Homospatial Process and Empathic Understanding

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The Creative Process of Psychotherapy

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The Index to Scientific Writings on Creativity:
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The Index to Scientific Writings on Creativity:
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Homospatial Process and Empathic Understanding

Empathy, and empathic understanding, constitute another type of creative effect of the homospatial process in psychotherapy. Initially described by workers in aesthetics, empathy is today a major clinical construct of treatment. This path from art and aesthetics to clinical theory and practice is by no means a new one. Sigmund Freud, the founder of the principle of modern psychotherapy, had a profound appreciation for the importance of art and literature and the insights of artists and writers throughout history. Indeed, he publicly acknowledged the deep understanding of the human psyche provided by writers and artists before him, as in the following: "But creative writers are valuable allies and their evidence is to be prized highly, for they are apt to know a whole host of things between heaven and earth of which our philosophy has not yet let us dream. In their knowledge of the mind they are far in advance of us everyday people, for they draw upon sources which we have not yet opened up for science."[1]

In line with this heritage, then, it can be no surprise that empathy and empathic understanding in treatment can be illuminated by considerations based on scientific research on creativity. The concept of empathy, introduced into clinical theory first by Freud, was earlier the cornerstone of a theory of artistic and aesthetic experience conceived by the German psychologist

Theodor Lipps.[2] Lipps also influenced Freud extensively in his theory of the comic and, as has been shown by Kanzer, Lipps's concept of an unconscious antedated Freud and directly influenced him as well.[3]

Lipps's term "Einfühlung," literally meaning "feeling into" was translated into English as "empathy," based on Latin and Greek equivalents, by the psychologist Titchener.[4] The English aesthetician Vernon Lee (Violet Paget) elaborated the concept and experience of empathy and considered it to be the major factor in aesthetic pleasure.[5] For example, Lee pointed out that we react positively to a metaphor such as "the mountain rises [up in front of us]"[6] because we have experienced raising our own heads when looking at a tall mountain. Controversy about the precise nature of such empathy developed between Lipps and Lee, and also Groos[7] who was famous for his psychological studies of play. The art critic Worringer later attempted to shift aesthetics away from empathy toward what he called abstraction.[8] Psychologist Groos had focused on "inner imitation" in his discussion, and for several decades after him, experimental and sensory psychology also emphasized the imitative factors in empathy. In more recent years, empathy has been of interest to psychologists involved in clinical and experimental investigations and developmental studies of socialization, altruism, and social learning.[9]

Clinical interest in empathy has been strong since the introduction by

Freud, and seminal papers on the mechanism of empathy in treatment have been written by Fliess, Greenson, Ferreira, Schafer, and Beres and Arlow.[10] Also, Rogers has put a good deal of emphasis on empathy in his nondirective therapy approach and it has been a focus of his psychotherapy research.[11]

A somewhat distinct development has been the work of Kohut[12] and his followers, in which a "central position"[13] of empathy in both human development and psychotherapy has been emphasized. Work of this group has focused on the role of empathy, and on the nature of empathy as a mode of understanding, more than on explanations of the mode of action or psychodynamic structure of empathy itself. Kohut, for instance, defines empathy as "vicarious introspection" and, while emphasizing an observational and data-gathering aspect to this function,[14] he does not explain how this type of introspection actually leads to understanding and knowledge. Historically, then, the empathy construct has passed from aesthetic discourse, involving considerations of the experience of pleasure and involvement in an artistic object, through Freud's work and into modern psychotherapy, where it is considered a factor in a treatment process involving both intrapsychic and interpersonal factors.

I have traced this history to throw into relief the variable nature of this construct, to put empathy in art and empathy in human relationships into a correct historico-theoretical perspective,[15] and to focus attention on the

challenges connected with considering the nature of empathy in the treatment process. The term “empathy” has accrued a number of overtones and meanings through popular as well as technical usage, and these additions are not necessarily intrinsic either to the psychological properties of the phenomenon or to its therapeutic effect. For example, in common parlance the word empathy has come to be used as a virtual synonym for the word sympathy, but it is important to distinguish these terms with respect to therapy. Whereas sympathy means to feel the same as someone else, as when one says, “I am in sympathy with you,” or “I share your feelings,” empathy means to understand as well as to share in a manner that goes beyond having the same surface feelings. Being empathic with a depressed person in a therapeutic setting would not consist of becoming depressed oneself or saying “I also feel your future is black and therefore feel sorry for (or with) you,” but it could involve understanding and responding to difficulties with aggression and self-esteem behind the depressive presentation and affect.[16]

Empathy is also often linked with love and warmth. People are described as warm and empathic or loving and empathic and, in therapy, warm interventions are often automatically described as empathic ones. Although I believe there are intrinsic connections between warmth, love, and empathy, they are not simple or direct.[17] A therapist’s empathy may be experienced by a patient as warm, or even loving, but warmth or love does not directly generate empathy and empathic understanding.

Usually, also, empathy is considered similar or related to intuition. Kohut,[18] as well as Beres and Arlow,[19] draws distinctions between these phenomena. In this case, however, this commonly made connection does provide some special clues to the psychological properties of empathy and its therapeutic effect. Intuition is similar to empathy because both are, in some way, sources of knowledge. After Freud introduced the idea of empathy into psychoanalysis, he defined it as "the mechanism by means of which we are enabled to take up any attitude at all toward another's mental life"[20] and pointed to an essential elucidating or knowing function. While intuition consists of drawing conclusions from minimal cues and tends to be primarily a cognitive skill pertaining to all realms of knowledge, empathy pertains primarily to human experience and has strong affective components. Both, however, have distinct cognitive and knowledge-generating functions. These latter functions of empathy, as suggested in Freud's comment, are crucial to the conduct of a treatment based on understanding, both cognitive and affective, of another's mental life.

Although there are many different ways of understanding and being with a patient that relate to empathy, or are called empathy, I propose that the role and function of the empathic process in treatment derive closely from the initial construction of "feeling into" another object. From tracing the nature of this operation of "feeling into" comes an explanation of both the mode of transmission and the type of understanding and knowledge achieved

about another's mental life. Not a self-evident operation, "feeling into" in treatment is related to empathy in aesthetic experience and is primarily a creative function.[21]

In the psychotherapeutic transaction, empathy involves the homospatial process. As with the creation of metaphors, the therapist cognitively and affectively formulates multiple entities as occupying the same space. However, beyond and including words and their meanings as in poetry, visual forms as in art, and sounds as in music, the therapist conceives his self representation together with the patient in the same space. In this process, the therapist actively "feels into" and superimposes his representation of himself with his mental model of the patient. He may conceive of himself as actually sitting where the patient is and also include in such a physical image the mentally represented word, visual, and sound experiences he has had in sessions with the patient. As the homospatial process can involve the visual, auditory, kinesthetic, tactile, olfactory, and gustatory sensory modes, the therapist experiences superimpositions of multiple sensory representations associated with the patient's location and psychological experience—how the patient sits, moves, experiences the taste of food, etc. Most important, there are superimpositions of the therapist's and patient's "lived space"[22] —the mental model of the patient's feelings, thoughts, and experiences and the therapist's mental representation of his own feelings, thoughts, and experiences. This mental model of the patient may—and, in the most effective

and fully developed empathic experiences, usually does — derive from a rather long and protracted association with the patient. Also, the therapist must have a fundamental base of systematic knowledge together with a preconsciously available storehouse of experience with human conflict, crisis, and suffering. The longer the association with the patient and the more developed the mental model, the more complex and protracted the empathic experience.

Let us look first at an example of what is appropriately described as an empathic "event," a short-term phenomenon: A middle-aged hospitalized male patient with a long history of impotence reported to his therapist that he had begun a relationship with a female patient having strong sexual overtones. Because the patient had fairly recently been focusing on concerns about homosexual masturbation fantasies, it first appeared to the therapist that a fairly strong acting-out resistance had developed. Furthermore, the hospital had quite explicit prohibitions against sexual relations among patients, and the picture was further complicated by the appearance of what seemed to be the patient's overt rebellion against hospital rules.

While the patient talked about his relationship with the woman, the therapist listened and tried to find an effective way of confronting him with his resistant behavior. Experiencing the patient's account as increasingly defiant and closed off with respect to the possibility of insight, the therapist

then began to change his mode of listening. He listened to this patient's words about his intense need to be with the woman and, actively but fleetingly, mentally represented himself sitting where the patient was and talking about this relationship. At that point he continued to hear the patient desperately trying to escape his homosexual concerns and also experienced another aspect of the patient's discourse. It sounded quite a lot like the words of an adolescent male who was having overdramatized feelings of love for a girl he had not known very long. Listening carefully to this aspect of the patient's production brought back his own feelings as an "in-love" adolescent and memories of concerns at that time. Specifically, he remembered the feeling of having something to live up to — he felt he had to live up to both the girl's and his own expectations. Remembering this, he commented directly to the patient about such a feeling, saying it seemed he felt he had something he had to live up to. In response to the intervention, the patient relaxed his defensive stance somewhat and began to talk of his fears of pursuing the relationship. The therapist then attempted to clarify the patient's fears; that led directly to the topic of his serious concerns about sexual performance.

In the therapeutic process, empathy is an active motivated function that leads to particular understanding of the patient's inner psychological state.[23] It is, as Schafer has described it, "a creative act" in personal relationships.[24] The product of a creative process is, as I have said, both new and valuable, and empathy produces useful interpersonal knowledge where it did not exist

before. Therefore, it should come as no surprise that a creative operation present in other types of creative activity should be involved. Therapeutic empathy is not the same as the general developmental function Herbert Mead called “taking the role of the other.”[25] Nor is therapeutic empathy the same as “getting with”[26] the patient, getting on his side, or simply conceiving how another person feels. These are probably early aspects of the empathic process, but simply being on a patient’s side does not produce knowledge by itself about the patient’s inner experience, nor does it necessarily lead to such knowledge.

Conceiving another person’s feelings primarily involves a shift of perspective alone. Although shifting of perspective has importance, like Mead’s construct it is not specific to therapeutic empathy but is an aspect of everyday human interaction and all functional relationships. Experimental support for this distinction comes from a study by Stotland in which instructions to subjects differentiated between imagining what another felt, imagining oneself in another person’s situation, and simply watching another person carefully. Subjects who experienced distinct physiological and subjective responses to another person’s pain were, to a significant degree, neither in the group instructed to imagine what the other person felt, nor in the one told to observe reactions carefully, but in the group specifically told to imagine themselves in the other person’s place.[27]

Since Freud's initial formulation of the psychodynamic structure of empathy, i.e., "a path leads from identification by way of imitation to empathy," identification has been considered a core aspect of the phenomenon.[28] Fenichel emphasized the function of body imitation in producing the identification.[29] Schafer described the gradual building up of a structural identification with the patient that optimally remained segregated within the therapist's ego "as an object of actual or potential contemplation," while Fliess earlier, and Beres and Arlow later, took the position that the identification was a modified type they termed "transient."[30] Greenson, Shapiro, Buie, Basch, and others have criticized such formulations on the basis that classical identification involves a structural change in the ego that is not evident in empathic processes.[31] In support of such criticism, Meissner's careful and systematic discussion of the identification mechanism stresses the need to take its intrinsic defensive roots into consideration.[32]

Defense and empathy do not appear to be at all connected. Although some writers have pointed out that empathy can be used for defensive purposes[33] and some have shown deceptive confusions between countertransference factors and empathy,[34] it is difficult to provide an adequate psychodynamic account for a defensive genesis of the empathy phenomenon. Moreover, as a largely passive and unconscious mechanism,[35] it is difficult to connect identification with empathy's conscious, actively motivated aspects. Similar considerations apply to the proposition that

projective identification is the basis of empathy.[36]

In the case example cited, the therapist did experience a subjective sense of feeling as the patient did, and some prior identification with the patient may possibly have been involved, but other aspects of the sequence of events need to be emphasized. For one thing, the therapist was clearly aware of his own separateness from the patient and the transient experience of being the same as the latter was succeeded by knowledge about the latter's preconscious contents. Such separateness within the empathic experience has been also cited by some of the above theorists emphasizing identification, but considered only as an indication of the functioning of a special *type* of identification, rather than as a contradictory piece of data.[37] More recognizable in the example is something similar to what Beres and Arlow call "signal affect,"[38] a premonitory sense of some event or change. The therapist experienced the patient as closed off and defiant but nothing happened automatically; he was then motivated to *change his mode of listening*. In this changed mode, he actively superimposed his self representation upon an image of the patient talking. He brought his own "lived space" into the same "lived space" as the patient and began the creative homospatial process leading to empathic understanding. He then continued to superimpose his self representation, specifically as an adolescent, upon the representation of the patient as an adolescent, in a continued "feeling into" process. This led to an understanding of the patient's preconscious concern

that he formulated into a verbal interpretation.

In the creative process in art and in psychotherapy, the homospatial process is actively oriented to the achievement of a goal. In the creation of artworks, such a goal may be the formulation of metaphors and other integrations; in the psychotherapeutic process, the goals may be sharing the patient's thoughts and feelings and understanding them. Precise motivation for achieving particular goals differs in different activities; in the therapeutic process, distinct experiences often move the therapist toward the empathic event. This may be dysphoric lack of comprehension, signal affect, or other. Embarking on the homospatial process, in both art and therapy, first involves absorption in the material—whether it be particular words and meanings or dynamic psychological forces —next a focused type of concentration and attention, and then a breaking away from previous constellations and configurations. Thus, in the creation of the metaphors "the branches were handles of stars" and "tarantula rays of the lamp spread across the conference room," the first step in the homospatial process involved the focus on the sounds and meanings of the words, then each pair of words "branches" and "handles" or "tarantula" and "lamp" were taken out of their ordinary perceptual contexts and brought into physically impossible mental configurations within the same spatial location. In the empathic event in therapy, the homospatial process first moves patient and therapist out of their usual contexts as totally separated objects and brings them into an

impossible configuration within the same space. Need I add that the therapeutic event also involves some psychological risks that are not as apparent-on the surface, at least-in the poetic homospatial process?

Following the break in the usual context, the therapist’s mental superimposition of his self representation with the patient representation involves simultaneous togetherness and separation. Thus, the therapist in the example experienced himself talking along with the patient. This was neither “just as” the patient nor “as if’ he were the patient. This was not the therapist simply substituting himself for the patient in a thought such as “How would I feel if I were in the patient’s shoes?” In order to carry out a mental superimposition, a full-blown and active “feeling into” the patient, the therapist must have a clear and well-developed sense of his own self boundaries. Representing himself within the same space as the patient does not involve fusion or merging but a fleeting and highly unstable sense of dynamic interactive sharing. Because it is unstable, cognitively conflictual, and arousing, the mental conception becomes progressive and generates new images and articulations, such as the example of the therapist and patient both being adolescents in love. As these new mental events within the homospatial process continue, a particular factor of understanding is crystallized. This factor of understanding is an important constituent of the creative progression and effect. When used in interpretations, or otherwise conveyed to the patient in the mutual creative process, it functions to produce

therapeutic movement and tangible insights. Creating insight is one of the major therapeutic actions of psychotherapy.[39]

THE NATURE OF EMPATHIC KNOWLEDGE IN PSYCHOTHERAPY

We now must look more specifically at the factor of initial understanding itself to see how the homospatial process operates to bring it about. In pursuing this, I shall propose some answers to scientific questions regarding the nature of empathic knowledge in therapy and how that knowledge is transmitted. Three explanatory foci are pertinent: (1) self and object representation, (2) intrapsychic operations, (3) cognition.

In the therapist's empathic experience, the homospatial process involves bringing the image or representation of the self into the same mentally conceived space as the image, representation, or model[40] of the patient. Just as in the homospatial process leading to the creation of poetic and other artistic metaphors, the elements of the representations are in dynamic interaction with each other. Consisting of both unconscious and conscious memories, ideas, and affects, these interacting elements modify each other in a continuing dynamic elaboration and they still retain discrete identifying features. With self and object representations within the same mental space, conscious and unconscious elements of the self representation modify the object representation and vice versa. Particular ideas, memories,

and feelings connected with the self representation interact with both experienced and postulated ideas, memories, and feelings incorporated within the representation of the object.

The bringing together has not been a matter of juxtaposition, condensation, or combination. Instead, there is mutual interaction and modification while self and object boundaries remain intact. Thus, with regard to the patient talking about his love affair, when the therapist conceived himself within the same space as this patient, he instantaneously experienced himself also as someone talking and thinking about love. Although the therapist's self representation was that of a mature person talking of love, the superimposition upon the patient's production led to interaction and subsequent modification of both self and object representations. Concomitantly, the therapist experienced the patient as an adolescent in love and felt himself to be a patient overdramatizing an infatuation. This led him to remember his own adolescent love affairs and to recognize his tendency to overdramatize himself at that time. He next thought of his concerns about living up to both his own and the adolescent girl's expectations; these concerns seemed to have a meaningful connection with the patient's productions.

Just as the poet's hazy mental superimposition of "branches" and "handles" or "tarantula" and "lamp" led to mutual modifications of shapes and

word representations, and to new images and ideas of “stars” or “rays,” respectively, so too the therapist’s hazy and fleeting superimposition of himself and the patient led to a mental interaction involving mutual modifications together with a series of images and ideas regarding expectations. Then, applying these images and ideas to the therapeutic context, just as a poet applies mental imagery to the realm of words and the painter to the realm of shapes and colors, the therapist recognized that the patient was concerned about the expectations both of the real woman and of the therapist himself. With this recognition, he decided to make an interpretation about the former as an introduction to the issue of transference expectations with the latter. The decision to follow this particular interpretive sequence was a matter of technical procedure pertaining to the context of that particular therapy session and need not delay us with further explanation here.

Another example can serve to clarify achievement of knowledge through the homospatial process over a longer, more extended period of time. An anorexic young female patient, in therapy for several years, had consistently complained of difficulties with her female co-workers as a factor interfering with her ability to function effectively. Over the course of therapy, the therapist had gradually developed a model of the patient as highly competitive with other women, resorting often to projective and introjective defenses, but perfectionistic and successful in a way that might indeed instill

competition and jealousy in others. They had worked together on her past difficulties with women. Recently she had repetitively complained over a series of sessions about being unable to sit in the company lunchroom with other women workers because of her inability to eat. She had also complained that these women gossiped too much. Unable to determine how the difficulty in eating related to the gossiping, or what was embodied in the patient's experience, the therapist focused primarily on her being excluded from the conversation.

In the next session, she started by talking about a woman friend —not a co-worker—who had bothered her. The therapist pointed out, in this particular instance, that this woman was attempting to provoke the patient's jealousy. To his distress and confusion, his comment induced a continuation of her complaints about not being able to sit with co-workers in the cafeteria. As the therapist then attempted to clarify whether the patient was being excluded or whether she excluded herself, he thought of an insight he had had one time about a problem of his own — he had believed that a girl friend had been too dependent on him, but instead he really had been too dependent on her. As he continued listening to the patient, who was now complaining that the other women talked about themselves all the time but she never did, he actively represented himself superimposed upon the patient's location in the cafeteria surrounded by women talking. He then experienced a feeling of both himself and the patient as dependent and overwhelmed in the situation.

Concomitantly feeling both the patient's dependency and a sense of himself as excluded in the situation a moment later—in an interaction of mental representations—a feeling of jealousy became crystallized. He realized that the patient was jealous that the other women were free to gossip and talk about people as they liked.

The therapist commented to the young woman that the workers were not exclusive or jealous of her because she did not gossip, but that she was jealous of them. This then led, gradually and in an unfolding way, to the patient's exposing other areas of her jealousy. She spoke of jealousy of her boss and another worker and eventually of jealous feelings toward her younger sister. In the next phase of the homospatial process, superimposition did not persist, but the therapist actively aided the patient in making connections in the type of articulation process described in Chapter VII.

The steps in this empathic experience consisted of the long-term development of a model of the patient, the therapist's confusion and intensified motivation to understand the material, his recognition and specification of an important factor in himself, and a purposeful and active superimposition of the fully developed self representation upon his mental representation of the patient. Also illustrated in the detailed dissection of a fleeting mental experience are the factors of interaction of mental representations, followed by crystallization of understanding and a

subsequent longer unfolding clarification and testing within the overall progression.

In another case, a middle-aged patient had led a highly schizoid isolated life and had been in therapy for over a year. In the course of a therapy session in which he was berating his elderly mother for cutting him out of her will, he talked of previous hatred for her and described himself as having tried to remove her completely from his life six years before. He stopped seeing her completely but "then," he said, with pain in his voice, "when I became desperate and really troubled I had no one to call but her. I had lived my life without any contacts at all with people and she was the only one I could call."

For a long moment, the therapist hearing this felt completely immersed in the patient's feeling and point of view. "Yes," the therapist said to himself, "this patient never had any real friends and sadly the only person he could turn to was his mother." He was, at this moment, feeling sympathy and oneness with the patient, not empathy. As he experienced the depth and intensity of the patient's feelings of helplessness and depression, however, he began to shift his perception. While continuing to experience the sad affect, he focused on the present circumstance in which he was sitting with the patient in the office. In a momentary but active shift, he represented himself both separated from and connected to the patient at once in a mental superimposition. The patient, he then realized, was also excluding *him* from

those he could call on. Did the patient feel that way “right now?” he asked, and, receiving an affirmative reply, pursued the reasons. The pursuit led the patient to acknowledge, for the first time, that although he hated his mother he also continued to be tied to her.

The homospatial representation of therapist and patient superimposed in this case involved an interaction of component elements similar to previous ones. However, rather than generating a specific insight or a factor of similarity, this interaction primarily emphasized separateness of therapist and patient and thereby clarified that the therapist was himself a subject of the patient’s feelings of alienation. The therapist felt at first merged with the patient until shifting to a homospatial conception involving discrete self and object representations superimposed and interacting. He shifted from a merged and sympathetic stance of experiencing the same conscious feelings as the patient to an empathic stance in which he experienced both the patient’s preconscious and conscious feelings together. In the homospatial process, the patient was bereft as well as attacking to him and he himself was also feeling bereft but, now, *unlike the patient*, he was able to mobilize active resources to cope with such feelings. Through the dynamic interaction of these representations he was able to separate himself and enlarge the scope of the inquiry.

PRESENTED KNOWLEDGE

The type of knowledge achieved in these examples of self and object representation within the same space should be differentiated from directly verifiable or so-called propositional knowledge and can best be termed “presentational” or, more simply, “presented” knowledge.[41] Rather than literally spelling out a specifically formulated series of verbal propositions about truth or validity, such as is found in textbooks and expository accounts, truth is displayed in a presented or embodied form as it is in artistic products and metaphors. For instance, in the first example I gave of the patient talking about his love affair with a woman, instead of specific formulations pertaining to oedipal, pre-oedipal conflicts or self-object impairments, the homospatial conception initially embodied a complex representation of both patient and therapist as adolescents in love. This representation *presented*, rather than proposed, several truths and the patient’s feelings of love were *experienced*, rather than only conceptualized, by the therapist. Through subsequent exploration and clarification in therapy, some of the truths may be rendered explicit but usually not all of them. In the same way, created metaphors present truth about broad and complicated issues of human concern. They present direct embodiments of truth — on both a cognitive and an affective level —and point also to specific areas of validity.

Going back to my early example of the metaphor “the branches were handles of stars,” the entire construction should, if effective, strike one as containing truth or validity. Thus, one might experience a sense of continuity

between the world of nature on earth and in the universe, or else see a natural configuration of physical objects seeming to attest to the grandeur of God, or see stars as the top of a torch in the woods leading the beholder out of darkness and disorientation. Presented in all these ideas is some element of truth: Earth and universe are common components of nature; the world of nature provides putative evidence for the working of God; stars do lead wanderers out of dark woods. Also, perceptually valid factors are present in this, as in any good metaphor. Branches can look like wooden handles of canes or torches, stars may touch and seem held by branches of tall trees, and so forth. As I continue to spell out these literal truths, it should be apparent, as I stated in the previous chapter, that I do some violence to the immediate and overall impact of the verbal phrase itself; at the same time, 1 do not exhaust the possible range and depth of truth it contains. Such presented or embodied truth of a metaphor is manifold, virtually inexhaustible, and more than the sum of its parts. This applies to metaphorical constructions ranging from "Life's but a walking shadow" from Macbeth's funeral dirge for his wife (Act V, Scene V), to "Oh let there be nothing on earth but laundry/ Nothing but rosy hands in the rising stream/ And clear dances done in the sight of heaven" from Richard Wilbur's poem, "Love Calls Us to the Things of this World,"[42] and to more extensive central aesthetic metaphors such as the character Blanche within the Williams play "Streetcar Named Desire," or to pictorial and metaphorical images such as the large man in the painting "Man With a

Hoe" by Millet. Also, it applies to scientific metaphors such as the productive one, "black holes in space." Presented and experienced truths, such as the deceptive insubstantiality of life, the gratification of redemption from sin, the loneliness of promiscuity, the grandeur and importance of simple labor, and visual paradox in nature, all come forward in these metaphors and there is always a sense of more. Also, all of these presented or embodied truths point to testable propositions about reality. Certainly, this has been clear in the field of astrophysics, where the "black holes in space" metaphor has proved especially generative of propositions and testable hypotheses and formulations.

In therapeutic empathy, truths embodied in and derived from the homospatial superimposition are similarly both manifold and testable. Like created metaphors, empathic presentations contain the cognitive and affective components of lived experience. Also, just as we use the Blanche metaphor to say rationally to ourselves we will not risk Blanche's particular fate in carrying out some action, empathic presentations may be the basis for an informed and rational decision to interpret or not interpret a patient's defensive stance. Such presentations are themselves evaluated and tested through specific derived interpretations, clarifying interventions, and the patient's responses.[43]

INTRAPSYCHIC KNOWLEDGE

With respect to the second focus of knowledge I mentioned, the intrapsychic, I have in previous works explained how unconscious material is actually unearthed and brought to consciousness during the creative process because of the psychodynamic structure of the particular creative functions themselves.[44] I described a mirror reversal of dreaming function of both the homospatial and janusian processes. Both have a mirror image relationship with unconscious dream and primary process mechanisms in that, as in all mirrors and mirroring, there is *reversal* along with similarity. The consciously willed homospatial process is superficially similar to unconscious primary process condensation, but concomitantly involves motivational, cognitive, and affective reversal. The janusian process has a mirror reversal relationship with the equivalence of opposites primary process mechanism. Because of these reversal relationships, both processes serve a directing and formative template function within the ego. As a psychological template, the function is homologous with physical templates that lock in and direct biological and other physical processes—the double helix genetic template is one example.

One psychological template function of these creative ego processes is to direct and reverse primary process operations and bring unconscious material into consciousness. Unearthing of unconscious material, the production of quasi-insightful experiences (not the full insight occurring in psychotherapy), and both arousal and reduction of anxiety—which has need-gratifying functions in its own right —are goals for the person engaged in

creative activity.[45] On a cognitive level, the reversal of condensation mechanisms by the homospatial process is manifest in the hazy and transitory images and representations, in contrast to the intense, vivid, and formed effects of the primary process. These hazy and transitory properties in themselves produce cognitive tension that evokes further mental progression rather than the binding and quasi-resolution of drive and drive-derivatives of primary process condensation.

Spatial configurations of conscious homospatial representations do, in a very broad and general way, resemble unconscious condensation configurations but, as the obverse of promoting concealment and repression, the homospatial process instigates uncovering and the appearance of unconscious derivatives in consciousness. This occurs following the superimposition phase. Because creative thinking has particular cognitive goals as well as cathexis for unearthing unconscious derivatives, the homospatial process subsequently brings condensation structures into consciousness and begins an unravelling sequence. This unravelling sequence operates somewhat similarly to an association sequence in a psychoanalytic session, except that the associations are not free but embedded within the creative activity. Fragments representing wishes, fantasies, and other unconscious contents are "decondensed" or expanded and are incorporated into the work in progress. However, without the help of a therapist "other" or guide, so to speak, they are usually not fully recognized as unconscious

derivatives by the creative thinker himself. While condensation mechanisms facilitate drive discharge, but keep unconscious material from consciousness primarily through disguise and distortion, the homospatial process operates in the reverse direction and facilitates unearthing and unconscious revelation.

For example, in the instance of the creation through the homospatial process of the metaphor of a horse and rider mentioned in Chapter I, the poet later became progressively—albeit dimly—aware of unconscious connections between the horse and feelings about his mother. These feelings were also incorporated into particular other ideas and metaphors within the poem, as well as into the poem's central poetic statement. He had, however, no inkling whatsoever of these connections beforehand.[46] Similarly, prior to the creation of the metaphor "the branches were handles of stars," that author had thought only of the sound and shape connections between branches and handles. Afterward, he became dimly aware of images of branchlike maternal arms encompassing a child. During further creative work related to this metaphor, the firelike intensity of the star led to conscious thoughts of warm, erotic sensations and to unearthed unconscious fantasies of erotic sensations in the held child. The unravelling stopped short, however, of connecting himself to the held child.

In the homospatial conception of therapist and patient within the same mental space, a similar unearthing of unconscious material occurs. Beres and

Arlow[47] emphasize the emergence of the therapist's unconscious fantasies in the empathic experience, and the clinical literature on empathy is replete with descriptions of the therapist's becoming aware of preconscious and unconscious contents both during and after dramatic empathic experiences.[48] Although conscious superimpositions of mental contents intrinsic to the homospatial process were not specified by the particular authors, a careful examination of the published reports strongly suggests such operations.

For example, Simon reports a dramatic empathic experience in regard to a patient who described being attracted to a stewardess on an airplane and then spilling a drink she gave him all over his lap. Documenting his own response to the patient's story, Simon reports his initial conception as follows: "Lusting after the stewardess —spilling the drink. Hmm, fouling his own nest. . . ."[49] After this actively formulated representation of a bird in a nest superimposed upon the image of the patient in the airplane, his thoughts then drift to other matters and the dramatic sequence of events occurs. Simon mentally envisions "a cormorant-like bird everting its stomach, as if through its belly button," and soon after the patient spontaneously talks about an image of "a black widow spider" who "turns her stomach out and her own digestive juices start to eat away at her body so that the little spiders can eat her up." Reporting that he felt hit "like a thunderbolt" by the concurrence between his thoughts and the patient's image, he then detailed the complex and manifold unconscious roots of his and the patient's constructions.

There is little doubt from this therapist's discussion that *both* constructions of bird and spider were primary process condensations; moreover, the therapist's condensation appeared not before but *after* he had conceived and actively superimposed the image of "fouling his own nest" upon a mental representation of the patient spilling his drink upon his lap. The active bringing of the image of "fouling" into the same space as the spilling of the drink in a homospatial conception was the beginning of the creative empathic process. The process then continued with the unearthing of the cormorant for the therapist, and a coincidental appearance of a similarly structured condensation by the patient. Following that, the therapist's condensation was unravelled and further clarification of unconscious material occurred to him.

Simon's example illustrates that the therapist's unearthing of his own unconscious contents leads to *valid understanding of the unconscious contents of the patient*. Although there is no necessary and sufficient reason for therapist's and patient's unconscious contents to coincide consistently or exactly, validity is nevertheless quite high. This is because the process is based both on the patient's production and on the therapist's model of the patient derived from the therapeutic experience. Based partly on the therapist's own memories and experiences as well, it differs from ordinary intuitions based on memory alone. Like other sources of a therapist's understanding, the products of the homospatial process are used as

interpretations that are then subjected to mutual verification within the therapy itself. Seldom as dramatic as the Simon example, the unearthing process continues through later therapy sessions and is incorporated into an unfolding creative process within the treatment.

For a less dramatic example of a similar psychodynamic sequence there is the following: In the process of working out a termination of therapy, a young male patient became quite rebellious toward his therapist. He threatened to get a job that he thought the therapist strongly disapproved of, he missed sessions, or he came late. In one session during this period, he arrived early but then tauntingly said he actually had hoped he was late. He proceeded further with this provocative tone and little the therapist did, such as interpreting his anxiety, seemed to produce any effect. Then, the patient said, still provocatively, “I would like to go outside and just sit.”

At first, the therapist experienced the remark as a hostile wish to escape the therapeutic situation. Still motivated to understand, however, he fleetingly thought of comfortably sitting outside on the lawn and then conceived a hazy image of the patient in the same spatial location. Remembering that it had always been extremely difficult for this patient to relax and enjoy himself, he commented appreciatively that it seemed that the patient was able to think of himself as relaxing. Immediately, the patient’s hostile and provocative stance melted and he said: “Everybody says I’m so

much better. But now I have to prove myself.” With this, the patient had introduced preconscious material and thereby gave evidence of the validity of the therapist’s interpretation. The remainder of the session consisted of a discussion of the patient’s concerns about having to prove himself during and after termination. Later within this session and those following, the therapist also became specifically aware of some of his own passive and regressive wishes that seemed to have been unearthed by the homospatial process along with the empathic understanding.

That full superimposition of mental images is involved in the homospatial process rather than such factors as analogic thinking, or merely shifting to a positive or sharing mode of listening, is demonstrated by another example involving the same therapist. In this case, he made a mistaken interpretation in a distinct failure of empathy. In an advanced phase of therapy, a middle-aged male complained about a childlike closeness between his mother and his aunt, a closeness that had always excluded him. His mother had recently had an accident and, when the patient phoned to talk to her, his aunt answered and promptly told him that she had moved in to be at his mother’s side. Listening to this, the therapist asked himself how the patient might be feeling. There were no superimpositions of images or representations. Instead, he remembered his own gratifying feelings of taking care of a sick mother and decided that positive feelings must underlie the patient’s resentment and complaint. He stated that it sounded as if the patient

wanted to be with his mother, even to take care of her, but that his aunt was interfering. Rejecting this interpretation, the patient said that the therapist was way off base —"I don't really want to take care of my mother. I have dreams about her sucking my blood." Merely listening for the patient's perspective, without a full superimposition of self and object representations, may put one on the patient's side but may not be empathically correct. The types of listening "from within the patient's state of mind" described by Lichtenberg[50] and as the subject rather than "object acted upon" described by Schwaber[51] are effective early means of entering into the empathic process but are not themselves sufficient means of providing understanding.

COGNITIVE KNOWLEDGE

The third type of knowledge derived from the homospatial process within the empathy experience, I designate as "cognitive" because it pertains most clearly to the thinking and perceptual field. It is, however, intricately tied up with affect, motives, and other intrapsychic and interpersonal dynamics. When, as is often the case, manifest perceptual imagery is involved in the mental superimposition, there is a *widening of the field of mental perception and of conscious thoughts*. Because the homospatial process involves elements occupying the same mentally conceived spatial location, composition displays and boundaries of component elements necessarily appear to change. Because of alterations in the dynamic balance and array of

elements, aspects of the perceptual field that previously were unnoticed become more prominent or newly delineated. Background features may come to the foreground and previously empty areas appear full. Contours of shapes are altered and a new topography appears.

All of this is highly transitory and the mental perceptions are usually dimly in awareness; for those who seldom experience conscious mental imagery, there may be little perception of imagery at all. The sense of a widening of the field of conscious thought is nevertheless experienced, although it may not have been heretofore described in the literature or in clinical discussions in just this way. This widening of the field of conscious thought consists of becoming aware, or paying attention, to aspects of a patient’s communication —verbal or nonverbal —that were previously ignored. Such aspects may be features of the patient’s current communication or they may derive from communications and interactions of the past. Cognitive widening of the field operates together with forces reversing the countercathexis of repression to produce remembrance as well as insight. It would be a mistake to postulate that either the cognitive function or the overcoming of repression comes first or is causally responsible; these two factors operate in conjunction with one another.

An example from Greenson of an empathic experience illustrates both the homospatial superimposition and the widening of the cognitive field:

> I had been treating a woman for several years and ... in one hour she recounted the events of a weekend and focused in particular on a Saturday night party. Suddenly she began to cry. I was puzzled. I was not "with it"—the crying left me cold —I couldn't understand it. I realized that I had been partially distracted by something she had said. At the party she mentioned a certain analyst and I had become side-tracked, wondering why he was present. Quickly reviewing the events she recounted, I found no clues. *I then shifted from the outside to participant listening. I went to the party as if I were the patient*. Now something clicked —an "aha" experience. A fleeting event told to me as an outsider eluded me, now in my empathy this event illuminated the crying. At the party a woman had graciously served the patient with a copious portion of food. To me as the observer, this event was meaningless. *But to me as the experiencer, this woman instantly stirred up the picture of the patient's good-hearted and big-breasted nursemaid*. The "aha" I experienced was my sudden recognition of this previously anonymous figure. Now I shifted back to the position of observer and analyzer. Yes, the longing for the old nursemaid had come up in the last hour. In the meantime the patient herself had begun to talk of the nursemaid. My empathic discovery seemed to be valid. When the analyst's association precedes and coincides with the patient's, it confirms that the analyst is on the right track.[52]

In this full and unusually detailed description, it is clear that the therapist's cognitive field was widened and new understanding, consisting partly of the overcoming of repression, occurred. He took notice of a previously ignored female food provider at a party. It is also worth noting that Greenson's empathic experience was explicitly conscious and deliberately motivated. It also involved the bringing together of self and object representations in such a manner that he continued to be aware of his separation from the patient. This was not fusion, nor was it identification in the traditional sense of a structural modification of the therapist's ego. It was

a process of superimposition of self and object representations in which perceptual imagery, memories, and thoughts appear.[53]

Greenson's reported feeling of lack of comprehension is rather typical of the onset of the homospatial process in the empathic experience. Some emotional event usually signals or begins the sequence. Here again, Beres and Arlow's term, "signal affect,"[54] seems suitably descriptive; it points to a motivating factor of affective importance to the therapist. I would add to or modify their formulation and point out that the homospatial process in the empathic experience operates specifically to unearth unconscious factors intrinsic to the signaling emotion or affect.

EMPATHY IN THE CREATIVE PROCESS OF PSYCHOTHERAPY

The sequence of events is directly analogous to a characteristic sequence in creative activities in the arts and sciences. Briefly summarized, it is, as follows: The creative process begins with what the aesthetician Beardsley colorfully termed an "incept."[55] In the interview studies that I performed, I found that for a poet this "incept" consisted of a word, phrase, image, or idea; for a visual artist it was colors and shapes; and for a scientist it was a metaphor, a puzzle, or a mathematical equation. All of these, including in a complicated way the puzzles and mathematical equations, had some personal and unconscious significance for the creative person.[56] Partly

because of this unconscious factor, the person was motivated to engage in a creative process that aroused personal anxiety and eventually resulted in some degree of unearthing, however small, of the unconscious material. For a lengthy set of reasons that I will not repeat here, this sequence was clearly part of the naturally occurring creative process and not induced by my presence as a psychiatrist investigator.[57]

In addition to the anticipated gratification of increased knowledge — personal as well as other types —another important motivating factor is the absorption in, and love for, the particular materials involved in the creative work. The poet's absorption in and love for words include their sounds, meanings, histories, and uses. His manipulation of words is itself an intense gratification and the homospatial process in poetry therefore often begins with an idea or feeling that particular words or phrases ought to be the same or related in some way. Both of the word pairs, "branches" and "handles," and "tarantula" and "lamp," it will be remembered, were superimposed partly because they were assonantal and shared similar sounds. Similarly, the painter and musician are motivated to explore and bring together sensory images of colors, shapes, and sounds that are foci of intense interest, love, and absorption. In this absorption, narcissistic investment has to some extent been overcome and there is love for sensory experience, ideas, and physical materials in themselves.

For the therapist engaging in empathy as a creative process, there are also emotionally charged incepts, both long-term and short-term, that begin the process. Long-term incepts consist of complicated self and object interactions and symbolizations directed by the particular contract for treatment and the background characteristics of both therapist and patient. The incept for the short term may be a feeling of being blocked or of not understanding the patient, the intrusion of a personal fantasy as cited by many previous writers on empathy, or a recognition of some similarity between what the patient has said or done and something experienced by the therapist. In all these circumstances, the therapist's absorption in, and love for, the material —be it an intriguing and puzzling dream report, recurrence and recognition of a resistant pattern, subtle or dramatic symbolization, or the complexity of the interactional field, indication of change and growth together with the connections between all of this with the health and welfare of the patient — instigated a creative homospatial process. Once begun, the therapist takes a risk and actually courts experiences of personal anxiety[58] in order to achieve understanding. It is because of this experience of anxiety followed by understanding that empathic events sometimes seem dramatic to the therapist himself.

Nevertheless, rather than a mysteriously driven process carried on out of the therapist's control, there is an important measure of active and specific creative activity —however fleeting and undetected even by the therapist

himself—when engaging in the homospatial process. The process has very likely been used regularly by competent and creative therapists heretofore, but because it is so fleeting, the volitional element and the experience of superimposition may often have been unattended. In the same way, creative subjects I worked with had by themselves never before traced the particular characteristics of their thinking in creative work.[59] It is not, therefore, a mechanical operation that can be mechanically applied but a creative skill that is both developed and learned, even though its detailed characteristics pass rapidly through awareness.

There may also be other more passive, or at least more automatic, types of empathy in the therapeutic context, but these are neither directly creative nor comparably productive of distinct understanding and knowledge. Regardless of the mode of knowledge achieved (and all three types are usually involved) through the homospatial process, there are always both affective and cognitive components. What I have called the widening of the cognitive field results from interactions between affective and motivational factors in the homospatial process and the effects of imagery manipulation through superimposition. The partial overcoming of repression concomitant with widening of the field is due in part to the template function of the homospatial conception —its mirror reversal with respect to primary process operations. Also, other particular creative operations with both cognitive and affective aspects, such as the janusian process, play a template role in

unearthing unconscious materials. After the therapist achieves understanding and some measure of anxiety reduction through unearthing of unconscious material, he uses this understanding in his general approach or subjects it to verification through formulations and interpretations to the patient. These can be overtly or implicitly denied or accepted. When the approach or formulations are effective, the patient usually introduces new material or otherwise collaborates in a mutual creative process.

Notes

1. Sigmund Freud, “Delusions and Dreams in Jensen’s Gradiva” (1907), *Standard Edition,* 9:7-93, New York: W. W. Norton, 1959, p. 8.

2. Theodor Lipps, “Empathy, Inner Imitation and Sense-Feelings” (1903), in Melvin Rader (ed.), *A Modem Book of Aesthetics*, New York: Holt, Rinehart and Winston, 1965, pp. 374-382; *Asthetik. Psycbologie des Schonen und der Kunst,* Hamburg and Leipzig: L. Voss, 1903-1906; “Empathy and Aesthetic Pleasure” (1905), in Karl Aschenbrenner and Arnold Isenberg, *Aesthetic Theories: Studies in the Philosophy of Art,* Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1965, pp. 403-412; “Das Wissen von Fremden Ichen,” *Psycbologiscbe Untersuchungen*, 1(1907):694—722.

3. Mark Kanzer, “Freud, Theodore Lipps, and ‘Scientific Psychology’” *Psychoanalytic Quarterly*, 50(1981) 393-410.

4. Edward B. Titchener, *Lectures on the Experimental Psychology of the Thought Processes,* New York: Macmillan, 1909, p. 21.

5. Vernon Lee (Violet Paget), *The Beautiful,* Cambridge: Cambridge University Press, 1913.

6. *Ibid.,* p. 61.

7. Karl Groos, *The Play of Man,* London: William Heinemann, 1901.

8. Wilhelm Worringer, *Abstraktion undEinfublung,* Miinchen: R. Piper Verlag, 1948.

9. Lois B. Murphy, *Social Behavior and Child Personality: An Exploratory Study of Some Roots of Sympathy,* New York: Columbia University Press, 1937; Carl R. Rogers, *Client-Centered Therapy*, Boston: Houghton Mifflin, 1951; Robert L. Katz, *Empathy,* Glencoe: Free Press, 1963; Norma D. Feshbach and Kiki Roe, “Empathy in Six- and Seven-Year-Olds,” *Child Development,* 39(1968): 1 33-145; Ezra Stotland, “Exploratory Investigations of Empathy,” in Leonard Berkowitz (ed), *Advances in Experimental Social Psychology,* New

York: Academic Press, 1969, pp. 271-314; Ezra Stotland, Stanley E. Sherman and Kelly G. Shaver, *Empathy and Birth Order,* Lincoln: University of Nebraska Press, 1971; Henry M. Bachrach, "Empathy," *Archives of General Psychiatry,* 3 3(1976):35—38; Paul H. Mussen and Nancy Eisenberg-Berg, *Roots of Caring, Sharing and Helping,* San Francisco: W. H. Freeman, 1977.

10. Robert Fliess, "The Metapsychology of the Analyst," *Psychoanalytic Quarterly,* 1 1(1942):21 1- 227; Ralph R. Greenson, "Empathy and Its Vicissitudes," *International Journal of Psycho-Analysis*, 41(1960):418-424, Antonio J. Ferreira, "Empathy and the Bridge Function of the Ego," *Journal of the American Psychoanalytic Association*, 9(1961):91 —105; Roy Schafer, "Generative Empathy in the Treatment Situation," *Psychoanalytic Quarterly,* 28(1959):342—373, and "The Psychoanalyst's Empathic Activity," *The Analytic Attitude,* New York: Basic Books, 1983, pp. 34-57; David Beres and Jacob A. Arlow, "Fantasy and Identification in Empathy," *Psychoanalytic Quarterly,* 43(1974):26—50.

11. Rogers, *op. cit.;* also see Carl R. Rogers and Rosalind F. Dymond (eds), *Psychotherapy and Personality Change: Coordinated Studies in the Client-Centered Approach,* Chicago: University of Chicago Press, 1954.

12. Heinz Kohut, "Introspection, Empathy, and Psychoanalysis," *Journal of the American Psychoanalytic Association,* 7(1959):459-48 3; "Forms and Transformations of Narcissism," *Journal of the American Psychoanalytic Association,* 14(1966): 261 -266; *The Analysis of the Self,* New York: International Universities Press, 1971; *The Restoration of the Self,* New York: International Universities Press, 1977; "Introspection, Empathy, and the Semi-Circle of Health," *International Journal of Psycho-Analysis,* 63(1982): 395-407.

13. Paul H. Ornstein, "Remarks on the Central Position of Empathy in Psychoanalysis," *Bulletin of the Association of Psychoanalytic Medicine,* 18(197 9): 9 5-108.

14. See, for an exposition of this aspect of Kohut's approach: Steven T. Levy, "Empathy and Psychoanalytic Technique," *Journal of the American Psychoanalytic Association,* 3 3(198 5): 35 3-378.

15. Compare, for example, some recent efforts at considering empathy in the artistic context without attention to earlier formulations in aesthetics: Jerome D. Oremland, "Empathy and Its Relation to the Appreciation of Art," and Mary Gedo, "Looking at Art from the Empathic Viewpoint," in Joseph D. Lichtenberg, Melvin Bornstein, and Donald Silver (eds),

Empathy I, New York: International Universities Press, 1984, pp. 239-266 and 267-300 respectively.

16. See also, for a similar comparison, Stanley L. Olinick, “A Critique of Empathy and Sympathy,” in Joseph D. Lichtenberg *et al., op. cit.,* pp. 1 37-166.

17. These connections are to some extent derivable from Lipps’s and Lee’s theories of empathy and aesthetic pleasure, and shall be spelled out in future communications.

18. Kohut, *op. cit.,* 1982.

19. Beres and Arlow, *op. cit.*

20. Sigmund Freud, “Group Psychology and the Analysis of the Ego” (1921), *Standard Edition*, 18:69-143, New York: W. W. Norton, 1955, p. 110.

21. Both Schafer and Wolf have pointed out that their experience of empathy in the treatment context differs from that in their everyday life with friends, etc. See Schafer, *op. cit.,* 1983, and Ernest S. Wolf, “Empathy and Countertransference,” in Arnold Goldberg (ed.), *The Future of Psychoanalysis,* New York: International Universities Press, 1983, p. 319.

22. Maurice Merleau-Ponty, *The Phenomenology of Perception,* translated by C. S. Smith, London: Routledge and Kegan Paul, 1962, pp. 243ff.

23. See also Alfred Margulies, “Toward Empathy: The Uses of Wonder,” *American Journal of Psychiatry,* 141(1984): 1025-1033. This author also emphasizes active will in empathy and relates empathy to creative activity. His view of creativity is based on Keats’s “negative capability,” a very broad construct but not incompatible with the processes and dynamisms presented here.

24. Schafer, *op. cit.,* 1959, p. 360.

25. G. Herbert Mead, *Mind, Self and Society,* Chicago: University of Chicago Press, 1934.

26. See Leston Havens, “Explorations in the Uses of Language in Psychotherapy. Simple Empathic Statements,” *Journal of Abnormal Psychology,* 87(1978): 3 36-345; “Explorations in the

Uses of Language in Psychotherapy. Complex Empathic Statements,” *Psychiatry,* 42(1979):40-48.

27. Stotland, *op. cit.*

28. Freud, *op. cit.,* 1921, p. 110.

29. Otto Fenichel, “Identification” (1926), *Collected Papers of Otto Fenicbel, Volume I,* New York: W. W. Norton, 1953, pp. 97-112.

30. Schafer, *op. cit.,* 1959, p. 357; Fliess, *op. cit.,* Beres and Arlow, *op. cit.* See also the earlier formulation of transient identification by David Beres, “The Role of Empathy in Psychotherapy and Psychoanalysis,” *Journal of the Hillside Hospital,* 17(1968): 362-369.

31. Greenson, *op. cit.,* Theodore Shapiro, “The Development and Distortions of Empathy,” *Psychoanalytic Quarterly,* 43(1974):4—2 5; Dan H. Buie, “Empathy: Its Nature and Limitations,” *Journal of the American Psychoanalytic Association,* 29(1981):281-307; Michael F. Basch, “Empathic Understanding: A Review of the Concept and Some Theoretical Considerations,” *Journal of the American Psychoanalytic Association,* 31(198 3): 101-126.

32. W. W. Meissner, “Notes on Identification. III. The Concept of Identification,” *Psychoanalytic Quarterly,* 41(1972) 224-260.

33. Shapiro, *op. cit.*

34. Annie Reich, “Empathy and Countertransference” (1966), in *Annie Reich. Psychoanalytic Contributions,* New York: International Universities Press, 1973, pp. 344-360.

35. Roy Schafer, “Identification: A Comprehensive and Flexible Definition,” *Aspects of Internalization,* New York: International Universities Press, 1968, pp. 140-180.

36. See Michael H. Tansey and Walter F. Burke, “Projective Identification and the Empathic Process,” *Contemporary Psychoanalysis, 21*(1985):42-69.

37. Schafer, *op. cit.,* 1959; Beres and Arlow, *op. cit.*

38. Beres and Arlow, *op. cit.*

39. See, for a discussion of the creation of insight in relation to the therapeutic action of psychoanalysis: Hans Loewald, “On the Therapeutic Action of Psychoanalysis,” *Papers on Psychoanalysis,* New Haven: Yale University Press, 1980, pp. 221-256.

40. For similar conceptions of the therapist’s model of the patient, see Schafer, *op. cit.,* 1959; Greenson, *op. cit.,* Daniel P. Schwartz, “Loving Action and the Shape of the Object,” in David B. Feinsilver (ed.), *Towards a Comprehensive Model for Schizophrenic Disorders,* Hillsdale, N.J.: The Analytic Press, 1986, pp. 32 3-344.

41. Langer’s original term referred to the presentational form of symbols, but it is readily applied to knowledge. See Susan Langer, *Philosophy in a New Key,* Cambridge: Harvard University Press, 1942.

42. Richard Wilbur, “Love Calls Us to the Things of this World,” *The Poems of Richard Wilbur,* New York: Harcourt, Brace and World, 1963, p. 65.

43. For a similar epistemological perspective, see Arnold Goldberg, “On the Scientific Status of Empathy," *Annual of Psychoanalysis*, 1 1(1983):155—169; Timothy Binkley, “On the Truth and Probity of Metaphor,” *Journal of Aesthetics and Art Criticism,* 3 3(1974): 1 71 -180.

44. Rothenberg, *The Emerging Goddess,* “Janusian Process and Scientific Creativity."

45. A seemingly paradoxical feature of the creative process is the arousal of anxiety. Creative persons deliberately engage and re-engage in thinking and activity that instigates anxiety. The motivation for this courting of anxiety in the creative process is both the achievement of some degree of insight and the pleasure generated by anxiety arousal and subsequent anxiety reduction. See Rothenberg, *The Emerging Goddess.*

46. *Ibid.,* pp. 15-99.

47. Beres and Arlow, *op. cit.*

48. Dean P. Eyre, “Identification and Empathy,” *International Review of Psycho-Analysis,* 5(1978):351-

359; Stephen L. Post, “Origins, Elements and Functions of Therapeutic Empathy,” *International Journal of Psycho-Analysis,* 61(1980):277—293; Bennett Simon, “Confluence of Visual Image Between Patient and Analyst: Communication of Failed Communication,” *Psychoanalytic Inquiry,* 1(1981):471-488; Ping-Nie Pao, “Therapeutic Empathy and the Treatment of Schizophrenics,” *Psychoanalytic Inquiry,* 3(1983): 145-167.

49. Simon, *op. cit.,* quotations in this example are all from p. 473.

50. Joseph D. Lichtenberg, “The Empathic Mode of Perception and Alternate Vantage Points for Psychoanalytic Work,” *Psychoanalytic Inquiry,* 1(1981):329-355.

51. Evelyne A. Schwaber, “Empathy: A Mode of Analytic Listening,” *Psychoanalytic Inquiry*, l(1981):357-392.

52. Greenson, *op. cit.,* p. 421, emphasis added.

53. Despite Greenson’s use of the linguistic construction “as if I were the patient,” the context makes clear that full mental superimposition, rather than substitution, occurred.

54. Beres and Arlow, *op. cit.*

55. Monroe Beardsley, “On the Creation of Art,” *Journal of Aesthetics and Art Criticism*, 23(1965) 291-304.

56. In his personal description of the process of creating the general theory of relativity, Einstein referred to his initial feelings in the following way: “The thought that one is dealing here with two fundamentally different cases (the Faraday and Maxwell-Lorentz theories) was, for me, unbearable [war mir unertraglich).” See Rothenberg, *The Emerging Goddess,* p. 112; Albert Rothenberg, “Einstein’s Creative Thinking and the General Theory of Relativity: A Documented Report,” *American Journal of Psychiatry,* 136(1979): 38-43.

57. See discussion of investigator interference effects in Rothenberg, *The Emerging Goddess,* p. 392, n.2, and description of mirror image effects in Chapter 3, pp. 53-81. See also discussion in Rothenberg, “Janusian Process and Scientific Creativity,” pp. 116-117.

58. See note 45 above.

59. See Rothenberg, *The Emerging Goddess,* and Albert Rothenberg, “Creativity, Articulation and Psychotherapy,” *Journal of the American Academy of Psychoanalysis,* 1 1(1983):55—85.