be tracked within the therapeutic relationship (as well as in the patient's life outside) so that the therapist learns where the developmental arrests and deficits exist. This is done by noting the fragmentation and dysphoria that may occur when the patient feels misunderstood or when their 'self-object' needs are not met in other contexts. Interestingly, there is another approach, set forth by Otto Kernberg, who recommends just the opposite. Kernberg is careful to set limits and to confront the patient with his rage from the onset of the treatment. However, when I thought of Kevin's situation, neither setting limits, delving into interpretations, nor immersing myself in his subjective world seemed to me to be the right atmosphere to create for our work together. I felt that I had to address my differences with him openly. To not do this would be hiding my agenda, my values, my skills; in short myself. If, on the other hand, I let him set the agenda (as he had tried with Dr. B.), I would enable him to dominate and sooner or later I

would attempt to break free. However, had I immediately set limits on his behavior, in anticipation of his rage, he would have most likely felt unbearably constrained and might have left: treatment.

The problem that Kevin and I faced can be understood in light of the construct of mutual recognition. With the other's loving recognition we come to know our selves and develop a sense of agency. However, in being seen we must recognize that the other person exists as a separate but equal center (Benjamin, 1999; Honneth, 1992). The capacity for mutual recognition is thought to be hard-won; slowly developed, and never fully realized. From the original emotional interplay between mother and infant, to the battles of will of the toddler, and the narcissism of adolescence; we strive to assert ourselves while reconciling the fact that our audience have their own wills. We hunger to be recognized for our uniqueness, for our value, and for our impact on the other. An undeveloped or uneven capacity for mutual recognition results in power struggles where assertion is exerted in such a way that attachment is lost. There are plenty of opportunities for problems in development. Mother must do her part in profoundly recognizing her infant (and later her increasingly independent child). She must also sustain a sense of her life apart from her children, despite internal, familial, and cultural pressures to be defined only in terms of her mothering role. This aids the growing child's realization that there are other subjects out there, not *just* objects of our desire or thwarters of our wishes, but separate others with their own initiatives who may or may not be indifferent to us. Kevin's clashing of wills with those around him seemed to grow out of a distortion of mutual recognition. His initial bid to "do it my way or else" reflected this lifelong problem that lay at the heart of his alienation. His symptoms expressed his ambivalence about human contact given his eat-or-be-eaten world. I needed to engage with him in a way that allowed us to both exist as equal subjects to each other (we were also objects to one another on conscious and unconscious levels).

The most authentic and empowering course of action seemed to be to share my dilemma with him. I "recognized" his power to hurt and control me and tried to link this to what had happened to him in so many significant relationships. Sometimes these recognitions were spontaneous and revealed my anger as well. Other times my responses were modulated and premeditated. However, he was only able to accept this realization when I balanced it with empathy for his subjective experience of both our relationship and the other situations. If I had only empathized with him (as if that were possible!), I would have infantilized him and taken away his enormous contributions to the vicious circles he found himself in as

he experienced himself as a passive victim. However, he needed and deserved significant and meaningful empathic connections as a backdrop to our work together. The self-psychology approach to track swings in his self-esteem based on his perception of my empathic responsivity was helpful but no substitute for sharing with him my subjective experience of our relationship.

Many months later, Kevin told me that my not imposing premature limits (as some other therapists before had done) was vital to his sense that he could be himself and trust me. He said he was surprised by my responsiveness, honesty, and insistence that I could not work in the way he had asked. We struggled and renegotiated these issues often and openly. Outside the therapy, Kevin continued to find himself in difficult impasses with others, but they were enacted on a smaller scale. He was sometimes open to my views about them and, even asked for my "advice." There were moments where our differences threatened to rock the foundation of our relationship. I had to continually rethink my position in order to find a balance that would enable me to hold my ground while taking his perspective seriously. Much to our mutual relief, there emerged a playful quality to our efforts. We both brought with us our senses of humor. This aspect of our relationship enabled us to survive his rage and my defenses. Our work seemed fruitful. We managed to crack the ice of his "mask"—to reach more of his feelings of being alive. At times he would protest that I was not being "empathic" as I was supposed to be. I did not fit either his ideal of the analyzing, neutral therapist or the empathic therapist who mirrors back the patients experience. I strove to be more involved and collaborative (Renik,1993; Rubin, 1998). What was as important to the therapeutic process (as empathy and interpretations) was our search to be together in ways that acknowledged our mutual influence without violating the differences in our roles (as patient and therapist). Kevin framed the dilemma he was in quite simply when he said, "I wish I could do this work alone, but I can't—I need you here to do it with me." This is what Benjamin calls the "paradox" of mutual recognition: to be profoundly recognized, you must recognize the one who sees you.

CONCLUSION

Empathy is undoubtedly a cornerstone of psychotherapy; whether it is considered an entree into the patient's world, a necessary dimension of a healing relationship, or a final goal of the therapeutic process. However, when an empathic approach becomes a dogma or an unattainable therapeutic ideal, we fail our patients. Empathy has been used as a screen to hide the therapists subjectivity. Likewise,

patients may demand empathy when curiosity or confrontation is needed. Hopefully we can embrace and articulate other ways of responding that inspire transformation and healing. Jessica Benjamin (1999) has identified the central project of relational theory as the formulation of identifying what happens when empathy and interpretation fail to keep the therapeutic relationship alive at difficult impasses. We also need to be sure that we do not do what Racker so courageously warned us about over 40 years ago in his writing on countertransference (Racker, 1968; Hoffman, 2000; personal communication). In this seminal work, he suggested that even empathy is not some purified, accurate portrayal of the patients inner being, but rather a very complex response that originates out of an ambiguous sea of the therapist's own conflicts and life history, conscious and unconscious responses to the patient's views of the therapist, and multiple identifications with external and internal objects and attitudes within himself and the patient. This kind of reading of empathy leads us, as therapists, to continue to explore and question our intentions to cure in a way that opens us up to relating in a more vulnerable and authentic way.

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