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CHAPTER 6

Empathy: Looking Out the Patient's Window

It's strange how certain phrases or events lodge in one's mind and offer ongoing guidance or comfort. Decades ago I saw a patient with breast cancer, who had, throughout adolescence, been locked in a long, bitter struggle with her naysaying father. Yearning for some form of reconciliation, for a new, fresh beginning to their relationship, she looked forward to her father's driving her to college—a time when she would be alone with him for several hours. But the long-anticipated trip proved a disaster: her father behaved true to form by grousing at length about the ugly, garbage-littered creek by the side of the road. She, on the other hand, saw no litter whatsoever in the beautiful, rustic, unspoiled stream. She could find no way to respond and eventually, lapsing into silence, they spent the remainder of the trip looking away from each other.

Later, she made the same trip alone and was astounded to note that there were *two* streams—one on each side of the road. "This time I was the driver," she said sadly, "and the stream I

saw through my window on the driver's side was just as ugly and polluted as my father had described it." But by the time she had learned to look out her father's window, it was too late—her father was dead and buried.

That story has remained with me, and on many occasions I have reminded myself and my students, "Look out the other's window. Try to see the world as your patient sees it." The woman who told me this story died a short time later of breast cancer, and I regret that I cannot tell her how useful her story has been over the years, to me, my students, and many patients.

Fifty years ago Carl Rogers identified "accurate empathy" as one of the three essential characteristics of the effective therapist (along with "unconditional positive regard" and "genuineness") and launched the field of psychotherapy research, which ultimately marshaled considerable evidence to support the effectiveness of empathy.

Therapy is enhanced if the therapist enters accurately into the patient's world. Patients profit enormously simply from the experience of being fully seen and fully understood. Hence, it is important for us to appreciate how our patient experiences the past, present, and future. I make a point of repeatedly checking out my assumptions. For example:

> "Bob, when I think about your relationship to Mary, this is what I understand. You say you are convinced that you and she are incompatible, that you want very much to separate from her, that you feel bored in her company and avoid spending entire evenings with her. Yet now, when she has made the move you wanted and has pulled away, you once again yearn for her. I think I hear you saying that you don't want to be with her, yet you cannot

bear the idea of her not being available when you might need her. Am I right so far?"

Accurate empathy is most important in the domain of the immediate present—that is, the here-and-now of the therapy hour. *Keep in mind that patients view the therapy hours very differently from therapists.* Again and again, therapists, even highly experienced ones, are greatly surprised to rediscover this phenomenon. Not uncommonly, one of my patients begins an hour by describing an intense emotional reaction to something that occurred during the previous hour, and I feel baffled and cannot for the life of me imagine what it was that happened in that hour to elicit such a powerful response.

Such divergent views between patient and therapist first came to my attention years ago, when I was conducting research on the experience of group members in both therapy groups and encounter groups. I asked a great many group members to fill out a questionnaire in which they identified critical incidents for each meeting. The rich and varied incidents described differed greatly from their group leaders' assessments of each meeting's critical incidents, and a similar difference existed between members' and leaders' selection of the most critical incidents for the entire group experience.

My next encounter with differences in patient and therapist perspectives occurred in an informal experiment, in which a patient and I each wrote summaries of each therapy hour. The experiment has a curious history. The patient, Ginny, was a gifted creative writer who suffered from not only a severe writing block, but a block in all forms of expressiveness. A year's attendance in my therapy group was relatively unproductive: She revealed little of herself, gave little of herself to the other members, and idealized me so greatly that any genuine

encounter was not possible. Then, when Ginny had to leave the group because of financial pressures, I proposed an unusual experiment. I offered to see her in individual therapy with the proviso that, in lieu of payment, she write a free-flowing, uncensored summary of each therapy hour expressing all the feelings and thoughts she had not verbalized during our session. I, for my part, proposed to do exactly the same and suggested we each hand in our sealed weekly reports to my secretary and that every few months we would read each other's notes.

My proposal was overdetermined. I hoped that the writing assignment might not only liberate my patient's writing, but encourage her to express herself more freely in therapy. Perhaps, I hoped, her reading my notes might improve our relationship. I intended to write uncensored notes revealing my own experiences during the hour: my pleasures, frustrations, distractions. It was possible that, if Ginny could see me more realistically, she could begin to de-idealize me and relate to me on a more human basis.

(As an aside, not germane to this discussion of empathy, I would add that this experience occurred at a time when I was attempting to develop my voice as a writer, and my offer to write in parallel with my patient had also a self-serving motive: It afforded me an unusual writing exercise and an opportunity to break my professional shackles, to liberate my voice by writing all that came to mind immediately following each hour.)

The exchange of notes every few months provided a *Rashomon*-like experience: Though we had shared the hour, we experienced and remembered it idiosyncratically. For one thing, we valued very different parts of the session. My elegant and brilliant interpretations? *She never even heard them.* Instead, she valued the small personal acts I barely noticed: my

complimenting her clothing or appearance or writing, my awkward apologies for arriving a couple of minutes late, my chuckling at her satire, my teasing her when we role-played.*

All these experiences have taught me not to assume that the patient and I have the same experience during the hour. When patients discuss feelings they had the previous session, I make a point of inquiring about their experience and almost always learn something new and unexpected. Being empathic is so much a part of everyday discourse—popular singers warble platitudes about being in the other's skin, walking in the other's moccasins—that we tend to forget the complexity of the process. It is extraordinarily difficult to know really what the other feels; far too often we project our own feelings onto the other.

When teaching students about empathy, Erich Fromm often cited Terence's statement from two thousand years ago—"I am human and let nothing human be alien to me"—and urged us to be open to that part of ourselves that corresponds to any deed or fantasy offered by patients, no matter how heinous, violent, lustful, masochistic, or sadistic. If we didn't, he suggested we investigate why we have chosen to close that part of ourselves.

Of course, a knowledge of the patient's past vastly enhances your ability to look out the patient's window. If, for example, patients have suffered a long series of losses, then they will view the world through the spectacles of loss. They may be dis-

*Later, I used the session summaries in psychotherapy teaching and was struck by their pedagogical value. Students reported that our joint notes took on the characteristics of an epistolary novel and eventually, in 1974, the patient, Ginny Elkin (a pseudonym), and I published them under the title *Every Day Gets a Little Closer*. Twenty years later, the book was released in paperback and began a new life. In retrospect the subtitle, *A Twice-Told Therapy*, would have been more apt, but Ginny loved the old Buddy Holly song and wanted to get married to its tune.

inclined, for example, to let you matter or get too close because of fear of suffering yet another loss. Hence the investigation of the past may be important not for the sake of constructing causal chains but because it permits us to be more accurately empathic.