



Converging through difference: A case of empathic incongruence in treatment of an elderly woman with psychosis

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ABSTRACT

Contemporary person-centered psychotherapy often references empathy as a basic component of the therapeutic alliance and, thus, effective treatment, such that nascent clinicians study this basic skill early in training. However, the psychotherapy literature often presumes a collective agreement about how empathy manifests as a clinical tool, in the process institutionalizing the ideal of omnipresent alignment with a client, applied across populations of patients, regardless of their conditions, ages, and personal and cultural characteristics. Misalignments between clinicians and clients have the potential to bely broadly imagined ethics of empathy (and the notion of collective agreement about what it is) by demonstrating the ways tension, difference, and incongruence promote treatment. Through an autoethnography of a 12-month psychotherapy dyad with an elderly woman committed for treatment at a U.S. psychiatric hospital, we discuss how moments of incongruence between clinician and client expand conceptualizations of empathy in treatment of psychosis. Specifically, in this context, deployment of empathy-as-alignment becomes a fallacy of care, risking the effectiveness of treatment through impossible epistemological assumptions of and counterproductive joining with the client. As such, this transtheoretical discussion presents two types of incongruence in the dyad—developmental and subjective—as a backdrop for expressing empathy. This paper makes space for a theory of empathy as the practice of working in genuine and careful service of the client's psychology through acts of incongruence as much as alignment.

Introduction

The concept of empathy has a primary, but often contradictory, position in American psychology. Central to psychotherapeutics oriented toward client-therapist alliance, and integral to a move away from paternalistic models that privileged clinician authority (Gay, 1989; Gurman & Messer, 1995; Ivey, Ivey, & Zalaquett, 2014), empathy's contextualized and conceptual malleability allows it to highlight both therapeutic values and the contradictions present in those values. Attributed to the work of Carl Rogers that began in the 1930s, empathy has remained a pivotal part of the way psychotherapy understands itself as a practice of care and facilitator of human development. With the therapeutic alliance considered by many to be the foundation for effective care, a frequently cited statistic reports that 30% of therapeutic relationships deemed “successful” by clients are due to basic factors underlying empathy: affirmation, caring, validation, and acceptance (Duncan, Miller, Wampold, & Hubble, 2010; Imel & Wampold, 2008; Kleinman, 1988). Likewise, even in the cognitive-behavioral turn of the second and third waves of clinical psychology, as therapists were

encouraged to take more vocal, directive, even didactic roles, empathy persisted as a principle of therapeutic efficacy (e.g., Bandura, 1977; Beck, 1976; Mueser, Rosenberg, & Rosenberg, 2009; Segal, Williams, & Teasdale, 2018), regardless of clinical presentations or treatment objectives. Empathy remains a pillar of therapeutic alliance, appearing in treatment manuals across different models of care (e.g., Frank & Frank, 1993; Ivey et al., 2014; Miller & Rollnick, 2012; Roemer & Orsillo, 2010; Thoma & McKay, 2014), as part of evidence-based practice, and among the basic skills of cognitive-behavioral therapies (Bohart & Tallman, 2007). And yet, though endorsed broadly, empathy produces little collective agreement on a clear definition (e.g., Hassenstab, Dziobek, Rogers, Wolf, & Convit, 2007; Hollan, 2012), a sign, perhaps, of the socially-embedded and malleable nature of psychotherapies, and, indeed, of the utility of open-ended ideas.

Perhaps the most common sense of empathy, often repeated as everyday wisdom, is the idea of “putting oneself in another's shoes.” The sartorial orientation of this notion - its implied reference to outside and inside, changeability, movement, feeling, and thought - suggests that one might gain experience of another's mindset. Though clinical

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empathy is rooted in the *emföhlung* of Robert Vischer's (1890, cited in Pigman, 1995) aesthetics and American mesmerism of in the 19th century (Pickren & Rutherford, 2010), Carl Rogers is typically credited with its introduction to psychotherapy in the 20th century. Characterizing a core skill of client-centered therapy, Rogers described empathy as occurring when the therapist "senses and expresses the client's felt meaning, catching what the client communicates as it seems to the client" (1967, p. 10). By so doing, the clinician resists diagnosis and shelves his own deductions about the client's case, including any unconscious or hidden meanings, while also allowing for extrapolating and restating the client's intended messages and perceptions (of internal and external experiences).

In Rogers (1951/1965) humanistic tradition, the role of therapists is to fully situate themselves in clients' psychological locale, temporarily inhabiting that world without interjection of questions or observations. Watson (2016) summarizes Rogers concept of empathy as "the ability to perceive accurately the internal frames of reference of others" (p. 115), while psychoanalyst Wolitzky (1995) frames this vision as "a partial, transient identification with the patient in which he/she attempts to apprehend in a cognitive-affective manner what it is like for the patient to experience his/her world" (p. 36). Indeed, in evocative psychotherapies, such as existential/humanistic approaches, the person-centered approach means the empathic clinician offers only a mirror, to borrow Freud's metaphor.

Empathy – as a principle, method, and goal – has also been operative in anthropology for several decades, consistently figuring in work toward understanding human subjectivity, culture and emotion, and the social and cultural dynamics of psychiatric and psychotherapeutic practices. In an influential strand of American medical anthropology, writing on doctor-patient interactions casts empathy as essential to the healing relationship and largely enacted through language (Kleinman, 1988). Arthur Kleinman, writing at the intersection of anthropology and psychiatry, attended to patients' stories as a process of "re-moralization" and "empathic witnessing," furthering the ethical goal of "existential commitment to be with the sick person and to facilitate his or her building of an illness narrative that will make sense of and give value to the experience" (1988, p. 54). For Kleinman, such congruence of purpose was central to the validating work of care. Likewise, anthropology's attention to empathy has also been a matter of method, of efficacy in anthropological terms, of encountering contradiction, challenges, and senses of limitation, as it poses empathy as at once a goal and a point of entry into more basic conundrums of life with others. Though put to different ends (theorizing social processes) than the therapeutic transformations Kleinman envisioned, ethnographic concerns with empathy – what it is, comparatively, and how it might serve our efforts – was similarly part of ethical stances, overt or implicit, and aligned with the methods, if not the goals, of therapeutics (Devereux, 1980). For ethnographers, empathy's limitations at points of incongruity – across cultures, languages, positionalities, and time – were likewise part of the work of knowing others.

We should ask, however, not just questions about what empathy means, but about what its failures mean, and how we know them. First, from the side of psychology, this must also include asking what it means to write inside and outside psychotherapy at the same time. From the side of anthropology, it might mean asking what it means to code-switch as a writer and clinician, whether and how it matters if one is "wrong" about disciplinary understandings. For example, empathy is known to occur when a client – not the clinician – deems it so (Gendlin, 1964, 1966; Rogers, 1951). Client-determined empathy might, understandably, suggest that "congruence" is an alignment of self and other. However, Rogers (1951) defined congruence not as a clinician's alignment with the client, but as the therapist's display of genuineness with the client, in other words, an authenticity that comes from a congruence between the clinician's behavior and thought. It is worth pausing in the space between the Rogerian sense of clinical congruence and the intersubjective and inextricably knotted thoughts and feelings at work in

the alliance. Here, congruence might come to mean a range of things, and empathy, as its agent, might be put into practice in various ways.

In this paper, we offer an essay at the limits of empathy, less to define empathy or its value to either anthropology or psychotherapy than to consider the kinds of work that happen in conversation with limitations. We do so in the spirit of a dialogue between a psychotherapist and an anthropologist, tracing empathy as a human, therapeutic, and analytic "attitude," in Rogerian terms, and stumbling upon the dilemmas that attitude produces. More specifically, this paper reflects on the practice of Dialectical Behavioral Therapy (DBT), engaging both empathy and congruence (in either sense) with the concept of *radical genuineness*. We present challenges in writing about empathy across disciplines (i.e., in terms of goals, ways of writing, and approaches to knowledge, categories, and concepts), reflections on how clinical practice produces a sense of the creative and experimental nature of empathy, and an inspection of the moral and practical concerns at play when a clinician engages the dialectic of radical genuineness.

This conversation is situated at the intersection of psychosis and aging, an important juncture at the edges of empathy. Care in later life condenses social crises of shifting political economies, demographics, and new forms and complexities of care (Buch, 2015) and identity (Erikson, 1959/1994). At the same time, dementia and Alzheimer's Disease, among a range of culturally-defined senses of transformation and loss attributed to old age, invoke moral reflection on the nature of the social as a source of such changes (Cohen, 1998), not to mention questions about the nature of the self (Sacks, 2019). New or altered forms of experience may, for some, appear to limit possibilities for communication and understanding while, for others, they may stretch understandings of how people "know" each other (Taylor, 2017). Psychosis may be similarly understood, inviting an expansion of what it means to be human or the battering down of norms (Jenkins & Barrett, 2004), as well as rearranging relations with a creative reckoning of what it means to be with and to know the perspective of another. Perhaps this contributes to why Rogers (1951) original undertaking of empathy research with schizophrenia patients established it as a basic clinical skill to be implemented with less serious mental illness.

Yet, according the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (American Psychiatric Association, 2013), the phenomenology of psychosis would appear to challenge the stability of empathy as a goal of therapeutic relationships. Positive symptoms of delusions, hallucinations, and disorganized speech and behavior are, by definition, unrelatable and, at their most severe, incomprehensible. Thought processes characterized as tangential and nonlinear are defined by their incomprehensibility as "not understandable to same-culture peers" (2013, p. 87). The often uncanny interlocking of extra-realistic expressions (in the form of delusions and hallucinations) with more recognizable frames of reference means that treatment can seem to go awry more often than it goes according to plan. The result may be that empathy becomes one of several balls the clinician juggles while attending to the client's needs, identity, and perspective. A client who asks, "What would you do if you were me?" thus presents a clinical challenge to the practitioner who aspires to bring warmth, validation, and compassion (i.e., empathic alignment) to treatment of an interlocutor with inaccessible, illogical, or unbearable perceptual experiences. As others have indicated (Henriksen, 2013; Jennings, 1987; Josephs & Josephs, 1986; Pienkos, 2015; Pienkos & Sass, 2012), psychosis offers a way of engaging with the possibilities of empathic failure, such that creatively working through intersubjective hiccups may not be a breakdown in the alliance but a validation of the psychosis experience as one of confusion and relational frustration – in other words, serving as a successful deployment of empathy. This notion, however, is amplified in U.S. forensic settings, as when a client has acted under psychosis and is deemed by the courts to be Not Guilty by Reason of Insanity (NGRI). Is there any relevance for such a model of empathy in this setting, and if so, how? What is the relevance of

incongruence with the client as part of psychosis treatment?

This paper is grounded in the clinical work of one author – a psychologist (Kristina), with reflection on the evolving practice of empathy in a single case, that involving a 72-year-old client with symptoms of delusional psychosis. Involving a 12-month treatment program for suicidal depression, Kristina's work with Rose (pseudonym) illuminates fallacies of empathy as emotional and cognitive alignment, showing this circumscription of empathy as a *breakdown* of the therapeutic project. In this case, a reckoning with the limits of empathy as an ethical/clinical goal found an amenable language in DBT, a modality of third-wave clinical psychology. Kristina's and Rose's experiments with empathy involved active shifting *between* alignment and incongruence, with DBT methods proving to be amenable to such movement. Reframing the therapeutic dyad toward concepts of compassionate *incongruence*, exemplified by the use of metaphor (Roemer & Orsillo, 2010) and radical genuineness (Linehan, 1993), DBT seemed to mark at once a departure from empathy, as both narrative tool and ethical project, and an opening to the work that is possible at empathy's limits.

Kristina

The scene for this case was a U.S. state psychiatric hospital on the East coast. The all-inpatient hospital has approximately 300 beds, and between 65 and 80% of its patient population comes through the court system, meaning the patients are committed for evaluation and/or treatment based on criminal acts or behaviors suggesting that they might be a danger to themselves or others. The patients, generally speaking, are described as having serious and persistent major mental illness, most commonly severe, recurrent major depressive episode, schizophrenia-spectrum disorders, and bipolar disorder with psychotic features. Most patients are dual diagnosis, admitted with multiple comorbidities and histories of substance abuse.

The hospital's treatment ethos is 'person-centered recovery.' It was built after the era of long-term, residential institutionalization and is geared toward community-based reintegration. Therapeutic treatment involves a team-based approach, with collaboration among a patient's psychiatrist, social worker, licensed psychologist or intern, occupational therapist, and nursing staff, in consultation with a community case worker and/or the patient's family. If not committed for longer care, forensic patients are admitted for 20 days of evaluation before returning to incarceration. The committed patients can reside at the hospital for periods of weeks to years, depending on legal charges, risk status if discharged, and level of psychiatric stabilization. Stays at the hospital focus on equipping patients with skills to function adaptively in the community, delivered through group and 1:1 treatment. Individual psychotherapy modalities are paired with patient needs, level of functioning, and presenting problems, but generally integrate motivational interviewing, CBT, or DBT.

Rose, a 70-year-old Caucasian, English-speaking female-identified client came into this setting with forensic commitment for treatment, following suicidal behaviors (cutting her wrists) after her arrest for attempted homicide of her adult son. She was married to her second husband, with whom she maintained regular contact, and identified as a retired school teacher and artist.

At the time she was referred for psychotherapy with Kristina, Rose carried a diagnosis of bipolar I disorder with mood-congruent psychotic features. Specifically, she presented with cycling between manic episodes (e.g., grandiosity, flight of ideas, increased involvement in risky activity) and major depression episodes (feelings of worthlessness, fatigue, anhedonia, and suicidality). Her psychotic features consisted of delusions of paranoia about her grandchildren's safety as a result of perceived neglect and abuse by their parents (her son and daughter-in-law), with secondary delusions of grandiosity about her responsibility for rescuing them.

In seeking treatment, Rose identified the following concerns: a) Daily, intractable anxiety about her future and a possible prison

sentence; b) shame and feeling she deserved to be punished; and c) depressed mood with suicidal intentions if sentenced to prison. Concerns identified by her treatment team included ongoing worry that her grandchildren were endangered (beliefs identified by hospital staff, family, and investigators at Child Protective Services (CPS) as lacking basis in reality and considered delusional by her treatment team).

Rose's psychiatrist referred her to DBT treatment, a cognitive-behavioral modality designed to support suicidal patients with envisioning a life worth living and engaging in behavior choices that are congruent with that vision. Patients participate in group therapy in which they learn and practice skills in mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Weekly individual psychotherapy is designed to reinforce the group curriculum by providing greater opportunity to discuss how core concepts, such as the dialectic of acceptance and change, play out in one's life. The client's therapist participates in a consult team, consisting of colleagues who give feedback on issues encountered in treatment.

I (Kristina) began working with Rose early in my clinical psychology traineeship, entering our relationship as a 40-year-old woman returning to graduate school after I earned a doctorate in developmental psychology 15 years ago. Following the referral, I read Rose's records through my lens as a feminist clinician who is also a parent, which became the catalyst for my thinking about clinical empathy with a forensic patient presenting with psychosis. In this dyad, my thinking about empathy had practical applications, along with implications for how clinicians may develop in their training and how empathy is conceptualized and becomes efficacious.

Over the course of a 12-month treatment relationship with Rose, our therapeutic encounters were documented in detailed treatment notes logged in her medical record and cosigned by my clinical supervisor at the hospital. These notes formed the basis for Rose's case conceptualization and my reflections on empathy-in-practice with this patient, who provided verbal consent to write about my experience of our treatment for publication.

Using both *emic* and *etic* theoretical approaches, I positioned my thoughts about our sessions within interdisciplinary theory and research on clinical empathy. Spanning the fields of clinical and counseling psychology, anthropology, and critical theory on the history of psychology, this discussion aims to create a dialogue between those fields and my grounded experience as a developing clinician. This approach has taken the form of writing extensively about how Rose's psychological condition and treatment might situate in relation to clinical theory about empathy, with feedback provided by academic clinicians who are experts in the areas of acceptance-based models of clinical treatment, psychodynamics, and DBT. Their feedback produced an iterative approach that both refined and deepened my interpretations of empathy in our therapeutic dyad. Representing an initial, exploratory inquiry and effort to broaden conversations about clinical models of empathy, this case history is offered in the spirit of reflective practice rather than as a prescriptive model or generalizable analysis.

Developmental incongruence

During clinical sessions with Rose, case discussions with my DBT supervisor and consult team, and in review of treatment notes from each session, there were recurrent reminders of the differences between Rose and me (Kristina). She often referred to me as "dear," underscoring our age difference, and she typically ended our post-session walk back to her unit by reminding me to "Be good," exemplifying our developmental incongruence through shifts in authority between clinician and elder in the relationship, and the fluidity of our identities in the dyad.

Such fluidity solidified in our discussions of Rose's developmental crisis to resolve a high-stakes phase of integrity-versus-despair about the course of her life (Erikson, 1959/1994), a recurring theme of treatment. Prone to rumination as a coping strategy for depression and

unresolved trauma about the assault on her son, Rose's suicidality featured regret that her timeline had landed her as an inpatient in a state psychiatric facility, charged with attempted homicide of her child, as well as an abiding fear of concluding that timeline in prison. Although expressing clinical compassion for her despair was not difficult, and cognitively I understood the logic of wanting death with dignity, I struggled to find empathic alignment with a phase of life that was decades away for me. Likewise, joining in anxious worry about her future would have been a dubious clinical practice. In the context of grandmotherly endearments and admonishments, joining with Rose's fear as an attempt at empathy also risked evoking a common response from those with delusional experiences: "you have no idea what it is like to be me." This could produce alienation in the dyad and possibly further entrench Rose's worry and rumination, behaviors we were trying to reduce to alleviate distress and suicidality.

I took direction from lauded psychotherapist Mary Pipher, who has written for beginning clinicians: "Compassion is only useful when coupled with clear-headedness" (2003/2016, p. 145). More Socratically, my clinical supervisor asked me pointedly, "Do you believe empathy is possible here?" My lack of clear-headedness around this question only intensified when addressing Rose's extra-realism in our sessions, specifically beliefs about her grandchildren.

Subjective incongruence

A recurring theme throughout Rose's psychotherapy was her shift between identification with the self who attempted to kill her son and her inability to understand how she could have tried to take his life. Often, Rose would recall the event and say she felt shame and confusion about how she could, as a mother, have tried to kill him, saying "it wasn't me" and "I just don't know who that crazy person was." During her confused and despairing recollections, she would usually transition from sad grief into anger, primarily about how she perceived her grandchildren were being mistreated by her son and his wife. In this state, she described their malnourishment and abuse and disputed the disconfirming results of investigations she had requested.

At such times, I felt a dilemma of intersubjectivity with several combinations of players in the dyad. In the treatment room, we had Rose who was full of shame, Rose who was angry and convinced she needed to take action to save her grandchildren, and Rose who was confused about who she was at all. Forging an empathic pathway through validation was not possible because Rose, like most people, was not firmly affiliating to any one way of thinking or feeling. Add to these fluid identities a clinician who is also a mother, obviously carrying my own tones of countertransference to the maternal transference that was routinely conveyed by Rose when she tried to elicit affirmation of her stance from me. In effect, in terms of these multiple stances, there seemed to be several generations and identities (crazy, sane, right, wrong) at work.

In direct pleas for empathy amidst fluid identities and accompanying affective experiences, Rose sought a cognitive and emotional joining I could not provide. More than once after rumination carried her along an emotional path from shame and grief through confusion to anger and conviction, she would look directly at me and ask, "Well, you're a mother. What would you have done if your son's father was hurting your child?" In this question, I heard a call for empathy with her quasi-utilitarian decision to hurt her son to save her grandchildren, an intergenerational ethical crisis seeking absolution.

Amid Rose's transmutations of subjective identity, her ethical crisis, and her persistent beliefs about her grandchildren's mistreatment, I was unable to converge with Rose's thinking and feeling. In our work, I faced not only moments of difficulty with "getting" her (e.g., as an elder in a life phase I have not experienced) but also moments of absolute impossibility for empathic alignment because multiple identities shifted between delusional beliefs ("I was right to do it") and healthy guilt and shame ("What did I do?"). Moreover, in the latter forms, feigning

empathic understanding presented a fallacy of care that could result in iatrogenic effects of deeper confusion and suffering. Thus, I faced both logical and ethical fallacies of care in deploying empathy as an attitude of joining Rose's shifting affective and cognitive states—logical due to the impossibility of aligning with her sense-making and ethical because of the risks posed to her wellness if I joined in her confused distress.

Empathic incongruence in practice

Third Wave psychotherapies such as Acceptance and Commitment Therapy (ACT) and DBT provide openings for new approaches to empathy through techniques involving metaphor (ACT) and radical genuineness (DBT). For example, ACT's Mountain Metaphor offers one means for communicating with clients that there are inevitable, logical challenges to empathy ("we're on different mountains in this process"), but ACT also employs metaphor more broadly to forge an empathic connection by meeting in the space *between* the clinician's assumptions and the client's actual experience. A guiding principle of ACT is that psychological distress derives from experiential inflexibility, in large part "through entanglement with verbal rules and the traps of language" (Stoddard & Afari, 2014, p. 2), and the clinical enterprise can rely on metaphor to support the client in stepping outside "the cage built by language" (p. 17). In the therapeutic dyad, metaphor may also provide a point of convergence despite incongruence between self and other as each participant relates to the concept. ACT theorists refer to the client's relationship to the idea presented by the metaphor and the concrete memories that it references as a *relation of equivalence*. It may also represent a relation of equivalence for the clinician and client, allowing them to find a shared understanding that can honor inevitable differences.

When I first met Rose, she often refused to change out of her bathrobe and spent much of the day isolating in her bed, reluctant to leave her room. At our first session, she met me at her door and said she didn't feel up to meeting, even when I offered to meet in the private room across from the hall. "I imagine it feels like you have concrete shoes," I offered. "Yes," she replied. "Concrete shoes that got you up from your bed to your door—that's pretty amazing strength. I wonder if the concrete shoes can shuffle the little way across this hall to talk with me for a few minutes; you made it this far." She joined me in the room 6 ft from her door, and in that brief time, we sat together, saying little.

In another example, Rose and I found that an effective coping strategy for reducing her ruminative cycle between shameful regret and righteous delusions was the use of a cloud metaphor for watching her thoughts and emotions move. This brought her attention to the impermanence of thoughts and emotional shifts by encouraging her to perceive her self as a context of containing states, as opposed to fixed realities. Rose and I had a shared understanding of what we each have experienced when watching clouds move, and because she could assume that I had an idea of what that experience was, we could meet in the metaphor when I could not converge with her shifting thoughts and emotions.

Validation, therefore, takes different forms and does not depend on empathy understood as agreement or confirmation. DBT provides a 6-tier validation model, in which congruence with the client is exhibited through being present, reflecting statements and meaning, validating based on past and current circumstances, and at the final level, showing radical genuineness (Linehan, 1993). In explaining the role of validation in DBT, Swenson writes that in empathy, authenticity of the psychologist's self-schema can entail "strategically withhold[ing] validation" (Swenson, 2016, p. 265) when directing attention toward behavioral change rather than acceptance. A dialectical transaction occurs in the clinician's delivery of principles about acceptance and change. Whereas acceptance demonstrates that the therapist "gets it," *radical genuineness* exemplifies the ways the dyad consists of two real people who are interdependent as they collaborate. In the therapeutic alliance, patient and provider experience "interbeing," which fosters

the “dissolution of boundaries” in a productive way (Swenson, 2016, p. 397). Through this attitude, discordance through radical genuineness may reduce client distress and cultivate change for the better. While deployed through decidedly non-Rogerian techniques of skill-building and sequential analyses of behavior, Swenson's presentation seems to concur with Rogers' assertion that empathy is not equivalent to identification but rather an evolving attitude toward the client that brings the clinician's genuine perspective into the dyad.

In my work with Rose, radical genuineness became a mainstay of our treatment because of her own irreverent, often sarcastic, style. During a session in which Rose conducted a behavior analysis of the events leading her to ruminate, she arrived at the problem on the day she was examining: psychotherapy with me. She quipped with irritation, “See, it's all your fault.”

I replied, “Then I guess my work here is done.”

This moment of irreverence for the clinical process, an affect that connotes genuineness in the DBT modality, brought us into shared laughter and an experience of congruence from a moment of (potentially uncomfortable) incongruence between my treatment and Rose's adverse consequences. From there, Rose and I agreed that I would interrupt her when she slipped into rumination in session so that we could practice coping (e.g., watching the clouds) and be better equipped later in the day when her thoughts and feelings were raw from therapy. My response to Rose's irritation met her in a shared discordance, and thus, while I did not join with her emotional reaction in the sense that I experienced her irritation as my own, I conceded to it with a response we might deem radically genuine, which paved the way for intervening in rumination.

Rose held the - logically fallacious - view that taking her own life in prison would prevent her from spending the rest of her life in prison. Because of the threat to her life, DBT's radically genuine approach could be deemed well suited to urgency, the pressing need for cognitive and behavioral change. This strategy likewise addressed the impossibility of truly knowing her emotional experience. Attempting genuineness, compassion, and nonjudgment, more than once I reflected back to Rose, “You're telling me that you plan to end your life in prison so you won't end your life dying in prison. I get that you want death with dignity, but I really can't make sense of this. You can't feel better if you're dead.” I refused congruence with the cognition that produced suicidal distress, and rather than converging with Rose in her pain, I aimed to assist her in finding a path for a life worth living that made sense emotionally and rationally. Over the course of the year, Rose shifted from a suicidal intention that debilitated her into days spent in bed to a revised plan of postponing her decision to the point of sentencing, if that point came, followed by pushing her decision even further out. “I got used to living here [in the hospital]; maybe I'll get used to that,” she reflected, deciding that she would wait and see how the initial period of a sentence progressed. As each shift in perspective gradually released the hold of suicidal intent on Rose's thinking, her care team deemed Rose to be making good strides.

Kristina and Sarah

Psychosis, aging, and the context of forensic care pose enmeshed dilemmas - of ethics, understanding, and care. But these dilemmas lean in different directions for anthropology and psychology. From the side of clinical psychology, improving quality of life is a baseline and goal, through which such dilemmas might be filtered. For anthropology, operations of meaning - social analysis, critique, interpretation - may direct the work we do with and through these dilemmas. These disciplinary orientations are not mutually exclusive, and there is not only compatibility, but shared languages, literatures, and histories. However, at the juncture of these fields, of empathic dilemmas, and states of being, it is possible to think of incongruence as not just effects of different meanings, but matters of practice and care.

Much of this involves deeply affective matters of clinical

imagination. In his collaborations with colleague Josef Breuer, Freud wrote, “I cannot imagine bringing myself to delve into the psychological mechanism of a hysteria in anyone who struck me as low-minded and repellent, and who, on closer acquaintance, would not be capable of arousing human sympathy” (Breuer & Freud, 1957, p. 265). Hardly demonstrative of the warmth and positive regard that Rogers contributed to psychotherapy, Freud's acknowledgment nonetheless provides a candid account of obstructions to understanding what someone is going through, especially when incurred by symptoms with which a clinician cannot identify, or identifies as immoral or even repugnant.

So, too, Freud named a problem that would come to be invoked in arguments that empathy cannot be implemented in treating illnesses such as psychosis (Frank and Frank, 1961/1991). Yet, contemporary practice seems to return to Rogers' work with schizophrenia in the 1960s by bringing empathy to encounters with psychosis as part of a package of approaches that emphasize strength in support, collaboration, and the goal of adaptation to symptoms (Kuipers et al., 2006; Thomas, 2015; Wright et al., 2014; Twohig, 2004).

Consistent with this move in third-wave clinical practice, anthropologists emphasize empathy as a shifting product of intersubjectivity (Throop, 2010). While some may position anthropology in conflict with psychology, this oppositional stance may commit the reductionistic error that it seeks to critique in focusing only on the language of norms and efficacy, which is but one strand of a thickly braided clinical discourse. For psychologists, empathy is often situated as vaguely located, experimentally and intersubjectively defined, redefined, and reimagined. Moreover, concepts such as evidence-based practice refer not only to the empiricism of randomized clinical trials but also to the evidence that arises in the discursive relationship that occurs in real time in the treatment room. Psychological literature would seem to concur with anthropologists who frame empathy as a human effort to ascertain another's experience in the first-person, and a matter of thought, language, emotion, and sensation (Hollan & Throop, 2008), by asserting that empathy is: a) a form of social cognition that requires recognizing and interpreting another's emotions and providing a response the other deems “correct” (Chryssikou & Thompson, 2016), b) a cognitive and affective experience (Hooker, Verosky, Germine, Knight, & D'Esposito, 2010; Thwaites & Bennett-Levy, 2007), and c) contingent on the worlds in which it appears, including the particular cultural world of practitioners (Hassenstab et al., 2007; Tirsch & Gilbert, 2014). Some clinical models of empathy remind us that, distinct from reaching agreement on objective fact, empathy can be a process of finding common ground through techniques that highlight difference (Bohart and Tallman 2007), aligning with the way treatment goals may seem to pull in different directions, such as with self-acceptance and change.

Clinical literature would suggest that as the clinician recognizes her own discordant emotional and cognitive experience, empathy requires placing it on hold in favor of the client's affective presentation, expressing understanding and congruence through specific acts that convey empathy (e.g., nonverbal and verbal validations). Doug Hollan, a psychoanalyst and anthropologist, writes, “one cannot empathize with another until one's imaginings about the other's emotional states and perspectives can be confirmed or disconfirmed in ongoing interaction” (2008, 476). Empathy often proves to be full of messy struggles, negotiations of vulnerability, and layered incongruities. Lawrence Kirmayer (2008) asks, in contexts of often radical difference in world-view (between clinician and patient), how can empathy be achieved even if understanding cannot? For Kirmayer, the answer is to pose empathy as a “stance” that need not depend on understanding (2008); empathy is something you aim for through specific cultivations of action and affect. Similarly, even for practitioners and theorists with divergent perspectives (such as Aaron Beck and Carl Rogers), empathy is an act of conceptualization and articulation, not agreement or identification.

But the core issue for us, arising from Kristina's work with Rose, is how contemporary clinical psychology might allow us to foreground

failures of alignment as a locale for empathy. Incongruence may be something we attend to as a worksite of imagination, as Rose's case and other clinical research point to the ways incongruence (entailed in clinician neutrality, discordance, and tension) can produce treatment deemed effective (Dreher, Mengele, Krause, & Kaemmerer, 2001; Banninger-Hubner & Widmer, 1999; Linehan et al., 2002). Of course, not all incongruencies facilitate therapy, and certain factors might distinguish between incongruence as a facilitator or inhibitor of efficacy (c.f. deRoten, Drapeu, & Michel, 2008). However, in certain contexts of care, we are invited to attend, as we have to empathy, with similar attention and verve to compassionate misalignments, even fallacies. And, taking a position of dialogue between psychology and anthropology, we are asked to attend to incongruence in recognition of the ethical goals of psychology. The failures of empathy that arise in moments of incongruence are not failures of ethics; they may be the point at which ethics begins. Indeed, incongruences that could be read as failures of empathy may be openings onto techniques of care, legible as punctuated moments of therapeutic effect. In contemporary American psychology, tensions and differences can enrich thoughts on empathy as a guide to effective practice precisely in the therapeutic contexts for which congruence seems infeasible.

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