THE INTERSECTION OF EMPATHY AND COMPASSION IN THE THERAPEUTIC STANCE WITH DUAL AND NONDUAL EXPERIENCE

Terri Rubinstein

THE INTERSECTION OF EMPATHY AND COMPASSION IN THE THERAPEUTIC STANCE WITH DUAL AND NONDUAL EXPERIENCE

A dissertation submitted to
The Sanville Institute
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy in Clinical Social Work

By

TERRI RUBINSTEIN

June 24 2017

CERTIFICATE OF APPROVAL

I certify that I have read THE INTERSECTION OF EMPATHY AND COMPASSION IN THE THERAPEUTIC STANCE WITH DUAL AND NONDUAL EXPERIENCE by Terri Rubinstein, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Sylvia Sussman, PhD, Chair — Date 3/17/17

Steve Zemmelman, PhD, Faculty — Date 3/17/17

Megan Rundel, PhD, External Committee Member — Date 3/23/17

Zonya Johnson, PhD, Dean — Date 3/31/17

ABSTRACT

This dissertation offers an exploration of the nature and role of empathy and compassion in psychotherapy. It uses psychoanalytic theory and Buddhist philosophy to differentiate between empathy and compassion in the context of dual and nondual forms of intersubjectivity. Specifically, empathy is defined as a dual phenomenon that transpires between two distinct subjectivities and compassion is defined as a nondual phenomenon that involves universality or a realm of oneness in which self and other are indivisible. The delineation of these phenomena serves as the platform from which it is hypothesized that empathy is a crucial element in the process of coming into being as a unique subjectivity and that compassion is essential for assuaging the aloneness and alienation that is inherent in the dual plane of reality.

In addition, two forms of enactments are proposed. The first, as described in relational psychoanalysis, transpires on the dual plane of reality and involves therapists engaging with patients through subject-to-object relating rather than subject-to-subject relating. In order to resolve this form of enactment, therapists need to regain empathy for the patient. Through empathy, they are able to recognize the patient's and their own subjectivity. The second type of enactment involves therapists becoming mired in a form of aggression that negates the nondual level of reality. When therapists enact this type of aggression, they lose access to universality. They seek to secure their ego-based selves and attempt to maintain or resist certain feelings or states of mind. In these moments, nondual compassion is needed to release the grip of ego-clinging and to dissolve the illusion that discomfort can be avoided.

As the foregoing suggests, this dissertation assumes an understanding of reality that recognizes both dual and nondual experiences. From this vantage point, it is concluded that a balance of empathy and compassion in the therapeutic stance is needed to address the full range of human suffering and to resolve the inevitable enactments that transpire between therapist and patient.

ACKNOWLEDGEMENTS

I am indebted and grateful to many who have knowingly and unknowingly helped to make the realization of this dissertation possible. My teachers and inspirations have come in various forms including: patients, colleagues, mentors, fellow students, friends, and family, as well as nature in its implicit wisdom and beauty. In response to those who have given to me knowingly, I am humbled by their generosity; and in response to those who have given to me both knowingly and unknowingly, my heart is filled with gratitude for the gifts they have shared with me.

In 1963, at a Thanksgiving Day proclamation, John F. Kennedy stated, "As we express our gratitude, we must never forget that the highest appreciation is not to utter words, but to live by them." I hope to embody this insight. As I continue to develop the ideas expressed in this dissertation, those who have taught and inspired me will be with me and will support my efforts to bring more empathy and compassion to the practice of psychotherapy and to the communities within which I live. I can think of no better way, in the words of President Kennedy, "to live by" my words of gratitude.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

Recent psychoanalytic theories have been influenced by postmodern developments, including feminism, the findings of quantum physics and the cross pollination of globalization (Bass, 2001; Gargiulo, 2010a; Shelton, 2010; Walls, 2004). As these developments have penetrated our worldview, the field has been developing theories that embrace the complexity of equal and opposite realities paradoxically co-existing and that integrate aspects of Eastern and Western psychological paradigms. While the mechanistic physics of the 19th century influenced Freud's structural theory of the mind, the more recent findings of quantum mechanics have informed the emergence of intersubjective and relational theories. Bass (2001) reflects the emphases that have emerged in his comment:

> The quantum vocabulary of entanglement, unity, shared points of origin, spooky connections, and uncanny linkages evokes something of the unusual quality of life for the contemporary psychoanalyst. Our psychic experience interpenetrates that of our patients; we become entangled in transference-countertransference matrices replete with dense processes of projection and introjection; we experience various forms of identification and merger, processes with effects we see and experience but cannot always understand; and our shifting states of self and affect shift in a stunning choreography that becomes the medium of analytic work. (p. 695)

Similarly, the globalization of the world has affected our thinking about the psychotherapeutic process. As Gargiulo (2010a) suggests, the human mind, "which

encompasses conscious and nonconscious functions, is best conceptualized...as an integrated manifestation of body, brain, and community" (p. 92). Given a global community, our minds and therefore our theories reflect the zeitgeist of the current world. As a result, Western psychological thinking has begun to integrate and embrace contributions from the East and vice versa.

This theoretical dissertation seeks to add to this emergent body of thinking and literature. It is an exploration of the intersection of traditional psychoanalytic theory with Buddhist philosophy at the nexus of dual and nondual realms of experience. In formulating my ideas, I draw from the wealth of psychoanalytic theory regarding empathy, subjectivity and intersubjectivity and the vast Buddhist teachings regarding compassion and nondual reality. I weave together aspects of both systems of knowledge and contend that the psychotherapeutic process is best served when therapists have access to empathy and compassion and can engage with patients on the dual and nondual planes of reality.

Intersubjectivity and the Therapeutic Stance

The field of psychotherapy has gone through several paradigmatic shifts in how the human condition is understood. As our thinking has changed, aspects of the therapeutic stance have evolved to match the emergent model. Psychoanalytic thinking began with Freud conceptualizing neurosis as stemming from man being instinct-driven and caught in a struggle between his sexual and aggressive drives on the one hand and the demands of civilized life on the other. With this understanding, Freud encouraged a therapeutic presence characterized by neutrality and abstinence. This stance was meant to facilitate patients' free associations in order to foster the expression of repressed wishes

and fantasies that could then be interpreted and made conscious. Freud valued therapeutic objectivity and understood the ideal therapist as an objective expert able to interpret patients' behavior and intrapsychic dynamics as revealed by the free associations. Gradually, however, the field came to recognize the reality of childhood trauma and the formative influence of early relational experiences. With this development came the recognition that relational deficits lead to developmental arrests, which become crystallized into neurotic character structures. As this thinking developed, adherence to neutrality and abstinence in the therapeutic stance loosened to accommodate an empathic component (Mitchell & Black, 1995). This perspective is most clearly captured by Kohut's approach to psychotherapy (self psychology). Although Kohut still maintained that the therapist has access to objectivity and is in ways an expert able to interpret the patients' material, he also very clearly asserted that the therapist is an empathic guide to patients in their process of self-discovery as well as a reparative object facilitating self-structuralization (Kohut, 1959, 1971, 1982).

Despite the differences between the Freudian and the Kohutian understanding of the patient-therapist relationship, both theoretical models view the therapist as an observer of the patient, not as an equal participant in the dyad. Today, this perspective has been deemed a one-person psychology. In contrast, the current paradigm, referred to as a two-person psychology, recognizes *both* the critical impact early relational experiences have on our development and overall functioning, *and* embraces the complex interpenetrating nature of subjectivity. Like previous stages in psychoanalytic thinking, this development has resulted in changes in the therapeutic stance. Rather than understanding the therapist-patient exchange as a unidirectional process, as it had

previously been understood, it is now most commonly thought of as a mutual and bi-directional process with each party affecting and influencing the other. As a result, the prevailing therapeutic stance embraces the therapist's unconscious processes, fallibility and participation in enactments as ubiquitous and inescapable in the patient-therapist exchange. In addition, there seems to be an assumption that the therapist remain empathic (Aron, 1996; Orange, 2011; Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1987).

I question, however, how an intersubjective perspective on the human condition affects our understanding of the nature and role of empathy in the therapeutic encounter. If subjectivity takes form in an intersubjective field and is itself interpenetrating, what does it mean to understand another's subjective experience through one's own? Further, how does this process relate to self-structuralization and coming into being as a unique subjectivity that is also fundamentally interconnected? Complicating these questions are the range of meanings ascribed to the term "intersubjective" as well as the subtle, but important, variations in how empathy is understood and defined. Benjamin (1990/1999) uses the term "intersubjective" to refer to subject-to-subject relating in which each person is recognized as a separate center of experience. She distinguishes such intersubjective relating from subject-to-object relating in which the subjectivity of the other is not recognized and is therefore in some way negated. Stolorow and colleagues use the term "intersubjective" to refer to our fundamental embeddedness in fields of experience – i.e., our subjectivity being fluid and shaped within the context of self/other interactions (Orange, 1995; Stolorow, 2011; Stolorow & Atwood, 1992; Stolorow et al., 1987). In addition, Blackstone (2007) suggests another realm of experience in which there is

self/other unity or a nondual basis of intersubjectivity. According to Blackstone, "when we realize nonduality, we experience the clear space of nondual consciousness pervading our own body and everything around us as a unified whole" (p. 32). In short, while Benjamin speaks to the quality of relating that happens when the subjectivity of the other is either recognized or is negated, Stolorow speaks to the interpenetrating nature of subjectivity, and Blackstone speaks to the unified dimension of subjectivity.

Given the different foci of these perspectives, it is not surprising that each evokes slightly different elements in the therapeutic stance. Benjamin's (1988, 1990/1999, 1995, 2004) model draws attention to the tension between our fundamental need for and experience of connectedness and separateness. She emphasizes the therapist making use of what she calls the *moral third* to cultivate and regain experiences of subject-to-subject relating or *mutual recognition*. Benjamin maintains that the intersubjectivity of mutual recognition is inevitably discontinuous. Because relating in our intrapsychic world is largely subject-to-object, mutual recognition collapses and we fall into *doer-done-to* relations in which the subjectivity of the other is negated. In doer-done-to relating the other is experienced and related to as an internal object, not as a separate subject. The moral third is an antidote to such relating. Like Ghent's (1990/1999) articulation of surrender, the moral third is a state in which the individual does not relinquish his or her own perspective while recognizing the experience of the other as equally compelling. It is a mode of being in which the therapist can feel and know the separateness and connectedness of the dyad's two minds.

In contrast, Stolorow's model draws attention to the systems or intersubjective fields that serve as the "contextual precondition for having any experience at all"

(Orange, Atwood, & Stolorow, 1997, p. 85). From this perspective, all experience, even the experience of subjectivity or distinctness, is a set of emotional conclusions or organizing principles that develop from our lifelong engagement in mutually influencing emotional environments or connections with others. These principles, or thematic internal structures, unconsciously organize experience according to earlier patterns of self and other interactions and can become rigid and invariant when there are insufficient alternative relational experiences. The more invariant the structures, the more interactions are experienced as repetitions of the developmental or archaic configurations of self and other. Thus, Stolorow and colleagues understand internal organizing principles, and especially invariant organizing principles, as the basis of transference. (Orange et al., 1997; Stolorow, 2011; Stolorow & Atwood, 1992; Stolorow et al., 1987). In addition, they emphasize the importance of therapists attending to how the patient's and the therapist's invariant organizing principles codetermine the transference-countertransference dynamics, as well as the therapist relating to the patient in ways that facilitate the development of alternative, more affect-tolerant organizing principles (Orange et al., 1997; Stolorow & Atwood, 1992). Consistent with this, Orange, one of Stolorow's collaborators, uses the concepts of dialogic exchange and compassion when describing the intersubjective therapeutic stance (Orange, 2006, 2010). The emphasis from this perspective is on the therapist "undergoing the situation with the other" (Gadamer, 1975 as cited in Orange, 2006, p. 15).

Lastly, Blackstone's (2006, 2007) conceptualization of nondual realization draws attention to preconceptual experience or to the domain in which one's subjectivity can be experienced "as an unbounded expanse of subtle consciousness, pervading one's internal

and external experience as a unity" (Blackstone, 2007, p. 1). She describes this state as non-volitional and as arising effortlessly when one relinquishes rigid organizations of experience and is thus deeply open. Blackstone's therapeutic stance emphasizes direct or bare perception with one's whole body and mind such that the senses function all at once to detect the subtle realm of self and other as a single consciousness. She uses the term empathy with a particular connotation to describe this process. In her words, empathy within nondual realization is "based on a transpersonal dimension of our senses...It is the ability to actually perceive the movement and qualities of another person's cognitions, emotions, and sensations within the internal space of that person's body" as opposed to experiencing those qualities in our own body (Blackstone, 2007, p. 35). This is notably different than Kohut's understanding of empathy as a *vicarious* process in which one objectively intuits the other's internal state without losing the distinction between self and other (Kohut, 1959, 1971, 1982, 1984).

Recognizing this difference between Blackstone's and Kohut's definitions of empathy begins to reveal variations in the therapeutic presence that are needed to address dual and nondual realms of experience. An exploration of the nature of empathy across the expanse of intersubjectivity reveals the dual and nondual dimensions of reality, which paradoxically and simultaneously coexist. The therapeutic encounter, like life itself, is not either a dual phenomenon or a nondual phenomenon - it is both. The linear nature of language, however, limits our ability to think of and certainly to express them simultaneously. As a result, any discussion of the multiple realms of experience that coexist inevitably fails to reflect the complex, interpenetrating and comingling nature of life and the therapeutic relationship.

The following descriptions are bound by this limitation and thus present dual and nondual phenomena as distinct modes of experiencing when in fact they interpenetrate and co-occur. Benjamin, Stolorow, and Blackstone provide three ways of understanding dual and nondual experience in the context of psychotherapy. Each of their perspectives subscribe to relational and intersubjective principles and assumptions such as perspectival realism (which suggests that all views of truth are relative and partial) and mutuality (which suggests that cause and effect are inseparable and that each participant in an interaction affects the other). However, despite these commonalities, Benjamin's central idea of mutual recognition between unique subjectivities reflects a level of reality that maintains the Cartesian split between self and other, internal and external. As such, her intersubjective form of relating can be conceptualized as a dual phenomenon in which subject and object, self and other, can be distinguished. Unlike Benjamin, Stolorow and colleagues are careful to avoid language that retains "Cartesian-laden-dualities" in articulating their contextualist or field theory (Ringstrom, 2010). They speak to a level of reality beyond the myth, as they call it, of the isolated mind (Stolorow & Atwood, 1992). An example of this can be seen in their statement:

> The concept of an intersubjective system brings to focus *both* the individual's world of inner experience *and* its embeddedness with other such worlds in a continual flow of reciprocal mutual influence. In this vision, the gap between the intrapsychic and interpersonal realms is closed, and indeed, the old dichotomy between them is rendered obsolete. (p. 18)

However, despite Stolorow and colleagues' conceptualization of intersubjective reality as reflecting this aspect of nondual, non-Cartesian thinking, it does not extend to the mystical or spiritual level of nonduality, which is reflected in Blackstone's interpretation of the nondual basis of intersubjectivity. At this level of nondual reality, we are not simply embedded in fields of experience, we are a fluid manifestation of a unified whole– a part of the universal consciousness and the unending interdependent flow of ecospheric occurrences. Stolorow's intersubjective realm of relating as well as Blackstone's self/other unity can be conceptualized as a continuum of nondual phenomena, with each perspective speaking to different aspects of this range of experience (i.e., Stolorow's conceptualization of intersubjectivity reflecting our embeddedness and Blackstone's conceptualization of self-other unity reflecting our indivisibility).

In the realm of dual experience, as I am defining these phenomena, self and other come into being and can meet in an encounter. This form of experience is supported by the everyday sense of space as three-dimensional and of time as linear such that we can only be in one place at a time and each person is experienced in their uniqueness as they are in the here-and-now. At the level of nondual experience, the constructs of self and other fall away, as do illusions of solidity and past, present and future. From this perspective, we are permeable, interconnected, and inseparable elements of a universal unity or oneness. These two planes of reality are reflected in our human capacity for primary and secondary process. A life devoid of either is incomplete and constricted at best. The subjective sense of oneself as alive and real takes form and expresses itself in the dual plane; yet, the illusive distinctions and demarcations of the dual plane invite an

experience of disconnection. Without the balance of the nondual plane and its interconnectedness, the subjective self is caught in an alienated existence. As a result, the individual human as well as humanity as a whole is more fully alive when both dual and nondual experience, just like primary and secondary process, is accessible and honored. Therefore, I believe psychotherapy better addresses the human condition when it attends to both dual and nondual phenomena.

In this theoretical dissertation, I contemplate aspects of the therapeutic stance needed to address this range of intersubjective experience. I suggest that at the dual level of experience, empathy is an essential element of the therapeutic process and at the nondual level of experience compassion is an essential element of the therapeutic exchange. This conceptualization is supported by an understanding of empathy, despite Blackstone's use of the term, as a phenomenon that transpires between two subjectivities, or two unique centers of being, and compassion as a phenomenon that transpires either between two inseparable beings or within a shared realm of oneness.

Empathy and Compassion in and Beyond Intersubjectivity

The concepts of empathy and compassion have existed for centuries; however, the definitions of the terms have varied. At times, they have been and are used interchangeably, and at other times, they have been and are considered distinct phenomena. In addition, although there is no consistent understanding of the role and nature of empathy and compassion in psychotherapy, many consider them essential to its practice (Bohart, Elliott, Greenberg, & Watson, 2002; Siegel & Germer, 2012). The trajectories each has taken in the field, however, have varied significantly. Although Freud mentioned empathy in his understanding of the therapeutic stance, he did not

expand on its definition or use in psychotherapy. Interestingly, despite a clinical mandate to help relieve suffering, Freud did not mention compassion. Instead, as noted above, he spoke of clinical neutrality and abstinence - advocating a dispassionate (i.e., objective) stance in order not to interfere with the patients' acquisition of self-knowledge. For Freud, insight, rather than engaging in any particular kind of relationship, was the curative element of psychoanalysis (Freud, 1912/1958a). This emphasis in the early foundation of psychotherapy may help explain why empathy has been discussed and defined for decades by multiple clinicians and theoreticians in clinical psychology and psychoanalysis, whereas compassion has only been mentioned by a few in each discipline.

Kohut, who formalized the discussion of empathy in psychoanalytic literature, was careful to distinguish empathy from compassion. He suggested that while empathy is essential to treatment, compassion, like lapses in neutrality, may obscure it (Kohut, 1977). In the last decade, however, compassion is gradually being acknowledged and written about more and more in the psychological literature (Eshel, 2013; Frie, 2010; Glaser, 2005; Orange, 2006, 2010; Siegel & Germer, 2012). For example, in writing about the dialogic nature of the intersubjective therapeutic stance, Frie (2010) stated, "compassion, in my view, demonstrates an attunement to, and awareness of our fundamental situatedness with the Other" (p. 464).

As implied by Frie's (2010) comment, recent reconceptualizations of empathy and compassion are taking shape concurrently with developments in the field of psychotherapy including the shift from a one-person to a two-person paradigm. This sea change was ushered in by the proponents of relational and intersubjective theory

(Mitchell, 1988; Stolorow et al., 1987). The relational and intersubjective platforms view all experience, even that which is deemed intrapsychic, as shaped in interaction with others and as transpiring in a shared intersubjective field. Unlike classical one-person-based theories of development in which the individual was seen as progressively moving toward greater degrees of separation and autonomy, the relational approach emphasizes "the simultaneity of connection and separation. Instead of opposite endpoints of a longitudinal trajectory, connection and separation form a tension, which requires the equal magnetism of both sides" (Benjamin, 1990/1999, p. 189). This development in psychological thinking highlights the dialectic between our connectedness and our separateness.

As two-person psychological thinking permeates the field of psychotherapy, it has already and will undoubtedly continue to affect the way constructs such as empathy and compassion are understood. In addition, given the two-person understanding of meaning-making as a bi-directional process, reconceptualizations of empathy and compassion will also affect the field of psychology. Just as the relational and intersubjective turn in psychotherapy has enabled us to embrace multiplicity and the complexity of paradoxical needs, it is inevitable that our thinking will continue to expand. One such emerging development addresses experiences not quite captured by Stolorow's paradigm of intersubjectivity. This line of thinking attends to the nondual and spiritual experiences that lie beyond two subjectivities, which have been shaped in and by their surround, meeting one another. Blackstone (2007) speaks to this in her book *The Empathic Ground: Intersubjectivity and Nonduality in the Psychotherapeutic Process*. In her discussion of nondual realization, she draws attention to the experience of self/other unity

as a state of being distinct from intersubjectivity. She goes on to suggest that intersubjective theory denies "the existence of a more essential dimension of being than subjective organizations of experience" (p. 13). As such, Blackstone furthers the conversation about the paradox of dual and nondual realms of experience in which there is a dialectic tension between subject-to-subject connection and universal oneness.

Eshel (2013) also extends this conversation with her concept of *withness*. In describing the phenomenon, she stated:

> The patient is able to transfer/project unbearable, split-off inner experiences into another psyche that is there to be used as an area of experiencing, processing, and transformation. Patient and analyst thereby forge a deep experiential-emotional interconnectedness, and thus a living therapeutic entity that is fundamentally inseparable into its two participants. Viewed in this way, it is not a one- or two-person psychology, but a process whereby analyst and patient interconnect psychically and become an emergent new entity that goes beyond the confines of their separate subjectivities and the simple summation of the two—an entity (unit or being) of "withness," interconnectedness, or "t(w)ogetherness": *two-in-oneness.* (pp. 928-929)

Although there have been similar concepts, such as Ogden's (1997, 1994/1999, 2004) *intersubjective analytic third*, Eshel's concept seems to maintain the bi-directional influence and comingling of patient and therapist subjectivity suggested by Ogden's delineation of the intersubjective analytic third, while paradoxically shifting the emphasis to the therapist's embeddedness in the patient's reality. According to Eschel, the

therapist "becomes psychically akin to a transplant or to chimeric antibodies... [forming an] interconnectedness that engenders a new possibility for being and experiencing" (2013, p. 929). Eshel frames the nondual state of *withness,* particularly when it involves the patient's agony and hopelessness, as compassion. In so doing, she opens the question of how empathy and compassion in the psychotherapeutic encounter differ from one another and how those differences relate to dual and nondual realms of experience.

Historical Overview of Empathy and Compassion in Psychotherapy

"Empathy" is a translation of the German word *Einfuhlung,* which literally means "feeling into" and the Latin roots of "compassion" literally mean "suffering or feeling with." The differences between "feeling into" and "feeling with" are subtle, yet relevant to the practice of psychotherapy. While empathy and compassion are both affective phenomena, empathy, and not compassion, includes a cognitive component of imagining the other's experience. Empathy or "feeling into" involves sensing the emotional experience as well as intuiting the internal experience of the other. Compassion or "feeling with" involves emotionally sharing the other's internal state on a purely affectively resonate level, while simultaneously wishing for all suffering to abate.

Within psychotherapy, the purpose of empathy has been conceptualized as providing information for understanding as well as being curative itself. In addition, whether empathy includes care has been debated within the field of psychotherapy (Aragno, 2008; Bohart et al., 2002; Bozarth, 1997; Coplan & Goldie, 2011; Gibbons, 2011). Definitions of compassion suggest that it involves some form of feeling or relating to suffering as well as the desire for that suffering to be alleviated. The definitions,

however, vary in the degree to which they maintain that compassion involves: feelings of loving-kindness in response to suffering, an understanding of the nature of suffering, if compassion is a dual or a nondual phenomenon, and whether it is a feeling or an attitude (Bornemann & Singer, 2013; Goetz, Keltner, & Simon-Thomas, 2010; Halifax, 2013; Siegel & Germer, 2012).

The concepts of empathy and compassion have received differential attention in the field of psychology. Rogers and Kohut are most noted for bringing the conversation about empathy into the foreground (Bohart & Greenberg, 1997; Clark, 2007; Kahn & Rachman, 2000). Prior to them, Freud mentioned empathy as part of understanding the other and therapeutic rapport, but he did not hinge his ideas about therapeutic action on empathy. Others, such as Ferenczi, Sullivan, Winnicott, and Fromm-Riechmann have made forays into this conversation, advocating for a treatment characterized by their own forms of empathic exchange. In fact, Ferenczi and Sullivan, in particular, can be seen as forerunners to Rogers and Kohut, who together are credited with humanizing the modern psychotherapeutic landscape. (Aragno, 2008; Chessick, 1998; Gibbons, 2011; Grant & Harari, 2011; Kahn & Rachman, 2000).

Rogers' approach to psychotherapy, client-centered therapy, and Kohut's approach to psychoanalysis, self psychology, have served to bring the concept of empathy into the clinical spotlight. Their understanding of empathy, however, differs in significant ways. According to Rogers, empathy always includes care and is itself curative. "It is impossible accurately to sense the perceptual world of another person unless you value that person and his world – unless you in some sense care" (Rogers, 1975, p. 9). For Rogers, care seems to involve a sense of acceptance and an intention to

welcome the other into the fold of humanity. This aspect of his understanding of empathy can be seen in his statement:

> Empathy is in itself a healing agent. It is one of the most potent aspects of therapy, because it releases, it confirms, it brings even the most frightened client into the human race. If a person can be understood, he or she belongs. (Rogers, 1986, p. 129)

Empathy for Kohut, however, does not involve care. Its core function is to gather data or knowledge that can be used to develop and communicate accurate interpretations and to ultimately facilitate the patient's increased self-comprehension. Although Kohut did eventually acknowledge the healing aspect of empathy itself, he continued to maintain that empathy informs appropriate action and is not the action itself. This was made clear in his 1982 paper, *Introspection, Empathy, and the Semi-Circle of Mental Health*, in which he stated:

> As an information-collection, data-gathering activity, empathy, as I have stressed many times since 1971, can be right or wrong, in the service of compassion or hostility, pursued slowly and ploddingly or 'intuitively', that is, at great speed. In this sense empathy is never by itself supportive or therapeutic. It is however, a necessary precondition to being successfully supportive and therapeutic. (Kohut, 1982, p. 397)

Thus, despite a common commitment to empathy in the therapeutic stance, Rogers and Kohut have distinct and at times contradictory ideas about what empathy involves and how it functions.

Although the essence of compassion – a desire to help alleviate suffering, has been implicit in the field of psychotherapy since its inception, it has received little direct attention in the literature until recently (Eshel, 2013; Frie, 2010; Gilbert, 2009a, 2009b, 2009c, 2013; Orange, 2006, 2010). Interestingly, Western and Eastern philosophy have provided two distinct entry points for this discussion. Orange and Frie rely on the dialogic stance as articulated by Western philosophers such as Buber, Gadamer, and Levinas to speak to the fundamental connection between self and other and therefore the basis from which one can feel with the other in such a way that allows suffering to subside. This can be seen in Orange's (2006) description of compassion:

> [It] is roughly equivalent to what I have called emotional understanding; it is the dialogic process of "undergoing the situation with the other" (Gadamer, 1975)...Where there was indifference, humiliation, rejection, shattering loss, and the like, compassionate psychoanalytic understanding does not simply replace or heal by intentionally providing new experience. Instead, when the analyst treats a person as endlessly worth understanding and his or her suffering as worth feeling-together, this attitude of compassion implicitly affirms the human worth of the patient. (p.15)

Gilbert on the other hand, draws from Eastern, particularly Buddhist, philosophy to speak to compassion in the psychotherapeutic process (Gilbert, 2009a, 2009b, 2009c, 2013; Gilbert & Choden, 2014). He emphasizes the quality of loving-kindness for self and other in compassion and defines it as "basic kindness, with deep awareness of the suffering of oneself and other living beings, coupled with the wish and effort to alleviate it" (Gilbert, 2009c, p. xiii). As reflected in these two examples, compassion, unlike

empathy, seems to consistently be conceptualized as including a sense of warmth and benevolence.

Despite the differentiation that emerges when comparing the psychological literature on empathy and compassion, little has been directly theorized about the distinctions and relationship between empathy and compassion in the psychoanalytic literature. Two partial exceptions to this are Kohut and Orange. As noted above, Kohut consistently distinguished empathy from compassion; however, he focused on empathy and its role in psychotherapy. It was not until his last work that he began to question the relationship between empathy and compassion, noting his observation that access to compassionate feelings seemed to increase his capacity for empathy (Kohut, 1984). As for Orange (2010), her clearest comment on the topic is in a footnote in which she stated:

> I tend to think of empathy as a larger capacity to understand another emotional experience from within an intersubjective field. [Whereas]...compassion, in my view, is that part of empathy that makes us willing and able to descend into and explore the Dantean realms of suffering with the other. (p. 114)

Thus for Orange, empathy and compassion seem to function differently with empathy operating as a broader phenomenon of emotional understanding and compassion providing the motivation and wherewithal to accompany the other in his or her emotional anguish. While this offers an interesting perspective, it is still a thin description of the differences between empathy and compassion and does not shed light on how the constructs can be situated in a dialogue that addresses dual and nondual experience. Therefore, I maintain that the field of psychotherapy would be well served to have more

depth and complexity in its thinking about the interplay of empathy and compassion and in particular the interplay of empathy and compassion in the therapeutic stance across the dual and nondual landscape of human experience.

Recent Developments in Understanding the Nature of Empathy and Compassion

In recent decades, neurobiology and psychology researchers have been examining how empathy and compassion may be related to, among other things, pro-social behavior and caregiver burnout or fatigue. Multiple studies are beginning to shed insight into the neurobiology beneath the phenomena, the felt experience of both empathy and compassion, and if they can be cultivated (Gilbert, 2013, Goetz et al., 2010; Keltner, 2009; Klimecki et al., 2012; Klimecki, Leiberg, Ricard, & Singer, 2014; Klimecki, Ricard, & Singer, 2013; Singer & Klimecki, 2014; Singer et al., 2004). For example, as part of this growing body of research, Singer and colleagues (2004) conducted "empathy-for-pain" experiments using functional magnetic resonance imaging (fMRI) with 16 couples, and found that directly experiencing painful stimulation and observing painful stimulation in a loved one led to overlapping activations in the anterior insula (AI) and the anterior medial cingulated cortex (aMCC). These two brain regions are associated with the affective dimension of a pain experience and have been associated with subjective reports of discomfort and distress (Klimecki, Ricard, & Singer, 2013; Lamm, Decety, & Singer, 2011; Singer et al., 2004). In addition, the higher the participants scored on two empathy scales, the stronger the activation in these regions of the brain while observing their partner experiencing a painful stimulation. This pattern of neural activation during empathy-for-pain experiments has been replicated in laboratories across the world and is consistent regardless of whether the other person in pain is a loved one

or an unfamiliar person and whether the pain stimulus is physical or emotional (e.g. observing a video of an actor describing a sad personal situation; Hein, Silani, Preuschoff, Batson, & Singer, 2010; Klimecki et al., 2013; Lamm et al., 2011; Singer & Klimecki, 2014).

While the above research examined the neural mapping of empathy alone, Singer and colleagues subsequently conducted studies in which the findings suggest that there may be neural differences between states identified as empathic and those identified as compassionate (Klimecki et al., 2012; Klimecki et al., 2014; Klimecki et al., 2013). Of particular note, is the single case study Singer and Klimecki conducted with Matthieu Ricard, a long-term Buddhist practitioner and compassion meditator, to examine his neural signature during states of compassion (Klimecki et al., 2013; Ricard, 2015). The findings in this study were unexpected and noteworthy. The researchers used a new fMRI technique that enabled them to see changes in brain activity in real time (fMRI-rt), whereas this data can only be analyzed after the fact with traditional fMRI. The study began with the researchers asking Ricard to immerse himself in non-referential compassion, compassion for the suffering of others and loving-kindness. "To the surprise of the researchers, all of these states elicited activation in rather similar networks. However, these compassion-related networks did not resemble the empathy-for-pain network...so frequently observed in meditation-naive subjects when exposed to the suffering of others" (Klimecki et al., 2013, p. 275). Ricard's pattern of neural activation, during states he described as forms of compassion, reflected activity in areas of the brain that have been previously associated with affiliation, love and reward, including the medial orbitofrontal cortex, striatum, ventral tegmental area/substantia nigra, and globus

pallidus (Beauregard, Courtemanche, Paquette, & St-Pierre, 2009; Klimecki et al., 2013; Kringelbach & Berridge, 2009; Ricard, 2015; Strathearn, Fonagy, Amico, & Montague, 2009).

In discussing these results with Ricard during a pause in the fMRI-rt process, the researchers discovered that he was experiencing a warm positive state with strong prosocial motivation rather than an unpleasant state related to experiencing or sharing pain with others (Klimecki et al., 2013; Ricard, 2015). This led to an fMRI-rt phase in which Ricard was asked "to engage in emotionally sharing the suffering of others without going into any form of compassion" (Klimecki et al., 2013, p. 275). Not only did this reveal the typical neuronal activation of the empathy-for-pain network, but Ricard's self-report shed light on the experience and dilemma of empathy fatigue. In his compelling words:

> When Tania Singer asked me to go into a state of pure empathy without engaging in compassion or altruistic love, I decided to empathically resonate with the suffering of children in a Romanian orphanage...Despite being fed and washed every day, these children were completely emaciated and emotionally abandoned...When I was immersing myself in empathic resonance, I visualized the suffering of these orphan children as vividly as possible. The empathic sharing of their pain very quickly became intolerable to me and I felt emotionally exhausted, very similar to being burned out. After nearly an hour of empathic resonance, I was given the choice to engage in compassion meditation...[Doing so] completely altered my mental landscape. Although the images of the suffering

> children were still as vivid as before, they no longer induced distress. Instead, I felt natural and boundless love for these children and the courage to approach and console them. In addition, the distance between the children and myself had completely disappeared. (Klimecki et al., 2013, p. 276)

Although this research is preliminary, it does suggest that there may in fact be neuronal as well as affective differences between empathy and compassion.

Recent studies have also begun to address the question of whether or not empathy and compassion can be cultivated by examining the efficacy of and neuronal responses to brief empathy and compassion trainings that focus on either sharing the pain of others or loving-kindness meditation, respectively. (Klimecki et al., 2012; Klimecki et al., 2013; Klimecki et al., 2014). Although further research is needed to confirm these findings, the studies have suggested that both empathy, meaning the emotional resonance with another's suffering, and compassion, meaning relating to another's suffering with loving-kindness and with prosocial motivation, may be cultivated through trainings as brief as 1 day long. In addition, training in empathy seems to be associated with stronger activation in neural areas involved in negative, painful affect, and training in compassion seems to be associated with increased neural activity in the brain regions associated with affiliation, love and positive emotions (Bibeau, Dionne, & Leblanc, 2016; Engstrom & Soderfeldt, 2010; Klimecki et al., 2012; Klimecki et al., 2013; Klimecki et al., 2014). While these findings and those of the study with Ricard (Klimecki et al., 2013) need replication, they seem to suggest that it may not only be possible to cultivate empathy and

compassion through short-term training regimens, but also that empathy and compassion may be distinct phenomena.

Method of Approach

Through this dissertation, I will endeavor to broaden the dialogue about the character and function of empathy and compassion in dual and nondual experiences. I will offer a particular way of integrating existing theories, to speak to the intersection of empathy and compassion with dual and nondual experiences of subjectivity in the psychotherapeutic encounter. I will also make a case that treatment is best served when the therapist has access to both empathy and compassion. Not only does each facilitate different aspects of patient healing and development, but a balance of empathy and compassion better equips the therapist to respond to enactments. I will support these conceptualizations with psychoanalytic theorizing on the nature of empathy and with Buddhist teachings on the nature of compassion.

Specifically, I will integrate aspects of Kohut's and Winnicott's theories in my conceptualization of empathy. Kohut's definition of empathy provides a theoretical basis for thinking of it as a dual or subject-to-subject phenomenon in which one affectively and cognitively attunes to the internal experience of the external other. According to Kohut (1984), empathy is an objective mode of observation; it "is the capacity to think and feel oneself into the inner life of another person" (p. 82). It involves a sustained immersion in the patient's inner life in order to intuit and understand the patient's experience from within the patient's personal, social, and cultural surround. Kohut regarded empathy as a process shared by two uniquely situated subjectivities. His empathic therapist does not merge with the patient, but rather has "vicarious" experiences and reflects upon them in

order to better understand the patient (Kohut, 1959, 1971, 1982, 1984; Kohut, Tolpin, & Tolpin, 1996; MacIsaac, 1997; Orange, 2011).

Winnicott's writing and theorizing about child development and the mother-infant relationship also supports thinking of empathy as a subject-to-subject phenomenon. However, unlike Kohut's understanding of empathy as a value-neutral stance of observation, Winnicott's ideas suggest that empathy is deeply related to states involving care and concern for the other. According to Winnicott, the capacity for externality - or recognizing the other as a separate subjectivity - develops concurrently with the capacity for care and concern for the other. It is through empathic exchanges between parent and child (or therapist and patient), that one's self is intuited and thus comes into being. In addition, care for the other emerges with the recognition of the other as a separate self that can also be intuited (Winnicott, 1963/1965a, 1963/1965c, 1967/2005b, 1969).

Drawing on both Kohut and Winnicott, I conceptualize empathy as a caring form of attuning to and intuiting the unique experience of the distinct other. It is a process that transpires on the dual plane of reality in which the therapist gathers information about the patient's internal experience and reflects it back to them. It involves the therapist resonating with and imagining the patient's personal and situated experience. The empathic therapist reflects on his or her vicarious experiences of the patient's internal states and on his or her knowledge of the patient's historical and social context. The therapist closely attends to the subtle and fleeting sensations and reveries that surface and move through his or her being and attempts to discerns that which is an expression of his or her own subjectivity and that which belongs to the patient. The therapist's care for the patient supports this process of coming to know the unique other. Gradually and

repeatedly, the therapist reflects that which was there to be seen and felt back to the patient. The repetition of such empathic exchanges enables the patient to coalesce and relate to him or herself and the world as an authentic subject.

The teachings of Theraveda and Mahayana Buddhism provide the theoretical basis of my conceptualization of compassion as a nondual phenomenon. For over 2,500 years, Buddhism has been developing teachings on the nature of compassion, its role in the relief of suffering and specific practices that facilitate the cultivation of compassion. Buddhist texts clearly delineate a discourse on the suffering that arises from trying to hold on to certain experiences and trying to avoid other experiences as well as from clinging to dual constructions of reality (e.g., self and other as separate). Buddhism maintains that suffering abates when we recognize the fluidity and impermanence of experience as well as when we embrace a nondual reality – that is a reality that sees through the illusion of dual constructions (Gilbert & Choden, 2014; Kyabgon, 2001; Loy, 2003; Makransky, 2012; Trungpa, 2005, 2013). As a result, Buddhism offers a particularly conducive platform from which to think about the nature of compassion and its role in nondual and mystical exchanges between therapist and patient. According to Theravada Buddhism, compassion centers on a wish for all beings to be released from suffering, whether or not they are obviously suffering in any given moment. Mahayana Buddhism agrees with this assertion, and suggests that compassion includes an understanding that goes beyond "the reified conceptual construct of a separate 'observer' and 'observed,' ...[and involves] a nonconceptual, nondual awareness that recognizes the entire world and its beings as ultimately like undivided space" (Makransky, 2012, p. 68).

In other words, compassion involves opening to all experience equally as well as sensing the unity of life - the indivisibility between you, me, and all experience.

Drawing on these two schools of Buddhist philosophy, I conceptualize nondual compassion as a benevolent response to suffering that arises in nondual states of intersubjectivity as well as in the spiritual realm of universal oneness. It is a welcoming response to suffering - a way of feeling and relating to suffering that involves both understanding the nature and causes of suffering and wishing for the relief from suffering – yours, mine, and ours. It is unconditionally feeling the full range of suffering as it takes form in the shared human field of experience and meeting that with acceptance and loving-kindness. Underlying this understanding of compassion is the belief that suffering diminishes when no experiences or feeling states are resisted. When a therapist is able to embody this state of being, he or she welcomes the patient and all of his or her experiences into the fold of humanity. The recognition of universality, when combined with benevolence and equanimity toward all experiences, softens the edges of suffering. As such, nondual compassion supports the therapeutic dyad in weathering the emotional storms of trauma and loss, while simultaneously assuaging the alienation inherent in the dual realm of existence.

Empathy and compassion may be alternately occurring or co-occurring. Empathy, transpires when the other is recognized as a unique subjectivity and his or her internal experience is intuited through either or both emotional resonance and imaginative perspective-taking. This may happen in the presence of the other as well as when the other is not present, but is brought to mind (e.g., when thinking about patients when not with them). Concurrent with this or independent of it, compassion occurs when the other

is recognized as an interconnected facet of humanity and the nondual other's internal state is felt, while simultaneously wishing for the amelioration of suffering. When we access the dual state of empathy, we *feel into* the other's unique experiences and when we access the nondual state of compassion, we *feel with* the nondual other and accept the universality of the experience as being within the human condition. Because of the interpenetrating nature of dual and nondual reality, empathy and compassion may happen distinctly or simultaneously.

Given the above descriptions of empathy and compassion, their distinct roles in psychotherapy can begin to be discerned. Empathy can be seen as the means by which we can come to know ourselves by being known by another and as such come into being as an individual (Kohut, 1973/1978, 1982, 1984; Winnicott, 1960/1965d, 1963/1965c, 1967/2005b). Empathy provides the medium in which the dual facets of our existence take form, the facets that are then able to engage in subject-to-subject relating as well as subject-to-object relating. (Benjamin, 1988, 1990/1999). Conversely, compassion can be seen as the means by which we do not feel alone in our suffering and as such are given a seat at the table of humanity and life itself. Compassion provides the medium in which our nondual nature, our fundamental interconnectedness, our oneness, is felt and known. Thus, both empathy and compassion are important elements of therapeutic action with each serving the patient in different ways that enrich a life capable of bridging dual and nondual realms of being and experiencing.

In addition, I contend that empathy and compassion are each needed to resolve different forms of enactments. The first transpires on the dual plane of reality and involves the therapist engaging with the patient through subject-to-object relating. When

this inevitably occurs, both therapist and patient relate to one another as a dissociated aspect of self or other. When the therapist is able to regain empathy for the patient, the dyad can begin the process of returning to subject-to-subject relating. The resolution of such enactments facilitates the internalization of disowned aspects of self and helps the patient expand his or her relational repertoire. The second type of enactment involves the therapist becoming mired in a form of aggression, which negates the nondual level of reality. When therapists enact this type of aggression, they lose access to universality. They seek to secure their ego-based selves and attempt to maintain or resist certain feelings or states of mind. In so doing, they alienate the patient and his or her experience. In these moments, compassion is needed to release the grip of ego-clinging and to dissolve the illusion that discomfort can be avoided. The inclusivity and impartiality of nondual compassion, transforms the aggression and brings both therapist and patient face-to-face with their indivisibility.

The components and assertions described above are taken up in the following chapters. Chapter Two provides background information about the history and meaning of the constructs empathy and compassion, as well as an overview of psychoanalytic theory regarding intersubjectivity and nondual phenomena. Chapters Three and Four address the theoretical material from which I will draw to structure my conceptualization of the intersection of empathy and compassion in the therapeutic stance with dual and nondual experiences of subjectivity. The integration of these threads of thinking will be articulated in Chapter Five. Lastly, Chapter Six will contextualize this conceptualization of empathy and compassion in the field of psychotherapy, as well as consider its limitations and delineate areas for further exploration.

Significance of Study

The development of theory that addresses the intersection between empathy and compassion in the therapeutic stance with dual and nondual realms of experience is relevant to the field of psychotherapy and human welfare for several reasons. First, research has begun to suggest that in addition to empathy and compassion having different neural maps, states of empathy may leave us susceptible to emotional fatigue and burnout, whereas states of compassion may engender a feeling of aliveness and wellbeing even in the face of profound suffering (Klimecki et al., 2012; Klimecki et al., 2013; Klimecki et al., 2014; Singer & Klimecki, 2014). Certainly, psychotherapists face vicarious trauma and burnout. A therapist being able to consciously shift from empathy to compassion, as needed, to restore his or her sense of wellbeing would not only be helpful for the therapist, but also for his or her patients, who as interconnected beings would also be affected by the therapist's internal state. In addition, a treatment that provides both an empathic and a compassionate milieu facilitates patients feeling known and the aliveness of being real (i.e., being a unique subjectivity), as well as the relief and joy of being inseparably woven into the fabric of humanity.

Having access to both empathy and compassion better equips psychotherapists to address the full range of human experience. A multiple, or at least two-truths, theory of reality in which there is both a relative reality and an absolute reality (Siegel & Germer, 2012; Townsend & Kaklauskas, 2008), enhances the healing potential of psychotherapy. At the dual level of relative reality, therapists can recognize and metabolize the natural urges of self-preservation, desires for security and wellbeing for self and loved ones, fear of the unknown, as well as sexual and aggressive urges, feelings of failure and shame,

and other human vulnerabilities. At the nondual level of absolute reality, therapists can be present with and accept the universality of all life, as well as the interdependence of all phenomena and the suffering experienced by clinging to pleasant sensations and seeking to avoid unpleasant sensations. Being able to attend to both levels of experience is an important aspect of being a therapist and empathy and compassion address both forms of reality. As Siegel and Germer (2012) state, "sometimes our patients need us just to understand [i.e., empathize with] their ordinary emotional experience, whereas other times they need us to see the bigger picture and understand [i.e., be compassionate with] how the mind creates suffering by not perceiving absolute reality" (p. 32).

Access to both empathy and compassion can also help psychotherapists respond to some of the particular challenges and conflicts that emerge in psychotherapy in the form of enactments. In addition, these same challenges and conflicts are mirrored and enacted in the broader community and here too empathy and compassion can help us to understand and respond to these aggression-weighted encounters. Both micro- and macro-systems that operate exclusively on either the premise of duality or the premise of nonduality are limited and open the door to alienation and marginalization. When we cannot recognize the subjectivity of the other, as well as when we cannot see the interconnectedness of all life, we are more likely to negate and otherwise fail to respond to the other. I believe this is particularly relevant in understanding and responding to matters of diversity and privilege as well as to the global ecological crisis. As humans we need compassion to be invested in relieving the suffering of all beings, regardless of cultural differences or where on the planet we reside. However, we also need empathy and the capacity to appreciate the uniqueness of each individual in order to understand

the particular causes of suffering experienced by the sociocultural- and bio-diversity of all life.

I believe and hope that this potential benefit of exploring the interface of empathy and compassion with dual and nondual experience can extend beyond the consulting room. If therapists cultivate and practice being empathic and compassionate on the dual and nondual levels of reality, their patients are likely to absorb and in their own ways begin to adopt similar ways of relating to themselves and to the world around them. As Williams and Levitt's 2007 study suggested, client's values become increasingly similar to their therapist's values. Thus, however subtle it may be, I believe my personal process in developing these ideas and sharing them in this dissertation can serve to broaden my patients' and perhaps the larger community's consciousness, as it has for me.

CHAPTER TWO: CONTEXTUALIZING EMPATHY, COMPASSION, INTERSUBJECTIVITY AND NONDUALITY IN PSYCHOTHERAPY

In this chapter, I discuss the literature regarding the four main themes that serve as the foundation of this dissertation, namely: empathy, compassion, intersubjectivity in psychoanalytic theory, and nonduality in psychoanalytic theory. I describe empathy as a philosophical construct and discuss how it has been understood and applied in clinical and psychoanalytic psychology, including Rogers' and Kohut's contributions, as well as contemporary perspectives on empathy. I then describe compassion as a religious and ethical construct and its interpretation and history within clinical and psychoanalytic literature. This is followed by an overview of intersubjective theory including a review of Stolorow and colleagues', Benjamin's, and Ogden's interpretation of intersubjectivity. I conclude the chapter with a discussion of nonduality in psychoanalytic literature. This section briefly reviews historical psychoanalytic perspectives on the spiritual and universal domain of experience and highlights Blackstone's recent contribution.

Empathy

Prior to the English word "empathy" being coined in 1909, its German antecedent, *Einfuhlung,* was used in aesthetics and philosophy to refer to the process by which one intuits and experiences the message and meaning of an object of art. The term "sympathy", however, was already in use to refer to the process by which emotion is transmitted from person-to-person (Coplan & Goldie, 2011). Today, "sympathy" is used to describe feelings of concern and sadness for a suffering other, and "empathy" is used to refer to the exchange of emotion from person-to-person, as well as to the process of intuiting the other's internal experience (Coplan & Goldie, 2011; Goetz et al., 2010).

Interpretations of the Construct "Empathy"

Philosopher David Hume used the term "sympathy" in *A Treatise of Human Nature,* in 1739, to describe the transmission of emotion from one person to another as an automatic and nearly instantaneous process (Coplan & Goldie, 2011; Hume, 1939/1978; Stueber, 2014). His conceptualization of sympathy is similar to what is now referred to as low-level empathy or mirroring in which resonance with another's feelings happens rapidly and without conscious or cognitive deliberation (Bernhardt & Singer, 2012; Coplan & Goldie, 2011; Goldman, 2006, 2011). In 1759, Adam Smith took up Hume's concept of sympathy in *The Theory of Moral Sentiments*. Smith's use of the term and conceptualization of sympathy maintains Hume's idea that sympathy involves the process of coming to experience another's emotion. For Smith, however, the process is not automatic and involves imaginative perspective taking (Coplan & Goldie, 2011; Stueber, 2014). According to 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, which though weaker in degree, is not altogether unlike them. (as cited in Coplan & Goldie, 2011, p. XI)

Smith's understanding of sympathy is similar to what is now referred to as high-level empathy, in which imaginative processes are involved in reconstructing a sense and experience of another's internal feeling state (Bernhardt & Singer, 2012; Coplan & Goldie, 2011; Goldman, 2006, 2011).

The term *Einfühlung* (from which the English word "empathy" is derived) was first used in aesthetics and philosophy in the late 19th century and early 20th century. In 1873, German aesthetics philosopher Robert Vischer created and introduced the word *Einfühlung* as a technical term referring to esthetic sympathy or "feeling-into" an object. Subsequently, in 1903, Theodor Lipps, also a German aesthetic theorist and philosopher, began using the word *Einfühlung* and is often credited with popularizing it (Clark, 2007; Coplan & Goldie, 2011; Halpren, 2001; Lipps, 1903, 1903/1931; Stueber, 2014). Lipps defined *Einfühlung* as "the power of projecting one's personality into (and so fully comprehending) the object of comprehension" (as cited in Halpren, 2001, p. 75). Lipps, who translated Hume's *A Treatise of Human Nature* into German, used the word *Einfühlung* in a way that bridged its initial use in aesthetics by Vischer with Hume's understanding of sympathy (Coplan & Goldie, 2011; Stueber, 2014). According to Lipps, *Einfühlung* refers to both the process by which one experiences aesthetic objects and the process by which one comes to know another's internal state of mind. Lipps emphasized the subjective or experiential nature of *Einfühlung* as reflected by its literal meaning, "feeling-into". For Lipps, *Einfühlung* involves an instinctual process of projecting one's own feelings onto physical and social objects and then experiencing those feelings as one's own by resonating with or imitating the movements and expressions of those objects (Clark, 2007; Copland & Goldie, 2011; Halpern, 2001; Lipps, 1903, 1903/1931; Stueber, 2014).

The concept of *Einfühlung* (and later empathy) has been deeply embedded in and debated in philosophical and psychological discussions of the human condition since Lipps introduced the term and no single explanation of the concept has emerged. Rather,

the dialogue draws attention to varying subtleties of human experience with each voice offering a valuable perspective. Edmund Husserl (1859-1938) and Edith Stein (1891-1942) wrote at length about *Einfühlung*. They both rejected Lipps' definition of *Einfühlung* and maintained that his conceptualization suggested a kind of merger - a collapse of intersubjectivity in which the other is assumed to be the same as the subject. From their perspectives, empathy involves the knowledge or experience of an external world. It is a mode of consciousness through which we experience the mindedness of the other while maintaining our own mind (Coplan & Goldie, 2011; Halpern, 2001; Husserl, 1977, 1989; Stein, 1989). Husserl asserted that *Einfühlung* involves one person regarding another person as another center of an emotional world (Halpern, 2001; Husserl, 1977). Similarly, Stein (1989) described *Einfühlung* as an imaginative process, which maintains an "as-if" quality. In her words, *Einfühlung* is "an imaginative 'announcement' and fulfilling explication of another 'I', rather than an imagined merger forming a 'we' subject" (as cited in Halpern, 2001, p. 82). Coplan and Goldie (2011) summarize Husserl and Stein's position by stating that:

> [They] interpret Lipps' notion of empathy as involving a type of fusion or 'oneness', which they consider deeply problematic. In their view, there is no loss of self during the process of empathy...the *Ein* in '*Einfühlung*' meant 'into', not 'one' and thus *Einfühlung* is best understood as a process of 'feeling into', not a process of 'feeling one with'. (Coplan & Goldie, 2011, p. XIV)

Einfühlung for both Husserl and Stein, maintains the distinction between self and other and as such, their conceptualization of *Einfühlung* lends itself to learning about another's

experience not only when it matches one's own perspective, but also when it is different or foreign to one's internal paradigm (Coplan & Goldie, 2011; Halpern, 2001).

The word "empathy" first appeared in English in 1909, when Edward Titchener (1909) used it in his book, *Elementary Psychology of Thought Processes.* In an effort to translate the term *Einfühlung,* Titchener coined the word "empathy" by using a transliteration of the Greek word *empatheia,* stating:

> Not only do I see gravity and modesty and pride and courtesy and stateliness, but I feel or act them in the mind's muscle. That is, I suppose, a simple case of empathy, if we may coin the term as a rendering of *Einfühlung.* (as cited in Coplan & Goldie, 2011, p. XIII)

Thus, empathy's entre into the English language brings with it a vagueness in which not only do we "see" emotions in another, we also "*feel or act* [emphasis added] them in the mind's muscle." Which is to say, empathy may involve automatically feeling the other's emotions *or* imaging them, and it may maintain an "as-if" quality in which self and other are distinct, *or* it may involve a sense of merger in which a "we" subject is experienced (Coplan & Goldie, 2011; Halpern, 2001; Stueber, 2014).

A Historical Perspective on Empathy in Clinical Psychology and Psychoanalysis

Although Freud used the term *Einfühlung* (i,e., empathy) sparingly, the body of his writings suggests he included (at least a version of) empathy in his understanding of the therapeutic stance and in the process of therapeutic listening (Aragno, 2008; Clark, 2007; Eagle & Wolitzky, 1997; Grant & Harari, 2011; Shaughnessy, 1995). Freud's treatment was one in which the analyst registered and interpreted the unconscious communications of the patient. In order to achieve this, Freud (1912/1958a) suggested

that the analyst has to "turn his own unconscious like a receptive organ toward the transmitting unconscious of the patient" (Freud, 1912/1958a, p. 115). Using oneself in this way evokes elements of emotional resonance and as such a form of empathy. Freud also maintained that in order for treatment to be useful, a rapport or working alliance with the patient was necessary and that such an alliance could not happen without *Einfühlung*, or empathy (Aragno, 2008; Freud, 1913/1958b, 1921/1955; Shaughnessy, 1995).

Freud, however, did not expand on the definition of empathy and only once defined it, and at that, in a footnote (Aragno, 2008; Clark, 2007; Freud, 1921/1955; Grant & Harari, 2011). His longest statement on the matter was to characterize empathy as the "mechanism by means of which we are enabled to take up any attitude at all towards another mental life" (Freud, 1921/1955, p. 110). In addition, although there were other clinicians and theorists of Freud's day and beyond (e.g., Ferenczi, Sullivan, and Winnicott) who advocated for an empathic presence in psychotherapy, it was rarely named as such, nor were its processes and components fully described (Chessick, 1998; Clark, 2007; Grant & Harari, 2011). For example, Ferenczi was known for his warmth and responsiveness as a clinician, and he saw the therapeutic relationship as an intimate, mutual partnership characterized by empathy. Yet, he too did not define exactly what he meant by empathy. The closest he came to describing the phenomenon was to liken *Einfühlung* to tact – or the process by which a therapist uses "the effect, or echo, produced in the mind and in the heart" to decide if and how to tell a patient something (Nachin, 2001, p. 171). Ferenczi, however, did offer several insights regarding the nature and role of empathy in psychoanalysis. Unlike Freud, Ferenczi came to believe the sexual abuse his patients reported was based in reality and not the result of fantasy. Ferenczi

attended to his patients' experience from their perspective, not from the perspective of an external expert. He also relied on his capacity to engage with his patients on an emotional and intimate level to understand their subjective experience. In addition, he advocated oscillating between this type of engagement and listening, which he referred to as empathy and a more detached position from which the analyst could make judgments and formulate interpretations. (Clark, 2007; Ferenczi, 1928/1955, 1949; Rachman, 1988). These two clinical orientations (i.e., alternating between an emotionally intimate position and a more detached and objective position) can be seen as foreshadowing Kohut's later theorizing on "experience near" and "experience-distant" modes of empathy (Clark, 2007; Rachman, 1988).

In the period between Ferenczi's writings in the 1920s and 1930s and Kohut's 1959 paper on introspection and empathy, there were other psychoanalysts whose writings also addressed empathy. Prominent among these are Sullivan, Fliess, Fenichel, and Fromm-Riechmann. Like Ferenczi, Sullivan did not elaborate on the definition of empathy, but referenced it and emphasized its role in the interpersonal aspects of development and treatment (Chessick, 1998; Clark, 2007). Sullivan (1953) introduced the term "empathic linkages" to refer to the phenomenon in which two people relate and are linked in such a way that one induces a feeling in the other. Fliess (1942) and Fenichel (1953) both wrote about empathy as it relates to and can be understood as a form of identification. Others, however, (e.g., Aragno [2008] and Halpern [2001]) have suggested that using the process of identification to explain the process of empathy is more confounding than helpful. According to this position, identification is an unconscious process by which one develops structural features of another's personality, frequently in

childhood, through repeated and ongoing exposure and interaction. Empathy, on the other hand, manifests in brief or immediate encounters and may involve purposefully imagining the other's experience. Aragno summarized this position when she stated "borrowing the term *identification* for the mirroring mechanism in empathy is a mistake: identification operates unconsciously during development and contributes to overall personality structure through wholesale internalizations that are neither transitory nor deliberate" (p. 718). Lastly, Fromm-Riechmann (1950) emphasized the importance of an empathic relationship and empathic understanding to the psychoanalytic endeavor. At the relational level, she saw empathy and the treatment process as a caring, collaborative process and at the level of understanding, she saw empathy as a means of linking the patient's unconscious with that of the therapist's (Chessick, 1998; Clark, 2007; Fromm-Riechmann, 1950).

Rogers and Kohut formulated their theories within this clinical backdrop. Their writings and approaches to treatment have given empathy a central place in and served to humanize the fields of both clinical psychology and psychoanalysis, respectively. Despite important commonalities in their understanding of and emphasis on the therapeutic value of empathy, however, there are noteworthy areas of divergence in their thinking.

Carl Rogers (1902-1987).

Rogers' approach, client-centered psychotherapy, has fundamentally affected and influenced the field of psychotherapy. His ideas about the therapeutic relationship were revolutionary (Clark, 2007; Kahn, 1991; Kahn & Rachman, 2000). For many psychotherapists, he "legitimized the therapist's concern about the quality of the relationship between therapist and client" (Kahn, 1991, p. 36). Rogers articulated

genuineness, empathy, and unconditional positive regard as a triad of therapeutic action. His later writings, however, name empathy as the primary attitudinal element in therapeutic exchanges (Rogers, 1975). In his words, "the gentle and sensitive companionship of an empathic stance – accompanied of course by the other two attitudes – provides illumination and healing" (p. 9). Rogers consistently maintained that empathy includes imagining another's subjective experience and resonating with (i.e., automatically feeling) his or her feelings. In addition, it is "focused on the client's presently available moment-to-moment meanings and experiences" (Bohart & Greenberg, 1997). Rogers (1942, 1957, 1975, 1986) emphasized the importance of the therapist understanding the client's inner world as he or she experiences it and respecting the legitimacy and authenticity of the client's subjectivity.

Empathy in Rogers' (1975) words,

> Means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living in his/her life, moving about in it delicately without making judgments, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensings of his/her world as you look with fresh unfrightened eyes at elements of which the individual is fearful. It means frequently checking with him/her as to the accuracy of your sensings, and

> being guided by the responses you receive...By pointing to the possible meanings in the flow of experiencing you help the person to...experience the meanings more fully, and to move forward in the experiencing. To be with another in this way means that for the time being you lay aside the views and values you hold for yourself in order to enter another's world without prejudice. In some sense it means that you lay aside yourself and this can only be done by a person who is secure enough in himself that he knows he will not get lost in what may turn out to be the strange or bizarre world of the other, and can comfortably return to his own world when he wishes. (Rogers, 1975, pp. 3-4)

In this statement, Rogers defined empathy as a process with several components. It includes sensing and perceiving the emotional and conceptual internal world of the other, being nonjudgmental and unfrightened, sensing that which is barely conscious, communicating the sensings, checking for accuracy in perception and articulation, and adjusting to feedback and responses to fine-tune the sensing of the other. In addition, for Rogers, the process of empathy includes the other gaining enhanced access to experiencing and the meanings of that experiencing coming forward. Lastly, Rogers described empathy as laying aside oneself in order to fully enter the world of the other without prejudice, a process that requires the security of knowing you can return to yourself at will. Rogers' understanding of empathy is consistent with Husserl and Stein's, in that he too saw it as a relational process between two subjectivities, not a process involving merger. For Rogers, the empathic exchange is one in which the therapist retains access to his or her internal, subjective world and consciously lays it aside in order

to understand and communicate back to the patient his or her world from an experience-near perspective (Bozarth, 1997; Coplan & Goldie, 2011; Rogers, 1957, 1975, 1986). He believed this form of empathy facilitated self-exploration while also providing the client with a sense of acceptance as a fellow human.

Heinz Kohut (1913-1981).

Through experiences with narcissistic patients, Kohut came to believe that the traditional experience-distant way of knowing or understanding patients in psychoanalysis was flawed and unhelpful. His theory, self psychology, maintains that empathic failures in childhood result in failures in the self-structuralization process and that empathy is critical to helping them resolve deficits in the self (Bohart & Greenberg, 1997; Clark, 2007; Eagle & Wolitzky, 1997; Kohut, 1971, 1982, 1984; MacIsaac, 1997). Kohut, like Rogers, made empathy a cornerstone of both his understanding of development and his approach to treatment. His thinking regarding the nature of empathy, however, was quite different from Rogers'.

While Rogers always maintained that empathy itself is a curative factor, it was not until the end of Kohut's life that he acknowledged that empathy is not only a means of gathering conscious and unconscious information about a patient's functioning and interior world, it is also beneficial in and of itself (Clark, 2007; Kahn & Rachman, 2000; Kohut, 1982, 1991). Kohut gave his last public address in October 1981 before dying a few days later. In this address, he voiced the conceptual shift he made regarding the function of empathy, stating "despite all that I have said, empathy, per se, is a therapeutic action in the broadest sense, a beneficial action in the broadest sense of the word. That seems to contradict everything I have said so far... But...it is true" (Kohut, 1991, p. 530).

Thus, in this final paper, Kohut (1982) described empathy as both an epistemological tool and as "a powerful emotional bond between people" (p. 397). However, despite Kohut's acknowledgement that empathy itself is an emotionally powerful phenomenon with therapeutic effect, his primary motivation for engaging empathically remained obtaining information that can be used to interpret or to explain the interplay of the patient's developmental history and present unconscious and conscious affective and behavioral experiences (for more on Kohut's understanding and use of empathy, see Chapter Three).

Contemporary Definitions of Empathy

To date, there remains no common definition of empathy in the psychological literature. Although most definitions include some aspect of shared emotion, there is ongoing debate about whether or not empathy includes either or both conscious and unconscious emotional processes, as well as whether it involves self-or other-focused perspective taking and the nature of the shared emotional experience. For example, Hoffman (2000) defines empathy as "an affective response more appropriate to another's situation than one's own" (p. 4). Eisenberg and Strayer (1987), however, define empathy as "an affective response that stems from the apprehension or comprehension of another's emotional state or condition, and that is identical or very similar to what the other person is feeling or would be expected to feel" (p. 5). Coplan (2011) goes a step further stating, "empathy is a complex imaginative process in which an observer simulates another person's *situated* psychological states [both cognitive and affective] *while maintaining clear self-other differentiation"* [emphasis added] (p. 5). For Coplan, empathy not only involves an identical or very similar affective response, it also requires that the boundary

between self and other be conscious and that the imaginative or perspective taking process be other-and not self-oriented. Goldie (2011) also takes up the idea that true empathy involves other-based perspective taking. He maintains that self-based perspective taking only mimics empathy and that this is possible only in "base cases" or those in which the empathizer's psychological personality is quite similar to the other and the other's situation is emotionally clear and not conflicted or confused. Thus, for Coplan and Goldie, true empathy entails purposefully imagining being the *other* in the other's shoes and *not oneself* in the other's shoes.

As the foregoing suggests, Coplan (2011) and Goldie (2011) emphasize the conscious aspects of empathy, whereas Hoffman (2000) includes conscious and unconscious processes in his understanding of empathy, but does not specify if the role-taking is self- or other-focused. Further, Coplan, Goldie, and Hoffman do not specifically address whether or not care is a requirement for empathy. Others, such as Noddings (1984), emphasize that care is an essential ingredient. Noddings links care with empathy and asserts that empathic care involves being receptive and willing to share the other's feelings. For Noddings, such receptivity to another can only emerge in the context of caring about the other and it involves attending to the other's needs through a process of "feeling with" the other. Noddings rejects the traditional conceptualization of empathy as projecting oneself into the other in order to understand the other, which she considers to be a "peculiarly rational, western, masculine way of looking at 'feeling with'" (p. 30). Coplan and Goldie (2011) describe Noddings' understanding of empathy as a process in which "'feeling with' the other begins not with an attempt to interpret the other or solve some sort of problem...it begins with simply attending to and sharing the other's

feelings" (Coplan & Goldie, 2011, p. XXVII). Noddings' conceptualization of empathy suggests that the phenomenon is not only a receptive process that includes care, but that its purpose is connective and not interpretive.

Like Rogers and Kohut, today's empathy theorists differ in their thinking with regard to whether empathy involves only conscious states of mind or both conscious and unconscious material, if care is involved, and the purpose of empathy. While Coplan and Goldie do not address whether or not care is required for empathy, their definitions, like Roger's conceptualization, describe empathy as a process by which one feels a similar affective state consciously being experienced by the other while maintaining a clear boundary between self and other. Hoffman and Kohut, however, maintain that empathy involves attending to both conscious and unconscious phenomena in the other. In addition, both Rogers and Kohut share with Coplan and Goldie, and not with Hoffman, a belief that true empathy involves other-based perspective taking. Lastly, Noddings' depiction of empathy as a caring process is more consistent with Roger's approach to empathy than with Kohut's. Her understanding of empathy as a receptive rather than a projective process, however, differs from both Roger's and Kohut's explication of the empathic endeavor.

Compassion

Compassion has long been understood in religious and ethical teachings as the basis of altruistic or prosocial behavior. This understanding can be seen in the 2009 Charter for Compassion, which was composed by spiritual leaders from around the world. In this statement, compassion was described as an injunction to "treat all others as we wish to be treated ourselves" (Armstrong, 2010, p. 6). Despite this broad definition

there remain multiple interpretations of the phenomenon. The word "compassion" is at times used synonymously with "sympathy" or "sympathetic pity" and at other times is clearly distinguished from sympathy. The *Oxford English Dictionary* defines compassion as "*sympathetic pity* [emphasis added] and concern for the sufferings or misfortunes of others" ("Compassion," n.d.). Buddhist texts, however, describe sympathy and pity as "near enemies" of compassion. As near enemies, they present similarly, but are actually distractions from true compassion. According to these teachings, sympathy and pity are both sorrowful responses to the dual other. They are characterized by feelings of grief and can foster distance between self and other as well as potentially degrade the other into positions of inferiority. Compassion, from the Buddhist perspective, is a welcoming and loving response to the nondual other who is understood as a fellow manifestation of the universal whole (Salzberg, 2002; Siegel & Germer, 2012; for more on the Buddhist understanding of compassion, see Chapter Four).

Researchers and scientists also vary in how they understand and define compassion. Some assert that compassion is a variant of either love or sadness while others maintain that compassion is a distinct emotion. For example, Post (2002) suggests "compassion . . . is love in response to the other in suffering" (p. 51). Lazarus (1991), however, distinguishes compassion from other emotions as well as from vicarious emotion, as in the case of empathy. He asserts:

> Compassion...[is] an emotion of its own...In *compassion*, the emotion is felt and shaped in the person feeling it not by whatever the other person is believed to be feeling [as in empathy], but by feeling personal distress at the suffering of another and wanting to ameliorate it. (p. 289)

As the foregoing suggests, exploring the field of contradictory ideas about the nature of compassion reveals subtle aspects of what may be meant by the term.

Interpretations of the Construct "Compassion"

The word "compassion" is derived from the Latin origins of 'com,' meaning "with" or "together" and 'pati,' meaning "to suffer" or "to endure." This suggests that compassion literally means, "to suffer with." However, over the centuries these same Latin roots ('com' and 'pati') have been used to mean sympathy and pity. For example, the Latin word 'compassio' was introduced as a translation of the Greek word 'sympatheia' and the English word compassion is based on the Old French (mid-14th Century) word 'compassion' also meaning sympathy or pity ("Compassion", n.d.). Throughout history, however, there has been consensus that compassion involves some form of relating to suffering. As Siegel and Germer (2012) point out, "we can be empathic with just about any human emotion – joy, grief, excitement, boredom...Suffering [however] is a prerequisite for compassion" (Siegel & Germer, p. 13).

The meanings ascribed to the terms "empathy" and "compassion" in the psychological literature have also been inconsistent with some writers suggesting that empathy, rather than compassion, means "feeling with." For example, as noted above, Noddings (1984) defined empathy in this way. Singer and Klemecki (2014) also defined empathy as "feeling with", and went a step further. They stated:

> Importantly, in *empathy one feels with someone*, but one does not confuse oneself with the other... In contrast to empathy, compassion does not

> mean sharing the suffering of the other...*Compassion is feeling for and not feeling with* [emphasis added] the other. (Singer & Klemecki, p. R875)

In defining compassion as "feeling for" the other, Singer and Klemecki also suggest that compassion includes "feelings of warmth, concern and care for the other, as well as a strong motivation to improve the other's wellbeing" (p. R875). These aspects of compassion (i.e., care and a desire to alleviate suffering) seem to be consistent elements in how compassion has been and is understood throughout history and across cultural and linguistic contexts.

There is controversy, however, as to whether or not compassion is an emotion, an attitude, or both. As noted above, those who assert that compassion is an emotion differ as to whether it is a distinct emotion or a vicarious emotion. On the one hand, Batson (1991) suggests, compassion is one of a "particular set of congruent vicarious emotions...that are more other-focused than self-focused" (p. 86). Lazarus (1991), on the other hand, maintains that compassion is a distinct emotion that is not vicarious – it is a feeling state generated in response to another, not the taking on of another's feelings. Others suggest that rather than compassion being an emotion, vicarious or not, it is actually an attitude. This can be seen in Sprecher and Fehr's (2005) statement:

> Compassionate love is an attitude toward other[s], either close others or strangers or all of humanity; containing feelings, cognitions, and behaviors that are focused on caring, concern, tenderness, and an orientation toward supporting, helping and understanding the other, particularly when the other is perceived to be suffering or in need. (p. 630)

Still others (e.g., Goetz et al., 2010) recognize compassion as both an emotion and as an attitude. From this perspective, compassion is understood as a distinct emotion that arises in response to another's suffering and that repeated experiences of compassion can develop into a trait or attitude that persists across context and time.

A Historical Perspective on Compassion in the Therapeutic Stance

The fields of clinical psychology and psychoanalysis have, until recently, minimally discussed compassion. Glaser (2005), who is a proponent of compassion in the therapeutic stance, observed:

> Words like love and, even more so, compassion are not often found in the literature of clinical psychology, as they tend to evoke images of ineffective therapists consoling patients and preventing them from feeling and working through their pain. Compassion seems to lack intelligence, precision, and savvy. It seems religious. Unscientific. (p. 28)

Psychoanalysis began during a period of tension between science and religion and because compassion was deemed unscientific, any discussion of it was often vague and cursory.

Freud epitomized this perspective with his emphasis on a scientific approach to the mind and his disparaging of religion as the "universal obsessional neurosis of humanity" (as cited in Rank, 1941, p. 291). Jung, who split from Freud and Freudian theory, however, disagreed and believed religion need not conflict with science. He saw them as two compatible approaches to understanding the psyche, with religion being an internal source of insight and science being an external means of mapping the psyche. Jung's analytic psychology embraces the reconciliation of opposites as an essential

element of love, development and life itself. However, in addition to emphasizing the binding of counterparts, such as lightness and darkness, Jung also "considered love a cosmogonic force beyond the influence of these opposites. He believed that love alone was stronger than death" (Glaser, 2005, p. 33). Despite this perspective, Jung did not write much about love, and even less about compassion. In one exception to this, Jung (1976) described a story of Kwan Yin, the Goddess of Love and Compassion. In the story, the Goddess:

> ...gives nourishment to all living things, even to the evil spirits in hell, and to do so she must go down to hell; but it would frighten the devils if she were to appear there in her heavenly form and, as the Goddess of Kindness, she cannot permit that to happen; so having such an extraordinary regard for the feelings of the devils, she transforms herself into an evil spirit and takes food down in that guise. (p. 215)

Jung went on to liken Kwan Yin's loving and compassionate care to "the psychological attitude which real love suggests" (p. 215).

In recent years, a handful of clinicians have begun to discuss the nature and role of compassion in the psychotherapeutic process. Eshel (2013) not only references compassion, but also applies her concept of *withness* to her understanding of compassion in the therapeutic stance. She describes compassion as "the analyst's 'withnessing' or interconnectedness with the patient's agonizing states of distress, annihilation, and hopelessness" (p. 933). She goes on to clarify that her notion of *psychoanalytic withness* differs from other conceptualizations of compassionate stances, such as Orange's (2006) description of witnessing and emotional understanding. Eshel asserts that Orange's

concepts refer to subject-to-subject phenomena, whereas her concept of *withness* involves "being there, within the experience of suffering, becoming at-one with it, in deep patient-analyst interconnectedness" (p. 936). The being *at-one with* that Eshel describes involves entering into a nondual mode of experiencing such that the therapist gives over him or herself to being with the patient "in deep interconnectedness in patient-analyst suffering" (p. 938). Kulka (2008) also suggests compassion is a nondual phenomenon. Drawing on Buddhist psychology, Kulka maintains that compassion is an ethical state of being which is supra-personal. It is "the repeal of the *individuality partition* between subject and subject" (p. 118).

Intersubjectivity in Psychoanalytic Theory

Psychoanalysis began with the Freudian model, which portrays the patient as a pathological subject in relationship to societal standards of normative behavior embodied in the healthy object of the analyzed analyst. The psychology in the consulting room that was attended to was the patient's. Because insight into one's sexual and aggressive drives was believed to facilitate participation in the external, objective world, treatment was aimed at making patients' unconscious thoughts, memories and fantasies conscious (Blackstone, 2007; Mitchell & Black, 1995). Since Freud's day, the field of psychoanalysis has gone through several paradigmatic transformations while remaining loyal to understanding and working with intrapsychic phenomena. The mid 20th century brought one such development with the emergence of British object relations theory and self psychology. Both schools of thought focus on the nature and function of human relationships and emphasize the importance of the therapist-patient rapport and exchange. Prior to this, there were individual analysts (e.g., Ferenczi and Sullivan) who responded

to patients' early developmental trauma and practiced empathically (Makari, 2008; Rachman, 1988). However, when the work of British object relations theorists (e.g., Winnicott, Fairbairn, Bolby, Guntrip, etc.) and Kohut's ideas (as articulated in self psychology), penetrated the field, the primary "goal of psychoanalysis [shifted] from helping clients adjust to society to helping them recover from the conforming, dehumanizing aspects of society, as well as the destructive elements of their childhood environments" (Blackstone, 2007, p. 19).

Kohut's self psychology emphasizes the importance of empathic attunement in the self-structuralization and psychotherapeutic process. His emphasis on empathy impacted the prevailing understanding of the therapeutic stance. No longer was the ideal therapist seen as a distant expert. During this iteration of psychoanalysis, the therapist was viewed as an empathic guide to patients in their journey of self-exploration and individual development. Objectivity, however, was still believed possible as revealed in Kohut's (1984) statement, "the analyst provides the patient with the opportunity to become more objective about himself while continuing to accept himself, just as the analyst continues to accept him" (pp. 184-5). The therapist in Kohut's model retains the authority to guide the patient toward objectivity and as such, is not an equal in a mutual and reciprocal relationship. Kohut's theory remains rooted in a one-person psychology in which the therapist is able to be objective and in which development is a uni-directional process toward greater degrees of autonomy (Kohut, 1977, 1984; Stolorow & Atwood, 1992; Stolorow & Lachman, 1980).

Today, the dominant thinking about mutuality in psychotherapy has changed. This trend began with Greenberg and Mitchell's (1983) delineation of relational theory as

distinct from classical psychoanalysis and Stolorow and colleagues' (1987) articulation of intersubjective theory, which has since morphed into intersubjective systems theory. While there are differences of opinion and emphasis between these two approaches, they share the "basic assumption...that development and unconscious phenomenon are marked primarily by relationships, not by drives" (Layton, 2008, p. 3). In addition, both relational and intersubjective thinking recognize connection as inherent to the human condition and therefore reject classical separation-individuation theories, which see the individual on a progressive course toward greater and greater separation and autonomy. Both theories also maintain that the therapist is an equal participant whose psychological organization and relational patterns influence the course of therapy. Transference and counter-transference are understood as inseparable, and as such, a relational or intersubjective field exists between the patient and the therapist (Benjamin, 1990/1999; Mitchell, 1988; Ringstrom, 2010, Stolorow & Atwood, 1992). This postmodern view of the therapist-patient dyad marks the shift from one-person to two-person psychology, and it currently pervades psychoanalytic thinking despite theoretical differences of opinion or emphasis.

Stolorow and Colleagues' Use of the Term "Intersubjective"

One such difference involves the way in which the term intersubjective is used. Stolorow and adherents of intersubjective systems theory use "intersubjectivity" to reflect an understanding of human existence as fundamentally interpenetrating. From this perspective, the very constructs of subject and object are reifications or fallacies of thinking that emerge from and are perpetuated by Cartesian ideas that permeate the industrialized and otherwise "developed" world (Orange, 1995; Orange et al., 1997;

Stolorow, 2011; Stolorow & Atwood, 1992; Stolorow et al., 1987). The "myth of the isolated mind," as Stolorow and Atwood (1992) call it, suggests that the individual exists separately from the natural and social environment in which he or she lives. This spell or illusion works to reify subjective experience such that the self is experienced as a stable and cohesive "it" from which we perceive an objective and external world. The intersubjective alternative to this reified self is a subjective *sense or experience* of self and of an enduring world of reality, which is sustained by the unique intersubjective fields in which the individual is embedded. Thus, according to Stolorow and colleagues, our experience of self is constantly being shaped within the context of self/other interactions - our *experience* of psychological distinctness and of oneself as real is actually an intersubjective phenomenon.

All experience, in fact, is considered subjectively constructed or organized; there is no direct, unmediated experience (Orange, 1995; Orange et al., 1997; Stolorow, 2011; Stolorow & Atwood, 1992). In Orange's words, "to experience is to organize the given" (1995, p. 87). In the context of psychotherapy, both patient and therapist are constantly organizing the given according to their organizing principles, which have developed as a result of their intersubjective fields of experience. Therefore, unlike Kohut's conceptualization of the therapist as having access to objectivity, intersubjective theory maintains that there is no objectivity, no absolute reality to be known. The goal of treatment then is to help the patient develop more functional and flexible means of organizing experience - not insight, nor greater degrees of autonomy. The therapist seeks to provide and engage the patient in a facilitating intersubjective field in which a wide range of affects can be felt and integrated into one's sense of self in order that the patient

may develop new, more flexible organizations of experience. In Stolorow and Atwood's (1992) words, treatment involves "increasing affect integration and tolerance evolving within an ongoing intersubjective system" (p. 13).

Benjamin's Use of the Term "Intersubjective"

Benjamin, speaking and writing from within the relational tradition, offers a different interpretation of intersubjectivity. According to Benjamin (1990/1999), "connection and separation form a tension, which requires the equal magnetism of both sides" (p. 189). Human existence is conceptualized as an inevitable dialectic or paradox between the need to be connected and the need to be separate. Unlike Stolorow and colleagues' use of the term "intersubjectivity" to speak to the interpenetrating and illusive nature of subjectivity, Benjamin proposes a model of mutual recognition in which connection with another occurs when one is distinct, and one's distinctiveness has been recognized by the other (Benjamin, 1988, 1990/1999, 1995; Layton, 2008; Orbach, 2008). Benjamin applies or extends her concept of mutual recognition to early childhood development, as well as to adult-to-adult relating. She asserts that relating throughout life involves striving for mutual recognition between two subjectivities (i.e., between two equivalent centers of being). The capacity to recognize the mother or caregiver as a subject is an important early developmental milestone. Not only does the baby come to recognize, "I am me;" he or she also comes to recognize "you are you." In other words, we are distinct from one another *and* we each have subjectivity or a mind with which we can feel and connect. According to Benjamin, the child gains pleasure in knowing and experiencing that he or she can and does elicit a response from the other. It is the response from the other that gives the child an experience of the other's subjectivity

(Benjamin, 1988, 1990/1999, 1995, 2004; Layton, 2008). In addition, Benjamin (1990/1999) asserts, "recognition between persons is essentially mutual. By our very enjoyment of the other's confirming response, we recognize her in return" (p. 188).

It is a challenge to achieve and maintain mutual recognition (i.e., relating from subject-to-subject), however, because relating in our intrapsychic world is largely subject-to-object. In fact, it is inevitable that mutual recognition is and will be discontinuous. Benjamin suggests that when the intersubjectivity of mutual recognition collapses, we fall into "doer-done to" relations. In this mode of relating, the other is the object of our feelings, needs and actions, not another separate, yet similar mind (Benjamin, 1990/1999, 1995, 2004). Benjamin assumes that a distinct subjectivity exists and that our challenge is balancing the tension between this separate self with our need to be connected and part of an interactional system. She suggests that when that balance is not achieved, we experience disconnection from either self or other as in the case of "doer-done to" relating.

Thomas Ogden's Concept of the Intersubjective Analytic Third

Ogden's intersubjective analytic third refers to the unconscious and situational co-mingling of subjectivities that happens in the psychotherapeutic encounter. It can be understood as the unique field of meaning that experience takes on as the two distinct subjectivities of patient and therapist engage with one another (Ogden, 1994/1999, 2004). In Ogden's (2004) words:

> The intersubjective analytic third, is the product of a unique dialectic generated by/between the separate subjectivities of analyst and analysand within the analytic setting. It is a subjectivity that seems to take on a life of

> its own in the interpersonal field, generated between analyst and analysand. (Ogden, 2004, p. 168)

Ogden's intersubjective analytic third can be seen as the meeting and interpenetrating of Benjamin's distinct subjectivities such that a new and unique intersubjective field shared by the two subjectivities is formed.

Ogden (1994/1999, 2004) conceptualizes the analytic third as largely unconscious and as coalescing "at the cusp of the past and the present, and involve[ing] a past that is being created anew (for both analyst and analysand)" (Ogden, 2004, p. 178). However, because the analytic third is experienced by therapist and patient through the context of his or her personal and social history and psychosomatic makeup, although created jointly, it is not experienced the same by each participant. According to Ogden (2004):

> The unconscious experience of the analysand is privileged in a specific way; i.e., it is the past and present experience of the analysand that is taken by the analytic pair as the principal (though not exclusive) subject of analytic discourse. The analyst's experience in and of the analytic third is (primarily) utilized as a vehicle for the understanding of the conscious and unconscious experience of the analysand. (p. 186)

Ogden's intersubjective analytic third ventures toward the nondual realm of experience in his assertion that a new entity coalesces from the interpenetration of patient and therapist subjectivities and that this intersubjective field is an atemporal domain in which the past can be created anew. However, his assertion that the analytic third begins with the meeting of two *separate* subjectivities and his suggestion that the conscious and unconscious experience of the patient can be

deciphered from the therapist's reveals ways in which duality remain present in his conceptualization of the analytic third.

Nonduality in Psychoanalytic Theory

Prior to the emergence of intersubjective theory, nondual and mystical experiences have, on occasion, been discussed in the psychoanalytic literature. However, like compassion, they have more often been relegated to the shadows. This too may be related to Freud's emphasis on the scientific and objective nature of the psychoanalytic endeavor as well as to his personal difficulty accessing universal states of oneness. Although Freud grappled with understanding spiritual feelings of eternal oneness, which he labeled "oceanic" feelings, he admitted that he could not experience or locate them within himself (Freud, 1930/1961). His window into this realm of experience came from friends and colleagues. For example, through a correspondence with the French poet Romain Rolland, Freud came to understand mystical or oceanic feelings as distinct from the unconscious, which he saw as extending infinitely inward. After reading Rolland's description of his spiritual experiences, Freud hypothesized that such oceanic feelings involve "a connection to the *external* world, a feeling of merger or oneness with all of creation, not a sense of the infinite depth of the unconscious" (Epstein, 2007, p. 167). However, perhaps because of his own inability to access and therefore to have a direct experience of states of oneness, Freud also equated oceanic feelings with the resurrection of "the bliss of primary narcissism, the unambivalent union of infant and mother" (Epstein, 2007, p. 164). In so doing, Freud wedded his thinking about nondual and mystical experiences to that which remains within the realm of the personal, narcissistically-oriented ego.

Unlike Freud, Jung was able to recognize not only the personal realm of experience, but also the non-personal realm of experience, which he articulated as the collective unconscious. Rather than an elusive state available only to some, Jung considered transpersonal phenomena, as embodied in the collective unconscious, to be an innate psychic substratum present in all humans. According to Jung, the collective unconscious consists of universal and pre-existent forms, or archetypes, which structure and influence the course of individual consciousness (Jung, 1929/1960; Williams, 1963). In his words,

> The existence of the collective unconscious means that individual consciousness is anything but a *tabula rasa* and is not immune to predetermining influences...The collective unconscious comprises in itself the psychic life of our ancestors right back to the earliest beginnings. It is the matrix of all conscious psychic occurrences, and hence it exerts an influence that compromises the freedom of consciousness in the highest degree, since it is continually striving to lead all conscious processes back into the old paths. (Jung, 1929/1960, p. 112)

Jung's collective unconscious can be considered a transcendental base of inherited potential human knowledge that unconsciously guides and influences the human individual.

There have been other individuals, even within the Freudian-lineage of psychoanalytic theory, who have spoken to the nondual and mystical realm of experience. For example, Loewald (1949/1980, 1977/1980,1988) suggested that humans have access to a nondual mode of being in which distinctions between self and other, internal and

external, past and present, fantasy and reality, dissolve. He maintained that the primal, undifferentiated mode of being at birth continues throughout life and that this affectively rich state gives meaning to life. Further, unlike Winnicott (1953/2005c), who conceptualized transitional phenomena as paradoxically both illusory and real (i.e., as a mode of experience between subjective omnipotence and objective reality), Loewald regarded undifferentiated (i.e., nondual) experience as equally "real" as differentiated experience. For Loewald, there is no illusion of the baby creating the mother; rather, on the nondual plane, mother and infant actually do co-create each other (Loewald, 1949/1980, 1977/1980,1988; Mitchell, 2000).

Bion (1965, 1970) offers another example of a psychoanalytic clinician and theorist whose writings evoke and discuss the mystical realm of experience. In particular, his later contributions explore spirituality, mysticism and metaphysics. Bion was fascinated with how we know what we know and postulated the existence of an inscrutable and ultimate reality or absolute truth (Bion, 1965, 1970; Grotstein, 1981, 2004). He initially symbolized this domain of the infinite as "O" and eventually as "God." Bion (1970) postulated that without the recognition of "O", "no psycho-analytic discovery is possible" (p. 30). He suggested that, "O" cannot be perceived through the external senses, but rather can only be experienced through intuition – through an inward sense that is unencumbered by memory, desire and knowledge. According to Bion (1970), the ineffable "O" "can be recognised and felt, but it cannot be known" (p. 30). In psychoanalysis, the containing function of the analyst serves to transform the intolerable aspects of absolute truth into emotional truth from which the analysand can learn and grow.

More recently, Blackstone (2006, 2007) has addressed the unified dimension of subjectivity (i.e., self/other unity) with her conceptualization of nondual realization. Blackstone extends Stolorow and colleagues' nondual, systems view of subjectivity into a transcendent and spiritual understanding. Drawing on Buddhist psychology, Blackstone maintains that the intersubjective or co-created relational field is not only a realm in which the individual self is an illusion, but also a domain of experience "in which one realizes one's own nature as all-pervasive space...as one with the object of experience" (Blackstone, 2006, p. 29). Blackstone (2007) refers to this aspect of intersubjectivity as nondual realization, asserting that this mode of awareness "appears spontaneously, as if a subtle dimension of our being has been unfolded or uncovered" (p. 35). It is a way of knowing or perceiving - that which is - directly, without our usual, conditioned ways of organizing experience. In Blackstone's (2006) words:

> As our habitual, created representations of ourselves and our environment dissolve, we discover our original, uncreated dimension of subjectivity. In this view, subjectivity is inextricably personal (the core of one's own being), and at the same time, it is the essential nature of the self/other field. (p. 31)

Blackstone's conceptualization of nondual realization bridges the paradox of deep contact with oneself with simultaneously being in full openness to one's environment. Nondual realization in the psychotherapeutic encounter involves the unmediated, direct experience of therapist-patient unity in the fabric of humanity and life itself. It is an encounter "beyond the narrative," an encounter with the shared internal depths of being (Blackstone, 2006, p. 34).

CHAPTER THREE: PSYCHOANALYTIC THEORY REGARDING EMPATHY

This chapter focuses on Kohut's and Winnicott's contributions to psychoanalytic theory regarding empathy. Both of these clinicians believed empathy is a subject-to-subject phenomenon and that it is an essential element of coming into being - of developing a coherent and authentic sense of self. In this chapter, I describe the core elements of each of their theories of development and treatment that address the nature and role of empathy in early life as well as in the psychotherapeutic context. The chapter concludes with a reflection on how their conceptualizations of empathy can be understood in light of dual and nondual phenomena.

Heinz Kohut (1913-1981)

Kohut made empathy a cornerstone of both his understanding of development as well as his approach to treatment and the therapeutic alliance. His theory, self psychology, maintains that empathic failures in childhood result in failures in the self-structuralization process and that a fragmented self leaves the individual with a sense of emptiness and a lack of vitality. Consistent with this, Kohut asserted that empathy, or an experience-near way of understanding patients, is critical to helping them resolve such deficits in the self. In terms of development, Kohut maintained that empathy or empathic attunement enables parents to recognize and to meet their children's selfobject needs, which he delineated as the need for mirroring, idealizing, and twinship (for more on selfobject needs, see Kohut, 1971). In the context of psychotherapy, Kohut maintained that empathy provides the data to accurately craft and communicate interpretations and creates a milieu that facilitates transferential feelings related to the patient's early unmet

selfobject needs (Bohart & Greenberg, 1997; Clark, 2007; Eagle & Wolitzky, 1997; Kohut, 1971, 1982, 1984; MacIsaac, 1997). As Bohart and Greenberg (1997) stated, when describing Kohut's approach to treatment,

> Empathic responsiveness in therapy created a corrective context in which particular types of transferential feelings toward the analyst related to empathic failures in the past could develop. In this context, occasional empathic failures on the part of the analyst provided the opportunity for clients to learn and to strengthen defects in their self-structures. (p. 10)

However, despite understanding and using empathy in this way, it was not until the end of Kohut's life that he acknowledged that empathy in psychotherapy is not only a means of gathering information about a patient's functioning and interior world, it is also beneficial in and of itself (Clark, 2007; Kahn & Rachman, 2000; Kohut, 1982, 1991).

In October 1981, Kohut gave his last public address before dying a few days later. In this address, he voiced the conceptual shift he made regarding the function of empathy, stating "despite all that I have said, empathy, per se, is a therapeutic action in the broadest sense, a beneficial action in the broadest sense of the word. That seems to contradict everything I have said so far... But...it is true" (Kohut, 1991, p. 530). Unfortunately, Kohut did not live long enough to fully explain what he meant by the "beneficial action" of empathy. Thus, although he ultimately described empathy as both an epistemological tool and as "a powerful emotional bond between people" (Kohut, 1982, p. 397), he is most known for elucidating and emphasizing the epistemological use of empathy in the process of crafting curative interpretations. Further, even at the end of his life, Kohut's primary motivation for engaging empathically remained obtaining information that can

be used to interpret or to explain the interplay of the patient's developmental history and present unconscious and conscious affective and behavioral experiences. This can be seen in the following statement Kohut (1991) made when discussing a section in his book *How Does Analysis Cure*?:

> I submit that the most important point that I made was that analysis cures by giving explanations – interventions on the level of interpretation; not by 'understanding,' not by repeating and confirming what the patient feels and says, that's only the first step; but then [one] has to move on and give an interpretation. (p. 532)

This statement was published posthumously and demonstrates Kohut's final perspective on empathy and therapeutic action.

Empathy as a Means of Understanding the Other

From 1959 until his final paper in 1982, Kohut almost exclusively referred to empathy as "a mode of observation attuned to the inner life of man" (Kohut, 1982, p. 396). He maintained that self-inquiry into one's own internal states when in relationship with another yields information about the other's conscious and unconscious experience. He frequently referred to empathy as a means of *vicarious introspection* – as the process, through self-examination or introspection into one's experience, that enables one to approximate the experience of the other (Bohart & Greenberg, 1997; Clark, 2007; Kohut, 1959, 1971, 1982, 1984; MacIsaac, 1997). In short, he asserted that empathy "is the capacity to think and feel oneself into the inner life of another person" (Kohut, 1984, p. 82).

Empathy, for Kohut, is not identification or being in the same shoes as the other. It is a process of intuiting the other's unique conscious and unconscious experience through cognitive and affective means. Kohut saw patient and therapist as two separate entities and he sensed the distinct others' internal subjectivity through a combination of listening to and reflecting upon what was expressed and what was felt vicariously. Kohut's empathic engagement seeks to grasp "the unconscious structure of experience that underlies the client's ways of being in the world" (Bohart & Greenberg, 1997, p. 7). This process involves a degree of scientific objectivity. As MacIsaac (1997) stated, it is "that which allows an individual to experience another's experience without losing one's ability to evaluate objectively another's mental states" (p. 248).

Kohut was also purposeful in distinguishing empathy from action. He maintained that empathy may include testing observations with a patient in order to fine-tune the understanding, however, it is not providing an emotional response to another's suffering. Rather, it is sustained immersion in another's inner life for the purpose of gathering interpretive data (Bohart & Greenberg, 1997; Clark, 2007; Kohut, 1959, 1971, 1982, 1984; MacIsaac, 1997). As MacIsaac (1997) stated when referencing many of the terms Kohut used to describe the process of empathy, it is a "slow and 'plodding,' 'trial and error,' 'long-term' process by which the...[analyst] 'tastes' to an attenuated degree the 'flavor' of the patient's experience while maintaining his or her objectivity" (p. 249). The purpose of the immersion in the other's inner life is understanding, not soothing or joining with the other. This was made clear in his 1982 paper, *Introspection, Empathy, and the Semi-Circle of Mental Health*, in which he stated,

> As an information-collection, data-gathering activity, empathy, as I have stressed many times since 1971, can be right or wrong, in the service of compassion or hostility, pursued slowly and ploddingly or 'intuitively', that is, at great speed. In this sense empathy is never by itself supportive or therapeutic. It is however, a necessary precondition to being successfully supportive and therapeutic. In other words, even if a mother's empathy is correct and accurate, even if her aims are affectionate, it is not her empathy that satisfies her child's selfobject needs. Her actions, her responses to the child will do this. In order, however, to achieve their end properly, these actions and responses have to be guided by correct and accurate empathy. Empathy is thus a precondition for a mother's appropriate functioning as the child's selfobject, it informs parental selfobject function vis-à-vis the child, but it is not, by itself, the selfobject function that is needed by the child. (Kohut, 1982, p. 397)

Consistent with this, Kohut (1984) very clearly maintained that empathy does not include care; it "is a value-neutral tool of observation which...can be used in the service of either compassionate, inimical, or dispassionate-neutral purposes" (pp. 174-175). Care and warmth for a patient, however, were present in Kohut's theory and therapeutic stance. He understood them as aspects of the selfobject functioning of mirroring, rather than as a component or requirement of empathy (Clark, 2007; Kohut, 1971, 1982; MacIsaac, 1997).

Empathy as a Two-Phase Process of Understanding and Explaining

In the clinical setting, Kohut described empathy as a two-step or two-phase process, which encompasses what he referred to as lower-level and higher-level empathy. He believed that:

> Only through an empathic immersion in the experience of a patient was it possible to acquire the in-depth psychological data needed...[while] it was [also] essential...to assume a perspective beyond an understanding level in order to be able to conceptualize what is empathically understood. (Clark, 2007, p. 131)

In other words, an initial experience-near level of observation and data collection needs to be followed by a more experience-distant or objective stance from which one can organize and make meaning of the data and communicate that understanding to the patient. Kohut delineated an understanding phase of treatment and an explaining phase of treatment (Clark, 2007; Kohut, 1971, 1982, 1991; MacIsaac, 1997). At times, he described these two modes of treatment such that the understanding phase involves empathy or vicarious introspection and the explaining phase involves an interpretive or objective process beyond or outside an empathic attitude. At other times, however, Kohut described the understanding phase and the explaining phase as two components of the empathic treatment process with each reflecting lower-level empathy or higher-level empathy, respectively. This can be seen in his statement:

> I believe that the move from understanding to explaining, from confirming that the analyst knows what the patient feels and thinks and imagines (that he's in tune with his inner life), and the next step of giving interpretations

> is a move from a lower form of empathy to a higher form of empathy. (Kohut, 1991, p. 532)

Although Kohut's understanding phase primarily relies on lower-level empathy, he saw the therapist as oscillating between lower-level empathy and higher-level empathy in order to deepen and clarify one's understanding of the patient for the ultimate purpose of explaining the meaning of that understanding to the patient. The explaining phase helps to shift the patient's archaic self-structure and the archaic bonding of the understanding phase to a more mature self-structure and a more complex form of bonding. With the higher-level empathy of the explaining phase, the analyst engages the patient in being more objective with regard to him or herself while continuing to accept him or herself. This results in a more self-reflective and flexible self-structure and a more nuanced and accepting empathic bond. As Kohut (1984) stated:

> The intensity of the archaic bond of an identity of inner experiences based on the analyst's ability to perceive the patient accurately and then to communicate what he perceives is lessened as the analyst moves from understanding to explaining. Yet, and this is the crucial point, while the archaic merger bond is lessened, an empathic bond on a more mature level of experience supplants what has been left behind...[T]he analyst provides the patient with the opportunity to become more objective about himself while continuing to accept himself, just as the analyst continues to accept him. (pp. 184-5)

Kohut's higher-level empathy, or explanations, relies on the understanding phase with its experience-near or lower-level empathy for accuracy. His approach to treatment and use

of empathy in the therapeutic stance moved back and forth between these modalities with each influencing the other.

Other-Based Perspective Taking

Kohut's empathic immersion with its understanding and explaining components involves focusing on what it is like to be the subject with a hermeneutics of trust in the patient's experience (Orange, 2011). Kohut (1984) spoke directly to this when he stated:

> I have learned...that what my patients tell me is likely to be true – that many times when I believed that I was right and my patients were wrong, it turned out...that *my* rightness was superficial whereas *their* rightness was profound. (pp. 93-94)

Kohut engaged in empathic immersion, intuiting and seeking to understand his patient's experience from within the patient's personal, social, cultural surround. He did not question the patient's experience or look at it as unanalyzed psychic phenomena (i.e., as a distortion that ultimately needed to be relinquished; Kahn & Rachman, 2000; Kohut, 1984; Kohut et al., 1996; MacIsaac, 1997; Orange, 2011).

As noted above, Kohut believed that the therapist must be able to access both the experience-near level of empathic attunement and a more expansive and evaluative level of cognitive engagement to facilitate comprehension and insight. During the latter, the therapist uses theory to organize the empathically gathered data. The understandings accumulated over time are reconstructed "to explain the meaning of the patient's experience as it relates to past experiences, to the intensity of inner forces, and to intrapsychic dynamics" (MacIsaac, 1997, p. 251). While both phases or modes include communication with the patient, the first, i.e., understanding, focuses on communicating

verbally and non-verbally an understanding of the patient's experience – including his or her feelings, defenses against those feelings, thoughts and the unique way the patient organizes his or her world. The second, i.e., explaining, relies on interpretations which transcend the patient's here-and-now experience and weave the patient's psychic experience into a framework, which ideally captures the fullness of the patient's deeply personal experience. The closer the conceptualization is to the patient's experience, the more accurate and effective the explanation and the greater the level of the empathy achieved. (Clark, 2007; Kohut, 1984; Kohut et al., 1996; MacIsaac, 1997).

A Kohutian therapist is committed to understanding the unique *otherness* of the patient. The therapist does not and is not merged with the patient. He or she is an attuned observer of the patient's experience. Kohut's empathic immersion involves "vicarious" experiences of the patient's internal world, which the therapist then reflects upon in order to more accurately understand the patient. Kohut was deeply concerned about the potential for empathy to be faulty and misguided by self-orientation and repeatedly tested and fine-tuned the aptness of his perceptions and formulations (Kohut, 1984; Kohut et al., 1996; Orange, 2011). Because of Kohut's deep abiding belief in the unknowability of reality, he emphasized the role of empathy in understanding and explaining. He focused on how empathy can be a means of plumbing the depths of another's unknowable reality and of providing a framework in which to conceptualize what has been sensed (Kohut, 1982).

Through the experience-near level of empathic attunement, Kohut's empathy includes feeling or resonating with the other's felt experience. Kohut alluded to both automatic, non-voluntary resonance and to purposeful perspective taking. This can be

seen in his statement that empathy can be "pursued slowly and ploddingly or 'intuitively', that is, at great speed" (Kohut, 1982, p. 397). As noted above, when explaining the process of vicarious introspection, Kohut (1984) stated "it is the capacity to *think* and *feel"* [emphasis added] oneself into the inner life of another person (p. 82). His use of the word feel and not just think reflects his understanding that empathy includes sharing another's mental states. The therapist's stance, however, is that of an observer of the patient and of him or herself. The therapist not only feels the other's internal states vicariously, he or she also reflects upon them in order to better understand the patient's personally situated experience.

Summary of Kohut's Conceptualization of Empathy

Kohut understood the core function of empathy as gathering data or knowledge that can be used to develop and communicate accurate, meaning other-based, interpretations and to ultimately facilitate the patient's increased self-comprehension. Seen in this way, empathy is "an experience-near level of participation, [which enables] an analyst or therapist...to acquire information that relates to the structure and functioning of the self" (Clark, 2007, p. 131). Kohut used empathy not only to sense the here-and–now experience that is available to the patient, but also to intuit the patient's unconscious or pre-conscious motivations and intentions. He then used knowledge about the personality, history, and social context of the individual, as well as psychological theory to organize and make meaning of the experience-near or empathically gathered data in formulating interpretations. He believed this two-phased process of empathically coming to be known and ultimately knowing oneself without distortion facilitates self-structuralization and with that a sense of vitality and aliveness.

Donald Woods Winnicott (1896-1971)

Winnicott's professional beginnings as a pediatrician informed his psychoanalytic writings and provided an important foundation for his innovative ideas about child development and the role of the mother or primary caregiver. In addition, in his early career as a psychoanalyst, Winnicott was analyzed by several Kleinian-influenced analysts and received supervision directly from Klein. As a result, aspects of his ideas were influenced by and resemble those of Klein. Winnicott, however, ultimately broke with traditional Kleinian and drive theory and offered an early relational perspective to development and psychotherapy (Jacobs, 1995; Mitchell & Black, 1995; Modell, 1985; Orange, 2011; Phillips, 1988). For Winnicott, our struggle is to both remain connected to others and to differentiate as individuals. The unit of study is not an individual clashing with external reality as Freud and Klein both maintained, but rather the empathic and interactional field within which the individual arises and seeks to make contact with and to articulate him or herself (Mitchell, 1988; Winnicott, 1960c1965a). As a result of this emphasis, Winnicott's extensive writings about child development, the mother-infant relationship[1] and the psychotherapeutic process provide another useful lens through which to think about empathy.

When describing the mother's role in development, Winnicott (1963/1965c) stated that the mother has "a special function, which is to continue to be herself, to be empathic towards her infant, to be there to receive the spontaneous gesture and to be

---

[1] While I recognize and honor the diversity of child-caregiver relationships, when referencing primary caregiver(s) and the parent-infant relationship, I will generally use the terms mother and mother-infant in order to be consistent with Winnicott's language.

pleased" (pp. 76-77). Welcoming the other's subjectivity in this way means inviting and relating to the other's full range of emotional experiences, regardless of whether they are pleasant or unpleasant to receive. According to Winnicott, it is in such an empathic milieu that we come into being. Furthermore, it is not only crucial to development; it is also the basis of psychotherapy. In his words:

> [The] glimpse of the baby's and child's seeing the self in the mother's face, and afterwards in a mirror, gives a way of looking at analysis and at the psychotherapeutic task. Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen. I like to think of my work this way, and to think that if I do this well enough the patient will find his or her own self, and will be able to exist and to feel real. (Winnicott, 1967/2005b, p. 158)

Winnicott sees the therapist, like the mother, as having the role of empathically intuiting and then giving back to the baby (patient) the baby's (patient's) own self as it is expressed in the shared relational field. He believed we only come into being - we only come to experience ourselves as real in a sufficiently empathic environment.

Winnicott asserted that we begin life with a primary developmental task of establishing and maintaining a stable sense of self (Jacobs, 1995; Mitchell & Black, 1995; Mitchell, 1988; Phillips, 1988; Winnicott, 1960/1965d). He believed our struggle is to remain connected to others while differentiating as individuals. In Winnicott's conceptualization of development, this process of coming into being as a distinct center

of experience takes place in a shared relational field (Mitchell, 1988; Winnicott, 1960/1965d). According to Winnicott, an authentic or true self emerges in the context of good-enough mothering (i.e., an empathic environment). A false self, however, develops in response to empathic failures, which result in the child shaping him or herself according to the mother's (i.e., caregiver's) needs (Mitchell, 1988; Winnicott, 1960/1965d, 1960/1965b).

The Development of Unit Status and the Capacity for Externality

Winnicott, like Klein, addressed the importance of the environment in early development and placed aggression and destructive impulses as pre-reactive to frustration. However, unlike like Klein, Winnicott maintained that there is an initial stage of absolute dependence and unintegration (Klein, 1940/1975b, 1952, 1957/1975a; Mitchell & Black, 1995; Winnicott, 1960/1965d). Winnicott asserted that, "*an infant cannot become an infant unless linked to maternal care*" (p. 43). He maintained that we begin life in absolute dependence in an unintegrated state of mother-infant unity and we only come into existence as a separate subjectivity within a sufficiently empathic milieu. In Winnicott's words:

> With 'the care that it receives from its mother' each infant is able to have a personal existence, and so begins to build up what might be called a continuity of being. On the basis of this continuity of being the inherited potential gradually develops into an individual infant. If maternal care is not good enough then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement. (1960/1965d, p. 54)

For Winnicott, subjectivity and with that a sense of oneself as real can only come into being in the context of good-enough (i.e., sufficiently empathic) mothering.

Winnicott envisioned the initial link to maternal care as a holding phase shared by the newborn and his or her primary caregiver. During this holding phase, the infant's reality is comprised of bits of experience (i.e., part-object and part-function experiences), which are characterized by primary process and primary narcissism. Winnicott, unlike Klein, made a distinction between the destructive impulses that exist during this early stage of unintegration and later aggression. While both agree that aggression exists internally and irrespective of frustration, Winnicott maintained that prior to personality integration destructive acts such as biting the breast are merely forms of activity and are not intentional acts of aggression (Klein, 1940/1975b, 1957/1975a, 1952; Mitchell & Black, 1995; Winnicott, 1947/1958b, 1950/1958a). Specifically, Winnicott stated,

> Prior to integration of the personality there is aggression...a baby chews the nipple with his gums; it cannot be assumed that he is meaning to destroy or to hurt. At origin, aggressiveness is almost synonymous with activity; it is a matter of part-function. It is these part-functions that are organized by the child gradually, as he becomes a person, into aggression. (Winnicott, 1950/1958a, p. 204)

Thus, Winnicott understood the young infant's destructive acts, which occur during the holding and unintegrated stage, to be part-object expressions, which lack the organization and intention of later forms of aggression.

The initial stage of infant unintegration as well as the ensuing gradual development to integration occur in conjunction with maternal preoccupation in which

the mother orients toward the infant and intuits and meets the infant's needs. According to Winnicott, half of the theory of the parent-infant relationship involves "the infant's journey from absolute dependence, through relative dependence, to independence" and the other half involves "the qualities and changes in the mother that meet the specific and developing needs of the infant towards whom she orientates" (Winnicott, 1960/1965d, p. 42). During this preverbal period, the good-enough mother uses empathy to attune to and respond to the baby's needs and internal experiences. As part of this, she tolerates the baby's part-object expressions of aggression and intuits the needs beneath them. According to Winnicott, babies in this stage experience subjective omnipotence, in which they operate under the illusion of being all-powerful, as if their wishes and desires create the world. Through the mother's attunement and preoccupation, she promptly meets the child's needs as they occur and in so doing she "brings the world" to the infant. Meanwhile, the newborn experiences the self and mother as discontinuous and indistinguishable sensations, which are gradually pieced together to become a coherent and cohesive self (i.e., an ongoing presence with unit-status) and the mother gains whole object status (Mitchell & Black, 1995; Winnicott, 1958/1956, 1960/1965d).

The achievement of unit-status involves three early processes of development, namely, (a) integration, (b) personalization, and (c) realization. During the first months to year of life, the infant relies on the mother's physical and emotional holding to organize the discontinuous bits of sensations he or she experiences. In effect, the good-enough mother uses her ego to hold the infant's psyche together. Gradually, as a result of the innate tendency to mature and develop, the infant achieves ego-integration as he or she

comes to have an inner world of experiences that he or she can organize free of the mother's ego-support. As this happens, the baby's psychic world transitions from a state of unintegration to a mode of being and experiencing in which object relating predominates (i.e., a state of being in which objects are experienced as more than part-functions, but remain projective and identificatory entities). The development of unit-status also involves personalization in which one comes to know that one's body is his or her own. The infant comes to have an inside and an outside, a "me" and a "not-me" and as such a personal or inner psychic reality which is contained within the body (Winnicott, 1945/1958d; 1950/1958a, 1956/1958c, 1960/1965d). Lastly, selfhood is not only coherent; it is continuous over space and time. This aspect of development involves the capacity for realization, which involves the ability to distinguish between fantasy and reality. Prior to realization, the infant is lost in unbounded and primary narcissism and fantasy where internal thoughts and feelings create external reality (Winnicott, 1945/1958d). As these capacities coalesce, the infant's destructive urges become more than activity and develop into expressions of intentional aggression - or destructive urges that are organized around establishing or securing oneself as a distinct unit and which are aimed at whole objects (Winnicott, 1947/1958b, 1950/1958a).

According to Winnicott, the process of becoming an individual, a person in one's own right, involves relinquishing subjective omnipotence. Embedded in this is the ability to experience an other as a separate subject (Benjamin, 1988, 1990/1999, 1995; Mitchell & Black, 1995; Winnicott, 1945/1958d, 1956/1958c, 1960/1965d, 1969). In Winnicott's model of optimal development, the mother gradually emerges from the state of primary maternal preoccupation in which her own subjectivity has been suspended. As her

wishes and personhood come into play, she is slower or less exacting in her attunement to the baby's needs. As a result, the infant slowly relinquishes subjective omnipotence and realizes that rather than creating the world, he or she is dependent on others, who like them also have a subjective self.

The Development of the Capacity for Concern

Winnicott (1963/1965c) asserted that gaining the capacity for concern requires the child not only to develop unit status and with that basic personality integration, but also to gain the capacity for ambivalence (i.e., love and dependence-seeking and intentional aggression directed toward one object). The anxiety linked with ambivalence involves the ability to retain a good object-imago along with the idea of destroying it. To advance from the capacity for ambivalence to the capacity for concern, a greater level of personality integration is needed. Winnicott maintained that concern involves the ability to feel care for the other's experience and to feel and accept responsibility for oneself and the other. In his words, "[concern] develops out of the simultaneous love-hate experience which implies the achievement of ambivalence, the enrichment and refinement of which leads to the emergence of concern" (Winnicott, 1963/1965c, p. 75). Achieving the capacity for concern was particularly important to Winnicott because he believed the ability to take responsibility that comes with concern is the root of creativity and aliveness.

The emergence of the capacity for concern happens concurrently with gaining access to object usage - an intersubjective mode of organizing experience that is distinct from the more primary intrapsychic mode of object relating. In other words, during the pre-concern stage of personality development the child relies on object relating in which

projection, identification and as such subjective omnipotence defines the other. As the child matures, if there is a facilitating environment (i.e., a good-enough empathic caregiver), the capacity for object usage (in which the other has his or her own independent subjectivity and self-agency) consolidates. Gaining the capacity for object usage happens concurrently with the recognition of externality. According to Winnicott, in order to love or have concern for another, externality must exist – the other must be experienced as a subject, a center of being, outside one's subjective, inner world (Benjamin 1988, 1990/1999, 1995; Mitchell & Black, 1995; Modell, 1985; Winnicott, 1969). In Winnicott's (1969) last presentation and now famous paper, *The Use of an Object*, he outlined the difference between object relating and object usage and how the child consolidates a true self with access to both a subjective and an intersubjective world (in Benjamin's [1990/1999] sense of the term). According to Winnicott, object relating involves the subject's use of projective mechanisms and identification processes that obscure the object's autonomous being. In contrast, object usage involves the subject relating to the object as if it is "real in the sense of being part of shared reality, not a bundle of projections...[but] a thing in itself" (Winnicott, 1969, p. 712).

The maturational process involved in the expansion of modes of experience to include object usage is complex and occurs in the realm of what Winnicott termed transitional phenomenon (i.e., an intermediary mode of experience between subjective omnipotence and objective reality). Transitional phenomena involve the paradox of creating something (i.e. an external reality) that already exists – as if discovering it creates it. For Winnicott, transitional space is an essential bridge between the intrapsychic world and outer reality and is the realm in which outer reality first takes form (Mitchell &

Black, 1995; Winnicott 1953/2005c, 1969). He asserted that when there is a facilitating (i.e., empathic) environment, the child's aggressive urges are directed at the object and in fantasy, or in the transitional realm, the child destroys the other (i.e., the subjectively defined other) and in this way places the surviving object beyond his or her subjective control. This makes possible a shared external reality in which the other is experienced as a distinct subjectivity – as an actual other one can sense and love. Thus, for Winnicott, when the other is able to survive the expressions and acts of object relating-based aggression (i.e., intentional aggression), the aggression facilitates the self as a distinct unit being able to make contact with the external world and the real other. (Benjamin, 1990/1999; Mitchell & Black, 1995; Modell, 1985; Winnicott, 1963/1965c, 1969). This is uniquely depicted in Winnicott's (1969) idiosyncratic words,

> The subject says to the object: 'I destroyed you', and the object is there to receive the communication. From now on the subject says: 'Hullo object!' 'I destroyed you.' 'I love you.' 'You have value for me because of your survival of my destruction of you.' 'While I am loving you I am all the time destroying you in (unconscious) *fantasy*.' Here fantasy begins for the individual. The subject can now *use* the object that has survived. It is important to note that it is not only that the subject destroys the object because the object is placed outside the area of omnipotent control. It is equally significant to state this the other way round and to say that it is the destruction of the object that places the object outside the area of the subject's omnipotent control. (p. 713)

Winnicott considered this transition one of the most difficult challenges in human development and a common early developmental failure. The difficulty lies in the object, which is to say the mother (or later, the therapist), surviving the attacks on her subjectivity or personhood without retaliating or withdrawing (Benjamin 1988, 1990/1999; 1995; Mitchell & Black, 1995; Modell, 1985; Winnicott, 1969). In these moments, the mother's or the therapist's ability to remain empathic, meaning attuned to the internal experience and needs of the child or patient makes survival possible.

Winnicott's Therapeutic Stance

As a therapist, Winnicott sought to provide a holding environment, not unlike the maternal holding environment, in which the patient can experience his or her spontaneous gestures and desires as real and meaningful to another. Winnicott, believed health, and therefore treatment, involves achieving a balance between subjective omnipotence and objective reality (Mitchell & Black, 1995; Winnicott, 1971/2005a). In addition, "it is a firm and solid sense of the durability of the other that makes a full and intense connection with one's own passions possible" (Mitchell & Black, 1995, p. 129). Therefore, the therapist, like the mother, must modulate his or her impingements upon the patient's mind, while surviving the throes of the patient's projections and fantasies, and as such remain empathically attuned and responsive (Mitchell & Black, 1995; Winnicott, 1969).

While the idea of the therapist providing a facilitating environment may not be revelatory today, at the time Winnicott was practicing and writing, it was a dramatic shift in the therapist's stance from that of the prevailing approaches to treatment. In particular, his analytic stance and interventions were dramatically different from those of Freud and Klein both of whom emphasized the necessity for neutrality, abstinence and interpretation

of unconscious material (Alford, 2007; Klein, 1957/1975a; Mitchell & Black, 1995; Modell, 1985). Instead, Winnicott used empathy to sense his patients' internal worlds and to reflect it back to them. He also used empathy to guide his responsiveness to his patients' needs. Winnicott offered himself to his patients to use in whatever way they needed to receive the developmental requirements missed in childhood. He believed the analyst needs to patiently provide the particular and necessary regressive features, whether they be joining the patient in unintegrated states, accepting the patient's need for omnipotence, providing an experience in which the patient can be alone with another, attuning and responding to the patient's inner experience or surviving destructive urges in the transference (Mitchell & Black, 1995; Modell, 1985; Winnicott, 1960/1965d, 1967/2005b, 1969). In Mitchell and Black's (1995) words, "content and interpretations, were nearly irrelevant in Winnicott's account; what was crucial was experience of the self in relation to the other" (p. 134).

Summary of Winnicott's Conceptualization of Empathy

Winnicott's empathic mother and therapist remain in contact with their own subjectivity while sensing and welcoming contact with the child's or patient's actual or emergent subjectivity. It is within such an empathic – i.e., attuned and responsive milieu that one's subjectivity coalesces. According to Winnicott, having one's internal experience, one's essence of being, sensed and reflected back creates the continuity of being that is the basis of feeling real as an individual. An empathic presence begins with recognizing the other as a separate or external other while being acutely interested in and welcoming of the other's subjectivity. It is within such an environment that the capacities for care and object usage also develop. When the mother or therapist can

empathically intuit the child's or patient's need to destroy the projection of the other to find his or her own and the other's realness as a separate subjectivity, the mother and therapist are able to survive and the child or patient is able to recognize and care for the other. Winnicott's conceptualization of the capacities for externality and for care developing conjointly, when in the context of an attuned and responsive environment, demonstrate his understanding of empathy as a caring process of intuiting and reflecting the distinct other. Within psychotherapy, Winnicott's empathy involves receiving, relating to, and reflecting back the patient's emotions and spontaneous gestures, as well as withstanding the patient's destructive urges without losing contact with both the patient's and one's own subjectivity.

Kohut's and Winnicott's Theorizing on Empathy Relative to Dual and Nondual Phenomena

Kohut and Winnicott both understood empathy as a dual phenomenon, as a subject-to-subject process. This can be seen in Kohut's emphasis on the therapist remaining objective, not merging or identifying with the other, and his recognition of the other as a uniquely situated other. Each of these elements locates Kohut's conceptualization of empathy in the dual plane of reality in which self and other can be objectively distinguished. Winnicott's understanding and linking of externality, the capacity for concern and a good-enough maternal environment also places empathy in the dual plane of reality. According to Winnicott, we need a distinct other to sense and to reflect back our being and for that same other to survive our explorations and even attacks on the boundary between ourselves and the other to develop the capacity to feel our own realness and to sense or intuit the realness of the other. These processes begin

with empathy – intuiting and responding to the other with care and concern – and end with mutual empathy in which two distinct centers of being are able to sense the other's unique experience. Thus, both Kohut and Winnicott are in alignment with Husserl (1977) and Stein (1989) in recognizing empathy as a mode of consciousness through which we experience the mindedness of the distinct or external other while maintaining our own mind. This aspect of empathy enables therapists to learn about a patient's experience not only when it matches his or her own perspective, but also when it reflects a different or foreign internal and/or socio-cultural paradigm.

There is an important difference, however, between Kohut's and Winnicott's conceptualization of empathy. Unlike Kohut, Winnicott clearly saw care for the distinct other and his or her affective experience as a component of empathy. Winnicott described care or love for the other, recognition of externality and empathy as co-occurring and intermingling phenomena. In contrast, Kohut viewed empathy as dispassionate or uncaring and believed it can be used to know the other for benevolent or malevolent purposes. Kohut's empathy when combined with the self-object function of mirroring is akin to Winnicott's empathy. However, when empathy is not linked with mirroring, it can be used in the service of the malignant side of duality for cruel or sociopathic motivations. In this context, unlike Benjamin's (1990/1999, 1995, 2004) doer-done-to dynamics in which relating slips into subject-to-object relating and Winnicott's object relating (as opposed to object usage), Kohut's dispassionate empathy seems to reflect the epitome of *othering* in which subject seeks to dominate subject. In contrast, Winnicott's explication of empathy as a caring process between two centers of being does not address

or provide a way of thinking about the use of intuiting the separate other for malevolent purposes.

Despite these differences, Kohut and Winnicott also understood empathy as an essential ingredient in the structuralization of a distinct or dual self. They both maintained that an autonomous and authentic subjectivity requires a sufficiently empathic milieu to develop. The repeated experience of having oneself reflected in the face and words of the other confirms and creates our realness. It is through repeated empathic exchanges that we come into being. However, given the interpenetrating nature of dual and nondual reality, in Winnicott's lexicon, empathy creates that which is already there to be created. This interpenetrating complexity of dual and nondual reality can also be seen in Kohut's theorizing. He understood that the self develops through being known (i.e., empathically sensed and understood) by another. Yet for that to be possible, the self must already exist in order to be knowable. Thus, both Kohut's and Winnicott's empathy can be understood as a dual phenomenon that operates at the intersection of dual and nondual reality.

CHAPTER FOUR: COMPASSION IN BUDDHIST PSYCHOLOGY

This chapter begins with an overview of early Buddhist, Theravada, and Mahayana teachings on compassion and highlights the similarities and differences between the teachings in each lineage. The following section goes into more detail about compassion in Buddhist philosophy and draws on teachings from multiple Buddhist traditions. I discuss the essential link in Buddhism between compassion and wisdom - or insight into the nature of suffering. I describe the Buddha's core teachings, as encapsulated in the Four Noble Truths and how they form the foundation for compassionate action. This section also discusses the practice of mindfulness and its role in deepening insight into both our nondual nature and how the habits of mind cause suffering. From here, the chapter takes up the concept of Buddha nature or brilliant sanity as the innate basis from which compassion springs. Buddhism teaches that our essential being is benevolent and interconnected. When we cultivate compassion, we do not learn a new skill, rather, we remove the obstacles to our openheartedness that is already there. In fact, Buddhism teaches that there are four innate states of openheartedness of which compassion is only one. These states are called the four immeasurables and are loving-kindness, compassion, sympathetic joy and equanimity. Each attitude is described and taken together they provide insight into the Buddhist understanding of compassion (Dalai Lama, 2001, 2003; Kyabgon, 2001; Makransky, 2012; Salzberg, 2002; Trungpa, 1969, 2003, 2005, 2013; Wallace 2004).

The last section in the chapter highlights Buddhist teachings on cultivating compassion. According to Analayo (2015), the cultivation of compassion "should ideally proceed from the opening of the heart that is genuinely receptive to the pain and suffering

of others, to the positive mental condition of being filled with the wish for others to be free from affliction and suffering" (p. 7). Buddhism provides pragmatic teachings on developing insight into nonduality, into our interconnectedness, and on strengthening our receptivity and tolerance for pain and suffering. As these building blocks of compassion become more accessible, Buddhism maintains that the courage to go toward the suffering nondual other and the openhearted wish for freedom from suffering emerge spontaneously (Analayo 2015; Dalai Lama, 2001, 2003; Salzberg, 2002; Trungpa, 2003, 2005, 2013; Wallace, 2004).

Early Buddhist, Theravada, and Mahayana Teachings on Compassion

The Buddha is purported to be the first known person to explicitly elaborate on the concept of compassion (Siegel & Germer, 2012; Williams & Lynn, 2010). He asserted that compassion is part of the remedy to human suffering and in particular, the suffering that results from failing to accept one's moment-to-moment experience. In the centuries since the Buddha lived and articulated the first Buddhist teachings,[2] Buddhism has developed several lineages, including Theravada and Mahayana, as it has taken root and been adopted in various countries. As a result, the teachings on compassion have slight variations in emphasis depending on which tradition one consults (Kyabgon, 2001; Makransky, 2012; Siegel & Germer, 2012).

---

[2] The exact details of the Buddha's birth are unknown, however he is believed to have been born in an area that is now part of Nepal, sometime between 563BC and 623BC, and to have lived for approximately 80 years (Gilbert & Choden, 2014).

Early Buddhist Teachings on Compassion

In the oldest Buddhist discourses, similes are used to describe compassion rather than providing a clear definition. The similes, however, collectively suggest that:

> An essential component of compassion is the concern for others to be relieved from suffering and affliction...[A] subtle but important point to be noted here is that the simile[s do]...not qualify the act of seeing the actual suffering as compassion. Rather, compassion is concerned with the other being free from affliction. (Analayo, 2015, p. 6)

Compassion, according to early Buddhist philosophy, does not dwell on suffering itself. The focus is on the relief from suffering. Therefore, although compassion involves a felt recognition of suffering, its predominant affective experience is one of benevolence and warmth (Analayo, 2015; Dalai Lama, 2001, 2003; Ricard, 2015; Trungpa, 2003, 2013). In this way compassion is similar to loving-kindness; however, it is not the same thing as loving-kindness. According to the Dalai Lama (2003), loving-kindness is a "state of mind which aspires that all sentient beings may enjoy happiness," whereas compassion is "the wish that all sentient beings may be free from suffering" (p. 67).

Given this understanding of compassion, it is important to understand the Buddhist view of suffering – or that which compassion seeks to alleviate. Buddhism asserts that change, uncertainty and impermanence are intrinsic to our physical existence and that it is attempts to deny or avoid these realities that creates an ongoing sense of discontentment (Chodron, 1997, 2001, 2012; Kornfield, 2009; Trungpa, 2005). In Chodron's (2012) words:

> We keep trying to get away from the fundamental ambiguity of being human, and we can't. We can't escape it any more than we can escape change, any more than we can escape death. The cause of our suffering is our reaction to the reality of no escape. (Chodron, 2012, p. 13)

The answer to our predicament is to accept and to be present with the full range of feelings and sensations we experience in our ever-changing world. In other words, according to Buddhist psychology, suffering is rooted in attachment to and avoidance of certain experiences. Rather than accepting whatever we are experiencing, we cling to desirable feelings and experiences and seek to avoid unpleasant feelings or experiences. This endless pursuit causes suffering. From this perspective, pain and discomfort as well as pleasure and ease are temporary states. (Chodron, 1997, 2001, 2012; Dalai Lama, 2001; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1969, 2003, 2005, 2013).

As an extension of accepting the ever-changing nature of existence, Buddhism also maintains that there is no stable, discrete and permanent self that is distinct from others and from our environment. Our separate or what is referred to as our ego-based self is an illusion and our repeated attempts to secure the illusion, which is to say to avoid the anxiety inherent in our ever-changing interconnectedness, lead to suffering. Further, existence is not only impermanent and interconnected, it is also insubstantial. As Wegela (2014), who teaches and writes about the intersection of Buddhism and psychotherapy from a Tibetan Buddhist perspective, states, "phenomena do not exist in a substantial way. Instead, they are the result of the coming together and falling apart of causes and conditions" (p. 14). In other words, our sense of solidity is also an illusion. There is no fixed self, no enduring, separate or substantial essence to be found and our attempts to

deny the interdependent, interconnected and transient nature of all phenomena lead to suffering. (Chodron, 1997, 2001, 2012; Dalai Lama, 2001, 2003; Darnall, 2008; Kornfield, 2009; Kyabgon, 2001, 2007; Loy, 2003; Trungpa, 1969, 2003, 2005, 2013; Wegela, 2009, 2014).

These basic principles regarding the nature of compassion and suffering underlie all Buddhist teachings. Each lineage, however, has emphasized different elements and developed different ways of cultivating compassion. The next two sub-sections highlight the differences between Theravada and Mahayana Buddhism.

Compassion in Theravada Buddhism

Theravada Buddhism, which developed in Southeast Asia and, which systematized the early discourses taught by the Buddha, maintains the foregoing understanding of compassion, however, it also adds to it. In Theravada Buddhism, compassion is inextricably linked to wisdom or insight into the human condition – into the internal causes of suffering (Kyabgon, 2001; Makransky, 2012). In fact, wisdom or insight into the nature of suffering, "rather than compassion per se, is upheld as the core liberating principle of the Theravada path" (Makransky, 2012, p. 67). According to these teachings, there are three levels or forms of suffering. The first is overt pain as in the typical forms of physical and mental pain we experience in life. The second two levels of suffering are related to the denial of impermanence and interconnectedness. These forms are the suffering of transience or the misery we feel from futile attempts to maintain pleasurable experiences and to avoid unpleasant experiences in a reality that is ever-changing, and the suffering of self-centered conditioning or clinging to an illusion of our unchanging, separate, and solid self in a stable and secure world (Gilbert & Choden,

2014; Kyabgon, 2001; Loy, 2003; Makransky, 2012; Trungpa, 2003, 2013; Wang, 2005). The Buddha's compassion wished all beings, regardless of their current condition, freedom from all forms of suffering. As Makransky (2012) stated:

> The Buddha's compassion, in wishing persons to be free from suffering, focused on *all three* levels, the last two of which are present even when obvious suffering are not. For this reason, the Buddha's compassion extended to all beings equally. It is this impartial, unconditional, and all-inclusive compassion that the Buddha imparted to his followers. (pp. 62-63)

Theravada Buddhism's emphasis on wisdom into impermanence, interconnectedness and the universality of suffering, highlights that Buddhist compassion naturally wishes for all beings to be released from suffering, whether or not they are obviously suffering in any given moment.

Compassion in Mahayana Buddhism

Mahayana Buddhism emerged as Buddhism spread to places such as Tibet, China and Japan during the first century BCE. In this tradition, compassion is given greater centrality than in Theravada Buddhism (Kyabgon, 2001; Makransky, 2012). Rather than emphasizing wisdom as a path to individual enlightenment, Mahayana Buddhism upholds compassion and freedom from suffering for all beings as the ultimate realization. This is based on the Mahayana understanding of wisdom, which focuses on our impermanent and interconnected nature as in Theraveda Buddhism, but also emphasizes the insubstantiality of life – the interdependent nature of existence. As a result of this emphasis, the Mahayana Buddhist path seeks relief from suffering for all sentient beings,

not just enlightenment for the individual. Mahayana Buddhism maintains that all-inclusive compassion is the automatic response to deep insight into the causes and nature of suffering. Therefore, wisdom and compassion are cultivated simultaneously with each strengthening and giving rise to the other (Dalai Lama 2001, 2003; Makransky, 2012; Siegel & Germer, 2012; Trungpa, 1969, 2003, 2005, 2013). This interpenetration of wisdom and compassion in Mahayana Buddhism is rooted in understanding the impermanence, interconnectedness and insubstantiality of all phenomena. In Makransky's (2012) words:

> The wisdom taught in Mahayana traditions open us to others in compassionate intimacy not only through insight into their condition but also through recognition of the ultimately undivided nature of all that exists. According to Mahayana teachings, not only are phenomena found to be impermanent and beyond reification into "me" and "mine" (as in Theravada), but upon further investigation, no independently existent phenomenon of any kind, impermanent or otherwise, is even findable. (p. 68)

Mahayana Buddhism teaches that not only do we suffer from clinging to the illusion of stable experiences or things, but we suffer even more fundamentally by our tendency to view the world through a dualistic lens in which there are independent phenomena onto which ideas of permanence can even be ascribed. Therefore, compassion in the Mahayana Buddhist sense goes beyond benevolently responding to the other or oneself, to embracing the indivisibility of all experience and all beings (Dalai Lama, 2001, 2003; Kyabgon, 2001; Makransky, 2012; Trungpa, 1969, 2003, 2005, 2013).

A Compilation of Buddhist Teachings on Compassion

The following material is drawn from both Theravada and Mahayana lineages and reflects a compilation of Buddhist teachings. Given the accumulation of Buddhist texts written over the centuries since the Buddha lived, it is beyond the scope of this dissertation to provide an exhaustive description of all Buddhist teachings on compassion. In the process of selecting which teachings to include, I have emphasized those of Tibetan Buddhism, the lineage with which I am most familiar. I have also chosen to highlight those teachings which best explicate the aspects of compassion that are distinct from empathy and which support an understanding of compassion as a nondual phenomenon.

Compassion and Wisdom

Contrary to many Western notions of compassion, compassionate action from a Buddhist perspective is not always pleasant. As Analayo (2015) stated, "the Buddha [acting from compassion] will at times say what is not pleasing to others" if it is truthful and beneficial. "Motivated by the wish to help others emerge from the conditions that cause their unhappiness, such compassion has the courage to do what is temporarily unpleasant" (p. 9). The boldness of the Buddha's compassion is informed and supported by wisdom. It is said that compassion without wisdom into the nature of suffering is oft misguided. In order to actually help relieve suffering, one must understand its source. It is for this reason that compassion in Buddhism is inextricably linked to wisdom or insight into the nature of suffering. Buddhism also teaches that mindfulness is the foundation for wisdom and compassion. It is through impartial moment-to-moment awareness that we gain insight into the transient, interdependent nature of existence and that suffering

results from grasping at or trying to avoid particular experiences or states of mind (Chodron, 1997, 2001, 2006, 2012; Dalai Lama, 2001, 2003; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1969, 2003, 2005, 2013).

The Four Noble Truths.

The *Dharma* or the Buddha's wisdom into the nature of suffering is described as the Four Noble Truths. The Four Noble Truths, which represent the earliest teachings of the Buddha, are the core of Buddhist psychology. These teachings address the ubiquity of suffering despite what is believed to be our Buddha nature or innate goodness and natural open-heartedness. They emphasize working with one's own suffering and one's own mind. The Four Noble Truths follow the Indian medical tradition that was common during the Buddha's lifetime, in that they state the problem, the etiology, the prognosis and the treatment plan. In short, they are:

1. The truth of suffering,
2. The origin of suffering,
3. The cessation of suffering, and
4. The path or way out of suffering (Kornfield, 2009; Kyabgon, 2001; Trungpa, 1973, 2013; Wegela, 2009, 2014).

According to the First Noble Truth, *duhkha*, or what has been translated into English as suffering, is an unavoidable part of life. The Sanskrit term *duhkha*, however, has a particular connotation to it, which is not completely captured by the word suffering. According to Trungpa (2013), *duhkha* refers to the "physical and psychological suffering of all kinds, including the subtle but all pervading frustration experienced with regard to the impermanence and insubstantiality of all things" (p. 472). In other words, *duhkha*

includes all forms of pain or discomfort that are inherent in our physical and impermanent existence, including the ephemeral nature of pleasure and the reality of death, as well as the uncertainty and insecurity that is intrinsic to our existence. The First Noble Truth states that the direct experience of pain and dissatisfaction are a given of life. Even when we attain happiness and the absence of pain, it is fleeting and therefore even with happiness, comes dissatisfaction. The First Noble Truth speaks to the unavoidable pain and the inevitable dissatisfaction that is part of the human condition (Epstein, 2007; 2013; Kornfield, 2009, Kyabgon, 2001, 2007; Trungpa, 1973, 2013; Wegela, 2009, 2014).

The Second Noble Truth addresses the origins of suffering. It maintains that suffering is the result of mistakenly clinging to and trying to protect a sense of permanence, separateness and solidity (Epstein, 2007; Kornfield, 2009; Kyabgon, 2001; Trungpa, 1973, 2013; Wegela, 2009, 2014). According to Buddhism, "when we start to examine ourselves and see how we respond to situations, how we act in the world, how we feel about things, then we...realize that the cause of suffering is within" (Kyabgon, 2007, p. 5). Although there is certainly pain and dissatisfaction from external socio-political and economic situations, Buddhism teaches that the main source of suffering is how our mind responds to these situations as well as to our perceptions, thoughts, and feelings. According to Buddhist teachings, phenomena including emotions, sensations, thoughts, and our sense of self are impermanent and the result of interpenetrating causes and conditions. In addition, this fluidity of reality is a source of *duhkha* or *dis-ease*. In other words, it brings with it a sense of groundlessness or a feeling that reality, as we know it in any given moment, is uncertain and unstable. The Second Noble Truth asserts

that groundlessness itself is not the problem, but that the problem (i.e., the suffering that is avoidable) comes from trying to evade or deny groundlessness or the impermanent, interconnected, and insubstantial nature of existence. We suffer because we repeatedly seek to maintain a fixed sense of self and of the world around us rather than recognizing that life is an ever-changing flow of experience, be it comfortable or uncomfortable (Chodron, 1997, 2001, 2006, 2012; Epstein, 2007, 2013; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1969, 1973, 2003, 2005, 2013; Wegela, 2009, 2014).

The Second Noble Truth can also be understood within the Buddhist principle of *anatta*, which is often translated as the "no-self" teachings. According to this tenet of Buddhism, the ego-based self, which we experience as stable, separate, and solid is an illusion. The premise does not deny a relative- and relational-self that helps us function in the dual (i.e., relative) realm of reality; instead, it highlights our tendency to concretize the fluidity of absolute (i.e., nondual) reality and our inclination to focus on personal desires and discomforts. According to the *anatta* teachings, we suffer by constantly trying to secure our illusive ego-based selves (Epstein, 2007, Kyabgon, 2001, 2007; Loy, 2003). The Second Noble Truth asserts that human suffering is embedded in the conditioned illusion of our skin-encapsulated, discrete and isolated selves (i.e., our ego-selves). This view of the human condition assumes our profound interconnectedness. It understands our experience of ourselves as separate and as defined by the soma as an illusion. Moreover, all solidity of existence is understood to be an illusion. We suffer as a result of our tendency to seek constant confirmation and reassurance that we are distinct and stable entities and that the phenomenal world around us is fixed and substantial. (Chodron, 1997, 2001, 2006, 2012; Epstein, 2007, 2013; Kornfield, 2009; Kyabgon, 2001, 2007;

Trungpa, 1969,1973, 2003, 2005, 2013; Wegela, 2009, 2014). According to Buddhist teachings, this faulty response to groundlessness and egolessness takes three forms: passion, aggression and ignorance, and are known as the "three poisons." As Wegela (2009) stated, "passion refers to hanging on to whatever supports ego; aggression is rejecting whatever threatens it; and ignorance is simply not noticing anything that neither supports nor threatens ego" (p. 19). Taken together, the three poisons constitute the causes of suffering that blind us to our true nature.

The Third Noble Truth asserts that the cessation of suffering is possible. "Instead of being lost in the confusion, and sometimes intense distress, of suffering, we can recognize our true nature" (Wegela, 2014, p. 15). The premise of the Third Noble Truth is that we can see through the illusion of ego and rest in the openness, clarity, and compassion of our true openhearted nature (Trungpa, 1973, 2013; Wegela, 2009, 2014). In Buddhist terms, we can awaken to our Buddha nature or brilliant sanity. This state of being still involves pain and unpleasant experiences, but lacks the "habitual habits of clinging to a nonexistent ego" (Wegela, 2009, p. 29). It is free from the three poisons - passion, aggression, and ignorance. When we can achieve this state, happiness is no longer based on a particular set of thoughts, feelings, and sensations. Instead, there is a sense of peace and tranquility even when faced with unwanted or uncomfortable circumstances.

The Fourth Noble Truth is the path to awakening or recognizing our brilliant sanity. It is sometimes referred to as the eightfold path; however, Tibetan traditions generally simplify it to the three main aspects of the path: discipline, meditation, and wisdom. According to these teachings, through the practice of discipline, or what is also

referred to as moral sensitivity, we are able to see through and overcome our egocentric and ego-clinging tendencies and as such become more compassionate toward ourselves and others. Through the practice of meditation, our mind becomes more focused and more aware, which together are believed to give rise to wisdom (Epstein, 2007, 2013; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1969, 1973, 2013; Wegela, 2009, 2014). "The essential quality of the path is bringing mindfulness and awareness to all aspects of our lives: actions of body, expressions of speech, and arisings of mind" (Wegela, 2009, p. 30). Mindfulness, in this context, refers to paying attention to the details of one's here-and-now or present experience without clinging to it, rejecting it, or judging it. Awareness, in this context, refers to noticing the background or wholeness of the moment, in addition to the details of perceptions, thoughts, feelings or sensations. The Fourth Noble Truth involves "attending to the details of what occurs in the present moment (mindfulness), but it also pays attention to the larger picture of how the present moment is born from previous moments and what implications are already indicated for the future (awareness)" (Wegela, 2014, p. 18). It emphasizes the cultivation of both mindfulness and awareness because a focused mind is needed to observe what is and a wise or insightful mind is needed to recognize the interdependent nature of phenomena. Further, the Fourth Noble Truth maintains that ending suffering is a gradual process - a path one follows (Epstein, 2007, 2013; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1973, 2013; Wegela, 2009, 2014). In other words, "it takes time to undo the habit of mind that clings to a mistaken sense of self and phenomena as well as the habit of trying to escape from unavoidable discomfort" (Wegela, 2014, p. 16).

Mindfulness as a foundation for wisdom and compassion.

The practice of mindfulness is an initial and important step in the process of relieving suffering – one's own and another's. It is more than focused attention; it is the repeated and gentle process of bringing positive feelings of acceptance, warmth and friendliness to whatever is experienced. Buddhism teaches this moment-to-moment awareness or mindfulness (i.e., paying attention to experiences, thoughts and feelings without discursive judgment) to recognize the ever-changing and interdependent nature of existence, as well as to become familiar with how the mind perpetuates suffering by seeking comfort, certainty or ground in a groundless existence. (Chodron, 1997, 2001, 2012, 2013; Dalai Lama, 2001, 2003; Darnall, 2008; Grossman, 2013; Trungpa, 1969, 1973, 2003, 2005, 2013; Wegela, 2009, 2014). According to the Dharma:

> When we have the ability to abide peaceably in the midst of our own suffering, we see that everyone else also suffers, and we spontaneously feel like helping others, much as the right hand assists the left hand when it's injured. (Siegel & Germer, 2012, p. 33)

Mindfulness develops the capacity to tolerate what is - be it pleasant or unpleasant, which in turn yields wisdom into the nature of suffering and the interconnectedness of all existence. With this insight, compassion arises automatically. Once we are in touch with the universality of suffering and our fundamental unity with all beings, we instinctively want to alleviate suffering – mine, yours and ours because they are fundamentally related and indistinguishable. Hence, true compassion, or compassion that is based on wisdom, is a nondual state of benevolence that embodies the wish for all sentient beings to be free

from suffering. (Chodron, 2001; Dalai Lama, 2001, 2003; Fischer, 2012; Kyabgon, 2007; Loy, 2003; Trungpa, 2003, 2005, 2013; Wegela, 2009).

Compassion as a Component of Buddha Nature or Brilliant Sanity

Western thought has been deeply influenced by the Augustinian (5th century A.D.) doctrine of original sin, which holds that everyone is born sinful. From this perspective, the eating of the forbidden fruit in the Garden of Eden was not only the first human sin, it was an act that made sinfulness innate to all humans. In the words of historian Boyce (2015), "the articulation of original sin and the making of the Western world were enmeshed" (p. 3). As the Roman Empire splintered, the Western worldview became dominated by the premise "that human beings were born sinners, subject to the wrath of God not only because of *what they did, but who they were"* (p. 4). Today, themes of shame and guilt are deeply present in the Western experience and perspective. In contract, the East has been influenced by Buddhism, which offers a paradigm free from the concept of sin and its related sequelae. It teaches that human beings are fundamentally good (Trungpa, 2005, 2008; Wegela, 2009, 2014). "According to the Buddhist perspective, there are problems, but they are temporary and superficial defilements that cover over one's basic goodness" (Trungpa, 2008, p. X). That which is deemed sin or evil in the Western worldview is understood as debasements and distortions of our fundamentally pure, interconnected and unconditional nature- our Buddha Nature. Evil in Buddhist thinking is not only the cause of suffering, it is a form and expression of suffering. A mind free from evil, free from defilements, is open and spacious; it is loving and compassionate. Thus, despite abundant evidence of hate and cruelty in the dual, mundane plane of reality, Buddhism maintains that in the nondual,

noble plane of reality our innate nature is pure. Non-compassionate actions and thoughts, even those that are hostile and violent, are the result of afflictions of the mind. They are not rooted in our basic nature, which even if expressed in misguided ways, seeks wellbeing and happiness (Dalai Lama, 2001; Trungpa, 2005, 2008; Wallace, 2004).

Trungpa (2005, 2008) used the term *brilliant sanity* to capture the essence of Buddha Nature or the concept that we each have a reservoir of goodness within us. "We do not have to be injected with something or receive something from outside as a gift...because we already have what it takes to go where we want to go" (Kyabgon, 2001, p. 88). As a result, enlightened or enlightening moments happen in everyday life as well as in meditation. One of the difficulties, however, in describing these moments and thus explaining the concept of brilliant sanity, is the ineffable nature of these experiences. They are often fleeting and do not lend themselves to words. As Wegela (2014) stated, moments in which we are in contact with our brilliant sanity are moments in which we are in contact with "the nondual, unconditioned mind that all of us have or are" (Wegela, 2014, p. 6). As such, brilliant sanity may arise during moments of pain or joy. However, a telltale sign of its presence is a feeling of aliveness (Kyabgon, 2001; Trungpa, 2005, 2008; Wegela, 2014).

Brilliant sanity has three main qualities: openness, clarity and compassion. The first, openness, is also referred to as spaciousness and it connotes what Buddhist philosophy refers to as emptiness. Rather than a void filled with nothingness, emptiness in Buddhism can be understood as the limitless potential of the mind. Like a vast empty pot, the emptiness of the mind holds the space to accommodate any and all experiences. Emptiness also refers to the spaciousness that opens when the lack of solidity or the

insubstantiality of phenomena is realized (Analayo, 2015; Dalai Lama, 2001, 2003; Epstein, 2007; Kornfield, 2009; Townsend & Kaklauskas, 2008; Trungpa, 1969, 2003, 2005, 2013; Wegela, 2009, 2014). This aspect of brilliant sanity is commonly compared to the sky. For example, Wegela (2014) stated when describing the openness quality of brilliant sanity:

> All kinds of things may appear in the sky, but the sky itself is unchanged: airplanes, birds, bees, clouds, tornadoes...None of these actually change the sky, the background of space in which they appear. The sky passes no judgment on them. In the same way, we can feel all of our feelings, think all of our thoughts, perceive all of our perceptions, and none of these experiences affects or changes the underlying space of the mind. (p. 7)

When we are in touch with our brilliant sanity, we are able to receive experiences - be they thoughts, emotions, images, perceptions or sensations without judging or rejecting them and without collapsing around them as fixed and stable entities.

The second aspect of brilliant sanity, clarity, refers to "the quality of mind that does not flinch but instead simply sees, hears, smells, tastes, touches, and 'minds' all aspects of our experience without distortion" (Wegela, 2009, p. 44). It is sometimes referred to as awareness or mindfulness and includes the capacity to observe the mind itself. This facet of brilliant sanity refers to our capacity to be aware without distortion of our thoughts, emotions, images, perceptions and sensations. Frequently, the openness and clarity of brilliant sanity are described as being inseparable (Trungpa, 2005, 2008; Wegela, 2009, 2014). "The vast openness of mind is imbued with awareness itself" (Wegela, 2009, p. 44).

The third aspect of brilliant sanity, compassion, is said to emerge out of the first two (i.e., openness and clarity). When we are able to be open to all experience and have the clarity or wisdom to be aware of all experience without distortion, compassion is automatically present. The compassion of brilliant sanity is nondualistic. It lacks a sense of "I" am being compassionate or caring toward an outside other (Chodron, 2001; Fischer, 2012; Kyabgon, 2007; Trungpa, 2005, 2013; Wegela, 2009, 2014). In describing this aspect of compassion when it arises in the context of psychotherapy, Wegela (2009) stated:

> To the extent that I have a sense of myself as separate from my client [or any being] and a sense of my compassion somehow going from me to him in a dualistic way, this is not a glimpse of brilliant sanity...A true experience of brilliant sanity would not contain the self-consciousness of ego. (p. 46)

Thus, compassion that stems from our brilliant sanity is unconditional, receptive to all experience and nondual (Evans, Shenpen, & Townsend, 2008; Kyabgon, 2001; Trungpa, 2005, 2008; 2013; Wegela, 2009, 2014).

Compassion as One of the Four Immeasurables

Within Buddhism, compassion is understood and cultivated as the second of the four immeasurable attitudes, which are loving-kindness, compassion, sympathetic joy, and equanimity. The four immeasurables are also referred to as the four limitless ones and are states of boundless openness or awakened heart. They are qualities of being that are beyond habitual self-interest and are believed

to be innate, even if often unavailable to us because of our frequent clinging to a dualistic, ego-based sense of self.

In Buddhist teachings, each internal stance is described as a distinct attitude, yet each is informed and supported by the other three attitudes. The attitude of loving-kindness involves recognizing and relating to all beings, including oneself, as precious and worthy of deep acceptance. Compassion involves the wish for all beings to be released from suffering. Sympathetic joy, which emerges naturally from loving-kindness and compassion involves feeling joy at others' good fortune and lastly, equanimity, refers to both maintaining a friendly and welcoming attitude toward all experiences be they pleasant or unpleasant, and sensing one's unity with all beings (Kyabgon, 2001; Makransky, 2012; Salzberg, 2002; Trungpa, 2013; Wallace 2004). Each of the four immeasurables is taught and cultivated both independently and together. Ultimately, however, they are understood as inseparable and as interpenetrating. As a result, fully grasping the Buddhist notion of any one of the four immeasurables requires an understanding of each of the other attitudes. Thus, an exploration of Buddhist teachings on compassion also requires a discussion of loving-kindness, sympathetic joy, and equanimity.

Loving-kindness.

The term loving-kindness is a frequent translation of the Sanskrit word *maitri* and the Pali word *metta*. Both Sanskrit and Pali, however, have another word for love. The root of the words *maitri* and *metta* is more literally translated as friendliness. Thus, loving-kindness as opposed to love itself, is an attempt to capture a quality of mind

characterized by unconditional friendliness. The heart-quality that underlies loving-kindness is goodwill and benevolence; it is not attachment nor care-giving responsibility. When loving-kindness is directed toward the self and other sentient beings, its friendliness takes the form of wishing for the person(s) on whom you are focusing to have happiness and ongoing access to that which brings happiness. Its benevolence is unconditional; it does not discriminate that some deserve happiness while others do not. Regardless of action or deed, loving-kindness embraces all beings as deserving of happiness. By happiness, the Buddhist teachings mean deep wellbeing and ease, not pleasure or other fleeting states, nor the gratification of acts of ego-clinging or aggression that cannot bring lasting happiness. Loving-kindness is the profound desire to promote deep and lasting wellbeing for oneself and for all beings.

The Buddha taught loving-kindness as an antidote to hate and ill will (Dalai Lama, 2001, 2003; Salzberg, 2002; Trungpa 2003, 2005, 2013; Wallace, 2004). He asserted that "it is not possible to practice loving-kindness and feel anger simultaneously" (Buddhaghosa, 2010, p. 313), In verse 5 of the Dhammapada, the Buddha is translated as having said:

> Hatreds do not cease through hatreds
>
> Anywhere at anytime.
>
> Through love alone do they cease:
>
> This is an eternal law. (as cited in Bogoda, 1994, p. 20)

According to the Buddha, when we are absorbed in loving-kindness all forms of aggression and hate fall away and it is only through such benevolence, such inclusivity,

that hate and any such expressions of suffering can be healed. From the limitless attitude of lovingkindness, all are worthy and welcome.

In addition to the wish for all beings to be happy, loving-kindness can also be felt and directed more broadly. Trungpa (2005) described this aspect of loving-kindness as directing unconditional friendliness and acceptance toward all experience. Here too, loving-kindness is unconditional and does not discriminate between those experiences that are welcome and those that are not. (Chodron, 2006; Trungpa, 2005; Wallace, 2004; Wegela, 2009). At this level, loving-kindness can be understood as the willingness and the ability to embrace all of life, including a full range of experiences, be they pleasurable and desirable or painful and unwanted. It is devoid of grasping and avoiding; it is welcoming of all that is. In this way, loving-kindness is also an antidote to fear. If there is nothing to which we cling and nothing we seek to avoid, there is nothing to fear. Salzberg (2002) uses the following anecdote about a student of hers who had been a child in Nazi-occupied Europe to demonstrate this aspect of loving-kindness:

> She [the student] recounted an instance when she was around ten years old...[and] a German soldier held a gun to her chest...She related feeling no fear at all, thinking, "You may be able to kill my body, but you can't kill me." (p. 43)

Salzberg goes on to say, "It is in this way that lovingkindness opens the vastness of mind in us, which is ultimately our greatest protection" (p. 43).

Buddhism maintains that all beings have access to this spaciousness of mind and that all beings seek happiness and want to be free from suffering. As part of this, Buddhism also asserts that our universal and deepest nature is to want happiness for all,

because in our deepest being we know our interconnectedness. Cultivating loving-kindness, therefore, is not learning something new, it is uncovering that which is already innately available to us. Unfortunately, our natural open-heartedness gets obscured by such things as ego-clinging, hatred and fear. When we are consumed by these states of mind, we lose access to our inherent loving-kindness and need to practice removing these obstacles for it to come forth. (Chodron, 2001, 2006; Fischer, 2012; Kyabgon, 2007; Salzberg, 2002; Trungpa, 2005, 2013).

Compassion.

The term compassion is a translation of the Sanskrit word *karuna* and refers to the wish for all beings to be free from suffering. According to Mahayana Buddhism, this desire is innate. This natural yearning for our own and others' suffering to abate is referred to as *bodhichitta*. Literally, *bodhichitta* means "awakened heart / mind" (Trungpa, 2013, p. 470). In Sanskrit, the word *bodhi* means "wide awake" or enlightened and the word *chitta* means both heart and mind. Taken together, *bodhichitta* is a fully open heart and mind. In Chodron's (2013) words:

> *Bodhichitta* communicates a mind that never limits itself with prejudices or biases or dogmatic views that are polarized against someone else's opinions...the word *chitta* means "heart" and "mind"; it means both things simultaneously...So you could say that *bodhichitta* is awakened heart-mind...or completely open heart-mind...[It is] becoming a completely loving person. (pp. 171-172)

In Buddhism, there are two forms of *bodhichitta*: absolute *bodhichitta* and relative *bodhichitta*. Absolute refers to "the way things actually are" and relative refers to "how

they appear or how we experience them" in everyday life (Wegela, 2009). The absolute domain is nondual and nonconceptual; it goes beyond the limitations of language. It can however be recognized when felt. It is those moments when the separation between self and other fall away. In Wegela's (2009) words:

> Bohdhichitta, or natural compassion...[is] experienced as an expansive nondual wisdom. In moments of experiencing this absolute bodhichitta, a person is able to perceive that compassion doesn't have to belong to anyone; it is not limited by the confines of ego or any ideas of separation between self and other. (p. 5)

Absolute *bodhichitta* recognizes that dual constructions like self and other are illusive habits of mind. As a result, true or absolute compassion is as much self-compassion as it is compassion for another (Fischer, 2012; Trungpa, 2013; Wegela, 2009).

In addition, when we can access absolute *bodhichitta,* we not only feel the unity of self and other, we also perceive the true insubstantial or empty nature of all phenomena. Here the concept of emptiness refers to the fact that all experience cannot be captured by our mental constructions of them. All experience is interdependent and part of an unending flow, not discrete happenings as we often perceive them to be. Buddhism does not take a nihilistic stance (i.e., that things do not exist at all); it maintains that things, while not solid and permanent, are dependent on an infinite series of conditions. Experience and phenomena come together and manifest and fall apart and dissolve in an ongoing flow of life. Within this nondual plane of realty, the unending flow of life is not only interdependent, it is multidirectional. In other words, in this context, time is not linear - past, present and future interpenetrate. Thus, the Buddha can be thought of as

both a wise person who lived in the past from whom we can learn, as well as a highly evolved visitor from the future here to help guide us. Similarly, absolute *bodhichitta* is both something to which we aspire and which is already inherently present within us (Analayo, 2015; Fischer, 2012; Trungpa, 2013; Wegela, 2009). As Fischer (2012) stated, "absolute *bodhichitta* is the empty, perfect, expansive, joyful, spacious nature of existence itself"; it is the fundamental basis of all compassion (p. 14).

Relative *bodhichitta* refers to the "the aspiration to wake up so that we can benefit all beings" (Wegela, 2009, p. 5). Essentially, relative *bodhichitta* is the desire to have access to absolute *bodhichitta* in which there is wisdom into the true nature of life and unending love and compassion for all. However, before absolute *bodhichitta* can be fully realized and the universality of all life can be kept in mind, relative *bodhichitta* means being loving and compassionate to messy mortals with all of their defilements and painful forms of suffering. In Trungpa's (2013) words, relative *bodhichitta* "is the common practice of involving yourself in the world with benevolence, fearlessness and kindness" (p. 5). It means dauntlessly accepting, even welcoming, painful and unpleasant experiences. It also means seeing through aggression, hate, and cruelty to the suffering that underlies such thoughts and actions. Therefore, relative *bodhichitta* as with absolute *bodhichitta* is unconditional, however, relative *bodhichitta* can only be extended as far as one can tolerate pain, his or her own as well as others. This capacity to stay present with pain defines the limits of compassion. Genuine compassion means feeling pain and suffering personally. As Fischer (2012) stated, "it is impossible to be truly compassionate, to receive another's pain, if you are unable to receive your own" (p. 33).

In addition to accepting pain, compassion also includes clarity into the nature of suffering and the courage needed to confront the true causes of suffering. As Wegela (2009) stated:

> Genuine compassion is not especially cozy. If we are truly interested in helping another to go beyond suffering, we first must be willing to be present with and acknowledge that suffering. Then we must have enough courage to go beyond what has been called "idiot compassion." Idiot compassion is the well-intentioned but ineffectual kindness that does not help others cut through their confusion but instead supports the habitual patterns [of avoiding what is] and ego-clinging that perpetuates their suffering. (pp. 80-81).

In addition, compassion is not only courageous and bold, it is also noble and dignified. It is built upon loving-kindness and with that it brings a gentleness toward all who suffer. In Trungpa's (1973) words, "compassion contains fundamental fearlessness, fearlessness without hesitation. This fearlessness is marked by tremendous generosity...[It] is completely open and welcoming. It is a generosity which excludes no one" (Trungpa, 1973, p. 208). Compassion also does not get bogged down with sorrow. While it may include fleeting feelings of sadness, it is not weighted by disempowering grief. True compassion has the vastness and deep acceptance of absolute *bodhichitta,* of loving-kindness. It is thus able to bring respect and dignity toward all who suffer while simultaneously bringing an ability to "act nobly in order to help others help themselves" (Trungpa, 2013, p. 74).

The Buddhist notion of compassion, unlike pity, which includes an aspect of separation and superiority, presupposes our interconnectedness and views all as worthy regardless of deed or position in life. Given the Buddha's insight into nonduality, compassion as a limitless attitude does not divide the sufferer from the observer. Suffering is recognized as a truth that affects all beings; it is embedded in the nature of life. Compassion also does not discriminate in its wish for freedom from suffering. Even those who commit egregious acts of cruelty are regarded as worthy of compassion. It is understood that acts of aggression towards oneself and others is a conditioned response, an expression of suffering itself. The Buddha is said to have described compassion as "a trembling of the heart in the face of another's pain" (Smith, 2002, p. 207). The heart trembles because it knows the pain; it recognizes the universality of it. The suffering other is understood as a fellow manifestation of the unified whole; he or she is not distinct or separate.

Sympathetic joy.

The concept of sympathetic joy (also sometimes referred to as *empathetic joy*) is a translation of the Sanskrit word *mudita*. It refers to unselfish joy or "rejoicing in the well-being of others" (Wegela, 2009, p. 89). It is an expansive feeling of delight that reflects the open-heartedness and wisdom of nonduality that is inherent in absolute *bodhichitta*. As with the limitless attitude of compassion, in which it is understood that suffering is universal and belongs to all beings, so too is it with wellbeing. Therefore, when we open to this reality, it is automatic to feel joy at another's wellbeing or happiness. It is a natural extension of loving-kindness and compassion. In Trungpa's (2013) words, "with maitri or loving-kindness we begin to like ourselves. With karuna, or compassion, we begin to like

others. Then, because we like both ourselves and others, we experience celebration or [sympathetic] joy" (p. 76).

Jealousy and envy are the opposite of sympathetic joy. When we want what someone else has or want them not to have some good fortune rather than celebrating their fortune, we are unable to recognize the emptiness and unity of life. When these craving-based feelings surface, they reflect a deluded and defiled state of mind. Cultivating sympathetic joy in these moments, enables us to make contact with our brilliant sanity and with that the wisdom and compassion of nonduality (Trungpa, 2005, 2013; Wallace, 2004; Wegela 2009).

Equanimity.

The word equanimity is a translation of the Sanskrit word *upeksha*. A deep understanding of equanimity reveals two facets of what is meant by *upeksha*. The first is more consistent with the typical understanding of the word equanimity as it is used in English, however, this usage does not really capture the subtly of what is meant by *upeksha*. Rather than *upeksha* meaning simply even-mindedness or calmness, the true quality of *upeksha* or equanimity is bringing an attitude of benevolence to all experiences and all states of mind. It is rooted in mindfulness and means welcoming and engaging fully with whatever is present without aversion or clinging. The second facet of *upeksha* or what is meant by equanimity is sublime unity. When all experiences are embraced equally, all boundaries fall away, as do the distinctions between self and other (Buddhaghosa, 2010; Dalai Lama, 2001, 2003; Hopkins, 2001; Trungpa, 2005, 2013; Wallace, 2004; Wegela 2009).

The first element of equanimity is reflected in Rumi, the 13th-century Persian poet's poem titled *The Guest House:*

This being human is a guest house.
Every morning a new arrival.
A joy, a depression, a meanness,
some momentary awareness comes
As an unexpected visitor.
Welcome and entertain them all!
Even if they're a crowd of sorrows,
who violently sweep your house
empty of its furniture,
still treat each guest honorably.
He may be clearing you out
for some new delight.
The dark thought, the shame, the malice,
meet them at the door laughing,
and invite them in.
Be grateful for whoever comes,
because each has been sent
as a guide from beyond.
(Rumi, 1995, p. 109)

Rumi captures the essence of equanimity - of being gracious and welcoming to whatever presents itself. When we inhabit an attitude of equanimity, the guest house of our being is

unconditionally open. Equanimity is not indifference or disengagement. Rather, it supports us in turning towards, in engaging fully with what is present (Buddhaghosa, 2010; Dalai Lama, 2001, 2003; Hopkins, 2001; Rumi, 1995; Trungpa, 2005, 2013; Wallace, 2004; Wegela, 2009).

The second facet of equanimity involves recognizing our commonality with all beings. The Dalai Lama is noted for repeatedly saying "Everyone wants happiness and doesn't want suffering." This is universal. No matter how misguided one is in his or her attempts to attain happiness and avoid suffering, the core yearning is the same. In Hopkins' (2001) words:

> Understanding that others are so much like oneself creates a different perspective, a startlingly changed worldview. When this view is internalized, you are no longer confronting another person over a divide, but meeting someone with whom you have much in common. (pp. 32-33)

Just as equanimity welcomes all experience, it recognizes the absolute *bodhichitta* in all beings regardless of their deeds or thoughts. Even our so-called "enemies" want to be happy and do not want to suffer. The wisdom of equanimity supports us in extending loving-kindness, compassion and sympathetic joy to all beings equally, not only to those near and dear to us, but universally - to all who suffer. Further, as the divide between oneself and the other evaporates, our interdependence becomes evident. With equanimity, we are able to recognize that our own wellbeing and the other's wellbeing are interwoven and inextricably linked. Therefore, when we embody the other immeasurable attitudes along with equanimity, they are equally directed to the other as to ourselves, because

fundamentally, self and other are undivided (Buddhaghosa, 2010; Dalai Lama, 2001, 2003; Hopkins, 2001; Trungpa, 2005, 2013; Wallace, 2004; Wegela, 2009).

These two facets of equanimity are reflected in Buddhaghosa's (2010) statement that the function of equanimity "is to see equality in beings...[and it] is manifested as the quieting of resentment and approval" (p. 312). Relinquishing resistance and attachment to the present moment enables one to embrace all experience and all life equally. In this way, equanimity is the antidote to greed, which is rooted in wanting certain experiences and not wanting other experiences. It is also the antidote to the near enemies of the other immeasurable attitudes. Recognizing the equality of all beings prevents loving-kindness from degrading into a form of attachment in which the longing for happiness is restricted to only oneself and the few deemed worthy. It prevents compassion from slipping into pity or sorrow in which the other is seen as distinct or in which an unpleasant experience is resisted. It prevents sympathetic joy from becoming an ungrounded form of excitement or individual pleasure. In short, the peacefulness or even-mindedness of equanimity makes one receptive, and once fully receptive (i.e., without resistance or approval), the unity of all is understood and embraced (Buddhaghosa, 2010; Dalai Lama, 2001, 2003; Hopkins, 2001; 1995; Trungpa, 2005, 2013; Wallace, 2004; Wegela, 2009).

Buddhist Teachings on Cultivating Compassion

After the Buddha's awakening, "the form his compassion took from then onwards was teaching the Dharma" (Analayo, 2015, p. 10). In this way, compassion is inextricably linked to the Four Noble Truths, which form the basis of the Dharma. According to Buddhism, liberation or freedom from suffering is the result of wisdom and compassion, which work together as two wings of the same bird. Therefore, cultivating compassion

includes developing insight into the Four Noble Truths, into the nature of suffering. It also includes opening one's heart or accessing one's innate brilliant sanity. When these two elements are embodied together, absolute *bodhichitta* is realized and expressed as boundless compassion that radiates toward all life forms (Analayo, 2015; Dalai Lama, 2001, 2003; Kyabgon, 2001; Trungpa, 1969, 2003, 2005, 2013; Wallace 2004).

Shantideva, an Indian Mahayana Buddhist teacher from the 8th-century provided the teaching on "exchanging self for other" as a means of cultivating both wisdom and the openheartedness of compassion. Shantideva teaches that self and other are constructed illusions.

> [He] argues, like *this bank and the other bank* of a river…[n]either side of a river is intrinsically an 'other bank'…Similarly, it is a cognitive error to think of other beings as intrinsically 'other.' For all are self from their own perspectives. (Makransky, 2012, p. 71)

All beings are the same in wanting happiness and freedom from suffering. Given this understanding of self and other, the practice of exchanging self for other involves reversing the associated feeling we usually have toward self and other. To do this, the self is thought of as a neutral other and the other is thought of with the feelings we generally reserve for ourselves (or others dear to us). Through the practice, one is able to gain insight into emptiness and the suffering that results from clinging to ourselves. One is able to feel greater compassion for others as all beings are recognized as like ourselves (Chodron, 2001, 2002, 2012; Fischer, 2012; Kyabgon, 2007; Makransky, 2012; Trungpa, 2013).

In Tibet, the practice of exchanging self for other has taken the form of meditation referred to as *tonglen* or sending and receiving. This practice is a component of *lojong* or mind training, which was formulated in Tibet in the twelfth century as a means of cultivating compassion (for more on *lojong* see Chodron, 2001; Fischer, 2012; Kyabgon, 2007; Trungpa, 2013). In *tonglen*, using the inhalation and the exhalation of the breath, "we take others' sufferings into the empty ground of our being while freely offering others all of our own virtue, well-being, and resources" (Makransky, 2012, p. 71). This practice develops the willingness and the capacity to "feel another's pain as one's own (Fischer, 2012, p. 32). Paradoxically, *tonglen* can also be practiced for oneself. While inhaling one's own pain is taken in and felt deeply and while exhaling, feelings of ease and wellbeing are sent or offered to oneself. Given wisdom into the unity of self and other, the practice of *tonglen,* regardless of to whom it is directed, builds the capacity to feel the fullness of suffering and the courage and benevolence to go toward it. In Fischer's (2012) words:

> The practice of sending and receiving has two main purposes: first to train your heart to do what it usually does not want to do: to go toward, rather than away from, what's painful and difficult in your own life; and second, to realize that your own suffering and the suffering of others are not different. When you discover this is so, you see that when you are willing to really take in your own suffering, you find within that very suffering, the suffering of others; and the reverse is also true: when you are able to truly take in the suffering of another, you find within it your own human pain. (p. 34)

Tonglen involves opening one's heart, being genuinely receptive to pain and suffering, and it yields wisdom into the unity of life, into our fundamental kinship with all beings (Chodron, 2001, 2002; Fischer, 2012; Kyabgon, 2007; Makransky, 2012; Trungpa, 2013; Wegela, 2009).

Tonglen begins with receiving, through the inhale breath, the raw feelings of pain and suffering, taking the unwanted emotion with all of its realness into one's body. Then, on the exhalation, sending out one's most personal experiences of ease, wellbeing and relief. In Chodron's (2002) words:

> As unwanted feelings and emotions arise, you actually breathe them in and connect with what all humans feel…By the same token, if you feel some sense of delight – if you connect with what for you is inspiring, opening, relieving, relaxing – you breathe it out, you give it away, you send it out. (pp. 36-37)

In order to do this without clenching, one must be connected to absolute *bodhichitta*, to the vastness of open heart/mind. Paradoxically, the practice simultaneously opens the heart/mind. Feeling the vividness, the indescribable depths of pain and suffering is only possible through the tenderness and spaciousness of absolute *bodhichitta,* and giving away our own wellbeing – that to which we normally cling, softens the heart and brings us into contact with absolute *bodhichitta* (Chodron, 2001, 2002; Fischer, 2012; Kyabgon, 2007; Trungpa, 2013; Wegela, 2009). Inhaling and exhaling in this way dissolves the boundary between self and other; it reverses "the logic of ego" and the "logic of suffering" (Chodron, 2001, p. 38).

This makes *tonglen* both a practice of cultivating compassion and an expression of compassion. Through the breath and the body itself, suffering is embraced and through that very embrace, it is transformed and diminished. When the body is recognized as a guest house of absolute *bodhichitta*, it has great capacity for compassion. "It has the capacity to breathe in suffering and transform it into healing" (Fischer, 2012, p. 36). In this way, *tonglen* is a doorway to recognizing our nondual nature and a means of bringing the compassion of absolute *bodhichitta* to the relative world of suffering.

In addition to *tonglen*, there are numerous forms of meditation that support the cultivation of compassion. For example, *metta* is a form of meditation that focuses on developing access to loving-kindness. The practice generally consists of silently wishing that oneself and others be happy and free from suffering. The practice gradually expands from directing benevolence to oneself and one's loved ones, to directing it to those toward whom we have neutral feelings and ultimately to those we experience as difficult or even as so-called "enemies." When we can genuinely direct loving-kindness toward all beings, we realize the nonduality between self and others. In this way, the practice of *metta* helps to open the heart, which naturally gives rise to compassion (Salzberg, 2002; Trungpa, 2013; Wegela, 2009). Similarly, other mediations and practices (e.g., meditations on sympathetic joy and equanimity and the contemplation of *koans*) serve to develop access to nonduality and to our innate *bodhichitta.*

CHAPTER FIVE: EMPATHY AND COMPASSION IN THE THERAPEUTIC STANCE

Psychotherapy seeks to reduce the emotional experience of suffering. The suffering experienced by patients is often related to impingements in the relative (i.e., dual) plane of reality that are related to personal survival and the expression and realization of one's subjectivity, and/or to impingements in the absolute (i.e., nondual) realm of reality that involve difficulties accessing states of universal oneness. At the level of relative reality, failures and difficulties in coming into being and relating as a subject who can recognize the subjectivity of the other underlies many patients' distress and unhappiness. In addition, at the absolute level of reality, many patients suffer from the alienation and aloneness that infiltrates and taints experience with hollowness when there is limited or no access to the spiritual realm of unity and oneness. As a result, psychotherapy needs to address both dual and nondual phenomena, or relative and absolute reality (Siegel & Germer, 2012; Townsend & Kaklauskas, 2008). At the dual level of relative reality, therapists need to engage with their own and their patients' natural human vulnerabilities including longings for security, sexual and aggressive urges, feelings of fear, anger, shame, etc. At the nondual level of absolute reality, therapists need to be present with and accept the impermanence, insubstantiality, and interconnectedness of life. They need to recognize the interdependence of all phenomena and embrace all experiences, whether they are pleasant or unpleasant. In other words, the landscape of human life includes valleys and mountains and when a therapist is able to see the view from both vantage points, he or she is better equipped to help patients heal

and grow as authentic and unique individuals who are simultaneously interconnected and indivisible facets of the whole.

Empathy and compassion in the therapeutic stance provides a means of moving between the valleys and mountains of human experience. When engaging in the dual phenomenon of empathy, the therapist is able to resonate with and intuit the patient's personal and situated experience. Like the view from the valley, the perspective offered by empathy is up close and fine-tuned. It is an encounter between two subjectivities, in which the therapist uses his or her care and capacity for externality to sense and discern the textures of the dual other – to come to know the distinct other. In and through such empathic encounters, our subjectivity coalesces and we are able to feel real and to recognize and engage with the realness of the other. Despite the aliveness and capacity for self-activation this engenders, it is based in the valley and lacks the larger sense of the whole that is gained from the vista on the mountaintop. Therapy without the highest of meta-positions, no matter how helpful in self-realization, does not assuage the alienation of disconnection. The deepest levels of this form of suffering can only be softened in nondual states. When a therapist is able to embody nondual compassion, he or she addresses this form of suffering. He or she brings equanimity and benevolence to all experiences and embraces the nondual, suffering other. This form of presence has insight into the nature of suffering and is unending and unconditional in its embrace. It touches our deeper selves and brings us into contact with our humanity and our unity with all life. Given the inseparability of valleys and mountains, the therapeutic task is best served when it engages at both levels, when it is characterized by both empathy and compassion.

A balance of empathy and compassion also better enables a therapist to respond to the inevitable enactments that surface between therapist and patient. When the therapist has access to empathy and compassion he or she is less vulnerable to negating the other as well as to resisting the full range of human experience. On the one hand, empathy can break the spell of an enactment in which therapist and patient are caught in subject-to-object relating or doer-done-to relating. It can enable the therapist to shift out of the adversarial perspective, which fails to see the fullness of the other's - or his or her own subjectivity. On the other hand, compassion can release the grip of aggression that can befall the therapist when he or she resists or clings to certain experiences. It can bring the courage and spaciousness to be with whatever is present with the benevolent wish for the amelioration of suffering. The therapeutic stance without access to both empathy and compassion relegates the therapist to either the dual or the nondual plane of reality and this is not only limiting, it is dangerous. Systems that operate exclusively on either the premise of duality or the premise of nonduality open the door to marginalization and alienation – to denying the subjectivity of the other and to negating our ineffable unity.

These themes are taken up in the following sections. First, I discuss and offer an integration of Kohut and Winnicott's contributions to understanding empathy as a subject-to-subject phenomenon, which serves as the medium in which the authentic and unique individual comes into being. I then offer an integration of elements of Buddhist philosophy that support an understanding of compassion as a nondual and as such impartial, unconditional, and all-inclusive, way of feeling and relating to suffering, which involves both understanding the nature and causes of suffering and benevolently or lovingly wishing for or aiding in the relief from suffering. In this process, I discuss the

role nondual compassion plays in assuaging feelings of aloneness and disconnection and in cultivating access to oceanic feelings of unity and oneness. I then address empathy and compassion in the context of enactments. I describe the relational psychoanalytic understanding of enactments as a form of subject-to-object relating and empathy's role in resolving such enactments. Following this, I present a new formulation of enactments. Drawing on the Buddhist understanding of aggression, I describe a nondual form of enactment and postulate compassion's role in resolving such enactments. The chapter concludes with a discussion of the risks of a therapeutic stance with access to either empathy or compassion alone and not the balance of these dual and nondual phenomena.

Empathy and Compassion in the Context of Therapeutic Action

Empathy and compassion in the therapeutic exchange facilitates distinct elements of therapeutic action or patient healing and growth. A therapeutic environment that embodies both empathy and compassion supports patients in developing a life capable of bridging dual and nondual realms of being and experiencing. As Kohut (1971, 1982, 1984) and Winnicott (1963/1965a, 1963/1965c, 1967/2005b, 1969) both suggest, empathy is an essential ingredient in the structuralization of a distinct or dual self. The repeated experience of having oneself reflected in the face and words of the other confirms and creates our realness. At the same time, as Buddhist psychology suggests, the dual self is illusive and attempts to secure such a self result in suffering (Chodron, , 1997, 2001, 2006, 2012; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1969,1973, 2003, 2005, 2013). Nondual compassion in the therapeutic stance softens the isolation of duality. It offers patients the wisdom of nonduality and the comfort of being a part of an

ever-changing and interconnected whole. When both empathy and compassion are present between therapist and patient, the unique individual is recognized and related to, and the shared domain of humanity and life itself supports the dyad in wading through the throes of experience.

Empathy and Subjectivity

As Kohut (1971, 1982, 1984) and Winnicott (1963/1965a, 1963/1965c, 1967/2005b, 1969) assert, empathy is a subject-to-subject phenomenon that is essential in the process of coalescing a distinct and authentic self. It is in and through a sufficiently empathic milieu that the sense of self as an autonomous and authentic subjectivity develops. This form of subjectivity comes into being in the context of and is expressed in the dual plane of reality. Furthermore, empathic failures in childhood result in failures in the self-structuralization process and empathy in the therapeutic milieu facilitates resolving these deficits. The repeated experiences of having one's subjectivity felt into and intuited by another subjectivity creates the environment in which one can be known by another and come to know oneself as real and alive. Embedded in this assertion are three elements: (a) that empathy is a subject-to-subject phenomenon; (b) that empathy provides the medium in which the dual sense of subjectivity - of oneself as distinct and real, takes form; and (c) that empathy is a caring mode of being through which one can be known by a fellow human. These three aspects of empathy are discussed in the next subsections.

Empathy as a subject-to-subject phenomenon.

The thread of thinking of empathy as a process between two subjectivities predates Kohut and Winnicott. Prior to the coining of the word empathy in English,

philosophers Husserl (1859-1938) and Stein (1891-1942) maintained that *Einfühlung* or empathy involves experiencing the external world or the mindedness of the other while maintaining one's own mind (Husserl, 1977, 1989; Stein, 1989). Husserl specifically asserted that empathy involves one person regarding another person as a separate center of being and experiencing (Halpern, 2001; Husserl, 1977). This is consistent with both Kohut's and Winnicott's conceptualization of empathy.

Kohut (1971, 1982, 1984) emphasized the importance of the therapist not merging or identifying with the patient. He was committed to understanding the unique *otherness* of the patient. Rather than merging with the patient, Kohut maintained that empathy involves immersion in and vicarious experiences of the patient's internal world. His aim was to understand the patient's experience from within the patient's conscious and unconscious structures and historical context. Merger would obscure this by blurring the line between what he would feel in the patient's current circumstances and what each unique patient was experiencing. Kohut was deeply concerned about the potential for empathy to be faulty and misguided by self-orientation. To guard against this, he repeatedly tested and fine-tuned the aptness of his perceptions and formulations (Kohut, 1984; Kohut et al., 1996; Orange, 2011).

Winnicott (1963/1965a, 1963/1965c, 1967/2005b, 1969) linked care and concern for the other with the capacity for externality. According to Winnicott, in order to recognize the other as someone about whom we can care and whose experience we can come to know as different than our own, we need to be able to discern internal from external. When there is an understanding of me and not-me, a shared external reality in which the other is experienced as a distinct subjectivity comes into being. Furthermore,

Winnicott maintained that the capacity for empathy develops from this mode of relating. In order to care for and intuit the other's experience, he or she must be recognized as an external and distinct unit of being. Thus, when a caregiver and child or therapist and patient are able to engage in mutual empathy, two distinct centers of being are able to sense the other's unique experience. Prior to gaining the capacity for externality, genuine empathy is not possible.

I, too, maintain that empathy is a mode of consciousness through which we experience and seek to intuit the conscious and unconscious mindedness of the uniquely situated external other. It is not a process of imaging the others' experience as if we were in their circumstances. Rather, empathy requires one to recognize his or her own and the other's subjectivity as unique and personally located. Only with this capacity can one begin to discern the other's experience when it matches his or her own perspective, as well as when it is different or foreign. An empathic therapist is both receptive to the patient's experience and uses knowledge about his or herself and the other to imagine oneself into the other's experience as the other (i.e., not as oneself). The therapist enlists self-knowledge and self-reflection to make meaning of the fleeting, subtle and multitude of feelings, sensations, thoughts, and reveries he or she experiences during the therapeutic encounter. In this process, the therapist sifts through his or her internal experiences in an effort to discern that which is an expression of his or her own subjectivity and that which belongs to the patient and only the latter is reflected back to the patient. The process of and the underlying premise that one's subjectivity can be demarcated from another's, places empathy in the dual plane of reality in which self and

other, internal and external can be distinguished. It is only in this context that vicarious experience of the other is possible.

This conceptualization of empathy not only assumes that self and other can be distinguished, it also assumes that subject-to-subject relating can be delineated from subject-to-object relating. Like Benjamin's (1988, 1990/1999, 1995, 2004) conceptualization of mutual recognition, true empathy from this perspective can only transpire when one relates to the other as a subject (i.e. not as a projection of an aspect of oneself). However, given the interpenetration of duality and nonduality as well as the vast complexity of the unconscious, it is not plausible that one can fully know when his or her personally and culturally located vantage point is blurring the differences between self and other and when one's intrapsychic world is obscuring the subjectivity of the other. Thus, I would argue that empathy is an aspirational stance. A stance in which we lean toward subject-to-subject relating with enough caution to question our perceptions and to look for our assumptions about the other and the world we both inhabit.

Empathy as the medium in which subjectivity takes form.

Kohut (1971, 1982, 1984) and Winnicott (1963/1965a, 1963/1965c, 1967/2005b, 1969) offer intersecting theories on the role of empathy in coming into being as an authentic self. Although Kohut's conceptualization of empathy in the therapeutic stance emphasizes its function in developing other-based interpretations, he described the centrality of empathy in the developmental process of self-structuralization and the negative consequences of empathic failures. Winnicott wrote extensively about maternal empathy serving as the medium in which the child comes into being and its similar role between therapist and patient. Taken together, their ideas make a strong case for empathy

being an essential ingredient in the process of subjectivity and a sense of oneself as real and alive developing within the individual. They each framed empathy as the means by which the mother or caregiver is able to know and then meet the child's needs. They also elaborated on the importance of empathic attunement in the therapeutic context. Both clinicians believed that patients heal and gain feelings of aliveness through being known by another and coming to know themselves through that experience. Although they each provided an accepting presence to their patients, their descriptions of empathy in the therapeutic relationship emphasized "understanding and explaining" in Kohut's lexicon and "reflecting what is there to be seen" in Winnicott's. This is notably different from Roger's description of empathy. For Rogers (1975, 1986), empathy provides belonging and empathy's reflection of understanding the other is the means by which belonging is communicated. Thus, Kohut and Winnicott, unlike Rogers, suggested that we develop as a person through the subtle experience of being known, not necessarily through belonging.

While I agree with Rogers that the need to belong, to feel a part of something larger than oneself is an essential element of human experience, I suggest that compassion, not empathy, is the source of this feeling. Also, like Kohut and Winnicott, I believe there is something profound about being intimately seen and understood. The everyday experience of oneself as real, as an individual with subjectivity and self-agency, coalesces in and through an empathic environment. Without such a milieu, a hollowness pervades the sense of self as does an experience of oneself as fundamentally damaged, unworthy, and otherwise not good enough. Through the experience of being known by another, we integrate a sense of ourselves as a unique and loveable being – a being who

when seen by another is recognized as a fellow subjectivity and deemed acceptable. Empathy is the process by which this happens whether in childhood or in the psychotherapeutic context.

Empathy as a caring process of knowing another.

Unlike Kohut (1971, 1982, 1984), Winnicott (1963/1965a, 1963/1965c, 1967/2005b, 1969) understood empathy as inextricably entwined with care for the other. It is possible, however, that if Kohut lived longer and had time to further his recognition of the intrinsic value of empathy in the therapeutic bond, that he, too, would have come to see that true empathy, at least in the therapeutic context, is by its nature a caring process. Kohut's (1984) repeated assertions that empathy "can be used in the service of either compassionate, inimical, or dispassionate-neutral purposes" does, however, raise the question of what is transpiring when another is intuited for malignant purposes (pp. 174-175). Winnicott does not address this question and clearly suggests that empathy is used by the attentive and concerned caregiver and therapist to understand and meet the needs of the other.

I contend that "feeling into" another in such a way that facilitates the structuralization of subjectivity is by its nature a caring process. It inherently includes a quality of acceptance and value of the other. While a sociopath may use something akin to empathy to determine how to take advantage of another, it is not a process that patiently and tenderly reflects the other back in order that they might come to know themselves as a distinct and worthy subject. The process of knowing the other as they know or will come to know themselves requires that care be intermingled with emotional resonance and other-based perspective taking. The motivation for such genuine empathy

is both connective and interpretive. Together, these motivations enable empathy to function as the medium of subjectivity – as the milieu in which an authentic and related self coalesces.

Nondual Compassion as an Antidote to Alienation

The illusions of stability, singularity, and solidity are revealed as sources of alienation when our patients' (and our own) suffering is considered through the wisdom of nonduality. Our resistance to certain experiences and our clinging to other experiences leaves us disconnected from ourselves, from each other, and from the natural world. Our failure to accept the impermanent, interconnected, and insubstantial nature of existence estranges us from our nondual selves and all that is alive. This form of suffering has been known in the East since the days of the Buddha and has been recognized in the West since at least 1960, when Fromm stated that:

> [Patients] come to the psychoanalyst without knowing what they really suffer from. They complain about being depressed, having insomnia, being unhappy in their marriages, not enjoying their work, and any number of similar troubles…These various complaints are only the conscious form in which our culture permits them to express something which lies much deeper…The common suffering is the alienation from oneself, from one's fellow man, and from nature. (pp. 27-28)

This is the level of suffering that is seen from the mountaintop and which is ameliorated by and through the impartial, unconditional, and all-inclusive experience of nondual compassion.

When in the presence of as well as when able to invoke one's own experience of such compassion, our relationship to the pains of duality shifts in such a way that suffering subsides. When a therapist is able to feel nondual compassion for and with a patient, both members of the dyad are embraced into the fold of humanity and within that unity emerges the courage to experience and ultimately to transcend experiences of alienation. I have distilled four elements of the Buddhist understanding of compassion that are interwoven into what I am referring to as nondual compassion. They are: loving-kindness, universality, wisdom into the nature of suffering, and equanimity. In the subsections that follow, I discuss these four facets of nondual compassion and reflect on their realization. I then consider how nondual compassion in the psychotherapeutic context serves to ameliorate alienation and disconnection.

Compassion and loving-kindness.

Buddhism offers an understanding of compassion that distinguishes it from its literal translation from Latin. Rather than simply meaning "being with suffering" or "feeling with," the Buddhist concept of compassion means "feeling with" while simultaneously being accepting and welcoming. It means being genuinely receptive to pain and suffering while at the same time enveloping self and other in boundless warmth and wishes for wellbeing (Analayo, 2015; Dalai Lama, 2001, 2003; Ricard, 2015; Trungpa, 2003, 2013). The Sanskrit and Pali word *karuna*, which as noted above, is often translated as compassion, is also translated as noble heart (Trungpa, 2013, p. 474). Trungpa describes a noble heart as "marked by tremendous generosity…[as] completely open and welcoming" (Trungpa, 1973, p. 208). Thus, Buddhist or what I am referring to as nondual compassion is imbued with deep acceptance, with loving-kindness. The heart-

quality that underlies loving-kindness is not attachment or caregiving responsibility; it is goodwill and benevolence. As a result, compassion offers respect and dignity toward all who suffer while simultaneously bringing an ability to "act nobly in order to help others help themselves" (Trungpa, 2013, p. 74).

The benevolence or loving-kindness that is present in nondual compassion is innate. Obstacles and distractions of the dual-oriented mind may prevent our access to it, but its essence is fundamental to our human existence. When we are able to be truly open and receptive without preconceived designations and constrictions about who is worthy of happiness and freedom from suffering, loving-kindness is automatically present. When we can peel back or step out of our subjectively defined ideas of good and bad actions, we recognize that all beings wish for wellbeing and ease. This recognition brings an unconditional quality to compassion. The presence of loving-kindness in compassion enables it to cut through subjectively-oriented anger and aggressive desires or aversions. It enables us to see that all beings regardless of action or deed are worthy and welcome.

The presence of loving-kindness in compassion also brings unconditional friendliness and acceptance toward all experience. No emotion or state of mind is rejected or regarded as foreign (i.e., not-me). Whether the experience is located in the nondual other or oneself, it is understood as being within the shared domain of humanity. As a result, the experience itself as well as the being having the experience is welcomed. The loving-kindness within nondual compassion makes it not only unconditional, but also all-inclusive. It is free from grasping and avoiding; it is welcoming of all that is.

Compassion and universality.

The universality that is embedded in nondual compassion refers to both the ubiquity of pain and the unity or indivisibility between self and other. Both of these aspects are present in the Buddha's description of compassion as "a trembling of the heart in the face of another's pain" (Smith, 2002, p. 207). The trembling is a resonance, like one violin vibrating when another violin is played in proximity. The Buddha understood that every human heart feels and comes to know the quivering of pain. It is an unavoidable element of our impermanent existence. The Buddha's description is also reflective of the subtle level at which the two violins are one instrument. When there is friction across the strings of one, both are affected. So too is it with the hearts of two humans. When one suffers, both suffer –they are not distinct.

A description of the fundamental universality that pervades nondual compassion is also found in the Mahayana teachings on interconnection and insubstantiality. As Makransky (2012) stated, "according to Mahayana teachings, not only are phenomena found to be impermanent and beyond reification into 'me' and 'mine'...but upon further investigation, no independently existent phenomenon of any kind, impermanent or otherwise, is even findable" (p. 68). This level of reality is reflected in the Buddhist concept of dependent arising. According to this premise, all experience is a result of an endless web of interpenetrating manifestations. All existence, including the experience of our subjectivity, reflects an infinite series of interacting and interdependent physical and mental processes (Kyabgon, 2007; Loy, 2003). The meaning of this abstract concept is captured in Thich Nhat Hanh's (1988) poetic words:

> If you are a poet, you will see clearly that there is a cloud floating in this sheet of paper. Without a cloud, there will be no rain; without rain, the trees cannot grow, and without trees we cannot make paper...we know that the sunshine is also in this sheet of paper. The paper and the sunshine *inter-are*. And if we continue to look, we can see the logger who cut the tree and brought it to the mill to be transformed into paper. And we see the wheat. We know that the logger cannot exist without his daily bread, and therefore the wheat that became his bread is also in this sheet of paper. And the logger's father and mother are in it, too. (Nhat Hanh, 1988, pp. 3-5)

Within the nondual plane of reality, a transcendent unity exists, a unity in which all phenomena interpenetrate. Nondual compassion has access to this awareness and greets the other as a fellow manifestation of a unified whole.

Compassion and wisdom into the nature of suffering.

The interweaving of wisdom into the nature of suffering in nondual compassion is essential to its usefulness in general and especially in the therapeutic encounter. Without it, true compassion is not possible and the therapist is at risk of blindly making efforts to provide short-term gratification and temporary relief from suffering. The unwavering understanding of what causes suffering and what brings relief from suffering guides compassion. It is the source of compassion's fearlessness. It brings to compassion the willingness to say and do what may be temporarily unpleasant and even highly uncomfortable, if it is in the service of long-term relief from suffering. Because nondual compassion seeks to alleviate the suffering that arises from clinging to dual constructions

of reality, its foundational wisdom involves seeing beyond the illusions and desires of dual experience, which deny the impermanence, interconnectedness and insubstantiality of nondual reality.

Drawing from Buddhist psychology, I maintain that pain, uncertainty, loss, and any number of other discomforts, are universal and inherent in our physical existence. Actual suffering, however, is a result of attempting to avoid the direct experience of these unpleasant sensations. As Buddhism teaches, accepting pain and uneasiness shifts our relationship to it such that it no longer causes suffering or an ongoing sense of discontent. In other words, suffering is rooted in attachment to and avoidance of certain experiences. The endless pursuit of wanted experiences and the persistent resistance toward unwanted experiences causes suffering. Embedded in this interminable process is the denial of impermanence. When we want only pleasurable experiences to endure, we paradoxically bind ourselves to disappointment. In addition, given the impermanent nature of physical existence, loss is inevitable and life as we know it is always uncertain. As taught in the Dharma, suffering abates when one can accept pain and discomfort as well as pleasure, and ease as temporary states and when one can receive all experiences equally (Chodron, 1997, 2001, 2012; Dalai Lama, 2001; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1969, 2003, 2005, 2013).

Drawing again on Buddhist teachings, life is not only impermanent, it is also interconnected. As with impermanence, the denial of our interconnected nature causes suffering. When we repudiate the unity of life, we are relegated to clinging to an elusive illusion of our solidity and stability as distinct entities. Our separate, ego-based self is a phantom of dual and relative reality. On an absolute level, there is no stable, discrete, and

permanent self that is distinct from others and from our environment. Buddhism teaches that when we are unable to recognize this, we suffer and create suffering through repeated attempts to secure the illusion. In other words, we are alienated from our deeper, universal selves and the nondual other, and we inadvertently create alienation - ours and others - by clinging to and defending the illusion of our separateness. Further, we are continually tempted to reify our subjectivity by our desire to avoid the anxiety or uncertainty inherent in our interconnectedness. Therefore, accepting our interconnectedness means tolerating, or even welcoming the lack of certainty and control that this brings. When we can abide in this groundlessness, alienation subsides and we are buoyed by our fundamental interconnectedness (Chodron, 1997, 2001, 2012; Dalai Lama, 2001; Kornfield, 2009; Kyabgon, 2001, 2007; Trungpa, 1969, 2003, 2005, 2013).

Lastly, as noted above, Buddhism goes a step further and asserts that in addition to life being impermanent and interconnected, it is also insubstantial. It is empty of permanent form. Our sense of ourselves and of all phenomena as solid is an illusion of perception. Rather, we are constantly coming together and falling apart in a complex mutually interdependent process of causes and effects. In other words, as a result of *dependent arising*, phenomena can co-occur in a non-linear fashion while simultaneously causing each other (Kyabgon, 2007; Loy, 2003). If we go back to Nhat Hanh's words, the cloud, which made possible the tree, is also made possible by the tree (1988). Extending this line of reasoning, the child is made possible by the mother and the mother is made possible by the child. Neither exists independent of the other and both causes the other to come into being. Wisdom into the insubstantial or empty nature of existence

means realizing that everything is dependent on something else. In Mahayana Buddhism, this is represented by the metaphor of Indra's net:

> In the abode of the great god Indra, there is a wonderful net that stretches infinitely in all directions. At each "eye" of the net there is a jewel that reflects all the other jewels in the net, and if one looks even more closely, one can see that every one of those infinite reflections in each "eye" is itself reflecting all the other jewels. In this cosmos each phenomenon is at the same time the effect of the whole and the cause of the whole, the totality being a vast, infinite body of members, each sustaining and defining all the others. (Loy, 2003, p. 183)

The failure to sense and recognize this binds us to the isolation of duality. In moments when we can grasp the profound insight of emptiness, or the interconditionality of all phenomena, we can recognize ourselves as a jewel in Indra's net.

Compassion and equanimity.

The equanimity in nondual compassion makes receptivity to suffering and the sufferer possible. Borrowing on the Buddhist (Buddhaghosa, 2010; Dalai Lama, 2001, 2003; Hopkins, 2001; Trungpa, 2005, 2013) understanding of *upeksha*, I take equanimity to mean both maintaining a benevolent attitude toward all experiences and sensing one's unity with all beings. The first element of equanimity involves the calmness or even-mindedness often associated with equanimity. However, it is not indifference or disengagement and does not involve distancing oneself from the immediacy of pain or suffering. To the contrary, it is deeply and fully receiving and experiencing whatever is present without aversion or clinging. This aspect of equanimity, and therefore

compassion, is easily misunderstood. Equanimity's calmness and non-attachment to particular states of mind does not come as a result of dissociating or somehow neutralizing the feelings. Rather they are a result of mindfulness and accepting all experiences be they pleasant or unpleasant. Equanimity means impartial openness or spaciousness.

In addition, when all experiences are embraced equally, all boundaries fall away, as do the distinctions between self and other. Insight into sublime unity is the second element of equanimity. As the divide between oneself and the other evaporates, our interdependence becomes evident. It is understood that not only do all beings want to be happy and free from suffering, but our own wellbeing and the other's wellbeing are interwoven and inextricably linked. This aspect of equanimity supports us in moving toward the suffering nondual other. It is reflected in Hopkins' (2001) comment that with equanimity "you are no longer confronting another person over a divide, but meeting someone with whom you have much in common" (pp. 32-33).

Equanimity, and therefore compassion, is not a form of distant or unengaged concern. Rather equanimity's openness and wisdom into our unity "[parts] the curtain of indifference that distances us toward the suffering other" (Chodron, 2002 p. 23). This aspect of nondual compassion was revealed in Ricard's description of feeling and directing compassion toward children in a Romanian orphanage, when he stated "I felt natural and boundless love for these children and the courage to approach and console them. In addition, *the distance between the children and myself had completely disappeared"* [Emphasis added] (Klimecki, Ricard, & Singer, 2013, p. 276). Thus, the

equanimity in compassion supports one in being intimately engaged with the nondual other through the full range of human experience.

Reflections on realizing nondual compassion.

Nondual compassion, like empathy, is largely an aspirational stance. Given the interpenetration of duality and nonduality, only the fully enlightened person, if such a person exists, could have full and ongoing access to nondual compassion. For most, if not all of us, fully realized nondual compassion rises to the surface of our consciousness only in momentary flashes. Like relative *bodhichitta* (as opposed to absolute *bodhichitta* in which there is wisdom into the true nature of life and unending love and compassion for all), access to nondual compassion is limited by our ego-clinging habits of mind and our resistance to feeling pain and discomfort. Relative *bodhichitta* and nondual compassion, however, both involve a commitment to "involving yourself in the world with benevolence, fearlessness and kindness" (Trungpa, 2013, p. 5). Thus, nondual compassion means repeatedly orienting toward and welcoming the universality of suffering with warmth and benevolence toward the suffering self-other unity. It means seeing through aggression and hate to the suffering that underlies such thoughts and actions and unconditionally bringing loving-kindness to the sufferer. Even when this cannot be realized, nondual compassion means being committed to regaining equanimity and access to wisdom into the nature of suffering. It means trusting in and striving toward the unending and indiscriminate compassion of absolute *bodhichitta.*

Nondual compassion and the amelioration of alienation.

When a therapist is able to embody nondual compassion, he or she is not distracted by ego-clinging states that create fear, anger and aggression; all of which create

distance and disconnection. In addition, the therapist is not entangled by care-giving responsibilities and urges to provide short-term gratification and soothing. Rather, the therapist has a vastness of mind that is willing and able to receive and be with the nondual other, no matter the depths of their anguish nor the heat of their fury. Each human and experience are related to as welcome faces and expressions of humanity. In these moments, the therapist engages with the patient as a fellow sufferer who longs for freedom from suffering. The accumulation of such experiences in the therapeutic encounter provides patients with an opportunity to consciously and unconsciously experience and absorb a profound sense of acceptance and belonging.

As these experiences accrue, a deep cavity of aloneness is gradually filled and the alienation that is embedded in the dual plane of reality dissipates. Patient and therapist share in the universality of suffering – in the experience and knowledge that it neither belongs solely to nor is solely located in the patient. Although the pain may be felt to an attenuated degree in one body, as in the case of the resonating violins, it is still felt in both. Not only does this offer patients an experience of being accepted and belonging to the fold of humanity, it also brings the presence of oceanic oneness to their doorstep. Consciously or unconsciously, such compassionate encounters bring patient and therapist into a deeply interconnected intimacy, which serves to heal the rifts of isolation.

Further, when the wisdom of nondual compassion is accessible to a therapist, he or she can recognize him or herself in all patients. With nondual compassion, no patient is mistaken for and related to as an other. There is a familiarity with the habits of mind that create suffering and a knowledge that these habits, in their own forms, afflict all of us. With this wisdom, therapists can engage with patients in ways that subtly and deeply

ease suffering. Understanding the impermanence of experience strengthens our ability to withstand whatever is present as it is. Embracing our interconnectedness invests us in the other's plight as an aspect of our own. Recognizing the insubstantiality of existence gives us insight into the interpenetrating causes and effects of suffering. With nondual compassion, no patient is left alone in his or her agony and the multiplicity of causes and effects related to suffering can gradually be discerned. The places of attachment and resistance that result in alienation and disconnection within and between patient and therapist can be gently and boldly challenged.

As Rumi's (1995) poem *The Guesthouse* teaches, every feeling, thought, state of mind, and experience is an opportunity embedded with possibilities. In the Buddhist practice of *lojong* (i.e., mind training in compassion), there is an aphorism that one should always *train without bias in all areas.* The commentaries about this maxim, teach that everyone and everything you meet is an opportunity to cultivate compassion and wisdom (Kyabgon, 2007; Trungpa, 2003). Likewise, when nondual compassion is accessible to a therapist, he or she is able to be receptive to each moment as it arises with curiosity and dedication to using every feeling, thought, and action as an opening to relieving suffering and to learning about the causes of suffering. This state of being may, at times, result in explicit exchanges between therapist and patient about the alienation from self, other and the natural world that clinging to and resisting certain emotional states creates. At other times, the therapists' nondual compassion may fill the implicit realm of being and knowing and gradually cultivate the soil of insight. Given the interpenetration of internal and external, nondual compassion soothes the pain of disconnection whether it is overt or tacit. It emboldens the therapist to meet the "suffering

face of the other" (Levinas, 1981) with benevolence, spaciousness, courage, and wisdom. In so doing, nondual compassion assuages the wounds of disconnection.

Empathy and Compassion in the Context of Enactments

In this section, I conceptualize two forms of enactments and the role of empathy and compassion in resolving each one. The first form that I discuss is informed by how enactments are understood in relational psychoanalysis. This type of encounter between therapist and patient transpires on the dual plane of reality and involves the therapist engaging with the patient through subject-to-object, or doer-done-to, relating. Empathy is an essential element in recognizing the dynamics of subject-to-object relating and in reestablishing subject-to-subject relating (i.e., mutual recognition; Benjamin, 1990/1999, 1995, 2004; Layton, 2008; Orbach, 2008; Stern, 2004). The second form involves the therapist succumbing to a form of aggression, which negates the nondual level of reality. When a therapist enacts this type of aggression, he or she loses access to our fundamental unity and seeks to maintain or avoid certain states of being. In these moments, compassion (with the four elements described previously) is needed to resolve the enactment. These assertions are discussed and elaborated upon in the following subsections.

Enactments in the Dual Realm and the Role of Empathy in Reestablishing Subject-to-Subject Relating

Relational psychoanalysis generally understands the self to be multiple and at times conflicting self-states that emerge from our relational experiences. Unacceptable or intolerable self-states are dissociated and yet affect interactions in the form of enactments

(Bromberg, 1998, 2003; Layton, 2008; Orbach, 2008; Stern, 2004). According to Stern (2004):

> Dissociated experience...does not simply disappear quietly into some hidden corner of the mind. It is enacted. I will "play out" the state of self I cannot tolerate experiencing directly, and I will thereby unconsciously influence those with whom I relate to adopt a variation of the same dangerous response that led me to dissociate the self-state in the first place. (Stern, 2004, p. 211)

In psychotherapy, an enactment can be understood as the meeting ground between a dissociated aspect of the patient's mind and a mutual or reciprocal aspect of the therapist's mind (Layton, 2008; Orbach, 2008; Stern, 2004).

Such encounters can also be thought of as a particular type of doer-done-to relating. In this mode of relating, the other is the object of our feelings, needs and actions, not another separate, yet similar mind (Benjamin, 1990/1999, 1995, 2004). When this happens within the therapist and between therapist and patient, not only is the patient seeing the therapist through the portal of his or her internal world, but the therapist is also relating to the patient as an object - not as a subject. The process of shifting from such intrapsychic relating to interpersonal relating in which the other is seen as a center of his or her own experience - not as an extension or reflection of one's own experience - is an essential aspect of treatment. Because much of our relating is intrapsychic, enactments between therapist and patient are inevitable. The resolution of them, however, facilitates the emergence of previously disallowed or disavowed parts of self and modes of being (Benjamin, 2004; Layton, 2008; Orbach, 2008; Stern, 2004).

Benjamin (2004) suggests that enactments are resolved when the therapist is able to act as a moral third. The therapist works to hold the tension of different needs or experiences between herself and her patient while remaining attuned to the patient. Layton (2008) described this process as the therapist regaining the capacity to see the patient in an "empathic rather than in an adversarial light" (p. 10). When the therapist is able to achieve this, she steps out of the cycle of helplessness and attack that is characteristic of doer-done-to relating. The therapist must enter into an empathic attitude in which he or she can directly or vicariously experience the disavowed states that make up the enactment as an internal conflict. Only then can the therapist begin to discern his or her own internal world from that of the patient's. He or she can then reflect the patient's disassociated aspect(s) of self or experience. As the patient is able to integrate the metabolized and returned aspect of self or experience, he or she is able to expand his or her sense of self and relational repertoire. In addition, the therapist's process of reestablishing empathy in the therapeutic stance facilitates the reestablishing of mutual recognition in which relating can be between two subjectivities.

This conceptualization of enactments involves the negation of the other's subjectivity. Empathy, which implicitly recognizes the distinctness of the other, enables a return to subject-to-subject relating. Remembering that the patient is a uniquely situated other can activate other-based perspective taking, and with that an interest in the patient's experience. As empathy returns to the therapeutic stance, the therapist is able to reflect on and make meaning of what is being vicariously experienced and communicated through the exchange. During this process, the therapist does not negate his or her own experience, but rather uses it to come to know the patient's more fully. Within such

encounters, patients' sense of self and relational maps expand. Not only do patients come to experience themselves as a multi-faceted subject, they also learn to shift from the intrapsychic relating of subject-to-object to the interpersonal relating of mutual recognition.

Enactments in the Nondual Realm and the Role of Compassion in Regaining Spaciousness and Clarity

When the therapist's access to the nondual realm collapses, I contend that he or she enters into another form of enactment. My conceptualization of this type of enactment draws on the Buddhist interpretation of both aggression and compassion. In Buddhism, aggression is regarded as an expression of suffering, as a manifestation of clinging to or resisting certain experiences. Thus, grasping at or attempts to secure our ego-selves as well as trying to avoid unwanted experiences are both forms of aggression (Trungpa, 2005, 2013; Wegela, 2009). Buddhism teaches that aggression "is an ungenerous attitude that goes directly against the idea of karuna, or compassion" (Trungpa, 2013, p. 283). Embedded in the Buddhist understanding of compassion is the willingness and the courage to face and to welcome all experience, including our fundamental interconnectedness as well as the discomforts related to the impermanence, fluidity and insubstantiality of life. Given this, even though aggression "goes directly against" compassion, compassion accepts, even welcomes aggression. As Trungpa (2013) stated, "you are not so much trying to suppress aggression, but rather, to get over the hypocrisy of failing to see the aggression" (p. 284). He went on to say, "the problem is the resistance...when you begin to realize aggression as it is, there is a sudden flash of spaciousness, and the aggression is completely cleared out" (pp. 287-288).

Using this understanding of compassion and aggression (i.e., nondual aggression), I postulate a form of enactment in which aggression against nonduality surfaces within the therapist. During such an enactment the therapist may feel angry at the patient in a form of ego-clinging or the therapist may simply resist a particular feeling state. The therapist may collude with the patient in an effort to deny what is, or seek to distance him or herself from certain feelings or states of mind. When this is happening, the therapist is unable to access compassion with its loving-kindness, universality, insight into suffering, and equanimity. Without it, the therapist is alienated from his or her deeper interconnected self and from the patient. He or she is caught in the illusions of duality and futile attempts to deny uncertainty and to create security. The presence of this cycle of grasping at an illusion and resisting experiences, involves both therapist and patient and their personal and mutual vulnerabilities to such states of aggression. In other words, the aggression is not only the therapist's; it belongs to both and has taken hold and expression in the therapist. When the therapeutic dyad is entangled in such an encounter, rather than healing the wounds of isolation, they are exacerbating and creating them.

Resolving this form of enactment requires opening to nondual compassion; it requires acknowledging the aggression and having access to wisdom into the nature of aggression and the suffering that underlies it. The four elements of nondual compassion (i.e., loving-kindness, universality, insight into suffering, and equanimity) can each serve as a gateway to regaining the spaciousness and clarity of nondual compassion. Loving-kindness cuts through anger, hate and other such expressions of aggression. As the Buddha taught, "it is not possible to practice loving-kindness and feel anger simultaneously" (Buddhaghosa, 2010, p. 313). Even a brief flash of loving-kindness can

reorient the therapist toward nondual compassion and the knowledge that all are worthy and welcome. With loving-kindness, the heart opens and the anger changes. It either dissipates or reconstitutes as a fierce commitment to relieving suffering for both therapist and patient.

Universality also offers a path back to nondual compassion. When the therapist can remember that all sentient beings feel pain and long for the absence of pain, he or she can find common ground with the patient no matter the discomfort either is feeling in the moment. Further, universality recognizes the illusion of our separateness. It enables the therapist to recognize "not only am I similar to my patient in not wanting to feel pain, I am indivisible with my patient – we *inter-are.*" When universality can be accessed, efforts to defend the ego-self dissolve. The other is recognized as an extension of oneself. With universality, the therapist softens the boundaries of his or her subjectivity into our interconnectedness - tolerating or even welcoming the uncertainty and the absence of control that this brings. Courage to be with whatever is present supplants the aggression. Compassion for both suffering beings moves to the foreground.

An enactment of nondual aggression can also be eased through a return to wisdom into the nature of suffering. When the therapeutic dyad is gripped by the tightness and alienation of aggression, they are caught in a ravine of the valley floor. Relating and thinking is confined by duality and personal wants and desires in the here-and-now. The recognition that there is another vantage point from which to view what is transpiring can evoke the meta-view as seen from the mountaintop. Even remembering that no valley exists without mountains, and vice versa, can guide the therapist and dyad back to alleviating suffering, rather than causing it. Remembering that aggression is both an

expression of and the cause of suffering can bring the spaciousness to breathe through what is extant and the clarity needed to embrace the other in nondual compassion regardless of his or her present guise.

Lastly, equanimity can bring a return to impartial openness to oneself, the other and all experiences. An enactment of aggression against nonduality closes down spaciousness while creating distance between therapist and patient. Equanimity enables direct experience of that which is present, including the aggression, resistance, and clinging. When the therapist is able to bring nonjudgmental awareness to his or her experience, the aggression dissipates. The ego-serving distance between patient and therapist also diminishes. The patient is recognized as an aspect and reflection of oneself. Rather than a perturbing other, the patient is recognized as a suffering nondual other with whom both suffering and wellbeing are shared. Through equanimity, a sense of unity is regained allowing the seeds of nondual compassion to germinate within and between therapist and patient.

In this form of enactment, our fundamental unity is negated. Nondual compassion, which implicitly recognizes our universality and aims to reduce suffering, enables a return to fearless and noble action on behalf of the indivisible therapist-patient unit. When the therapist regains the tenderness and receptivity of nondual compassion, whether toward him or herself or toward the patient, the suffering of alienation as it takes form in both therapist and patient diminishes. Within the temporal frame of the session or even the course of treatment, the material causes of pain and suffering may not be mutable. However, abiding in the Dantean realms of existence together transforms the

suffering from that which keeps you separate and alone to that which unites and connects you.

Integrating Empathy and Compassion Across Dual and Nondual Phenomena

Empathy and compassion each offer a means of engaging with aspects of the human experience as it manifests in dual and nondual planes of existence. Despite the fact that they are based on contradictory assumptions (e.g. we are distinct and we are inseparable beings), they can be integrated and paradoxically co-exist. Each on its own offers something useful and is simultaneously missing something. When empathy and compassion and therefore dual and nondual reality are held together, they more fully serve the psychotherapeutic endeavor than either one on its own. Together they enable the therapist and patient to work with both relative vulnerabilities and anxieties and with absolute longings and distractions from realizing our place in the ever-changing cosmos. On the one hand, the tasks of coming into being as a unique subjectivity and of metabolizing and responding to the attacks on being that a patient faces in life are served by empathy in the therapeutic stance. On the other hand, the roots of alienation from one's deeper interconnected self, from others, and from the ecospheric whole are assuaged through the embodiment of nondual compassion. Ultimately, both are needed to address the full range of the human condition.

In addition, as the foregoing suggests, empathy and compassion are means of responding to different forms of enactments. Therefore, a balance of empathy and compassion in the therapeutic stance leaves the therapist less vulnerable to negating the other and to negating our essential unity and the range of human experience. An empathic attitude operates at the dual level in which self and other can be distinguished. Within this

plane, we also live according to certain assumptions of solidity and linearity of time (e.g., cause and effect). Therefore, when empathy is maintained to the exclusion of nondual reality, it can preclude access to states of universal oneness and acceptance of the fluidity, interpenetration, and interdependence of all experience. When this transpires in the context of psychotherapy, the therapeutic process can augment disconnection and suffering. When a therapist is orienting toward the patient only as a uniquely situated other, he or she can emphasize the differences between them and obscure their unity. The privileging of empathy can also leave the therapist vulnerable to colluding with or simply having desires to avoid unwanted feeling states that create distress in either or both the therapist and the patient. Further, as long as the duality of self and other is accepted as a given, a bifurcation between human and the natural world is also implicitly accepted. Therefore, relying exclusively on this mode of being and thinking exacerbates alienation.

In contrast, the nondual presence of compassion invokes or is in response to our indivisibility. However, the unity of this perspective can obscure the needs and voice of the individual. This risk is aptly revealed in the story of the Buddha himself. The Buddha, whose mother died several days after his birth, was raised by his aunt in the splendid and isolated confines of his father's palace. He did not leave this protected world until he was 29 years old. When he ventured beyond the walls of the palace he encountered sickness, old age, and death and realized that human life was filled with suffering. He became disillusioned with his own life, left his home, and devoted himself to finding a way to relieve human suffering. After 6 years as an ascetic and mendicant, seeking and contemplating the nature of existence and release from human suffering, he experienced enlightenment. As an expression of compassion, he began teaching the Dharma. Some

time after this, he returned to his village. Upon his return, his aunt asked that she and other women be given access to his teachings and the spiritual path he offered. Despite enlightenment and transcending duality, he declined her request three times. During her fourth appeal, 500 other women joined her. At this point, the Buddha agreed that his aunt could found the Order of Nuns and thereby be granted access to the joy and awakening of enlightenment ("Buddha Biography," 2014; Buddha Dharma Education Association Inc. [BDEA], 2008; Ohnuma, 2006). In so doing, he was able to recognize his aunt's and the other women's subjectivity. Prior to this, he may have understood his fundamental unity with them and wished for their freedom from suffering, however, he did not have empathy for their experience of being excluded from his teachings. He negated his aunt's and the other women's subjectivity and was unable to see how his situated subjectivity was still being shaped by his patriarchal cultural context. Similarly, when therapists have access to nondual compassion without access to empathy, they can fail to recognize the subtlety and nuance of patient's unique experience and can make assumptions about the patient based on their own historical and cultural context.

Thus, enactments on the dual plane are possible even when therapists have access to compassion. Because compassion operates at the nondual level of reality, it does not provide a gateway to recognizing the subjectivity of the other. As in the case of the Buddha, it can even help to obfuscate the presence of subject-to-object relating or cultural bias. Empathy for the situated other is needed to see through such doer-done-to relating. Similarly, enactments on the nondual plane are possible even when the therapist has access to empathy. Nondual compassion with its loving-kindness, universality, wisdom into the nature of suffering and equanimity is needed to sustain the dyad's access to unity

and to benevolence toward all experiences. Therefore, in addition to empathy and compassion serving a role in patient healing and growth, the absence of either leaves the therapist vulnerable to failing to recognize the patient's subjectivity or to alienating the patient and his or her experience.

CHAPTER SIX: CONCLUSION

To write I would have to be a failure. A pain a writer, at least this writer, must live with.

(Eigen, 2014)

The field of psychotherapy is situated in a mutually influencing discourse with the historical context of its practitioners and patients. As Lev (2016) suggested, "in addition to profoundly influencing Western culture, psychoanalysis is also deeply influenced by it" (p. 313). The psychological suffering that psychoanalysis seeks to treat and how health and a good life is viewed is, at least in part, shaped by the prevailing worldview, while simultaneously informing it. Philosopher Charles Taylor (2007) hypothesized three worldviews or perspectives, which episodically come into vogue and shape the cultural understanding of what it is to live and experience life. According to Taylor, the three overarching perspectives are: religious (or spiritual), secular-humanism, and postmodernism. Because each captures some aspects of human life and aspiration, while simultaneously missing others, there are always some adherents to each worldview and the prevailing zeitgeist periodically shifts from one perspective to another. Lev suggested that classical psychoanalysis (including ego psychology) developed during a secular-humanist period in which psychotherapy was viewed as an objective and scientific process of investigation in order to help the individual work through clashes with reality. In contrast, relational and intersubjective psychoanalysis developed during a postmodern perspective. Under this cultural context, psychotherapy has been viewed as "a field of interactions in which the individual tries to create relationships and express himself (Lev, 2016, p. 319). Presently, some are suggesting that the postmodern reign is nearing its end

and that we are moving into a religious- or spiritually-oriented epoch (Lev, 2016; Toth, 2010).

This dissertation sits squarely in the confluence of these two worldviews. My description of empathy is reflective of postmodern thinking, while my description of compassion, as well my assertion that psychotherapy best serves patients when it attends to both dual and nondual realities, extends my ideas into the spiritual realm. Further, using Buddhist philosophy to structure and support my thinking about the nature of compassion clearly locates my ideas in the spiritual domain. The integration of spirituality into psychoanalytic theory better equips psychotherapists to treat the alienation of isolation and the meaninglessness that is embedded in the postmodern mentality. Unfortunately, however, it also introduces more ambiguity and mystery into the psychotherapeutic process and may obscure aspects of treatment brought to light by the secular-humanist perspective.

The contributions and limitations of this dissertation are related to its historical and cultural context. While it bridges both postmodern and spiritual worldviews, it minimally reflects the rational, scientific and precise contributions of the secular-humanist worldview. The postmodern perspective underlies my discussion of empathy's function in the unique subjectivity coalescing and in negotiating and resolving intersubjective enactments. The spiritual perspective informs my discussion of the role of compassion in healing the wounds of alienation and in relinquishing the grasp of aggression from a nondual perspective, when it surfaces in and between the therapeutic dyad. I do not, however, provide specific interventions or even clinical examples to tie the theoretical ideas to the lived reality of the therapist-patient exchange. These and other

contributions and limitations as well as a more detailed exploration of the current cultural context of this dissertation are discussed in the following sections.

The Postmodern and Emerging Spiritual Contexts

The premise that psychotherapy best serves patients when it attends to both dual and nondual phenomena through moments of empathic and compassionate connection reflects elements of the current public discourse. A therapeutic presence that embodies both empathy and nondual compassion is built upon the socio-cultural developments, psychological theories, and scientific findings of the 20th century, while also speaking to the newly emerging zeitgeist of the 21st century. In the 1980s and 1990s, the rigidity and one-sided interpretation of truth that characterized classical psychoanalysis and other one-person psychologies gave way to the perspectivist framework of two-person psychologies, such as intersubjective theory and relational psychoanalysis. These theoretical developments were influenced by the scientific developments of quantum theory as well as the rise in feminism and civil rights movements. Gradually, these and other related factors worked together to shift the prevailing Western worldview from secular-humanist, with its belief in predictable (not probable) science and absolute truth, to postmodernism, with its orientation toward multiplicity. In the context of psychoanalysis, this shift brought changes in both the predominant nature of presenting problems and in how the psychotherapeutic endeavor was understood. During the secular-humanist period, patients were more likely to present with discrete illnesses and complaints (e.g., hysteria) and during the postmodern era, patients more frequently presented with vague symptoms of dysphoria, emptiness, and relational difficulties. Similarly, the process of psychoanalysis shifted from a method for the analyst to reveal

truth about the patient to a process in which "reality is simultaneously created and found, constructed and revealed and...the analyst's subjectivity and theory influence what she sees (Lev, 2016, p. 318).

Presently, the rise of anxiety related to the postmodern burden of defining oneself and to finding personal meaning in a fluid and multi-directional intersubjective field, the decline of cohesive communities, and mounting fears of a global ecological and social collapse seem to be giving rise to a religious or spiritual worldview. According to Lev (2016), the contemporary version of this perspective seems to emphasize personal spirituality over institutionalized religion. This *New Spirituality*, as Lev refers to it, involves a quest for a meaningful life and is being "gingerly and gradually" incorporated into an emergent spiritually-sensitive psychoanalysis. Lev goes on to suggest that "the capacity to integrate sensitivity to the spiritual with the sharp clarity of the psychoanalytic lens could be seen as creating a new synthesis that offers a fuller picture of the human condition and its potentials" (p. 323). While it is too early to forecast the changes this emerging worldview will have on the nature of patients' presenting problems and the corresponding changes in the therapeutic stance and process, we may find more patients complaining of pathologies of spirit and therapists being called upon to access spiritual and transcendent states of being.

The Contribution of Conceptualizing Empathy and Compassion as Dual and Nondual Elements of the Therapeutic Stance

The conceptualization of subjectivity and the nature and role of empathy and compassion that I am suggesting reflect aspects of both a postmodern and a spiritual worldview. The conceptualization of subjectivity as ranging from the dual phenomenon

of personal uniqueness to the nondual phenomenon of intersubjectivity reflects the relativism, mutuality, and dialectical tensions of postmodernity. It echoes the complexity of quantum physics and the inclusivity of feminism and civil rights. When equal and opposite things can paradoxically co-exist we can embrace the intersubjectivity of Benjamin's mutual recognition and the intersubjectivity of Stolorow and colleagues' embedded and inseparable self. It is the emergence of a budding spiritual worldview, however, that supports Blackstone's intersubjectivity of self and other unity.

The entanglement and mystery of postmodern quantum physics suggest that our perceived (i.e., deterministic) world operates under completely different suppositions from the imperceptible (i.e., probabilistic) world and that they paradoxically co-exist. It also suggests that reality (i.e., that which we perceive) is constructed and is, in itself, meaningless (Gargiulo, 2010b, 2016). This dovetails with Buddhist teachings, which have been gaining more and more presence in Western discourse over the last century. From this spiritual perspective, the failure to recognize our interconnected, interdependent, and insubstantial (i.e., nondual) nature causes us to suffer. At the same time, the continued growth and spread of capitalism and secularized life has emphasized self-realization and human-to-human relationships (Loy, 2003; Taylor, 2007). Postclassical psychoanalytic theory, from self psychology and object relations theory to intersubjective and relational theories, has focused on these domains of human experience and suggests that suffering, at least in part, results from impingements in self-structuralization and self-expression and from constrictions in the intersubjective field. This dissertation integrates the spiritual and the postmodern understanding of suffering and suggests that a life that privileges the realm of the individual subject and a life that

loses sight and access to unique subjectivity are both lives filled with suffering. It is only in having access to both the dual and the nondual planes of experience that humans can begin to escape the tentacles of suffering.

Integrating empathy and nondual compassion into the therapeutic stance and process can enable the psychotherapist to facilitate patient's gaining relief from both forms of suffering. It is in an empathic milieu that the therapist comes to know the unique patient and through that process the patient comes to know him or herself as real and alive. Empathy also provides an essential ingredient in the processes of reestablishing mutual recognition and increasing the flexibility of relational patterns and organizing principles. Through empathic exchanges in which the unique subjectivity of the patient is felt, intuited and reflected back to the patient, previously disowned affects and parts of self can be integrated into a new and fuller sense of self. The distinct subjectivity, however, is prone to feelings of isolation and reflexive attempts to secure itself. Thus, no matter how self-actualized one is, no matter how expansive one's capacity is to tolerate affect and to make interpersonal meaning of life's events, without the balance of being a part of something larger than oneself, something that defies the reification of language and ideas, a form of alienation persists. This discontent is an inevitable byproduct of the dual plane in which the distinct and authentic subjectivity takes form and is able to engage with life.

A sense of our profound unity is the salve to the malaise of the singularity of subjectivity. Beyond the intersubjective premise that subjectivity, while experienced as distinct, is embedded in and morphs according to changes in the intersubjective field, is our ineffable unity with all life. Without access to our fundamental unity, the human

spirit is adrift, disoriented, and haunted by a sense of meaninglessness. Empathy - being known by the distinct other - does not assuage this form of suffering. Compassion is needed to sustain and find meaning through the vicissitudes of life. In the context of psychotherapy, I suggest that nondual compassion enables the therapist to go toward and to embrace the patient with the healing presence of loving-kindness and equanimity no matter what feelings this stirs in the therapist. It enables the therapist-patient dyad to transcend the somatic divide that fosters a sense of aloneness. It brings the courage to accept what is present in a such a way that suffering subsides.

Nondual compassion also offers therapists and patients a gateway to resolving enactments of aggression against nonduality. The postmodern paradigm yielded a conceptualization of the therapeutic process in which intersubjective enactments occur and in which empathy facilitates their resolution. Embracing a nondual, spiritual realm, I offer the field another conceptualization in which nondual enactments occur and are resolved through compassion. This form of enactment involves the therapist losing access to nonduality and our fundamental unity. When this happens, the therapist is in a state of aggression against nonduality. Unable to recognize the illusions of duality, the therapist makes futile attempts to create personal comfort and security. This in turn serves to augment both therapist's and patient's alienation from one another as well as from their deeper interconnected selves. Resolving this form of enactment requires opening to nondual compassion. It requires mindfully accepting the presence of the aggression with equanimity and loving-kindness, while recognizing that the aggression itself provides an opening to realizing our universality and is both an expression and a source of suffering.

In addition, a conceptualization of compassion as bold and informed by wisdom into the nature of suffering offers the field of psychoanalysis a reparative relationship to this innate and transcendent capacity. Rather than compassion lacking "intelligence, precision, and savvy" (Glaser, 2005, p. 28) and being a hindrance to treatment, compassion serves therapeutic action. It is not about gratifying patients or colluding with them. Nondual compassion, as I have conceptualized it, is bold and insightful into the nature of suffering. The compassionate therapist has the courage to go toward the patient, to benevolently welcome the patient and their full range of experiences, while simultaneously having the clarity to challenge the patient to see and to relinquish the sources of suffering. Nondual compassion in the therapeutic stance serves to ameliorate suffering by accepting the full range of human feelings, by embracing the nondual other, and by exposing the habits of mind that perpetuate the alienation of duality.

By itself, however, compassion is insufficient to address patients' suffering. It needs the balance of empathy. Compassion has wisdom into nonduality and as such it has insight into the impermanent, interconnected, and insubstantial nature of existence. It does not, however, recognize subjectivity – one's own and that of the unique other. Without this, therapists, like the Buddha in his response to his aunt, can fail to see the impact of their social and historical location on their perceptions and judgments. In addition, from within its universality, nondual compassion cannot provide a reflective mirror for the other to come to know him or herself. This is the role of empathy. Thus, it is only when therapy includes empathy and compassion that therapists are able to help

patients achieve psychospiritual wellbeing through realizing their dual and nondual selves.

Further, as noted above, psychoanalytic theory is not only influenced by its cultural surround, its ideas also penetrate and influence culture and, by extension, human consciousness. Certainly, many Freudian concepts have permeated our thinking and our language. Similarly, as empathy gained recognition in psychoanalytic theories, it became generally accepted as an important aspect of relationships (including parent-child, student-teacher, doctor-patient, etc.). Therefore, balancing empathy with nondual compassion in the context of psychotherapy may serve to bring the values of universality and compassion to the larger communities in which we live. Eventually, this may facilitate greater cultural recognition of both the unique individual and the inseparable, nondual other. In addition, the capacity to bridge dual and nondual experience has the potential to help heal the wounds of alienation, the divisions of race, class, gender, etc., and the bifurcation of humanity from the natural world.

Limitations

As I turn to consider the theoretical and clinical limitations of the ideas I am putting forth, I am aware of the impossibility of capturing the whole – the whole of which I am a part and yet blinded to by the sediment of my own particular mind. As Eigen (2014) stated, to write is:

> To accept mortality. My work would be imperfect. It would miss the thing itself, X, the Truly Real. It would be less than I wanted. To write, this had to be accepted, tolerated, admitted, like death. I would have to bear my work not being what I wanted it to be. (pp.126-127)

Not only have I failed to put the *Truly Real* into words, I have emphasized some facets of human experience and omitted others, accepted unprovable things as givens, and created constructions that, at least on the nondual plane, have no substance. Like all theory, my conceptualizations are self-disclosure. They tell of my personal proclivities and reveal aspects of the socio-cultural context in which I live. Beyond that, they are attempts to create structure, to organize experience, to find ground in a groundless existence. As a result, they paradoxically offer something, while simultaneously misguiding us. In the following subsections, I attempt to discuss the biases, omissions, and failures that theoretically and clinically render my description of my ideas unfinished, imperfect, and ultimately mortal.

Theoretical Limitations

As noted above, my conceptualizations are influenced by the postmodern and spiritual worldviews and minimally by the secular-humanist worldview that gave rise to an understanding of intrapsychic phenomena. As a result, my ideas tilt toward the intersubjective and spiritual facets of human life. Although I discuss subjectivity as a dual construct and discuss subject-to-subject and subject-to-object relating, the focus of my discussion of the therapeutic process is on: the interpersonal process through which subjectivity arises, the resolution of intersubjective and nondual enactments, and the need to and means of healing the wounds of alienation. This emphasis can leave the unconscious and the classical psychoanalytic process of working through intrapsychic dynamics in the shadows.

This limitation is consistent with other critiques of postmodern relational and intersubjective theories. From this vantage point, when the intersubjective realm is

emphasized, the meaning and role of the unconscious is under-discussed and under-developed (Cohen & Schermer, 2004; Layton, 2008; Mills, 2005). Because the concepts of depth and the unconscious were initially formulated within an intrapsychic (one-person) model, the application of these concepts to intersubjective and relational (two-person) perspectives has been limited (Cohen & Schermer, 2004). In addition, some relational and intersubjective writers have at times "reifie[d] intersubjectivity at the expense of subjective life; subordinat[ing] the role, scope, and influence of the unconscious" (Mills, 2005, p. 167). There are some relational writers (e.g., Donnel Stern, Phillip Bromberg, Thomas Ogden, and Jody Messler Davies), however, who have attended to unconscious processes in their writings (Mills, 2005). In particular, this has been addressed by suggesting that the unconscious consists of dissociated self-states and modes of being that result from relational experiences in which the parent or other has implicitly or explicitly deemed some aspect of the self unacceptable (Bromberg, 1998, 2003; Layton, 2008). While I have referred to this aspect of theory regarding unconscious processes in my conceptualization of intersubjective enactments, this fails to fully address that which may arise from and remain relegated to the unconscious not only because it is disavowed by the relational environment, but because it is intolerable to the individual mind. In this way, the ideas presented in this dissertation do not sufficiently address primitive states, intrapsychic conflicts, and other dynamics of the unconscious.

In addition, although I mention Winnicott's ideas regarding aggression and discuss a nondual interpretation of aggression, I do not describe how these two conceptualizations fit within a framework that bridges dual and nondual phenomena. This limitation may reveal a personal bias as well as a vulnerability of the spiritual worldview,

which privileges themes of altruism and unity. In contrast, classical psychoanalysis privileged themes of sexuality and aggression. This influence was still present in Winnicott's thinking even as his theory spanned the secular-humanist and postmodern worldviews. Winnicott viewed aggression as innate and pre-reactive to frustration and delineated part-object aggression, which is synonymous with activity, from whole-object aggression in which destructive urges are organized around establishing or securing oneself as a distinct unit. In this dissertation, I borrow from Winnicott and suggest that coalescing as a unique subjectivity facilitates feelings of aliveness and self-assertion, while I simultaneously suggest that the experience of oneself as separate or distinct is an illusion of duality. This begs the question, if aggression, from within a dual platform, can be understood as urges and attempts to establish or secure oneself, how does this coexist with the nondual premise that aggression is a negation of unity? In other words, given a theoretical perspective that embraces both dual and nondual realms of being, how does one distinguish the differences between innate and life-supporting acts of aggression and deluded acts of ego-clinging? This complicated area of inquiry is not taken up in this dissertation. As a result, it does not offer a way of discerning when the patient needs the therapist to empathize with and in so doing support and facilitate the expression and working through of aggression and when the patient needs the therapist to engage compassionately with aggression as a source of suffering.

Clinical Limitations

I maintain that empathy needs to be balanced with compassion and the nondual realm with that of the dual, but I do not specify how a therapist is to achieve this. I also do not demonstrate, through clinical examples, what is happening during empathic and

compassionate exchanges and how one is recognizable from the other. As a result, I do not provide insight into technique and clinical intervention. This level of specificity will ultimately be needed to bring these ideas into practice. Further, I mention Buddhist practices that are designed to cultivate access to compassion, but do not discuss how these practices translate to nondual compassion in the psychotherapeutic context.

While these limitations may reflect aspects of the narrow scope of a theoretical dissertation, they also reflect vulnerabilities inherent in both the postmodern and spiritual worldview. When the secular-humanist perspective informs the practice of psychotherapy, it brings the precision of science to interventions; however, when the postmodern and spiritual perspectives inform the practice of psychotherapy, they bring a multiplicity and an ineffable quality that are difficult to quantify and cannot be captured by specific techniques. In the *lojong* practice, one of the slogans of contemplation is *regard all dharmas as dreams*. In Trungpa's (2003) words, this teaching reminds us that "everything is shifty" (p. 17). Despite appearances, nothing is solid. Similarly, I have presented my ideas and their limitations as if they are substantial and as if they offer therapists a reliable filter through which to make meaning. In actuality both are fluid, illusive, and faulty attempts to grasp the ungraspable. As a result, they are best held softly with a dreamy quality. Only then do they begin to approximate the subtle mystery of what transpires between therapist and patient, or the *Truly Real*.

Areas for Further Research and Exploration

Winnicott's understanding of aggression was deeply influenced by classical psychoanalysis. Similar to both Freud and Klein, Winnicott considered hate or ruthlessness as primary to love. As a result, his theories echo classical psychoanalysis in

its privileging of pre-reactive aggression as a central motivational drive. Yet as Eigen (1981) stated, "to select hate as the primary moment of a subtle experiential flow is simply to assert one's own phenomenological prejudice. Clinical and life evidence can be marshaled for either view – primary love or hate" (p. 108). Therefore, it is not surprising that some postclassical approaches have taken alternative perspectives. Attachment theory, for example, has privileged fear as fundamental and suggests that aggression is reactive to threats to physical and psychological survival. As Slade (2008) stated, "in the traditional model, anxiety is the result of threatened aggression from within; in the attachment model, aggression is a response to anxiety about both internal and external threats to one's essential safety and integrity" (p. 776). Freud's privileging of aggression may have had much to do with his understanding of most psychopathology as being of Oedipal origin. In contrast, attachment theory emphasizes pre-Oedipal psychopathology and focuses on helping patients relinquish defenses and other maladaptive behaviors that developed in order to secure survival. In Slade's (2008) words:

> From this perspective, the defenses not only function to protect the ego from unbearable affects, but also to protect the *other* from unbearable affects (e.g., rage at a caregiver for absence or abandonment), and to protect the self from thus *losing* the other (even if only internally). And aggression is seen as reactive to fear, rather than fear being the result of inherent aggression. (p. 776)

Thus, in addition to understanding aggression as activity in the context of part-object relating and as an innate and pre-reactive means of securing oneself, it can also be understood as a reactive means of protecting oneself and one's relational field.

This understanding opens new areas of inquiry when integrating dual and nondual phenomena into psychoanalytic theory and practice. On the dual plane, discerning in any given moment if a patient is presenting with an essentially aggressive or an essentially fear-based organization (which may reflect Oedipal or pre-Oedipal organizations, respectively) may be helpful in accurately empathizing with the patient. From a nondual perspective, both aggression and fear reflect some form of clinging to or resistance to what is present and both are expressions of and causes of suffering. As a result, therapists who attend to both the relative and the absolute realms of life move between empathically resonating with, metabolizing and reflecting aggression (that may be reactive or pre-reactive) and fear (that may be based in self or interpersonal preservation), and compassionately receiving and accepting these experiences while acting from insight into their relationship to suffering. An exploration of each of these facets and their intersections would be useful in more fully conceptualizing how psychotherapy can facilitate psychospiritual wellbeing.

Also, an approach to treatment that integrates empathy and compassion across dual and nondual realities may address both aggression and fear, while simultaneously privileging a different aspect of human experience. How exactly this emphasis will come to be articulated remains to be seen. However, it may speak to the pathology of alienation that arises when our longing to feel a part of the larger whole is unfulfilled. It may speak to our fundamentally interconnected nature and the suffering that arises when that is negated.

Other areas for further exploration and research include understanding how a balance of empathy and compassion affects and relates to therapist burnout and how best

to cultivate and teach psychotherapists the capacities that underlie empathy and compassion. Interestingly, mindfulness meditation may offer practitioners a means of developing both attitudes. This practice involves noticing and accepting one's here-and-now thoughts and feelings without discursive judgment. According to Trungpa,

> What Buddhism has to teach the Western psychologist is how to relate more closely with his own experience, in its freshness, its fullness, and its immediacy. To do this, one does not have to become a Buddhist, but one does have to practice meditation. (2005, p. vii)

In terms of empathy, a familiarity with the workings of one's own mind and being able to notice subtle and fleeting fluctuations in feelings, thoughts, and sensations may facilitate the accuracy of empathy. Mindfulness meditation, however, also reveals the ever-changing and interdependent nature of existence and this level of realization exposes our fundamental universality. In this way, mindfulness meditation may also serve to expand one's access to compassion. In many Buddhist traditions, however, mindfulness meditation is foundational and other specific practices (e.g., *tonglen* and *lojong*) are used to cultivate, or in effect, to gain access to our innate capacity for compassion. How best to translate these practices to the Western psychotherapist has yet, to my knowledge, been explored and would be of great benefit to psychotherapists who seek to engage with patients through both the dual and nondual portals of experience.

THE SANVILLE INSTITUTE
PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project The Intersection of Empathy and Compassion in the Therapeutic Bond with Dual and Non-Dual Experiences in Psychotherapy - Sylvia Sussman

Principal Investigator: _____
(print name and degree)

Investigator: Terri Rubinstein
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the Student and Faculty Handbook), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

X Are not "at risk." - This is a theoretical dissertation project.

_____ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Sylvia Sussman, PhD
(signature of principal investigator/date)

Terri Rubenstein 10/10/16
(signature of investigator/date)

Action by the Committee on the Protection of Research Participants:

Approved ✓ Approved with Modifications _____ Rejected _____

Mary M. Cornuk Ph.D. Date 11/15/2016
Signature of representative of the Committee on the Protection of Research Participants

Sonya [illegible] PhD 12/1/2016
(signature of academic dean & date)

REFERENCES

Alford, F. (2007). Levinas, Winnicott and therapy. *The Psychoanalytic Review, 94*(4), 529-551. https://doi.org/10.1521/prev.2007.94.4.529

Analayo, B. (2015). *Compassion and emptiness in early Buddhist meditation.* Cambridge, UK: Windhorse Publications. https://doi.org/10.1177/0003065108322097

Aragno, A. (2008). The language of empathy: An analysis of its constitution, development, and role in psychoanalytic listening. *Journal of the American Psychoanalytic Association, 56*, 713-740.

Armstrong, K. (2010). *Twelve steps to a compassionate life.* New York, NY: Knopf.

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis.* Hillsdale, NJ: The Analytic Press.

Bass, A. (2001). It takes one to know one; Or, whose unconscious is it anyway? *Psychoanalytic Dialogues, 11*, 683-702. https://doi.org/10.1080/10481881109348636

Batson, C. D. (1991). *The altruism question: Towards a social-psychological answer.* Hillsdale, NJ: Erlbaum.

Beauregard, M., Courtemanche, J., Paquette, V., & St-Pierre, E. L. (2009). The neural basis of unconditional love. *Psychiatry Research, 172*(2), 93-98. https://doi.org/10.1016/j.pscychresns.2008.11.003

Benjamin, J. (1988). *The bonds of love: Psychoanalysis, feminism, and the problem of domination.* New York, NY: Pantheon.

Benjamin, J. (1995). *Like subjects, love objects: Essays on recognition and sexual difference.* New Haven, CT: Yale University Press.

Benjamin, J. (1999). Recognition and destruction: An outline of intersubjectivity. In S. Mitchell, & L. Aron (Eds.), *Relational psychoanalysis: The emergence of a tradition* (pp. 181-210). New York, NY: Routledge. (Original work published 1990)

Benjamin, J. (2004). Beyond doer and done-to: An intersubjective view of thirdness. *Psychoanalytic Quarterly, LXIII*(1), 5-46. https://doi.org/10.1002/j.2167-4086.2004.tb00151.x

Bernhardt, B. C., & Singer, T. (2012). The neural basis of empathy. *Annual Review of Neuroscience, 35*, 1-23. https://doi.org/10.1146/annurev-neuro-062111-150536

Bibeau, M., Dionne, F., & Leblanc, J. (2016). Can compassion meditation contribute to the development of psychotherapists' empathy? A review. *Mindfulness, 7*, 255-263. https://doi.org/10.1007/s12671-015-0439-y

Bion, W. R. (1965). *Transformations.* London, England: Heinemann.

Bion, W. R. (1970). *Attention and interpretation.* London, England: Tavistock.

Blackstone, J. (2006). Intersubjectivity and nonduality in the psychotherapeutic relationship. *The Journal of Transpersonal Psychology, 38*(1), 25-40. Retrieved from http://www.atpweb.org

Blackstone, J. (2007). *The empathic ground: Intersubjectivity and nonduality in the psychotherapeutic process.* Albany, NY: State University of New York Press.

Bogoda, R. (1994). *A simple guide to life.* Retrieved from http://enlight.lib.ntu.edu.tw /FULLTEXT/JR-AN/an140439.pdf

Bohart, A., Elliott, R., Greenberg, L., & Watson, J. (2002). Empathy. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 89-108). New York, NY: Oxford University Press.

Bohart, A. C., & Greenberg, L. S. (Eds). (1997). *Empathy reconsidered: New directions in psychotherapy.* Washington, D.C.: American Psychological Association.

Bornemann, B., & Singer, T. (2013). A cognitive neuroscience perspective: The ReSource model. In T. Singer & M. Bolz (Eds.), *Compassion: Bridging science and compassion* (pp. 178-191). Retrieved from http://www.compassion-training.org/?page=download&lang=en

Boyce, J. (2015). *Born bad: Original sin and the making of the Western world.* Berkeley, CA: Counterpoint Press.

Bozarth, J. D. (1997). Empathy from the framework of client-centered theory and the Rogerian hypothesis. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 81-102). Washington, D.C.: American Psychological Association. http://dx.doi.org/10.1037/10226-003

Bromberg, P. (1998). Speak that I may see you: Some reflections on dissociations, reality, and psychoanalytic listening. In P. Bromberg (Ed.), *Standing in the spaces: Essays on clinical process, trauma and dissociation* (pp. 241-266). New York, NY: Psychology Press.

Bromberg, P. (2003). Something wicked this way comes: Trauma, dissociation, and conflict: The space where psychoanalysis, cognitive-science and neuroscience overlap. *Psychoanalytic Psychology, 20*(3), 558-574. https://doi.org/10.1037/0736-9735.20.3.558

Buddhaghosa, B. (2010). *The path of purification: Visuddhimagga.* (B. Nanamoli, Trans.). Retrieved from http://www.accesstoinsight.org/ lib/authors/nanamoli/PathofPurification2011.pdf

"Buddha Biography." (2014). Retrieved from http://www.biography.com/people/ buddha-9230587

Buddha Dharma Education Association Inc. (BDEA). (2008). *Buddhism and women.* Retrieved from http://www.buddhanet.net/e-learning/history/pajapati.htm

Chessick, R. D. (1998). Empathy in psychotherapy and psychoanalysis. *Journal of the American Academy of Psychoanalysis, 26*(4), 487-502. Retrieved from http://aapdp.org/index.php/publications/journal/

Chodron, P. (1997). *When things fall apart: Heart advice for difficult times.* Boston, MA: Shambhala.

Chodron, P. (2001). *Start where you are: A guide to compassionate living.* Boston, MA: Shambhala.

Chodron, P. (2002). *The places that scare you: A guide to fearlessness in difficult times.* Boston, MA: Shambhala.

Chodron, P. (2006). *Practicing peace in times of war.* Boston, MA: Shambhala.

Chodron, P. (2012). *Living beautifully with uncertainty and change.* Boston, MA: Shambhala.

Chodron. P. (2013). *How to meditate: A practical guide to making friends with your mind.* Boulder, CO: Sounds True.

Clark, A. J. (2007). *Empathy in counseling and psychotherapy: Perspectives and practices.* Mahwah, NJ: Lawrence Erlbaum Associates.

Cohen, B. D., & Schermer, V. L. (2004). Self-transformation and the unconscious in contemporary psychoanalytic therapy: The problem of "depth" within a relational and intersubjective frame of reference. *Psychoanalytic Psychology, 21*(4), 580-600. https://doi.org/10.1037/0736-9735.21.4.580

Compassion (n.d.). In*Oxforddictionaries.com.* Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/compassion

Coplan, A. (2011). Understanding empathy: Its features and effects. In A. Coplan & P. Goldie (Eds.), *Empathy: Philosophical and psychological perspectives* (pp. 3-18). New York, NY: Oxford University Press.

Coplan, A., & Goldie, P. (2011). Introduction. In A. Coplan & P. Goldie (Eds.), *Empathy: Philosophical and Psychological Perspectives* (pp. IX-XLVII). New York, NY: Oxford University Press.

Dalai Lama. (2001). *An open heart: Practicing compassion in everyday life.* N. Vreeland (Ed.). Boston, MA: Little Brown and Company.

Dalai Lama. (2003). *Lighting the path: The Dalai Lama teaches on wisdom and compassion.* South Melbourne, Australia: Thomas C. Lothian.

Darnall, K. T. (2008). Contemplative psychotherapy: Integrating Western psychology and Eastern philosophy. In F. J. Kaklauskas, S. Nimanheminda, L. Hoffman, & M. S. Jack (Eds.), *Brilliant sanity: Buddhist approaches to psychotherapy* (pp. 299-308). Colorado Springs, CO: University of the Rockies Press.

Eagle, M., & Wolitzky, D. L. (1997). Empathy: A psychoanalytic perspective. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in*

psychotherapy (pp. 217-244). Washington, DC: American Psychological Association.

Eigen, M. (1981). Guntrip's analysis with Winnicott – a critique of Glatzer and Evans. *Contemporary Psychoanalysis, 17*, 103-111. https://doi.org/10.1080/00107530.1981.10745646

Eigen, M. (2014). Moments that count. In S. Kuchuk (Ed.), *Clinical implications of the psychoanalyst's life* (pp. 125-134). New York, NY: Routledge.

Eisenberg, N., & Strayer, J. (1987). Critical issues in the study of empathy. In N. Eisenberg & J. Strayer (Eds.), *Empathy and its development* (pp. 3-16). Cambridge, England: Cambridge University Press.

Engstrom, M., & Soderfeldt, B. (2010). Brain activation during compassion meditation: A case study. T*he Journal of Alternative and Complementary Medicine, 16*(5), 597-599. https://doi.org/10.1089/acm.2009.0309

Epstein, M. (2007). *Psychotherapy without the self: A Buddhist perspective*. New Haven, CT: Yale University Press.

Epstein, M. (2013). *The trauma of everyday life.* New York, NY: Penguin Books.

Eshel, O. (2013). Patient-analyst "withness": On analytic "presencing," passion, and compassion in states of breakdown, despair, and deadness. *The Psychoanalytic Quarterly, LXXXII*(4), 925-963. https://doi.org/10.1002/j.2167-4086.2013.00065.x

Evans, J., Shenpen, A., & Townsend, P. (2008). Maitri space awareness: Developing the therapist within. In F. J. Kaklauskas, S. Nimanheminda, L. Hoffman & M. S. Jack (Eds.), *Brilliant sanity: Buddhist approaches to psychotherapy* (pp. 195-211). Colorado Springs, CO: University of the Rockies Press.

Fenichel, O. (1953). *The collected papers of Otto Fenichel: First series*. D. Rapaport (Ed.). New York, NY: W. W. Norton.

Ferenczi, S. (1949). Confusion of tongues between the adults and the child – (The language of tenderness and of passion). *International Journal of Psycho-Analysis, 30*, 225-230. Retrieved from http://onlinelibrary.wiley.com/

Ferenczi, S. (1955). The elasticity of psychoanalytic technique. In *Final contributions to the problems and methods of psychoanalysis by Sandor Ferenczi, M.D.* (Vol. 3). New York, NY: Basic Books. (Original work published 1928)

Fischer, N. (2012). *Training in compassion: Zen teachings on the practice of lojong*. Boston, MA: Shambhala.

Fliess, R. (1942). The metapsychology of the analyst. *The Psychoanalytic Quarterly, 11*, 211-227. Retrieved from http://psycnet.apa.org/

Freud, S. (1955). Group psychology and the analysis of the ego. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund*

Freud (Vol. 18). London, England: Hogarth Press. (Original work published 1921)

Freud, S. (1958a). Recommendations to physicians practicing psycho-analysis. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12; pp. 109-120). London, England: Hogarth Press. (Original work published 1912)

Freud, S. (1958b). On beginning the treatment. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12; pp. 121-141). J. Strachey (Ed. and Trans.). London, England: Hogarth Press. (Original work published 1913)

Freud, S. (1961). *Civilization and its discontents* (J. Strachey, Trans.). New York, NY: W. W. Norton & Co. (Original work published 1930)

Frie, R. (2010). Compassion, dialogue, and context: On understanding the other. *International Journal of Psychoanalytic Self Psychology, 5*, 451-466. https://doi.org/10.1080/15551024.2010.508212

Fromm, E. (1960). *Psychoanalysis & Zen Buddhism.* London, UK: Unwin Paperbacks.

Fromm-Reichmann, F. (1950). *Principles of intensive psychotherapy.* Chicago, IL: The University of Chicago Press.

Gargiulo, G. J. (2010a). Mind, meaning, and quantum physics: Models for understanding the dynamic unconscious. *Psychoanalytic Review, 97*, 91-106. doi: 10.1521/prev.2010.97.1.91

Gargiulo, G. J. (2010b). *The psychoanalytic unconscious in a quantum world: A contribution to interactional psychoanalysis.* Mt Sinai Hospital, NYC March 23, 2010 [Transcript]. Retrieved from http://internationalpsychoanalysis.net/wp-content/uploads/2010/0/GargiuloThePsychoanalyticUnconsciousinaQuantumWorld.pdf

Gargiulo, G. J. (2016). *Quantum psychoanalysis: Essays on physics, mind and analysis today.* New York, NY: International Pyschoanalytic Press.

Ghent, E. (1999). Masochism, submission, surrender: Masochism as a perversion of surrender. In S. Mitchell & L. Aron (Eds.), *Relational Psychoanalysis: The emergence of a tradition* (pp. 211-242) New York, NY: Routledge.

Gibbons, S. B. (2011). Understanding empathy as a complex construct: A review of the literature. *Clinical Social Work Journal, 39*, 243-252. https://doi.org/10.1007/s10615-010-0305-2

Gilbert, P. (2009a). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2009b). *The Compassionate mind: A new approach to life's challenges.* Oakland, CA: New Harbinger Publications.

Gilbert, P. (2009c). *Overcoming depression: A self-help guide using cognitive behavioral techniques*. London, England: Constable & Robinson.

Gilbert, P. (2013). The flow of life: An evolutionary model of compassion. In T. Singer & M. Bolz (Eds.), *Compassion: Bridging science and compassion* (pp. 127-149). Retrieved from http://www.compassion-training.org/?page=download&lang=en

Gilbert, P., & Choden (2014). *Mindful compassion: How the science of compassion can help you understand your emotions, live in the present, and connect deeply with others.* Oakland, CA: New Harbinger.

Glaser, A. (2005). *A call to compassion: Bringing Buddhist practices of the heart into the soul of psychology*. Berwick, ME: Nicolas-Hays.

Goetz, J., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin, 136*(3), 351-374. https://doi.org/10.1037/a0018807

Goldie, P. (2011). Anti-empathy. In A. Coplan & P. Goldie (Eds.), *Empathy: Philosophical and psychological perspectives* (pp. 302-316). New York, NY: Oxford University Press.

Goldman, A. I. (2006). *Simulating minds: The philosophy, psychology, and neuroscience of mind-reading*. Oxford, England: Oxford University Press.

Goldman, A. I. (2011). Two routes to empathy: Insight from cognitive neuroscience. In A. Coplan & P. Goldie (Eds.), *Empathy: Philosophical and psychological perspectives* (pp. 31-44). New York, NY: Oxford University Press.

Grant, D., & Harari, E. (2011). Empathy in psychoanalytic theory and practice. *Psychoanalytic Inquiry, 31*, 3-16. http://dx.doi.org/10.1080/07351690.2010.512844

Greenberg, J. and Mitchell, S. (1983). *Object relations in psychoanalytic theory*, Cambridge, MA: Harvard University Press.

Grossman, P. (2013). Kindness and compassion as integral to mindfulness: Experiencing the knowable in a special way. In T. Singer & M. Bolz (Eds.), *Compassion: Bridging science and compassion* (pp. 192-226). Retrieved from http://www.compassion-training.org/?page=download&lang=en

Grotstein, J. S. (1981). Wilfred R. Bion: The man, the psychoanalyst, the mystic a perspective on his life and work. *Contemporary Psychoanalysis, 17*, 501-536. https://doi.org/10.1080/00107530.1981.10746566

Grotstein, J. S. (2004). The seventh servant: The implications of a truth drive in Bion's theory of 'O'. *The International Journal of Psychoanalysis, 85*, 1081-1101. https://doi.org/10.1516/0020757042259485

Halifax, J. (2013). Understanding and cultivating compassion in clinical settings: The A.B.I.D.E. compassion model. In T. Singer & M. Bolz (Eds.), *Compassion:*

Bridging science and compassion (pp. 208-226). Retrieved from http://www.compassion-training.org/?page=download&lang=en

Halpern, J. (2001). *From detached concern to empathy: Humanizing medical practice.* New York, NY: Oxford University Press.

Hein, G., Silani, G., Preuschoff, K., Batson, C. D., & Singer, T. (2010). Neural responses to ingroup and outgroup member's suffering predict individual differences in costly helping. *Neuron, 68*(1), 149-160. https://doi.org/10.1016/j.neuron.2010.09.003

Hoffman, M. (2000). *Empathy and moral development: Implications for caring and justice.* Cambridge, England: Cambridge University.

Hopkins, J. (2001). *Cultivating compassion: A Buddhist perspective.* New York, NY: Broadway Books.

Hume, D. (1978). *A treatise of human nature.* In P. H. Nidditch (Ed.). Oxford, England: Oxford University Press (Original work published 1939)

Husserl, E. (1977). *Cartesian mediations: Introduction to phenomenology.* The Hague, Netherlands: Martinus Nijhoff.

Husserl, E. (1989). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: Second book: Studies in the phenomenology of constitution.* (R. Rojcewicz & A. Schuwer, Trans.). Dordrecht, Netherlands: Kluwer Academic.

Jacobs, M. (1995). *Winnicott.* London, England: Sage.

Jung, C. G. (1960). The significance of constitution and heredity in psychology. In C. G. Jung (Ed.), *Collected Works* (Vol. 8; pp. 229–230). London, England: Routledge & Kegan Paul Ltd. (Original work published 1929)

Jung, C. G. (1976). *The visions seminars* (Vol. 1). Zurich, Switzerland: Spring Publications.

Kahn, M. (1991). *Between therapist and client: The new relationship.* New York, NY: W. H. Freeman.

Kahn, E., & Rachman, A. W. (2000). Carl Rogers and Heinz Kohut: A historical perspective. *Psychoanalytic Psychology, 17,* 294-312. http://dx.doi.org/10.1037/0736-9735.17.2.294

Keltner, D. (2009). *Born to be good: The science of a meaningful life.* New York, NY: W. W. Norton.

Klein, M. (1952). The origins of transference. *International Journal of Psychoanalysis, 33,* 433-438. Retrieved from http://onlinelibrary.wiley.com

Klein, M. (1975a). Envy and gratitude. In *Envy and gratitude and other works 1946-1963* (Vol. III; pp. 176-235). New York, NY: Delacorte Press. (Original work published 1957)

Klein, M. (1975b). Mourning and its relation to manic depressive states. In *Melanie Klein: Love, guilt, and reparation* New York: Delacorte Press. (Original work published 1940).

Klimecki, O. M., Leiberg, S., Lamm, C., & Singer, T. (2012). Functional neural plasticity and associated changes in positive affect after compassion training. *Cerebral Cortex, 23*(7), 1552-1561. doi:10.1093/cercor/bhs142

Klimecki, O. M., Leiberg, S., Ricard, M., & Singer, T. (2014). Differential pattern of functional brain plasticity after compassion and empathy training. *Social cognitive and affective neuroscience, 9*(6), 873-879. doi: 10.1093/scan/nst060

Klimecki, O., Ricard, M., & Singer, T. (2013). Empathy versus compassion. In T. Singer & M. Bolz (Eds.), *Compassion: Bridging science and compassion* (pp. 272-287). Retrieved from http://www.compassion-training.org/?page=download&lang=en

Kohut, H. (1959). Introspection, empathy and psychoanalysis: An examination of the relationship between mode of observation and theory. *Journal of American Psychoanalytic Association, 7,* 459-483. https://doi.org/10.1177/000306515900700304

Kohut, H. (1971). *The analysis of the self.* New York, NY: International Universities Press.

Kohut, H. (1977). *Restoration of the self.* New York, NY: International Universities Press.

Kohut, H. (1978). Psychoanalysis in a troubled world. In P. H. Ornstein (Ed.), *The search for the self* (Vol. 2; pp. 511-546). New York, NY: International Universities Press (Original work published 1973)

Kohut, H. (1982). Introspection, empathy, and the semi-circle of mental health. *International Journal of Psychoanalysis, 63,* 395-407. Retrieved from http://onlinelibrary.wiley.com/

Kohut, H. (1984). *How does analysis cure?* A. Goldberg & P. E. Stepansky (Eds.). Chicago, IL: The University of Chicago Press.

Kohut, H. (1991). On Empathy. In P. H. Ornstein (Ed.), *The search for the self: Selected writings of Heinz Kohut: 1978-1981* (Vol. 4; pp. 525-536). Madison, CT: International Universities Press.

Kohut, H., Tolpin, P., & Tolpin, M. (1996). *Heinz Kohut: The Chicago Institute lectures.* Hillsdale, NJ: Analytic Press.

Kornfield, J. (2009). *The wise heart: A guide to the universal teachings of Buddhist psychology.* New York, NY: Bantam Books.

Kringelbach, M. L., & Berridge, K. C. (2009). Towards a functional neuroanatomy of pleasure and happiness. *Trends in Cognitive Sciences, 13*(11), 479-487. https://doi.org/10.1016/j.tics.2009.08.006

Kulka, R. (2008). From civilization and its discontents to culture of compassion: Optimistic contemplation on Freud's pessimism. In G. Shefler (Ed.), *Freud: Civilization and Psychoanalysis* (pp. 98-121). Or-Yehuda, Israel: Kinneret, Zmora-Bitan, Dvir & Magnes Press.

Kyabgon, T. (2001). *The essence of Buddhism: An introduction to its philosophy and practice.* Boston, MA: Shambhala.

Kyabgon, T. (2007). *The practice of lojong: Cultivating compassion through training the mind.* Boston, MA: Shambhala.

Lamm, C., Decety, J., & Singer, T. (2011). Meta-analytic evidence for common and distinct neural networks associated with directly experienced pain and empathy for pain. *NeuroImage, 54*(3), 2492-2502. https://doi.org/10.1016/j.neuroimage.2010.10.014

Layton, L. (2008). Relational thinking: from culture to couch and couch to culture. In S. Clarke, H. Hahn, & P. Hoggett (Eds.), *Object Relations and Social Relations* (pp. 1-24). London, England: Karnac Books.

Lazarus, R. S. (1991). *Emotion and adaptation.* Oxford, England: Oxford University Press.

Lev, G. (2016). The question of aims: Psychoanalysis and the changing formulations of the life worth living. *Psychoanalytic Psychology, 33*(2), 312-333. https://doi.org/10.1037/pap0000025

Levinas, E. (1981). *Otherwise than being: Or, beyond essence.* Boston, MA: Nijhoff.

Lipps, T. (1903). *Asthetik.* (T. I. Leipzig, Trans.). Hamburg, Germany: Leopold Voss Verlag.

Lipps, T. (1931). Empathy, inward imitation and sense feelings. In E. F. Carritt (Ed.), *Philosophies of beauty: From Socrates to Robert Bridges being the sources of aesthetic theory* (pp. 252-256). Oxford, England: Clarendon (Original work published 1903)

Loewald, H. (1980). The ego and reality. In H. W. Loewald (Ed.), *Papers on Psychoanalysis* (pp. 3-20). New Haven, CT: Yale University Press. (Original work published 1949)

Loewald, H. (1980). Primary process, secondary process, and language. In H. W. Loewald (Ed.), *Papers on Psychoanalysis* (pp. 178-206). New Haven, CT: Yale University Press. (Original work published 1977)

Loewald, H. (1988). *Sublimation.* New Haven, CT: Yale University Press.

Loy, D. (2003). *The great awakening: A Buddhist social theory*. Somerville, MA: Wisdom.

MacIsaac, D. S. (1997). Empathy: Heinz Kohut's contribution. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 245-264). Washington, DC: American Psychological Association.

Makari, G. (2008). *Revolution in mind: The creation of psychoanalysis*. New York, NY: Harper Perennial.

Makransky, J. (2012). Compassion in Buddhist psychology. In C. K. Germer & R. D. Siegel (Eds.), *Wisdom and compassion in psychotherapy* (pp. 61-78). New York, NY: The Guilford Press.

Mills, J. (2005). A critique of relational psychoanalysis. *Psychoanalytic Psychology, 22*(2), 155-188. https://doi.org/10.1037/0736-9735.22.2.155

Mitchell, S. (1988). *Relational concepts in Psychoanalysis: An integration (5th ed.)*. Cambridge, MA: Harvard University Press.

Mitchell, S. (2000). *Relationality: From attachment to intersubjectivity*. Hillsdale, NJ: The Analytic Press.

Mitchell, S., & Black, M. (1995). *Freud and beyond: A history of modern psychoanalytic thought*. New York, NY: BasicBooks.

Modell, A. H. (1985). The works of Winnicott and the evolution of his thought. *Journal of the American Psychoanalytic Association, 33S*, 113-137. Retrieved from https://us.sagepub.com

Nachin, C. (2001). From 'tact' in Ferenczi to 'resonance' in Nicolas Abraham. *Psychoanalysis and History, 3*(2), 171-177. Retrieved from http://www.euppublishing.com

Nhat Hanh, T. (1988). *The heart of understanding*. Berkeley, CA: Parallax Press.

Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education.* Berkeley, CA: University of California Press.

Ogden, T. H. (1997). *Reverie and interpretation: Sensing something human*. London, England: Karnac.

Ogden, T. H. (1999). The analytic third: Working with intersubjective clinical facts. In S. Mitchell & L. Aron (Eds.), *Relational psychoanalysis: The emergence of a tradition* (pp. 459-486) New York, NY: Routledge. (Original work published 1994)

Ogden, T. H. (2004). The analytic third: Implications for psychoanalytic theory and technique. *Psychoanalytic Quarterly, 73*, 167-195. https://doi.org/10.1002/j.2167-4086.2004.tb00156.x

Ohnuma, R. (2006). Debt to the mother: A neglected aspect of the founding of the Buddhist Nuns' Order. *Journal of the American Academy of Religion 74*(4), 861-901.

Orange, D. (1995). *Emotional understanding*. New York, NY: Guilford Press.

Orange, D. (2006). For whom the bell tolls: Context, complexity, and compassion in psychoanalysis. *International Journal of Self Psychology, 1*, 5-21.

Orange, D. (2010). *Thinking for clinicians: Philosophical resources for contemporary psychoanalysis and the humanistic psychotherapies*. New York, NY: Routledge.

Orange, D. (2011). *The suffering stranger: Hermeneutics for everyday clinical practice.* New York, NY: Routledge.

Orange, D., Atwood, G., & Stolorow, R. (1997). *Working intersubjectively: Contextualism in psychoanalytic practice.* Hillsdale, NJ: The Analytic Press.

Orbach, S. (2008). Democratizing psychoanalysis. In S. Clarke, H. Hahn, & P. Hoggett (Eds.), *Object relations and social relations* (pp. 25-44). London, England: Karnac Books, Ltd.

Phillips, A. (1988). *Winnicott.* Cambridge, MA: Harvard University Press.

Post, S. G. (2002). The tradition of agape. In S. G. Post, L.G. Underwood, J. P. Schloss, & W. B. Hurlbut (Eds.), *Altruism and altruistic love; Science, philosophy, and religion in dialogue* (pp. 51-64). New York, NY: Oxford University Press.

Rachman, A. W. (1988). The rule of empathy: Sandor Ferenczi's pioneering contributions to the empathic method in psychoanalysis. *Journal of the American Academy of Psychoanalysis*, *16*(1), 1-27. Retrieved from https://www.pep-web.org

Rank, O. (1941). *Beyond psychology*. New York, NY: Dover.

Ricard, M. (2015). *Altruism: The power of compassion to change yourself and the world.* New York, NY: Little, Brown and Company.

Ringstrom, P. A. (2010). Meeting Mitchell's challenge: A comparison of relational psychoanalysis and intersubjective systems theory. *Psychoanalytic Dialogues*, *20*(2), 196-218. https://doi.org/10.1080/10481881003716289

Rogers, C. R. (1942). *Counseling and psychotherapy: New concepts in practice.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95-103. Retrieved from http://www.apa.org

Rogers, C. R. (1975). Empathic: An unappreciated way of being. *The Counseling Psychologist*, *5*(2), 2-10. https://doi.org/10.1177/001100007500500202

Rogers, C. R. (1986). Rogers, Kohut, and Erickson: A personal perspective on some similarities and differences. *Person-Centered Review*, *1*(2), 125-140. Retrieved from http://psycnet.apa.org

Rumi. (1995). *Rumi: Selected poems.* (C. Banks with J. Moyne, A. J. Arberry, & R. Nicholson, Trans.). New York, NY: Penguin Books.

Salzberg, S. (2002). *Loving-kindness: The revolutionary art of happiness.* Boston, MA: Shambhala.

Shaughnessy, P. (1995). Empathy and the working alliance. *Psychoanalytic Psychology*, *12*(2), 221-231. https://doi.org/10.1037/h0079632

Shelton, C. (2010). Spirituality, mental health and the new physics. *International Journal of Applied Psychoanalytic Studies*, *7*(2), 161-171. Retrieved from http://onlinelibrary.wiley.com

Siegel, R. D., & Germer, C. K. (2012). Wisdom and compassion: Two wings of a bird. In C. K. Germer & R. D. Siegel (Eds.), *Wisdom and compassion in psychotherapy* (pp. 7-34). New York, NY: The Guilford Press.

Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology*, *24*(18), R875-R878. https://doi.org/10.1016/j.cub.2014.06.054

Singer, T., Seymour, B., O'Doherty, J., Kaube, H., Dolan, R. J., & Frith, C. D. (2004). Empathy for pain involves the affective but not sensory components of pain. *Science*, *303*(5661), 1157-1162. https://doi.org/10.1126/science.1093535

Slade, A. (2008). The implications of attachment theory and research for adult psychotherapy: Research and clinical perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 762-782). New York, NY: The Guilford Press.

Smith, J. (2002). *The beginner's guide to walking the Buddha's eightfold path.* New York, NY: Bell Tower.

Sprecher, S., & Fehr, B. (2005). Compassionate love for close others and humanity. *Journal of Social and Personal Relationships*, *22*(5), 629-651. https://doi.org/10.1177/0265407505056439

Stein, E. (1989). *On the problem of empathy: The collected works of Edith Stein* (Vol. 3; 3rd revised ed.). (W. Stein, Trans.). Washington, DC: ICS Publications.

Stern, D. B. (2004). The eye sees itself: Dissociation, enactment, and the achievement of conflict. *Contemporary Psychoanalysis*, *40*(2), 197–237. https://doi.org/10.1080/00107530.2004.10745828

Stolorow, R. D. (2011). From mind to world, from drive to affectivity: A phenomenological-contextualist psychoanalytic perspective. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis Journal*, *5*,1-14.

Stolorow R. D., & Atwood, G. E. (1992). *Contexts of being: The intersubjective foundations of psychological life.* Hillsdale, NJ: The Analytic Press.

Stolorow, R. D., Brandchaft, B., & Atwood, G. E. (1987). *Psychoanalytic treatment: An intersubjective approach.* Hillsdale, NJ: Analytic Press.

Stolorow, R. D., & Lachman, F. (1980). *Psychoanalysis of developmental arrests: Theory and treatment.* New York, NY: International Universities Press.

Strathearn, L., Fonagy, P., Amico, J., & Montague, P. R. (2009). Adult attachment predicts maternal brain and oxytocin response in infant cues. *Neuropsychopharmacology, 34*(13), 2655-2666. https://doi.org/10.1038/npp.2009.103

Stueber, K. (2014). Empathy. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy.* Retrieved from http://plato.stanford.edu/archives/win2014/entries/empathy/

Sullivan, H. (1953). *The interpersonal theory of psychiatry.* New York, NY: Norton.

Taylor C. (2007). *A secular age.* Cambridge, MA: Belknap Press of Harvard University Press.

Titchener, E. (1909). *Lectures on the experimental psychology of thought processes.* New York, NY: Macmillan.

Toth, J. (2010). *The passing of postmodernism: A spectroanalysis of the contemporary.* Albany, NY: State University of New York Press.

Townsend, P., & Kaklauskas, F. J. (2008). Therapist subjectivity in contemplative psychotherapy. In F. J. Kaklauskas, S. Nimanheminda, L. Hoffman, & M. S. Jack (Eds.), *Brilliant sanity: Buddhist approaches to psychotherapy* (pp. 39-65). Colorado Springs, CO: University of the Rockies Press.

Trungpa, C. (1969). *Meditation in action.* Boston, MA: Shambhala.

Trungpa, C. (1973). *Cutting through spiritual materialism.* Boston, MA: Shambhala.

Trungpa, C. (2003). *Training the mind and cultivating loving-kindness.* Boston, MA: Shambhala.

Trungpa, C. (2005). *The sanity we are born with: A Buddhist approach to psychology.* C. R. Gimian (Ed.). Boston, MA: Shambhala.

Trungpa, C. (2008). Preface: The meeting of Buddhist and Western psychology. In F. J. Kaklauskas, S. Nimanheminda, L. Hoffman, & M. S. Jack (Eds.), *Brilliant sanity: Buddhist approaches to psychotherapy* (pp. v-xii). Colorado Springs, CO: University of the Rockies Press.

Trungpa, C. (2013). *The profound treasury of the ocean of Dharma: The Bodhisattva path of wisdom and compassion* (Vol. 2). J. L. Lief (Ed.). Boston, MA: Shambhala.

Wallace, B. A. (2004). *The four immeasurables: Cultivating a boundless heart* (2nd ed.). Z. Houshmand (Ed.). Ithaca, NY: Snow Lion.

Walls, G. B. (2004). Toward a critical global psychoanalysis. *Psychoanalytic Dialogues, 14*(5), 605-634. https://doi.org/10.1080/10481880409353129

Wang, S. (2005). A conceptual framework for integrating research related to the physiology of compassion and the wisdom of Buddhist teachings. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research, and use of in psychotherapy* (pp. 75-120). New York, NY: Routledge.

Wegela, K. K. (2009). *The courage to be present: Buddhism, psychotherapy, and the awakening of natural wisdom.* Boston, MA: Shambhala.

Wegela, K. K. (2014). *Contemplative psychotherapy essentials: Enriching your practice with Buddhist psychology.* New York, NY: W. W. Norton & Co.

Williams, M. (1963). The indivisibility of the personal and collective unconscious. *Journal of Analytic Psychology, 8*(1), 45-50. https://doi.org/10.1111/j.1465-5922.1963.00045.x

Williams, D. C., & Levitt, H. M. (2007). A qualitative investigation of eminent therapists' values within psychotherapy: Developing integrative principles for moment-to-moment psychotherapy practice. *Journal of Psychotherapy, 17*(2), 159-184. https://doi.org/10.1037/1053-0479.17.2.159

Williams, D. C., & Lynn, S. (2010). Acceptance: An historical and conceptual review. *Imagination, Cognition, and Personality*, 30(1), 5-56.

Winnicott, D.W. (1958a). Aggression in relation to emotional development. In D. W. Winnicott (Ed.), *Through paediatrics to psycho-analysis* (pp. 204-218). New York, NY: Basic Books. (Original work published 1950)

Winnicott, D.W. (1958b). Hate in the countertransference. In D. W. Winnicott (Ed.), *Through paediatrics to psycho-analysis* (pp. 194-203). New York, NY: Basic Books. (Original work published 1947)

Winnicott, D.W. (1958c). Primary maternal preoccupation. In D. W. Winnicott (Ed.), *Through paediatrics to psycho-analysis* (pp. 300-305). New York, NY: Basic Books. (Original work published 1956)

Winnicott, D.W. (1958d). Primitive emotional development. In *Through paediatrics to psycho-analysis* (pp. 145-156). New York, NY: Basic Books. (Original work published 1945)

Winnicott, D. W. (1965a), Communicating and not communicating leading to a study of certain opposites. In D. W. Winnicott (Ed.), *The maturational processes and the facilitating environment* (pp. 179-192). New York, NY: International Universities Press (Original work published in 1963)

Winnicott, D.W. (1965b). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment* (pp. 140-152). New York, NY: International Universities Press. (Original work published 1960)

Winnicott, D.W. (1965c). The development of the capacity for concern. In *The maturational processes and the facilitating environment* (pp. 73-82). New York, NY: International Universities Press. (Original work published 1963)

Winnicott, D.W. (1965d). The theory of the parent-infant relationship. In *The maturational processes and the facilitating environment* (pp. 37-55). New York, NY: International Universities Press. (Original work published 1960)

Winnicott, D.W. (1969). The use of an object. *International Journal of Psycho-Analysis*, 50, 711-716. Retrieved from http://onlinelibrary.wiley.com/

Winnicott, D.W. (2005a). Creativity and its origins. In D.W. Winnicott (Ed.), *Playing and reality* (pp. 87-114). New York, NY: Routledge. (Original work published in 1971)

Winnicott, D.W. (2005b). Mirror- role of mother and family in child development. In D.W. Winnicott (Ed.), *Playing and reality* (pp. 149-159). New York, NY: Tavistock. (Original work published 1967)

Winnicott, D.W. (2005c). Transitional objects and transitional phenomena. In D.W. Winnicott (Ed.), *Playing and reality* (pp. 1-34). New York, NY: Tavistock. (Original work published 1953)