Why everyone should be wary of empathy and why psychoanalysts shouldn't do it all.
SYD_short

In 'Normal counter-transference and some of its deviations' the psychoanalyst Roger Money-Kyrle writes, 'How exactly a patient does succeed in imposing a phantasy and its corresponding affect upon his analyst in order to deny it in himself is a most interesting problem. …..In the analytic situation, a peculiarity of communications of this kind is that, at first sight, they do not seem as if they had been made by the patient at all. The analyst experiences the affect as being his own response to something. The effort involved is in differentiating the patient's contributions from his own.'

Some analysts have advocated empathy as a way to read the patient's communications. I shall argue first, that in the psychoanalytic counter-transference it is the analyst's sympathy doing this, not empathy. Second, that empathy is (just) sympathy together with psychological projection. Third, that psychological projection can be a way of imposing a power relation on another person, and for that reason should not be done by psychoanalysts (and everyone else should be careful too). In what follows I treat sympathy as a passive power, or capacity, not an active power or capacity to act (which is what projection is). I argue against empathy as a practice informed by a method by arguing against the method.

Countertransference.

What is the 'countertransference'? The patient's transference is the focus of psychoanalytic work: the patient unintentionally and unconsciously re-directs to the person of the analyst his feelings, wishes, attitudes, beliefs, about his parents or, more precisely the figures or 'objects' in his inner world who he thinks of as his parents. Part of the analytic work is then, to read back from what is thus transferred to the analyst, to what is unconscious in the relation to the internal parent or if conscious, what lies beneath the distorted representation the patient is aware of possessing. In her counter-transference the analyst responds, initially unreflectively and unconsciously, to the patient's transference, with her own feelings, wishes, attitudes and beliefs. Her mind is a 'finely tuned phenomenological instrument' for reading what her patient 'gets her to feel' by projecting his imagined relation with an internal parental figure into the analytic space and enacting his phantasies (or, unconscious imaginings) there.

The psychoanalyst's 'counter-transference' is the field of her own feelings in relation to the patient's transference, and these she interprets to herself in trying to understand what the patient is trying to tell her and on that basis, to interpret this back to the patient. She does this by first, listening with evenly suspended attention to her patient, building up knowledge of him over time. The clinical setting facilitates the externalisation of the patient's transference into the analytic space of the session. To what he says and does, and how he says and does it, the analyst receptively 'resonates'; she is both attuned to his affects immediately, and is receptive in her feelings to his verbal communications (as incomplete speech acts). She contains all this in her imagination: she does not act upon it, but instead maintains what has been called a 'reverie'. As her feelings and thoughts in response to her patient become apparent to her, she can gauge their significance. For example, if she experiences an emotion that is dissonant with her own state of mind she may wonder what it may be telling her about her patient, as something he is getting her to feel as a way of getting her to understand his position *vis a vis* the parent that she is detailed to be in the transference.

Rather than spell out exactly how this amounts to sympathy I will give material from Money-Kyrle's patient, a young man, who described feeling 'vague' and 'useless' while on the way to the analyst; once in the session, the psychoanalytic work became stalled, the psychoanalyst himself experiencing a 'useless vagueness' in his interpretive activity, and the patient becoming angry and contemptuous.

Money-Kyrle writes: 'When I eventually recognised my state at the end [of the session] as so similar to that [which] he had described as his at the beginning, I could almost feel the relief of a re-projection'. He continues, 'By then the session was over. But he was in the same mood at the beginning of the next one — still very angry and contemptuous. I then interpreted that [told him I thought] he felt he had reduced me to the state of useless vagueness he himself had been in; and that he felt he had done this by 'having me on the mat', asking questions and rejecting the answers, in the way his legal father did. His response was striking. For the first time in two days, he became quiet and thoughtful. He then said this explained why he had been so angry with me yesterday: he had felt that all my interpretations referred to [came from] my 'illness' [or, incompetence] and not to his.'

Here, the patient confirms the psychoanalyst's interpretation: the psychoanalyst had not on the first day been able (until the end of the session) to realise that the patient was communicating - 'sharing' - his feelings. The patient was behaving in such a way (we are not told just how) as to induce in the psychoanalyst the feelings that were part of the patient's 'illness', the young man's un-articulated experience in relation to his own father. During that first session the psychoanalyst felt these feelings to be his own 'illness', so that his attempts at communicating something back to his patient failed as interpretations for him, the patient becoming more angry as a result.

Money-Kyrle describes the reflective work he himself needed to do before he could interpret effectively to the patient: 'I had to do a silent piece of self-analysis involving the discrimination of two things which can be felt as very similar: my own sense of incompetence at having lost the thread, and my patient's contempt for his impotent self, which he felt [unconsciously] to be in me [by projection]. Having made this interpretation to myself I was eventually able to pass the second half of it on to my patient and by so doing, restored the normal analytic situation'.

In order to bring out how sympathy and countertransference map on to each other I draw some parallels between Smith's characterisation of sympathy (the sensations of 'our brother on the rack') and what Money-Kyrle calls his piece of 'self-analysis', the work done to disentangle what the patient's communications (what he has said and done) have contributed to Money-Kyrle's feeling of incompetence.

Recall that Money-Kyrle recognised his own state at the end of the first session as very similar to what his patient had complained of at the beginning. Smith tells us that 'It is by changing places in fancy with the sufferer, that we come either to conceive or to be affected by what he feels.'

What happens here is that the patient, by behaving like ('being') his legal (accusatory) father, has got Money-Kyrle into the same muddled state of incompetence that he himself arrived in. This is projection on the patient's part, but not 'magic'; the patient 'becomes' - he acts like - his father to 'nudge' or push Money-Kyrle into feeling as he, the patient, used to feel. Money-Kyrle, reflecting on how he is feeling muddled (and separating this from feeling incompetent from having 'dropped the thread') is able to 'change places in fancy' to himself become the son of the legal father, bemused by the father's contemptuous treatment.

Money-Kyrle interprets this to the young man; that he 'felt he had reduced me to the state of useless vagueness he himself had been in; and that he felt he had done this by "having me on the mat", asking questions and rejecting the answers, in the way his legal father did (to him).'

Smith: 'By the imagination we place ourselves in his situation, we conceive ourselves enduring all the same torments …..[we enter as it were into his body, and] become in some measure the same person with him, and thence form some idea of his sensations and even feel something though, while weaker in degree, is not altogether unlike them'.

Smith is not himself talking about a projective origin in another for the sympathiser's feelings but, he is clearly here retaining the difference between what we feel and what the other feels. Even if we feel something 'very like' what the other, the patient feels, it remains that we only know what he feels through our (sympathetic) imagination: 'It is by the imagination only that we can form any conception of what are his sensations…Neither can that faculty help us to this any other way, than by representing to us what would be our own, if we were in his case'.

[This is what the analyst does when he arrives at the interpretation he makes by reflecting on his own feelings of incompetence: these are feelings indeed 'very like' what the patient is feeling and it is no accident that the one, the analyst's own sense of incompetence, and the other, the incompetence that patient has induced in him by being contemptuous, are congruent. But Smith's point stands: the work the analyst has to do here is to separate the two. Thus, he does a 'piece of self-analysis' which involved 'the discrimination of two things which can be felt as very similar: my own sense of incompetence at having lost the thread, and my patient's contempt for his impotent self which he felt [unconsciously] to be in me.'

It is the latter, the feeling the patient has stimulated in the analyst's mind and has got him to sympathetically imagine for him, that allows the analyst to form a 'conception of what are his [patient's] sensations….. by representing to us what would be our own, if we were in his case'.]

I take sympathy itself to be receptive, not active: nothing is acted, nothing is done in the world. I claim that empathy is sympathy with active projection added on. In the 'Einfuhlung' of Vischer and Lipps, projection of the subject's point of view into the place of the individual or art object is an act of the imagination. Here, we might use 're-location' or 'displacement' for the move of 'chang(ing) places in fancy with' the other, rather than the term 'projection'. But however we decide to label the mental/ideational move of putting oneself in the other's place (Wollheim's 'centrally imagining' oneself in another's position or, centrally imagining that person's perspective) it is important to note that it is just that, imagining; it all occurs in thought, in the mind of the sympathiser, and not in the real world of people (but, see Wollheim on two sorts of projection). While this makes explicit what was implicit in Humean sympathy, the imaginative putting oneself into the position of the other, it is this explicit addition of active projection to sympathy as an epistemic route to knowing the object or person which has 'momentous' unintended consequences, to which psychoanalytic observation alerts us: the enactment of what is imagined. Although it is a puzzle of philosophy just how what is imagined (as 'phantasy') gets into the world, Freud showed it plainly does: the early psychoanalytic literature is replete with descriptions of a person's actions where we read not only his conscious intentions but the unconscious wishes that get realised in the behaviour or symptom. This central Freudian message should by now be uncontentious. The important question is how does it happen? And as Isabel Menzies used to remark, 'it doesn't happen by magic'.

How, in particular, does 'projection' of an affect or phantasy, imagined as a relocation of something mental within the mental field, get turned into action (get enacted) in the world?' so as to 'impose it on the analyst'? To begin to answer this I say more about projection.

The Penguin Dictionary of Philosophy entry for 'Projectivism' tells us it is the 'theory that certain properties which we ascribe to their bearers do not really belong there but are projections of subjective states'. Projecting is, the act of throwing outward or forward; psychological projection is the attribution of some part or aspect of subjective experience to the objective world (all within the domain of thought).

Hume may be taken as the *locus classicus* for the statement of psychological projection (though not in connection with sympathy), writing in the Enquiry that 'taste….has a productive faculty, and gilding or staining all natural objects with the colours borrowed from internal sentiment, (it) raises in a manner a new creation.' For Hume: what is projected is 'sentiment' (both feeling and belief) and where it is projected is onto 'natural objects' (the world). What Hume does not tell us is how it is projected, but it is uncontentious that this is an act of the imagination.

Projection is not Hume's term, of course, but it is in this Humean sense that projection is initially taken up by Freud, who writes that 'internal perceptions of emotional and thought processes can be projected outwards in the same way as sense perceptions; they are thus employed for building up the external world..' in a way that Freud sees as normal. Our picture, representation, or idea of the external world carries features we have put there. Projection is used defensively when unwanted aspects of the self are disowned and attributed to other people. Such projection can distort our perception of the world: as Jung remarked: 'The unwanted aspects of the self tend to turn up in the guise of a hostile neighbour'. But the change is in our perception, not in the world: in aesthetics, in Hume, and in psychoanalysis, psychological projection is occurring in, is a mental act confined to the imagination.

However, as noted, psychological projection can also make itself felt in the world. Distinguishing these two domains, of the imagination and the world is important since projecting in imagination is just that, an imagined act of relocation of mental contents. But projection enacted in the world is a different matter: it does not occur 'by magic' but in behaviour – in what is said and done – as with Money-Kyrle's patient. Something is done to bring about a situation in which it is for the patient as if what he disowns has indeed 'turned up' elsewhere, as a feature of someone else's thought or behaviour. Just what is done, and how this works, will have to be left aside.

What is important for my argument here is that two modalities of projection entail two sorts of empathy. More exactly, two different sorts of interaction between projection and sympathy. One is 'intra-psychic': here projection is part of Humean sympathy, the self-perspective is projected into the position of the other (with disowning the opposite of sympathy occurs: imagining the 'hostile neighbour' so as to project unwanted parts of the self into them). Here, so long as projection is taking place only within the imagination 'empathy' reduces to, ie amounts to no more than, sympathy as placing oneself in the other's position….Smith's subjunctive 'what would be our feeling, were we in his case…'.

The other interaction of projection with sympathy is inter-personal. When empathy involves projection put into actions (whether speech acts or 'symptomatic' behaviours) it has effects upon the world and upon persons in the world. This is where the ethical question becomes salient: first, for analytic reasons – to act on some part of the real world is to enter a relation of power with it. Second, power in the social world is a complex function of the material (resources), the structural

(normativity) and the psychological (pain and pleasure). All three dimensions in the constitution of power present an ethical minefield for the practitioner of empathy to trample across.

So far I have said that there are two modalities (or domains) for projecting, and accordingly two 'sorts' of empathy: empathy that reduces to sympathetic imagining with its re-location of the self-perspective, and empathy that is actively projective and other-involving. This distinction, if understood, can be used to explain and to justify the ethics of avoiding the latter implicit in more rigorous schools of psychoanalytic practice. I now want to show how ignoring this distinction, and tacitly (or explicitly) endorsing a practice of actively projective empathy is ethically compromised, and that is is so compromised on the analytic ground of showing how projection interacts functionally with sympathy.

The differences between the intrapsychic and the interpersonal forms of empathy lie in whose sympathy and whose projection are in play; in real-world interpersonal empathy the interaction is between two persons. I'll start by talking about Person A as the patient and Person B as the analyst, recalling the clinical vignette given earlier. I'll also use a distinction, noted by Smith and by recent commentators on empathy, between the more 'resonant' or immediate form of sympathetic response and the more 'cognitive' or reflective sort. Person A (the patient) projects what Person B (the analyst) sympathetically responds to. Here is an interpersonal interaction between persons in a relation of communication. In this case Person A actively (by projection) produces a sympathetic response (immediate or mediate) in B who as analyst contains and reflects before interpreting. But if B doesn't or can't contain her sympathetic response, but betrays or evinces her feelings or thoughts, A can observe these (as the patient observed M-K's response of unsuccessful attempts at interpretation). A might also, from what we have been saying, use his own sympathy to imagine B's state of mind ('resonantly' picking up B's muddle, for instance); A might also use this to add to his own reflective sympathetic understanding of B, as when M-K's patient (correctly) saw the analyst's response as 'his' ie the analyst's 'illness'. Normally, one might say, this sort of probe-and-read interaction is part of what is meant by calling sympathy the 'practical imagination'; an ongoing sympathetic imagining deployed to gain knowledge of others and both predict their actions and monitor their ongoing mental states.

But as well as using his knowledge to predict B's actions, A can use his knowledge to control B more actively. How? Well, via not just the gamut of psychological or social routes to manipulating someone's psychological states, from the obvious and direct (threats, cajolements, flattery, bribes) to the indirect, for example 'gaslighting'. Sympathy has, again, a specific role to play: not only by giving A a way to monitor the success of his manipulation but yet more sinisterly. For A's sympathetic reading of B's responses can give A a basis on which to act to control B by further projections (probes or prods) arousing anxiety or pleasure by sympathetically reading these and then, by titrating his projections against B's response. In such ways A 'practises', or plays, upon B's psychology in subtle ways that B may be quite unaware of (or if aware, then uneasily, and unclearly). And, finally, not only may B be consciously unaware of these effects; A may be consciously unaware of them too. This complex interaction of projection and sympathy is, with certain theoretical qualifications, what psychoanalysis calls projective identification.

This sketch of the functionally complex set of relations in which projection and sympathy interact to provide not just knowledge of others but a conduit for power and control that may be invisible to one or both parties, should suggest more restraint in the endorsement of empathy. I shall go on to take up the importance of this for empathy as practice but we should note that the analysis bears also on empathy as an investigative method (epistemological category). The complexity that I have outlined militates against its straightforward usefulness as a way of knowing the mind of the other, since A the investigator's perception of the other person (B) is distorted by what A has 'empathically'

projected onto B. More than this, A the investigator is often motivated not to withdraw those projections and so is motivated not to know what he purports to be trying to find out (he is 'in bad faith'). When it comes to trying to read B's state of mind in order to predict her actions, we have further seen that A's investigative probing is motivated by more than A wanting to respond appropriately to B. A may, all unconsciously, want to know what will best predict B's actions, and also what will best control them. Thus as an epistemological concept, the knowledge of the other empathy supposedly provides is less reliable than might be thought; the 'other' who becomes known in this way is not so readily distinguished from parts of the self projected into them. Matt ffytche has tellingly called empathy as a 'weakening social construct', one whose projective dimension has an occluding (eroding) effect on the 'empathising' subject's knowledge of her own emotions.

Finally, I take up the question of empathy as a practice. Consequences for practice arise when pressure is put upon practitioners (in the caring professions generally) to be more empathic, accessible, intersubjective. On analytic grounds, invoking 'empathy' to license a practice in which the empathiser engages with another person to project into them, is ethically dubious because of the internal conceptual relation between action and power. We should be very careful before advocating empathy, particularly in therapeutic situations, where power relations with clients in a dependent relation are unavoidable.

I have given two conceptual grounds for mistrusting empathy – its epistemological unreliability and its ethical dangerousness. Without a training that takes account of this the 'practitioner' of empathy risks being ethically compromised, by (culpable) ignorance on the one hand, by malevolent unconscious motivation on the other or by both. First, from the practice of 'empathising' being conducted in ignorance of its direct connection to power (conceptually and practically) whether for good or for harm. To fail adequately to understand how empathy works and what it involves, or when it is uncritically taken to license the enactment of one's own imaginings on the other, is un-ethical. Indeed, there is an untold amount of harm that is done in the name of therapy from unconscious motives on the part of the 'empathising' therapist. Would-be practitioners' ignorant carelessness about the potential of empathy for exerting psychological power through unconsciously motivated 'practising' is bad enough, but there is a second more sinister aspect to 'empathy', as we have seen. This is its intentional and instrumental use, conscious and unconscious, in the control and coercion of the other.

But, why shouldn't psychoanalysts do empathy 'at all'? Why can't they be trained to do it more carefully?

The short answer is, that there is no such thing as empathy anyway. But empathy is probably not going to go away so a response is needed. I contend that the ethical ground for psychoanalysts actively avoiding 'doing empathy' is decisive for psychoanalysis, once we consider that what lies at the core of psychoanalysis is the patient's relation to the analyst and, that is 'all about' power. It is about the power that patient feels himself to have, or not to have, and – most importantly - feels the analyst to have over him in the parental transference. It is therefore crucial to the therapeutic work that this transference power relation be addressed, free of the interference of an actual power relation of the sort feared or phantasised by the patient.

To make the point: Money-Kyrle describes 'a patient's dream, which did not seem very promising to him at all at first as all he could remember was that there were two straws, one longer than the other. This reminded him, however, both of blow-pipes for poison darts, and of a story of a vet who was trying to give a horse a stomach powder by blowing it down its throat – when the horse blew first. He was not quite clear if he was the vet or the horse, but he did realise, with a sudden shock,

that this is how the analysis had always seemed to him'. Money-Kyrle writes that in such patients, there is 'a specific fear: that the analyst in trying to help them will only succeed in muddling them up. And perhaps below this is the greater one that he (the analyst) will expose an underlying sense of worthlessness….What has to be analysed (here) is a specific form of persecutory fear – the patient's fear of becoming the victim of projective identification emanating from the analyst – the analyst 'blowing first', and so [for the patient] of being overwhelmed with confusion……'

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