

**Narcissism, Self Psychology, and the Listening Perspective**

*Evelyne A. Schwaber, M.D.* 

In the continuing evolution of psychoanalytic theory, the focus of interest has moved increasingly toward a deepening consideration of the vicissitudes of narcissism. Present efforts extend to a formulation of a depth psychology of the “self,” and a delineation of its place within the matrix of analytic theory. There has been some debate as to whether these efforts are prompted by a change in our theoretical perspective or in our patient population. Certainly, to remain viable, any theory must be able to change and grow—within its own inherent pathway—but this very process will also reflect the broader scientific and cultural outlook. Thus, I believe that sociohistorical, political, and scientific shifts, profoundly influencing the way of thinking and experiencing of both our patients and ourselves, will, by necessity, interdigitate with psychoanalytic trends.

The artist or writer is often the first to herald these changes; the character prototype already exists in the arts before we see him in our office. What we read about in psychoanalytic writings is a product of the already ongoing historical moment. This has been particularly apparent in the women's movement, which has opened new vistas for rethinking analytic understanding of female development—a new kind of woman, a new view of feminine psychology. So, too, as the role of religion in man's life has become socially acceptable—often even esteemed—we have taken a second look at the intrapsychic meaning of religion, with a view that has shifted the emphasis from its regressive aspects (as in Freud's *The Future of an Illusion* [1927]),

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to its adaptive, even creative attributes—a view that sees it as a capacity of man to create symbolic representations of the core of himself and of his inner world.

Currently self experience, self fulfillment, is at the forefront of artistic and creative recognition as a powerful social force. Both the pleasure in ethnicity, in one's own uniqueness, in doing one's own “thing,” as well as the pain in the resulting sense of isolation and aloneness, have become the focal points of what is considered meaningful experience today. Self affirmation has taken up competitive battle with the maintenance of relationships and institutions. It is in this context that the “narcissistic character,” as described and experienced by us now, may be the prototypical character of today, much as the “hysterical character” of the turn of the century—understood in the language and tools of that time—was its neurotic archetype, leading then to a focus on libido theory.

There have indeed been many significant contributions to the ongoing effort to establish a depth psychology of the “self”—some of which have described it as a new paradigm.<sup>1</sup> In this regard the work of Heinz Kohut has been pivotal in stimulating further creative endeavor, both in agreement and in rich and sharpened controversy.

Kohut's first point of departure occurred when he described the self experience—the pathway of narcissism—as having its own intrinsic developmental directions and maturational landmarks, culminating in the capacity for empathy, wisdom, humor, and creativity (1966). This view represented a significant conceptual shift from the model in which narcissism moved via autoerotism onto object love (**Freud, 1914**), which ultimately had the higher maturational priority. It also reflects a concomitant changing direction in our cultural value system.

**Kohut (1968)** first described the narcissistic transferences within the analytic situation as specific to patients whose central pathology lay in the core experience of the self. (I am using the term “self” here as meaning an experiential construct which has a stability and continuity over time—not as a mental structure.) Kohut noted that these transferences differ from the more classical, object-differentiated ones in that the analyst is experienced as part of the self, a selfobject. He noted further that such a transference should be seen not as a defense from, nor a way station to, an object-differentiated one, but as having its own evolution, an ongoing developmental continuum in its own right. If a patient could form and consolidate such a transference, a “classical” analytic treatment could take place.

In contrast to borderline or psychotic patients, those with narcissistic character pathology (more recently called “self pathology”) were understood as having attained developmentally a degree of self cohesiveness enabling them to form and utilize such a transference. However, their central pathology has to do with the fragility, the vulnerability of this state of self cohesion, which thereby could only

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<sup>1</sup> Cf. **Kuhn (1962)** on “paradigm” formation, especially Chap. 2, and **P. Ornstein (1979)**.

be maintained with considerable ongoing effort. What had been lacking for these patients was a childhood experience of an empathically responsive milieu, one which, beyond caring and availability, could recognize and delight in the child's separateness and uniqueness. Thus, they remain vulnerable to any number of painful, often dreaded, experiential states—such as a feeling of unreality, of boredom, a sense of emptiness, of vagueness, of deadness—for which relief is often desperately sought in a variety of pathways, whether in reality or in fantasy. A new dimension is now offered to our understanding of such symptomatology, as addictions, perversions, kleptomaniacs, obsessions, and hypochondriasis, which—going beyond the notion of drive and defense—may be understood as having the function of offering a vital sense of aliveness to the self. I had a patient who is a compulsive liar, with pleasure. He felt “dead” inside when not involved in telling some fantastic tale. Such patients remain in constant, often urgent, pursuit of something or someone to affirm them or to define them, to strengthen the weakened structure or function. The therapist, or analyst, in performing thereby some selfobject function, may become an increasingly important part of the structure of the patient's self experience—the dynamic understanding of which will permit gradual internalization and maturation.<sup>2</sup>

My own evolving understanding of the selfobject phenomenon arose in trying to conceptualize and to experience what it meant to let myself be used in this way, as part of the core of the patient's self.<sup>3</sup> I slowly came to recognize that listening in this way—having to place myself inside the patient's self experience—called somehow for another mode of listening, of perceiving, than one in which I would be positioned somewhat “outside”—that is, as target rather than subject of the patient's affects, drives, and defenses. The outside, or “objective” perspective, is one which attempts to apply logic, reality testing—active efforts to encourage an alliance with us in sharing a rational, “objective” view. The “subjective” perspective asks us to ally with the perceptual validity of what is expressed, however irrational it may seem—not as a confirmation of an external reality, but only as an intrapsychic one. Thus, this “inside” focus may sharpen attunement on the more experience-near, on the patient's state, on the immediate relation to the surround—and thereby to the interaction between patient and analyst. This latter idea—of the analyst and patient as part of a system—I have called a “contextual unit.”<sup>4</sup> And, as we shall see, it lends to our having to take added notice of the analyst's contribution and its immediate impact. It is this listening stance which is what I mean by empathy.<sup>5</sup>

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2 “Therapist” and “analyst” may be used interchangeably here, since the applicability of the listening mode which I am addressing is equally relevant to the psychoanalytic and to the psychoanalytically oriented psychotherapeutic process.

3 Cf. **Schwaber (1977a)**.

4 Cf. **Schwaber (1979)**.

5 In a recent contribution (**Schwaber, 1981**), I have further extended my views on the concept of empathy. Considering the relation of this concept of Kohut's writings, I commented as follows:

Empathy, then, is not a background given of our therapeutic stance; it is not equivalent to tact or compassion, to gratification or some all-embracing warmth. It is a specific, scientific mode of perceiving—the matrix of depth-psychological observation. I shall later consider this concept in further detail.

Patients with their basic pathology in the fragility of the self have helped us to gain understanding of the nature of this quality of listening, the empathic mode, by their particular sensitivity to it. Often, they will report just such a failure in their past—that is, a sense that *their* feelings, *their* perceptions had not been taken seriously. As in the child's development, so, too, in our analytic endeavors, the self is defined and thereby affirmed by a genuine attempt to elucidate its intrinsic experience; this permits a greater tolerance for a deepening regression, while encouraging further participation in the introspective process. In contrast, when these patients feel a failure of such an attempt—when, for example, the analyst is perceived as imparting his own point of view, be it of a clarification of reality or a view that what they are perceiving is a defense against their *real* experience (in other words, that the “real” experience is somewhere else, or a view that something must be given up)—there is a sense that the analyst is insisting on his own separateness, not responding from within their experience. What may then be recreated is the feeling of the earlier environment, which had been perceived as noxious. The failure for these patients lies in their inability to experience a sense of their own autonomy, of being in charge of their actions; instead, they may feel themselves as victims, or as passive spectators moved by currents, rather than as participants on the world's stage. Thus, there may be an exquisite sensitivity to feeling controlled or manipulated—an injury from which they must find a way to shield themselves. They may overtly comply—perhaps in search of some definition or to maintain a sense of unity, of oneness with the analyst—but other manifestations bring evidence that an injury was experienced.

They may begin to find fault with the analyst's appearance or mannerisms, with the office furnishings, the smell of the room, the temperature of the air. They may seem more constricted or deadened in their affect, less graceful in their posture; they may become hypochondriacal or develop a depersonalizing experience, or some other, perhaps familiar, symptom may reappear; or, they may become

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In his early paper on empathy (1959), Kohut noted the presence of the empathic observer as defining *in principle* the psychological field observed.... I believe it was Kohut's rigorous use of empathy—introspection as the primary mode of data gathering, suspending the inferential imposition of a reality from without, which led him to the discovery of the varieties of transferences which he subsequently elaborated. It was not that empathy, as Kohut defined it, was a specific discovery of self psychology; it was rather that its fundamental use as a *perceptual* mode...permitted the systematic unfolding and elaboration of another realm of subjective experience....Empathy is not the domain of any one theoretical view, and any theory (including that which employs the self-psychological framework), once elaborated, can again be used to impose its own view of reality from without.... Understood as a specific, scientifically trained mode of perceiving the data...the intrinsic nature of empathy would warrant clarification independent of the particular theory upon which one draws [in press].

come increasingly demanding or engage in a control struggle, even appearing as though paranoid—wondering, for example, whether the office is “bugged.” The analyst is felt as not to be trusted, because he has been experienced as out of empathic contact. Some means must be sought to maintain the sense of integrity and cohesiveness of the self. This is the primary psychological task of these patients, and correctly so; it is precisely the ways in which they do this and with which it gets interfered that then must become the focus of introspective observation. This will permit the genetic reconstructions of some of the subtleties of perceived parental failures—now felt to be re-created within the transference. Insofar as this also allows the elucidation of how the self then developed, such a focus will include a maturational, creative potential to the solutions attempted.

I shall offer some clinical vignettes, in the attempt to illustrate some of these ideas.

A young man, a gifted photographer, told me at the beginning of one hour that he couldn't wait to leave to get to his new job, in which he felt more interested than in his analysis. He then said I had looked at him when he entered as though I wasn't so happy to see him either, but he dismissed this idea, believing that he was probably just placing onto me what he felt.<sup>6</sup>

Here, I could have pursued his negative feelings or the defense against them, or waited longer. Or, again, I could have chosen to stay close to *his* described perceptions and explored them. I asked him to say more about the “look” on my face. He said my face looked “neutral, indifferent” to him. Then he began to recall memories of mother's seemingly “neutral, indifferent” looks, especially when he was interested in something in which she didn't participate—like his photography—just as he is now invested in the job that awaits him after his hour. Subsequently, we came to see the development of his exquisite sensitivity to “looks” and, as a photographer, to a particular interest in “trying to capture a moment's look forever.” Further memories revealed his highly cathected responsiveness to visual stimuli, including not only painful but also pleasurable states within the visual mode.

The position taken was that the described experience or perception may have meaning and a genetic history which can be pursued in its own right. Here, we had the bonus of being able to elucidate an actual creative development to deal with an originally painful stimulus. The specific use he made of the camera, beyond its defensive aspect, represented—though of course it was multidetermined—an imaginative pathway for healing his painful state.

Another example of just such an added dimension: A patient complained one hour that he felt his girl friend didn't seem to like him, that she wasn't “touching” him very much, and so he did not feel “talkative.” Words then came slowly and

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<sup>6</sup> Cf. **Schwaber (1979)** which expresses some of the ideas and examples which have been elaborated upon in this paper.

dissipated. He paused, I said nothing, and then he told of hearing music and silently listening to it. Exploring this sequence, he noted, "It seems my hearing music came when I was waiting for you to comment and you didn't." In the course of my silence, he revealed that he felt "untouched" by me, too, and since "touching" from me would have had to take place in an auditory mode, he soothed himself in that same mode, on an imaginative level, by "hearing" music.

Here, again, one may focus one's attention on the defensive aspects of the turning to music, the retreat from negative feelings in the transference, the retreat from painful object relationships—which indeed it may be. But if we stay closer to his immediate experience, we may be able to trace the process, the steps by which he attempts to heal a painful affect, to explore how he even learned to shift sensory modes from tactile to auditory, or how he developed the capacity to effect a symbolic representation of a soothing mode (i.e., he only imagined hearing music), let alone to explore the meaning of music to him. In this man's case, we came to learn that this ability to turn to music was very salutary, aiding his development, permitting a retreat that helped him maintain a feeling of "aliveness," which in his isolation he may otherwise not have been able to sustain.

A patient who suffered from bouts of hypochondriasis with varying somatic complaints described, after being hurt by his wife, a sadistic revengeful fantasy with some homosexual elements. As he told of his shame about this, particularly of his being sexually aroused by it, I focused on some of the sexual aspects in the fantasy—which the patient then pursued with me. The following hour he didn't feel much like talking; he described certain mannerisms of mine and aspects of my office furnishings that he didn't like. It seemed like a very labored session. The next hour he came late and soon began to focus on bodily discomforts that he was experiencing. The hypochondriacal concerns returned, and I began to wonder whether the previous labored hour, with the negative image of me, had already heralded this state. I asked that we look for its source. He told me how angry he had felt, spontaneously recalling the hour before yesterday when he told me of his fantasy and I focused on the homosexual and other elements. I seemed to him, he felt, not to respond to his shame, or to what he really wanted from his treatment—namely, to become more lovable to his wife. That is, his retreat to a discomfort and preoccupation with his own body returned when I failed to understand his experience or his wish, when I responded instead in a way that revived the sense of shameful badness about him, and re-created the message he felt in his family's communications to him.

There are some very important considerations here. In the first place, I may have been incorrect in my understanding of the fantasy, regardless of the vantage point from which one is speaking. On the other hand, one could consider that although his response was defensive, the "correctness" of my comments was not necessarily invalidated; in fact, the very defensiveness could seem to confirm them.

But even if this were so, it still does not deal with the question of why he responded in the particular way he did. Of course, right or wrong, the analyst will inevitably say things that don't feel good to the patient. But I am suggesting that a point of view which sees the resistance as arising *only* from the unfolding intrapsychic content and its relation to transference, again as emerging entirely from within the patient, would not take into account the nature and specificity of the patient's response to the analyst's contribution—the patient as part of a system, which, if drawn upon, would help illuminate onto what old would salt had been rubbed. This latter perspective may lead us to search for *what* may have happened between *us*, not just within *him*, what wish was disappointed that resulted in his withdrawal.

A patient said he had expected my bill earlier in the month than when I had given it to him, feeling for the first time that he almost wanted the bill because he had been earning more money and now had a sense of greater success at work. He was looking forward to the opportunity to send his father the check for his share of it. I questioned the patient's need to wait for my bill in order to send father the check, relating this to his familiar conflicts about money matters. For a while he seriously pursued this, and his mood seemed to become more sober. Pensively, he spoke of other issues, seeming to imply the need for him to feel in charge of his own choices. When I then recognized this, and he felt that I understood, he became more excited, saying, “That's why I like how I feel now, good about having more money, making me feel more confident, more of a sense of control!” I realized that he had returned to an aspect of his original material which I had not addressed—that is, the “good” feeling, the newly experienced wish of wanting my bill, giving him a sense of feeling in charge and of wanting to “show off” that feeling to me as well as to his father. Instead, I'd spoken to the defensive aspects about money. When I shared this with him, he replied that he had noticed this. “I had even thought, but didn't say, ‘I should know by now not to bring this up,’” he said. We saw then that he had felt me as having “pulled the rug out from under,” a particular experience, which, now perceived, allowed for the emergence of analogous experiences with mother. She, in his early years, had “deflated” his exuberant, performing self, and he responded in turn with apparent compliance (like a mother who focuses on the spelling mistakes when the child is eagerly showing off a new composition). Here, too, his mood shifted from one of buoyant interest to that of more monotonous, less spontaneous reflection.

What I hope to have illustrated is a view which sharpens attention to the impact of the analyst's contribution on the patient's immediate self experience. Patients with narcissistic pathology may use the analyst's responsiveness as essential for the maintenance of the stability of the self. Whatever the descriptive phenomena or the character symptomatology, it is the urgency of the selfobject use of the

analyst that heralds the definition and provides the locus for the treatment process. As I've indicated, this can be expressed at times as though the patient hangs on every word, or paradoxically it may appear that he doesn't acknowledge, let alone notice, our existence—but it is in fact our *separate* existence which goes unnoticed.

A patient told me he missed me when I was away, neither as a doctor nor as a person nor as a woman, but as a “personification” of his own listening process.

Once understanding this, I could more readily accept letting myself be “used” by the patient—often silently, often with intense demandingness—as a part of himself. I could more comfortably hear his repeated questions of me as indicating a search for structure or definition or affirmation. Then, such frequently described negative countertransference affects as irritation with seemingly demanding “entitlement,” boredom, or drowsiness, which can occur when we simply have not been responded to as separate and autonomous, began to subside.<sup>7</sup>

Let us consider some further clinical material:

A young woman described being very upset that her boyfriend wasn't at her apartment when she wanted him to be. She came in to the hour furious about this. What had happened? She had asked him earlier in the day *if* he was going to be there later and he replied “yes.” She had not, however, asked him to make it a point to be there, or in any way indicated that she herself was planning to be; nor was she even counting on him.

This woman characteristically had difficulties in her relationships and often experienced such frustrations at these kinds of expectations. There are several technical approaches one could consider here; one might try to help her see the lack of reality to her perhaps “entitled” expectation; or, one might pursue a “defensive” aspect to the anger, perhaps an envy of men, a projection of her own failures, or a transference displacement. As another alternative, one might inquire more about the rage and frustration so painful to her, sharpening the focus on the more experience-near, on what had seemed so threatening as to cause such an intense reaction.

Choosing this last route, we learned that one aspect of her perception was that her boyfriend had let her down (and, in fact, she herself felt “bad” to react so angrily). How? What is it that she wanted that he failed to provide? From within this perspective, the answer seemed clear and could be told to her: “What you wished for,” I said, “was to have your boyfriend there without your even having had to ask— just to have your unspoken needs met.” This put her wish into words, and she felt that this side of her experience was understood. She then utilized this recognition and spontaneously recalled memories, previously repressed, of early images of mother in which she was perceived as “failing” her in this regard— as somehow unable to “read,” to respond to her unarticulated feelings. This

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<sup>7</sup> Cf. **Kohut (1971)**.



sense of injury, coming so early and in a particular developmental and historical context (with the birth of a sister, to whom she felt mother did respond), led her to explosive rages. Our approach, then, takes the position that if the patient reacts so intensely to what seems from an “objective” reality so hard to understand (hard even at times for the “objective” side of the patient), it is precisely then that it may be touching on an old wound.

This vignette illustrates a particular perspective on what may be called “narcissistic entitlement”—he should just be there and she needn't have to ask him to do so—and the fury at its frustration. The goal is to help the patient to be empathic with the “subjective” side of her experience, so as to be able to expose and acknowledge it more freely, rather than asking her to reality test, to be rational and objective—a perspective more distant from herself.

Had we taken this latter stance, she might have complied, attempting to change her behavior, even her responses. But this would not have been consistent with her won inner reality, nor would it have deepened this other side of her experience. As it happened, when her wish subsequently entered awareness, she was able to integrate its meaning so that it no longer needed to manifest itself in disavowed forms in demanding conflictual relationships; that is, her own perspective changed. Eventually, she too had to see that the analyst's very understanding had in its own way met the unspoken needs, which gradually abated in their urgency.

Another patient, in anticipation of a new job, asked for some months about various possible schedule changes. I tried my best to be as flexible as I could as he continued to ask for more changes. There was still one hour undecided, and he wanted to know if I had two possible times open. I said that at the moment I did; however, when it took a full week until he indicated a preference, I no longer had *both* options available—only one. He was furious. I offered a new alternative; he wouldn't hear of it. It seemed, objectively, that with little effort he could have arranged for the mutually convenient hour, but he became utterly frustrated with me, and all my ability to have been flexible over the preceding times went entirely unnoticed. Coincidentally, later that evening the other hour became free for me, and so I called him, lest he in the meantime attempt some other changes. He said he was pleased, but there was no “thank you.”

The next hour he said that he felt somewhat better after my call, but there was still no sense of appreciation. Then he asked, somewhat demanding, “Why *did* you call so late in the evening? Did you have another patient who needed the hour?” I didn't answer, but found myself feeling quite irritated, very unappreciated. I had thought I'd been rather nice. He then recounted an incident at work in which he'd made quite a fuss because he hadn't gotten what he wanted. No *objective* observer could have taken his side, even in response to his own version.

It was my countertransference annoyance that was the telltale sign for me to do

some work on myself, before saying *anything*, before answering his questions—which seemed like interrogations. I felt that my effective experience was a signal that I wasn't *inside* the patient's shoes, but, rather, inside my own. As he persisted in his questions about why on earth I called when I did—I finally noticed what he was asking. “There is so much doubt,” I said to him, “about the sincerity of my motive; was I motivated really in your interest or was it primarily my own?”

This turned out to be a crucial interpretation. He recognized and elaborated in many ways how this was indeed a major concern for him—with his family as well. He told a poignant story of a boy who had delightedly thought his father's gift to him had been chosen especially for him, only to be painfully let down when he discovered that the motivation for the selection was entirely in father's self interest.

The countertransference was the clue.

To revise, then, the crucial dimension of the selfobject concept is its suggestion of a system, a contextual unit, between analyst and patient, which recognizes thereby the fundamental aspect of the *immediacy* of the surround as intrinsic to the organization and perception of intrapsychic experience.<sup>8</sup> Such a conceptualization offers a way of listening and organizing clinical data in which the analyst's contribution, silent or stated, is seen as meaningfully influencing and ordering the nature of the patient's response—of transference, of memory, and essentially of ongoing regulation within a system. The examples of my look or my not touching or my not understanding are especially illustrative here.<sup>9</sup>

Thus, the unfolding expression of the self, whether via maturational, pathological, or disavowed pathways, the very appearance or reappearance of symptoms are seen now in the context of the subtle interplays of an interaction—whether between parent and child or analyst and patient—understood in its depth-psychological meaning.<sup>10</sup>

A reconsideration of our understanding of such concepts as transference, resistance, and negative therapeutic reaction is implied.

Transference now weaves the analyst's intervention more sharply into its definition. In its selfobject meaning, it utilizes a point of view which is basically different from one which considers that this is by necessity a defensive stance against experiencing the analyst as autonomous, with a center of volition of his own.

The negative transference may emerge, then, not solely from some intrinsic

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<sup>8</sup> It has been noted by researchers and theoreticians that a major difficulty in conceptualizing at the psychological level had arisen from a “tendency to view the organization of behavior as the property of the individual rather than as the property of the more inclusive *system*, of which the individual is a part” (Sander, 1975p. 147; italics mine).

<sup>9</sup> While attentive to this aspect of the patient's response, we must recognize that concomitantly there is a fundamental need on the patient's part to express his *own* integrity, continuity, and stability. Cf. Schwaber (1980).

<sup>10</sup> This added study and credence given to the specific nature and style of the parenting suggests a rethinking of the implications of Freud's early shift from the “seduction theory” to the “fantasy theory” of neurogenesis. Cf. A. Ornstein (1977).

drive or defense derivative, but from some felt failure within the contextual unit—be it from what the patient brings or from what the analyst brings. It should be clarified that this point of view in no way dilutes the emergence of negative transference affects. One may, in fact, have the opportunity to deepen the delineation of some of the subtleties of the genesis and maturational progression of affective experience (as from somatic expression to one more psychologically perceived), particularly since within a securely held selfobject transference, patients may feel freer to be in touch with and to acknowledge these affects.

Resistance is similarly viewed—whatever drive and affect derivatives may serve as stimulus, as emerging within the context of the analyst-patient “unit”; there may be the concomitant experience of some felt threat to the integrity, the ongoing sameness of the self. For some patients, if this self experience is particularly fragile, the very entry into therapy may stimulate the dread of being taken over, molded, or controlled. I had a patient whose need to cancel, come late, take days off, choose vacation time freely, etc., was for a long time absolute. No amount of analysis of this as resistance touched it. It was a simple, direct expression of a basic requirement to be “free as a bird”—in as concrete a sense as possible. Living his life needing much spacious woodland, loving the freedom of horses, of driving his car—“don't fence me in” was his *modus vivendi*. Any issue I raised, since it was then on *my* initiative—no matter how subtly so—would make him feel “cornered” in my attempt to “mold” him. Further, the specific nature of what may be viewed as resistance may have bound within it a creative potential—as in this patient's love for animals, or as in the example of the man who turned to music, having in the past sustained even the child.

The concept “negative therapeutic reaction” may likewise be viewed—rather than from the perspective of unconscious guilt—as an attempt at maintenance of the integrity of the self.<sup>11</sup> When patients, despite considerable insight, still feel unable to make a shift in their behavior or inner experience, one must consider the persistence of a perhaps unrecognized defect in the self—something not yet understood.<sup>12</sup> I have a patient whose “acting out” represents an often desperate effort to avoid the experience of “nothingness,” preferring even pain to provide her at least with a focus, as well as a sense of aliveness.

I should like at this point to return to a review of some ideas in a further consideration of the concept of empathy—the subjective listening mode (cf. n. 5). The analyst, placing himself into the other's intrapsychic reality, views himself as being used and responded to as part of the context of that reality. This will, I feel, limit thereby the imposition of his own preconceived values, perceptions, notions of reality, and countertransferences. But one must be able to do this without one's

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<sup>11</sup> Cf. **Loewald (1972)** and **Valenstein (1973)**, who have offered cogent alternative explanations for this concept.

<sup>12</sup> Cf. **Kohut (1977)**, especially p. 46.

own self being threatened, or enhanced, by the other's experience. As with the mother who gets anxious when the child is anxious, she, too, has trouble being empathic. Why? She is not only placing herself inside the child's world, feeling what the child is feeling, but she also *needs* the child not to be anxious for the sake of *her* own self experience; or, a mother who, in rocking her baby, merges so with its rhythm that she falls asleep with it, is also no longer *empathic*. For empathy to remain, the integrity of one's own separate self must not be dependent on that of the other. That is its paradox—that we offer ourselves as selfobject, yet we do not take the patient in as selfobject for our own purpose. Empathy, then, is in a sense the antithesis of projection—in which we would place *our* intrapsychic reality into that of the other.

Such a point of view returns the concept of empathy as an inherent part of the introspective process—indeed, as a form of cognition, employing affective and perceptual modalities, for which there is a maturational requirement. In this respect, it becomes important to consider how we may be obtaining our clinical data—whether by seeking empathic recognition or by drawing upon other avenues of knowledge.

If we reflect on our clinical experience, I think we may recognize that one's capacity for empathy, if there are no defensive processes mitigating against it, varies to a large extent in proportion to the similarity of the psychological-physiological experiential world between that of the observer and the observed, and that the limits of this similarity define the limits beyond which empathic observation cannot reach.<sup>13</sup> Observing the infant's state, or listening to the colloquialisms of another, whose native language differs from our own, are examples of such occurrences in which certain leaps of inference have to be made beyond the limits of empathy, since we are standing outside the frame of reference of the other. I have found this to be similarly true, in trying to understand some of the physiologically based bodily experiences of the opposite sex—whereas with one's own sex, one can, on such issues, more readily respond from within the patient's experience. Data gathered inferentially, without a focus of empathic resonance, must fill the gap of experiential dissimilarity. It is then, by necessity, more speculative and needs to be recognized as such.

In a recent endeavor to review the literature of the Holocaust, to consider the psychological aftermath on survivors and their children, I noted that when I attempted to immerse myself into the centrality of the camp victim's experiences, I was, after a point, stopped (**Schwaber, 1978**). I believe this occurred not only because my own defenses against increasingly intolerable psychic pain mitigated against it, but also because of an actual inability to imagine fully and thereby to identify with the nature of the experience. The assault on mind and body went, it seemed, beyond the capacity of the human mind to envision—having reached, as

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<sup>13</sup> Cf. **Kohut (1959)**.

survivors put it, the “unthinkable.” Therefore, I noted, I had to make an inferential leap in my attempt to arrive at psychological understanding.

I believe that psychological studies on survivors have had just this limitation—clinical information is gathered in large measure via inferences made without empathically arrived-at data. That may be why we so often hear protests from those who survived about what is written and theoretically formulated about them. The psychiatric literature is replete with such concepts as “survivor guilt,” “regression to primitive modes of functioning,” “identification with the aggressor,” and others—as though somehow an attempt is being made to have *their* experience more understandable for *us*, to bring it within the range of known or familiar psychological phenomena. Furthermore, theoretical formulations may serve us in any event as a defensive opportunity, via affective isolation and intellectualization, to move a step back; this is especially so in studying the impact of conditions of extremity. Knowing and understanding will in themselves reduce our sense of helplessness. That very process of feeling less helpless can serve to limit that identifying link as well—that is, the identification with the patient's helplessness.

This may become the predicament of the children of survivors; they may be unable to grasp empathically this aspect of their parents' experience—and similarly their parents may not grasp theirs—leaving a certain experiential gap between them.

What I am trying to underscore—perhaps to restore—is the very specific status of empathy as the scientific mode of psychological data gathering. This is in contrast to the more colloquial, more all-embracing, rather nonscientific meaning of the term—be it tact, kindness, sympathy, intuition, gratification—something that is part of the ambience, rather than the matrix of depth-psychological observation. Thus, an ambiguity has arisen, the reasons for which may warrant our further consideration.

In a developmental focus, empathy is understood to be a mode of communication and response essential to the child's early psychological nourishment and a fundamental mode throughout life, of human relatedness.<sup>14</sup> Now we ask that this be used as a scientific tool. Our training must then require that we learn how to convert this psychological capacity to a scientific form.

Further, we employ the concept to convey both a method of data gathering, as well as a means of communication to our patients; one is a perception, and the other a translation of understanding derived from that perception. In between, some more cognitive steps must take place to order the data, so as to permit the response. Perhaps, then, the concept empathy would be more clearly retained as specific for the perceptual act itself, with the response understood as secondarily derived from it.<sup>15</sup>

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<sup>14</sup> **Kohut (1975).**

<sup>15</sup> **Kohut (1975)** has speculated that there is a resistance to the acceptance of empathy as a scientific mode and that this has arisen out of the need of scientific man to reject subjectivity, as he had to learn to relinquish the animistic conception of nature.

Another conceptual difficulty may have arisen from the fact that patients with more serious pathology seem to require some more active responsiveness on our part. Since they so often communicate a heightened urgency to their needs, we may feel we ought to say or do something more immediate—make some offer of more clarification, some change in schedules or fees—something felt as gratification, perhaps, to alleviate the distress. Such an intervention has often been taken as synonymous with an empathic response. But here again, if we were to refine the understanding of empathy as the perceptual mode, we may limit its confusion with specific technical interventions. It is, then, not the analyst's direct action—whether or not it is taken—but always the search for meaning of the patient's quest, taking cognizance of its dynamic imperative, which would utilize the work of empathy.

Viewed from within the patient's intrapsychic reality, there may be any number of narcissistic injuries we inflict—the physical discrepancy between analyst and patient, the lack of visual cues, the fee, the fact that our available time is not limitless, our decision as to when we take a vacation is based on our needs. The very entry into analysis necessitates the acknowledgement that one isn't entirely in charge of one's own thought processes; the analyst may decide technically not to meet a particular request—for example, not to answer a question directly—which may be experienced as a frustration with genetic familiarity. Empathy employs the recognition of this perspective—that is, that the patient may be experiencing something in the analytic situation or in our response as an “empathic failure.”

It should be noted that the concepts “narcissistic injury” or “empathic failure” are used to refer to the intrapsychic experience and perception of the child or the patient; that is the only reality we are trying to elucidate.<sup>16</sup> That is why the point of view of “reality testing” seems so antithetical to this perspective, for only by coming to learn what the “failures” are, do we come to recognize the nature of the patient's self experience and perceptions. Empathic failures, then, are not synonyms for technical errors. They may become that by virtue of their being repeated without prior clarification of their meaning—that is, through unwitting repetition. Thus, if one listens as carefully as possible to what the patient is communicating, limiting one's own inferences or preconceptions, there may be fewer empathic failures. But they cannot be eliminated in this way, because there is no way one can know ahead of time what will be uniquely felt by any individual patient as a failure—that is, what traumatic or painful perceived parental response

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<sup>16</sup> **Dr. L. Sander (1975)**, who has made in-depth observational studies of infants and their mothers utilizing this “system's” framework (that is, of infant and caretaker as a unit), refers to a developmental need for “validation”; that is, the child's experiences and responses, tangibly or affectively perceived, must be given recognition, definition, and credence by a confirming, approving adult. The child is thereby allowed opportunity for awareness and understanding of his perceptions and affect states, as well as for the security that comes from the fact that they are permitted. Furthermore, if it is empathically in tune, if it feels real to the child, what is validated is the core of the child's self experience.

is being repeated. Listening for cues to such a repetition allows us to learn what is unique to each patient—as with the man to whom I interpreted homosexual anxiety, or the one who perceived an “indifferent” look on my face, or the one who had the problem paying the bill. Only when I saw the subsequent response, which may be communicated any number of ways—articulated directly or by shift in subject matter or shift in state—was I able to learn how I may have replicated an old injury. (Similarly, if it seems to be a gratification or fulfillment of a wish that is being re-created—as when one woman excitedly exclaimed I was “right on”—and we notice a shift in state, we must wonder what in our communication triggered this shift and what it may mean.)

Perhaps the ultimate test of our empathic capacity arises when we are called upon to place ourselves inside the experience of a patient who is doing something in the outside world which we find abhorrent—that is, the test of our capacity for recognition of “human suffering in depravity” (Kohut, 1975). Here, we may further consider the point of view that the very acknowledgment of an abhorrent act may come with great shame, often only after some trust has taken place. That the patient is willing to share this with us may then be viewed as a statement of hope. I had a patient who told me only after some time of beating her child. By then she felt ready to try to deal with the meaning of this—that is, to try to give this behavior up. Kohut (1975) relates an example of an analyst's difficulty with a patient who described precipitously and impulsively throwing his cats against the wall, often killing them in the process. For that patient and for mine, their actions came to be understood as a re-creation of how beaten they had felt psychologically, in their own childhood.

We are speaking, then, of the search for some resonance of “essential human likeness,” which would permit us to extend our empathic grasp to such difficult terrains. Many great writers and poets have demonstrated their capacity to grasp the humanness of the outcast, of the derelict. (Dostoevski's *Notes from the Under-ground* offers a poignant illustration.) Our task, then, as analysts and therapists is to attempt a translation of such a capacity into a scientific mode—the rewards of which, in deepening our perceptions and understanding of the meaning of such experience will, I believe, be manifold.

In summary, we may see that the narcissistic character sounds at times like the rather prototypical literary or stage character of today—the “anti-hero.” It may be that this search for self affirmation has become such a vital component of experience today because it is concomitant with man's growing disillusion with the exclusive power of his rational mind to create a higher order of civilization. Psychoanalytic theory has taken a significant direction that reflects this cultural phenomenon: a depth psychology of the self—in ongoing continuity throughout the life cycle.

This theoretical framework holds that primitive narcissistic strivings such as grandiosity and idealization, when met with developmental appropriateness in

childhood, are *transformed*, not relinquished for replacement with object love—transformed into such attributes as the capacity for empathy and creativity, expressed in such forms as art, music, poetry, dreams, mythology, and religion. In other words, there is an inner core of belief in oneself and others which has a continuum which must be maintained and which transcends what some may feel to be rational objective givens—a core of belief that represents not only a need, but a capacity. So expressed, we see an implicit shift from the view that man's creation of fantasies, even illusions, serves only regressive pathological purposes which must be relinquished or else are maladaptive.

An interesting paradox—that a study of this more serious pathology has led to a deepening understanding of development and a concomitant lessening emphasis on pathology.

It is within this theoretical framework that I have been addressing a focus on a particular listening perspective. This use of empathy as the introspective mode may be akin to the way in which one listens to a small child or comes to appreciate a work of art or a symbol. Although it is when the suffering is within the self—when the self is in repeated danger of losing its sense of cohesiveness—that these issues on which I've focused come more sharply to attention, this view has broad-ranging potential, one which may offer a clinical conceptual framework that may be applied to some more unified whole.

The patient who listened to music, the man who wants his wife to love him better, the woman who wants her boyfriend to read her mind, or the man who needs to be free—each offers a chance for us to reconsider these wide-ranging implications.

Winnicott, in his paper, **“Transitional Objects and Transitional Phenomena” (1953)**, has written:

...the “good enough” mother [is one who] allows the infant the illusion that what the infant creates really exists—this intermediate area of experience, unchallenged in respect to its belonging to inner or external [shared] reality [may I substitute “perspective”?], constitutes the greater part of the infant's experience, and throughout life is *retained* in the intense experiencing that belongs to the arts and to religion and to imaginative living and to creative scientific work—what emerges from these considerations is the further idea that paradox accepted can have positive value. The resolution of paradox leads to a defense organization which in the adult one can encounter as true and false self-organization—my contribution is to ask for a paradox to be accepted and tolerated and respected, and for it not to be resolved—by flight to split-off intellectual functioning, it is possible to resolve the paradox, but the price of this is the loss of the value of the paradox itself...[p. 14; italics mine].

I believe this is a beautiful description of how the *subjective* perspective—from within—can exist side by side in psychic illness or health, with the *objective* perspective—the view from without.



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