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The Eighteenth Annual Frieda Fromm-Reichmann Memorial Lecture

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ALBERTA B. SZALITA, M.D.

SOME THOUGHTS ON EMPATHY

THE EIGHTEENTH ANNUAL FRIEDA FROMM-REICHMANN MEMORIAL LECTURE*

BEFORE embarking on the subject of this evening, I would like to share with you some memories of Frieda—memories of the late forties and early fifties, when I met her and worked with her at Chestnut Lodge.

She played a special role in my life. In 1947, as Medical Director of a social agency caring for the remnants of the Jewish population of Western Europe and North Africa, I came to the United States for the first time to study public health at Johns Hopkins on a fellowship from the American Joint Distribution Committee. Through a mutual acquaintance, I met Frieda in a Baltimore hotel on March 4, 1948. She encouraged me to talk about my work and studies. I believe I referred vaguely to my feeling that there were "holes in my education." I spoke about the chaos and devastation of postwar Europe and the tragic experiences of displaced persons. Halfway through a conversation lasting less than half an hour, Frieda suddenly got up, picked up the telephone, and called Sarah Tower; I was then summoned to the phone to make an appointment with Dr. Tower. With Frieda thus serving as deus ex machina, I entered psychoanalysis two days later. I am still grateful to both of them—perhaps a sign of unresolved transference. This led me to my decision to change careers midstream and begin analytic training.

During my four years in Rockville, Maryland, my many encounters with Frieda Fromm-Reichmann were both professional and social in nature. She supervised me for a brief period. Later, our relationship deepened into friendship.

I have spoken to many persons who knew her professionally, whether as analyst, teacher, or consultant. I have found that they share my impres-

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sion of her as a very generous and unique person. Despite her small stature and soft-spoken manner, she emanated that special quality known as *presence*. Some foreign psychiatrists who observed her in action during their visits to Chestnut Lodge recalled the sense of calm her appearance spread over disturbed patients as soon as she entered a ward.

Fromm-Reichmann was a superb listener. Listening attentively, as we well know, is a rare ability, and even more rare is the ability to hear, and to understand what one hears. One therapist who was supervised by her in 1942 recalled the indelible impression Frieda Fromm-Reichmann made on her: "She put things so simply and naturally . . . I kept on asking myself, why didn't *I* think of that."

In the role of supervisor, she was very reassuring, without swerving in any way from the task at hand. She always had something useful to say; an observation that was not helpful in resolving the immediate problem could be retained and eventually applied in some other situation.

Anna Gourevitch, an outstanding analyst in New York City who was supervised years ago by Frieda, said to me that each session with Frieda was a source of inspiration for her.

> She unquestionably taught me not to disregard anything which seemed to me as irrelevant. She took into account every detail. It was impressive—the respect she had for the patient's communications of any kind. She was never judgmental. She tried to understand. It didn't make any difference whether she liked or didn't like the patient. She treated them all with the same seriousness and concern; and, at that time, this was particularly impressive and instructive to me.

My own experience with Frieda was similar. I was impressed by the simplicity and usefulness of her remarks. I like to quote one incident. At that time, we felt it very inappropriate to get angry at a patient. And it's easy to understand how taxing it was for me when engaged in intensive psychotherapy with schizophrenics. One day, a patient threw a pillow at me in anger. I got red in the face and became very angry, which surprised me, as it was only a pillow. I recounted this incident to Frieda with embarrassment, and she simply said, "So what." This gave me a sort of permission to use my feelings more freely. I must admit that while I was reassured and gratified by her response, I wasn't convinced that there was not some personal selective reaction in my response, and

eventually, in my analysis, I did find memories of a pillow fight with my brother where I was losing ground. Nevertheless, Frieda's attitude had a profound influence upon the way I used myself as a therapist subsequently.

She was able to judge character, to sense immediate need, and to anticipate further development or future action—at times, with uncanny accuracy. A therapist with these qualities hardly needs to have anything else. She was able to make decisions promptly, and she did not need to know all the facts in order to make up her mind.

Foremost a clinician, she was more devoted to the well-being of her patients than to elaborating abstract concepts about them. She believed in people and she believed in change. She emphasized the strength of the patient. Like a good actor, she used herself flexibly and spontaneously and helped the patient to engage in meaningful dialogue. She had an inimitable way of establishing contact and intimacy with patients which gave her an entrance into their subjective world.

Frieda Fromm-Reichmann was an industrious and sensible person who did not permit wild guesses and fantasies to corrupt the clarity of her purpose. Persons she treated recalled the appropriateness of her interventions and her use of dramatic language. She taught them to convert complex communications into ordinary thoughts and more or less sound actions.

She wrote about psychotherapy in the same manner as she expressed herself to her patients and students. Whatever she wrote was derived from her own clinical observations and personal experience. When a student asked her how she had obtained her boundless knowledge of people, she replied, "By observing my friends and relatives."

Undoubtedly, these characteristics account for the continuing and widespread appeal of her book and other publications. As one therapist put it:

> There was a deceptive simplicity in whatever she wrote. When I was young, I thought I knew it all and dismissed her writing as elementary. It is only when I became more experienced that I understood how difficult it is to achieve this so-called simplicity.

It is of interest that Frieda Fromm-Reichmann herself did not have a high opinion of her own writings. I recall her referring to her *Principles of Intensive Psychotherapy* as a cookbook. The fact that this book has

become required reading in many medical schools attests to its value in facilitating the learning and teaching of psychotherapy. But Frieda disparaged her own intelligence and uncluttered style of writing. She even told me that her great awe of a few exceptionally brilliant patients interfered with her analysis of them—or so she thought. The frequency with which students nowadays refer to her work and their familiarity with her clinical examples would have astonished her.

Frieda Fromm-Reichmann pioneered in integrating the teachings of Freud and Sullivan in a meaningful and practical way. This required a great deal of courage in those years.

The negative attitude that the psychoanalytic establishment took toward her equally courageous efforts to adjust the classical method to the therapeutic needs of schizophrenics greatly hurt her. My teachers' fears of being identified as heretics angered me at first, but eventually I was contaminated by such fears myself. It took me a long time to shake them off.

Frieda Fromm-Reichmann was a quarter of a century ahead of her time. The methods by which she and the staff of Chestnut Lodge attempted to come to grips with the schizophrenic predicament are widely accepted and followed today.

In December 1956, during the meetings of the American Psychoanalytic Association in New York, I had breakfast with Frieda. That was our last meeting. We sat face to face, but she was unable to hear most of what I said to her. Her hearing was greatly impaired, and my Russian accent didn't help matters. She seemed lonely and unhappy. Because of her increasing deafness, her final years must have been permeated with great loneliness.

More instructive than the memories of the professional associates and friends are those of the patients of a psychotherapist. One patient's memories of Frieda Fromm-Reichmann are certainly more enduring than anything I might say. In *I Never Promised You a Rose Garden,* Hannah Green (1964) created out of her own experience with Fromm-Reichmann the character of Dr. Fried, with the result that Frieda is now recognized and respected by the public at large (see also Green, 1967). Just two weeks ago, I was told that there have been 40 reprintings of the paperback edition of this book—a total of 4,915,000. It is a pity—and perhaps the ultimate irony of her life—that this modest and often lonely woman did not live long enough to enjoy this public recognition and respect as well as the appreciation of those she helped.

It seems appropriate to talk about empathy on this occasion because the subject was close to Frieda Fromm-Reichmann's heart, and also because she kindled my own interest in it during a research seminar she conducted in 1953–54.[1] She was particularly interested in finding ways of developing intuitive understanding in the training of therapists. The problem of understanding the psychotic's way of thinking and the role of empathy in establishing rapport with the patient were topics she focused on in a seminar course she conducted for years in Washington and New York. I conducted this course jointly with her in 1955–56 at the William Alanson White Institute in New York, and since then, I have devoted much thought to the role of empathy in both the practice and teaching of psychotherapy.

Empathy, like life itself, is perpetual discovery, even on a small scale. It operates continuously between humans, most often imperceptibly but on rare occasions in sudden flashes. The mini-discoveries that we make in conducting therapy are likely to spurt into the mind when we suspend intellectual judgment. In the words of Albert Einstein: "The intellect has little to do on the road to discovery. There comes a leap in consciousness, call it intuition or what you will, and the solution comes to you and you don't know how or why. All great discoveries are made in this way."

The concept of empathy originated in esthetics, the branch of philosophy that is concerned with the reflection of life in art. The term itself is the equivalent of the German *Einfühlung*—the literal translation being "feeling into"—which was introduced in 1885 by Theodor Lipps (Stein, 1927, pp. 187 ff.). The word was rendered in English as empathy, modeled after sympathy, and was introduced about 1912. After studying optical illusions, Lipps elaborated a psychological doctrine based on the premise that every esthetic object represents a living being; furthermore, a person who projects himself into the life of such an object experiences a specific psychic state. Lipps applied this doctrine to the plastic arts, such as sculpture, rather than to the literary arts.

There is an endless variety of definitions of empathy. Some include almost all human understanding, but most writers stress the emotional element. Fromm-Reichmann used the term synonymously with "intuition." I shall cite here the two definitions that appeal to me most.

[1] In January 1955, a report on the seminar appeared in the *Journal of the American Psychoanalytic Association* as a series of papers by Marvin Adland, Donald Burnham, Harold Searles, and Alberta Szalita, with an introduction and discussion by Frieda Fromm-Reichmann (see Fromm-Reichmann, 1955).

One is by Edith Weigert, who characterized empathy as emotional participation. She added, "It is the tool of psychological understanding. It results in intuitive discoveries. The psychotherapist reflects about these discoveries and becomes aware of the philosophic premises of his art" (Weigert, 1962, pp. 143 ff.).

The other is Peter McKellar's definition: "Imaginatively placing oneself in the shoes of another person in such a way as permits sympathetic understanding of his mental life. One can, however, empathize without necessarily experiencing sympathy for the other person; empathy involves understanding rather than 'siding with'" (McKellar, 1957, pp. 220–221).

In conducting seminars, I have said on a number of occasions, "It is good to be able to put yourself into someone else's shoes, but you have to remember that you don't wear them." One resident told me a few weeks later, "I did put myself into the patient's shoes, but I forgot to remember that I didn't wear them." I was gratified as well as amused by this remark. He had understood that he had overidentified with the patient and not maintained the necessary distance. Eventually he grasped my idea that responding to the *need* one senses in another person and responding for the sake of the other person represent the essence of the empathic interaction.

Freud's remarkable essay on Michelangelo's statue of Moses, at the San Pietro in Vincoli church in Rome, provides a good illustration of the use of empathy as conceived by Lipps. Works of art, particularly sculpture and literature, exercised a powerful effect on Freud and he spent long hours trying to account for their effect upon him. He said that he derived almost no pleasure from works of art that he did not understand.

The greatest works of art, Freud observed, present "unsolved riddles to our understanding" (Freud, 1914, p. 211). Art critics do not solve these riddles for the "unpretending admirer," he went on to say, because each critic says something different. Freud then advanced the interesting assumption that "what grips us so powerfully can only be the *artist's intention*" (Freud, 1914, p. 212. Freud italicized "intention"; I have added the emphasis on "artist's").

Freud described at length how he tried to "feel himself" into the statue of Moses. He wrote:

> I can recollect my own disillusionment when, during my first visits [to the church], I used to sit down in front of the statue in the expectation that I

> should now see how it would start up on its raised foot, dash the Tables of the Law to the ground and let fly its wrath. Nothing of the kind happened. Instead, the stone image became more and more transfixed, an almost oppressively solemn calm emanated from it, and I was obliged to realize that something was represented here that could stay without change; that this Moses would remain sitting like this in his wrath for ever. [Freud, 1914, pp. 220–221]

As he proceeded to contemplate and project himself into the statue, examining every part in greater detail, Freud found himself modifying his views and feelings. He looked at the statue many times, and read many critical essays about it before reaching a conclusion that satisfied him.

In short, Freud demonstrated the consecutive steps that one takes in empathizing—at least those that we are conscious of. He drew certain inferences from the data he observed, and from his own inner response, and finally formulated a hypothesis. The validity of a hypothesis may be verified by consensus with other observers, or without such consensus, one can simply hold to one's inner conviction; neither procedure makes the hypothesis true or false. In the case of the Moses statue, the critic Watkiss Lloyd did come to the same conclusion as Freud and thus confirmed Freud's impression of Michelangelo's intention (Freud, 1914, p. 234).

Freud assumed intention to be a conscious aim. He defined it as an impulse for an action that has already found approbation but whose execution is postponed for a suitable occasion. I assume that often, if not invariably, an unconscious element accompanies a conscious intention. However, there are occasions when conscious and unconscious intentions coincide and give rise to a sense of inner harmony and conviction—the "that's it" effect we hope to experience in working with a patient (Freud, 1901, p. 159).

Freud's attempt to explain the impact of the Moses statue is, in some measure, similar to what the therapist does when he tries to decipher the facial expression of a patient or to understand his mood during a therapeutic session. The therapist communicates this understanding and may reach consensus with the patient.

Freud was convinced that he had grasped Michelangelo's intention. But who can say? Michelangelo was unavailable for comment and

statues don't argue. I question whether we can ever be certain of another person's intent. It is even difficult to be fully aware of our own intentions.

Other writers have also been preoccupied with the issue of intention and effect. Joseph Conrad, for example, said that we are responsible only for our intentions, and that the effects they produce are beyond our control; and Goethe is credited with saying that only the intentions are worth studying. But at a certain point in my experience as a therapist, I noticed the problems that arise from equating intention with effect. If I thought I knew my intentions, I assumed automatically that the patient should know them too. And I also felt that I was responsible only for my intentions, until it dawned on me that I could not always be certain of my intentions, and that my main responsibility was to take into account my effect on the other person. And this again changed my attitude as a therapist. I realized the importance of scrutinizing our intentions, so that we notice the *form* a communication takes, follow the *content,* observe the *effect,* register the feedback, and correct or modify when necessary (Szalita, 1968, p. 85).

About twenty years ago, I treated a college graduate who had been hospitalized following a schizophrenic episode. In the five years or so that I worked with him, he made a relatively good recovery. Ten years later, he phoned me and said he wanted me to meet his fiancée. During our meeting, I asked him what stood out in his mind about his work with me; I was curious about what he had retained from the treatment. He said he would think about it and put a few recollections in writing. In the four-page account he sent me, he stated:

> You were able to bounce off the murky gray of misery with a constant, steady blue pastel. . . . It seems to me a tricky job, but as the years have passed, I can see how this planted a dandelion in my unconscious.

But more apropos is his recollection of the first interview, which took place in the spring of the year. He wrote:

> I finished my spiel in an hour or so. We arranged to start in the autumn. Then I said, "Okay, that's good. I'll go now." Your answer was, firmly, "It's not your responsibility to finish the hour." And you continued with some supportive discussion of my need to get the job done with. Here, I thought, was someone who could help me with the problem of running away to

> loneliness, and I might never have returned in September without this specific diagnosis and attention.

I also remembered saying, "That's my responsibility," but my conscious intent was totally different from what the patient heard. I was not asking him to stay or trying to be supportive; I was simply trying to indicate that I was in control. It never occurred to me that this remark would have the impact that he recalled.

I ascribe ever-greater importance to scrutinizing the relation between intention and effect, and to using feedback for correcting discrepancies. By studying the effects we produce and matching them with our intentions, we become more aware of our unconscious impulses, especially when our intentions misfire. We thus learn that intention cannot be equated with effect.

Nevertheless, we meet situations in which the patient responds so dramatically that there is no need to ponder the appropriateness of the intervention. An insight emerges in a ready-to-use form. Such situations are so rare that we do not forget them.

One such situation occurred in 1944, when I was working as a neurologist in Moscow and had to give a spinal tap to a man I had never seen before. My hands were scrubbed and I was ready to begin, but the patient refused to lie down on the table. As the nurse tried to persuade him to cooperate and spoke reassuringly to him, I recall standing by, rather preoccupied and bored. While waiting somewhat impatiently for him to lie down, I glanced without any particular thought in mind at his case history, which was lying nearby. I noticed that it identified him as a Tartar and I found myself mumbling in Arabic, "Bis Malah Al-Rahman Al-Rahim," which means "God is merciful and kind." I had often heard this expression while working in the Soviet Republic of Uzbekistan. The man lay down without further ado and I went through the procedure swiftly. Then he sat up and smiled at me and was rolled out of the room. The nurse, who probably had not understood or even heard what I had said to him, looked at me with amazement and asked, "What happened?"

The precise mechanisms by which empathy is achieved, like other inner workings of the mind, are probably as difficult to penetrate as the bottom of the ocean. In the manner of the marine geologists who are mapping out that vast opaque world from whatever samplings they are able to procure, we too work from random samplings as we try to account for the operation of empathy. All our explanations thus far fall

within the speculative sphere of metapsychology. This may sound mysterious, but as Sullivan remarked, "there is much that sounds mysterious in the universe, only you have got used to it; and perhaps you will get used to empathy" (Sullivan, 1953, p. 42).

Most observations and explanations of empathic processes have emerged from studies of childhood development or from interactions between patient and psychotherapist. To summarize, in very cursory fashion, some representative explanations: The mental mechanisms most frequently referred to are identification, projection, and introjection. Although Freud did not focus systematically on the subject, he referred to a path leading "from identification by way of imitation to empathy" (Freud, 1921, p. 110n). Some psychoanalytic theorists link empathy to transference, partial and temporary identification, or splitting of the ego or projective identification. Many writers, among them Sullivan, Escalona, Scheler, and Weigert, stress the elements of emotional contagion and induction of feelings. Some investigators assume that empathy is an innate predisposition; Mumford (1967), for example, regards it as a genetically determined faculty that is enhanced or inhibited by life experience (pp. 58–63).

I have omitted the whole subject of pathology related to the use of empathy because to attend to it would require another paper. Perhaps it would suffice to mention that for us psychoanalysts, empathy is a process of collecting observational data, but it should include judicious application of the data. It may become a form of acting out by the therapist when used indiscriminately, but failure to make use of the empathic understanding renders the therapy sterile.

Finally, I must mention the view that empathy operates through some extrasensory mode of communication. As a matter of fact, it is becoming increasingly difficult to reject telepathy and ESP in the light of recent developments and research. Freud's fascination with the paranormal was apparently played down by his biographer, Ernest Jones. In a letter to Hereward Carrington in 1921, Freud wrote that if he were just beginning his career, he might consider dedicating himself to psychic research (E. Freud, 1960, p. 334).

Sullivan did not specifically refer to telepathic processes, but described empathy as the emotional contagion or communion which exists between people outside the communication through sensory channels or through spoken words (Sullivan, 1953a, p. 20). The anxiety that an anx-

ious mother may cause in her infant, he stated, is the very earliest evidence of the empathic linkage (Sullivan, 1953b, pp. 42–44).

To quote Sullivan further:

> *The tension of anxiety, when present in the mothering one, induces anxiety in the infant.* The rationale of this induction . . . is thoroughly obscure. . . . I bridge the gap simply by referring to it as a manifestation of an indefinite . . . interpersonal process to which I apply the term *empathy.* I have a good deal of trouble at times with people of a certain type of educational history; since they cannot refer empathy to vision, hearing, or some other special sense receptor, and since they do not know whether it is transmitted by ether waves or air waves or what not, they find it hard to accept the idea of empathy. [Sullivan, 1953b, p. 41; Sullivan's italics]

Fromm-Reichmann explicitly associated herself with Sullivan's formulations and confined herself to clinical descriptions. One incident illustrating her use of empathy involved an assaultive patient who was in a pack during her treatment sessions. At the request of the superintendent, Frieda asked whether the patient would sign a check in payment for her hospitalization. The patient declared that she would gladly sign it if she were unpacked. Fromm-Reichmann's report continues:

> As I went for the nurses to ask them to do so, some *empathic notion* for which I cannot give any account made me turn back toward the patient. I saw an expression of utter despair and discouragement on her face, which made me decide to unpack her myself. After her recovery, she was capable of telling me that she considered my taking her out of the pack myself the starting point of her recovery. [Fromm-Reichmann, 1950, p. 30]

I agree with Sullivan and Fromm-Reichmann that verbal communication plays a secondary role in the use of empathy. But Sullivan's view that it exists "outside the communication through sensory channels" has always puzzled me. I do not exclude the possibility that telepathy plays a role in empathy. But it could be explained as a virtually instantaneous response to nonverbal communications such as body language. Gestures, postures, facial expressions, convey messages that are more or less universally understood. It has been estimated that more than 700,000 such gestures are produced by one or another movement of the body. I do not know who counted them and how, but as you are probably aware, the field of kinesics bubbles over with fantastic information these days.

To the scientific investigator of kinesics or body language, a movement is a message, to paraphrase McLuhan, and it is also *visible behavior*.

In the anecdote just referred to, Fromm-Reichmann mentioned that she noticed the patient's facial expression. She could not account for her impulse to turn back, and certainly we cannot know what went on in her mind. But the response was obviously swift—her impressions of the patient's need led her to turn back, and the patient's expression convinced her that unpacking the patient herself was the right thing to do. The decision was unencumbered by much deliberation. A feeling generated by another person's need was understood and acted upon. I describe such a reaction as spontaneity-with-purpose or goal-oriented spontaneity.

Marked variations in what one senses in another have been noted. Jan Frank (1960), for example, has pointed out that some therapists respond to sinister aspects of another person. Kenneth Artiss (1973) suggested that sex might also influence empathic responsiveness. Calling attention to differences between Sullivan's observations and Fromm-Reichmann's, Artiss stated:

> Such a comparison brings into sharp focus the fact that Sullivan, the man, was challenged by and was exquisitely sensitive and alert to the aggressive factors in his patients, as compared with Fromm-Reichmann's feminine patience and calm as she waited for aggressive displays to run their course so that something more tender, and to her, more interesting, could take place in the relationship. [p. 1047]

Frieda Fromm-Reichmann maintained that empathy can be expanded through training. I subscribe to this view. All human beings have a capacity for empathy, whether latent or manifest, but even the most creative therapist has to invest some effort in developing it. In my supervisory activity and teaching of psychotherapy during the past quarter of a century, I have found that the majority of therapists do increase their potential and readiness to respond empathically to suffering human beings. From being rare or brief, empathic responsiveness changes, tending to become more or less habitual.

The question then arises: By what methods can therapists be helped to develop this capacity? Unquestionably, personal analysis comes first. But experience shows that personal analysis and supervision may not entirely overcome the rigidifying effects of medical training. Freedom of

response, spontaneity, and trust in one's own judgment are not emphasized in our medical studies. Those who commit themselves to a field like ours, where personality is the essential tool, have to do a great deal of unlearning even after the completion of their personal analysis.

In teaching psychotherapy, one becomes painfully aware of the need to repair any damage sustained from either academic or psychoanalytic training. Latent capacities for creative thinking need to be cultivated; tendencies to blunt one's feelings need to be counteracted; attentive observation, responsiveness, and spontaneity need to be fostered. The student who is reluctant to experience painful emotions has to recognize how his defensive armor obstructs his empathic responsiveness. When pain is experienced, it can be shared; then it becomes possible to reflect on it dispassionately and to achieve sufficient distance to respond to it objectively.

Empathic understanding seems to depend on life experience and the capacity to combine imagination with stored memories and new experiences. Over the years, I have experimented with many devices to help students broaden their experience of life and to stimulate them to use their imaginations and express their own ideas rather than clinging to what they have learned from textbooks.

The study of world literature is another effective way of developing empathy and learning from the experiences of others. In reading professional literature or listening to case presentations, I have always searched for analogies from my own life or from the infinite variety of characters and situations in novels, plays, short stories, and biographies. While listening to a patient, too, I scan my memories for experiences that might match those the patient is reporting. Literary masterpieces offer profound knowledge of the human condition, knowledge that is obviously essential in psychiatric work.

Freud felt the same way, as he frequently acknowledged. For example, he admired Ibsen for his "simplification of problems" and in 1906 wrote to Schnitzler, "I have often asked myself in astonishment how you came by this or that piece of secret knowledge which I had acquired by a painstaking investigation of the subject and I finally came to the point of envying the author whom hitherto I had admired" (E. Freud, 1960, p. 251).

Assigned readings and discussions of characters and families depicted in novels and dramas proved to be an instructive experience for a group of psychiatric residents I recently trained in the use of family interviewing

in child psychotherapy. In a published account, they reported that examining detailed studies of these families was "exciting and entertaining" training (Mahon & Egan, 1973). They found outstanding clinical material in Ibsen's *The Wild Duck,* D. H. Lawrence's *Sons and Lovers,* and many other works. Case histories drawn from these works were familiar to each of the participants, which facilitated discussion. Talking about a character in a book is less anxiety-provoking than exposing one's work with a patient.

As members of a helping profession, we combine empathy with sympathy and compassion for those we serve, and more or less take it for granted that empathy is invariably utilized in this way. In psychotherapy, empathy is commonly used to induce feelings of hope or other feelings that will raise the patient's self-esteem, as well as to promote inquiry and growth. A patient who enters the office feeling desperate or hopeless may leave with a somewhat brighter outlook. But understanding the feelings of another person does not guarantee that this understanding will be utilized in his interest.

The induction process is ubiquitously active and may be used to exploit or manipulate others. The demagogue characteristically uses it to influence people to suspend their judgment, and to submit to or even participate in destructive action. I assume that that was why Koestler (1964) characterized empathy as a "hidden persuader" (p. 296).

The German playwright Bertolt Brecht shared this distrust. After repeatedly observing Hitler's manipulative use of empathy, Brecht became convinced that the theater had to be liberated from empathy and catharsis. According to Frederick Ewen, his biographer, Brecht maintained that audiences are bathed in illusions in the theater to make them forget the outside world and to exploit their feelings. Brecht confessed that fascism compelled him to emphasize the rational rather than the emotional. Hitler's use of deliberate and conscious theatricality to induce the German people to feel as he did convinced Brecht that emotions should be examined as critically as ideas (Ewen, 1967, pp. 213 ff.).

That is precisely what therapists are supposed to do before imparting understanding to the patient. Although previously acquired knowledge may be used at times to achieve a specific effect on the patient, empathy in treatment is not calculated gimmickry. Brecht advocated the use of empathy only to induce curiosity and wonder, never to produce catharsis—a view I do not wholly agree with. Consonant with the patient's

immediate need, we use empathy at times to induce thought and at *other times* to induce abreaction.

Does the therapist have to feel what the patient is feeling in order to understand him? Answers to this question differ. Some investigators believe that empathy operates only when the therapist is able to identify with the patient's immediate feelings; they conceptualize this mechanism as temporary or partial identification. My own view is that one does not need to experience the emotions that grip the patient at that particular moment. What is necessary is to recognize a feeling, a thought, or a psychological configuration, which, by analogy, stirs up one's own imagination, memory, or experience. In other words, the observer may identify a feeling similar to one he experienced in the past; thus, he maintains his separateness from the person he is with (Aring, 1958). It seems to me that one often applies empathy more productively when one is not encumbered by intense feelings.

I have already singled out two ways of enhancing our empathic responsiveness and helping others to cultivate it. One way is to learn as much as we can about the human condition. As Maimonides observed, "It is not given to one alone to see all that others see." We learn much from our patients. We also learn from the experiences of persons we know or read about. Another way is through personal analysis—the study of one's own life. But it is perhaps through personal suffering that we learn most about empathy. In the words of Bertrand Russell (1967), "One needs, as the key to alien experience, a personal knowledge of great unhappiness" (p. 253).

Suffering is not a guest we have to invite; it comes unasked and may even become an inseparable companion. Suffering per se does not lead to wisdom, as some people maintain. Wisdom is more readily acquired when we gradually emancipate ourselves from narcissistic preoccupations.

Empathy becomes more accessible as we come to grips with fears of death. Confrontations with sorrow, grief, and bereavement are always painful, but often engender a more compassionate attitude toward others and a commitment to life.

It little matters how imaginary or insignificant are the concerns we confront in ourselves or others. One person may react to petty grievance as intensely as another person reacts to a great tragedy. The test of one's empathy is the capacity to relate to the sensitivity of the sufferer rather than to the magnitude of the misfortune.

In this culture, compassion or feeling sorry for oneself or others is often frowned on. Feeling sorry means being close to oneself or others.

There are two kinds of compassion. One is fraught with pain and resentment (Szalita, 1974). This is a self-protective form of compassion; because one's vulnerability evokes angry feelings toward the object, one wants him out of the way. The other kind of compassion is free of self-centeredness. There is empathic consideration of another person's feelings and readiness to respond to his needs without having to shield or spare one's own sensibilities, and without making his burden one's own. With this kind of compassionate attitude, empathy resolves grief. The resolution of grief, in turn, inspires courage to live and commitment to fellow *human beings* and to *work*.

To summarize: I view empathy as one of the important mechanisms through which we bridge the gap between experience and thought. How it operates is still unknown. Empathy is an expansion of self-awareness which reduces the distance between perception and insight. Expansion of empathy leads to a better contact with oneself—a sense of being rather than appearing, which is usually accompanied by pleasure. The specific contribution of therapists as compared with writers is that the data obtained through empathy are transformed into an applied skill to be used selectively and responsibly by the therapist. How each of us uses empathy in his work depends on his emotional and esthetic attitudes and his ethical values.

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