

# Master's Thesis

Empathic Engagement in Caregiving Professions  
- In Light of Heinz Kohut's Self Psychology

By

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The master's thesis is carried out as a part of the education at the University of Agder and is therefore approved as such. However, this does not imply that the University answers for the methods that are used and the conclusions drawn.

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*- In Light of Heinz Kohut's Self Psychology*

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UNIVERSITY OF AGDER

“Place the [oxygen] bag on yourself before attending to those in your care”

Malaysia Airlines security instructions, January 2010

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## Summary

*Title:*

Empathic Engagement in Caregiving Professions  
- In Light of Heinz Kohut's Self Psychology

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*Abstract:*

This thesis explores and illustrates ways in which a conceptual framework based on Heinz Kohut's self psychology, complemented by Kristin D. Neff's conceptualization of self-compassion, can help illuminate how six professional caregivers from different disciplines relate to themselves as they are faced with the call for empathic engagement in their practices. The study is qualitative insofar as the goal of the investigation is describing, discovering and understanding, rather than predicting and confirming. However, in the collection of data this thesis combines the use of a qualitative method, conducting semi-structured interviews, with a quantitative self-report scale.

Whereas empathic caregiving has been the topic of several studies, this thesis found that this specific conceptual framework helps us discover additional dynamics and connections that are relevant for understanding some of the special challenges inherent in empathic caregiving.

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## Chapter 1. Introduction

This thesis seeks to explore the extent to which certain aspects of Heinz Kohut's self psychology, supplemented with Kristin D. Neff's conceptualization of self-compassion, can help illuminate the dynamics of how professional caregivers relate to themselves as they are faced with the call for empathic engagement in their practices. As I will explain in chapter 2 the argument is abductive in the sense that it reinterprets a known phenomena within a new conceptual framework. The data were collected through a combination of qualitative and quantitative methods. In this first introductory chapter I share some reflections on the research theme, place it in a broader research context, offer some initial terminological clarifications and, finally, present a summary disposition of the structure and argumentation of the thesis.

The dynamics of empathic caregiving among professionals is a research topic that engages concerns within and across the disciplines of "religion, ethics and society" (the Master's program for which this thesis is written). It utilizes a conceptual framework derived from empirical research and philosophical reflection on interpersonal dynamics in order to further understand the factors that shape the phenomenon of professional caregiving. The theme overlaps theoretical and practical issues in each of these fields,

For example, caring for others is a topic of concern in religious texts and traditions across the globe. One of the most well known religious texts in our Western societies is: "love your neighbor as yourself" (Leviticus 19:18, Matthew 19:19, Matthew 22:39, Mark 12:31, Luke 10:27, Romans 13:9, Galatians 5:14, New International Version). Despite the process of secularization, itself a contestable phenomenon, many moral principles such as this one found in the Hebrew Bible and Christian New Testament are still relevant for many, if not most, persons within our society. This is the case even for those who do not believe that these

principles are commanded by a personal divine being, or that the rewards for caregiving acts include benefits like divine resurrection. Although most of the focus in the religious traditions seems to have been on how to care for your neighbor, and less about how to care for yourself, the religious texts clearly states the interconnectedness of the two. Kohut's theory has already been applied to the treatment of religious questions (cf. Jones, 2002). Even if it is not this thesis' main focus, as we will see, the role of religious belief came to expression several times in the professional caregivers' reflections.

This research theme is also relevant for discussions within the study of ethics and society. With concerns like what is good and bad, right and wrong, the traditions of moral philosophy, or ethics, are as long standing as many of the religious traditions. However, as pointed out by Arne Johan Vetlesen in his book *Perception, Empathy, and Judgment: An Inquiry into the Preconditions of Moral Performance*, "[t]he vulnerability of moral perception is in a large part due to the frailty of the faculty of empathy on which it rests" (1994: 7). He argues, inspired by Kohut and others, that empathy is in fact a precondition for moral performance, and that to have empathy you need to have experienced others having empathy for you.

Here again we see an issue already identified above: the balance between caring for oneself and caring for others. Like so many religious traditions, the field of moral philosophy is attentive to how to best care for others. Vetlesen is illustrative of the growing awareness of the importance of understanding the preconditions for developing the ability to empathically care for others. Insofar as empathic caregiving in some sense is a condition for the cohesion of any human group, however large or small, this theme is also of obvious importance for the scientific study of society.

The topic of empathic engagement is clearly relevant for several disciplines and professions. Moreover, it is not just an abstract academic topic, for it deals with how we understand and engage one other across significant boundaries, such as disciplinary, professional, and religious affiliation. Whereas the topic of empathic engagement could be illuminated by theories from a variety of perspectives, for reasons explained in more detail below this thesis utilizes a conceptual framework developed within the context of interdisciplinary psychological discourse and therapeutic reflection. This thesis adopts and adapts some key aspects of this theoretical framework and argues that they can help us (abductively) reconceptualize the dynamics of professional caregivers' empathy for others and for themselves.

After this very brief reflection on how the conditions for empathic engagement are

relevant across the disciplines of religion and ethics, as well as for society in general, I now turn to a presentation of the research theme. Instead of beginning with a research question or a problem statement, I chose the option of organizing my research around a research *theme*, as outlined by professor Pål Repstad in the REL500 course.<sup>1</sup>

## Research Theme

*The thesis explores ways in which a conceptual framework based on Kohut's "self psychology" can illuminate professional caregivers' experience of self-compassion as they are faced with the call for empathic engagement in their practices.*

Extensive reading of different psychological theories, both psychodynamic (Kohut, 1971, 1977, 1984; Lachmann, 2008), developmental (Mikulincer & Shaver, 2007) and family systems theory (Bowen, 1978; Kerr & Bowen, 1988), has left me with the intuition that there is a strong connection between the way we relate to ourselves, and the way we relate to others. It has also lead me to see that many ethical theories describing how we are supposed to care for others are not sufficiently concerned with the conditions for our capacity to care (cf. Vetlesen, 1994). These conditions are partially shaped by the way we ourselves have been cared for, and the extent to which we keep taking care of ourselves.

Take the example of professional caregivers. They are surrounded by ethical theories on how to care for others. However, the problems of exhaustion and burnout are widely known. Despite this, there are not many theories concerned with how the caregivers can care for themselves. A recent Norwegian study, "Thriving Despite Adversity: Job Engagement and Self-Care among Community Nurses" (Vinje, 2007), explored why some community nurses who experience high levels of involvement in their job succeed at staying healthy despite demanding working conditions. The study suggested that whereas job involvement promotes a sense of thriving in the job, when this involvement and enthusiasm is accompanied by a strong sense of duty and heavy self-demand, it might result in experiences of moral distress,

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<sup>1</sup> Handout and Notes from lecture with Professor Repstad 9. September 2010

exhaustion and even burnout. Based on this I asked myself: might there be certain ways of holding on to our care for others that generate more care, whereas other ways threaten to exhaust us?

My intuition is that this theme can be clarified by Kohut's self psychology, which represents a significant contribution to intersubjective and relational approaches within psychoanalysis. It is a psychodynamic theory containing both a developmental model and a model for clinical consultation and therapy. Of particular interest for this thesis, however, is Kohut's model for conceptualizing the development from an archaic narcissism where psychological functioning is dependent on others, to a mature narcissism where psychological functions like soothing, tension-regulation and other adaptive functions are internalized in the person him or herself, making the person less dependent on other people to provide these functions for them.

In addition I will use Kristin D. Neff's conceptualization of self-compassion as a resource to complement Kohut, suggesting that the state of self-compassion Neff describes is the *product* of the *process* Kohut outlines as the maturation of narcissism. Whereas Neff's conceptualization of self-compassion is less attentive to how this attitude towards the self was brought about, Kohut, on the other hand, made a clinically informed theoretical contribution on the developmental conditions for how we become healthy selves. More accurately one might say, Kohut describes how we end up as unhealthy selves, and how to successfully treat these disorders. However, implicit in his theory of how to understand and therapeutically engage patients for the transformation of narcissism also lies an understanding of how archaic narcissism is transformed in development into a mature narcissism.

Kohut's theory offers a framework for understanding the conditions for healthy development, helping us take on a broader perspective, attentive to the developmental origins as well as how this healthy attitude towards the self might look like in the present. Neff tops it off by giving us additional concepts to help illuminate how professional caregivers relate to themselves as they are faced with the call for empathic engagement in their practices. We will outline the conceptual framework in more detail in chapter 3, but here it is important to introduce some of the relevant literature and empirical research that bears on our theme.

## Placing the Theme within the Research Field

In accordance with Kohut's own wish, expressed in his last public address at the Fifth Conference on Self Psychology at Berkeley in October 1981, the ideas embodied in his self psychology have been further developed in promising ways by his successors. Kohut himself, probably both in respect for his predecessors and fear of being rejected by his colleagues, initially tried to conceptualize his theory within the framework of classical drive theory. This attempt caused him to stumble into some of the same meta-theoretical pitfalls as Freud did (cf. Siegel 1996: 195; Lessem, 2005: 15).

Among others, Robert D. Stolorow and George E. Atwood have made significant contributions to the further expansion of psychoanalytical theory and treatment by thoroughly rethinking Kohut's ideas in light of intersubjectivity theory (1984, 1992, 1993). Especially concerned with the metaphysical assumptions hindering a relational and contextualized view of the clinical phenomenon, understanding the intersubjective field in which the meeting of two subjectivities takes place, Stolorow and Atwood revise self psychology in accordance with a non-dualistic metaphysics. As important as their contribution is for development of theory and psychoanalytical treatment, it is not directly relevant for this thesis. Whereas the theory of intersubjectivity inevitably will serve as a background for my reflections, being more of a matter of course for contemporary thinking, I will not let it distract me from the main points initially formulated by Kohut, that is, the maturation of narcissism and its significance for mental health.

Another thinker worth mentioning is Frank M. Lachmann. Like Kohut, and most of his followers, Lachmann is mainly concerned with the therapeutic process. In his book *Transforming Narcissism: Reflections on Empathy, Humor and Expectations* (2008) Lachmann uses Kohut's article "Forms and Transformations of Narcissism" (1966) as a springboard to explore and supplement Kohut's theory of narcissistic maturation. Lachmann notes that in both professional and common language the term "narcissism" is still primarily used as a judgment on a certain kind of self-centered behavior. His main goal was to update Kohut's proposal for contemporary clinicians, especially recognizing the extent to which actions and attitudes usually called "narcissistic" serve self- and interactive regulatory functions.

Lachmann's decision to offer new reflections on themes by Kohut was triggered by his realization of an ongoing and prevailing tendency to denigrate the importance of having a

nuanced understanding of narcissism. His book elaborates, expands and modifies Kohut's thesis that narcissism can be transformed in development, or in therapy, into empathy, humor, creativity, and acceptance of transience. Even if Lachmann's book is primarily written for clinicians, and treats a broader specter of the traits Kohut suggested to be attained from the maturation of narcissism, it is relevant for the thesis in two ways. First, it affirms Kohut's notion of narcissism as something more than just a character structure that needs to be eliminated. And secondly, it supports Kohut's opinion that a broader understanding of narcissism is essential to facilitate growth and transformation.

Although Kohut's theory has had a significant influence on psychoanalytical approaches for clinical consultation and therapy, it was not until relatively recently that extensive attempts have been made to examine his theory empirically. For example, Banai, Mikulincer and Shaver, leading scholars on attachment theory within social psychology, have published a study (2005) operationalizing some of Kohut's key construct and examining their links to attachment styles, self-cohesion, affect-regulation and adjustment. In this study a self-report scale, the Selfobject Needs Inventory (SONI), was developed to assess a person's orientation towards the selfobject needs of mirroring, idealization and twinship. The SONI self-report scale was further administered together with several other self-report scales to show the links between orientations towards selfobject needs, psychological well-being and personality functioning. These quantitative studies also affirm Kohut's theoretical proposal of the connection between narcissism and mental well-being. As explained below, I used the SONI self-report scale to measure the professional caregivers' orientation towards selfobject needs, further illuminating the findings of the interview interpretation.

Over the years there have been done several studies on compassion fatigue and burnout in a variety of types of professionals, such as teachers, general practitioners, nurses and students. One example is the Norwegian study mentioned in the section outlining the research theme (Vinje, 2007). The study of community health nurses showed that habitual introspection and reflection about job engagement helped the nurses make positive, adaptive adjustments in their working life, leading the nurses to thrive despite difficult working circumstances. In another study on general practitioners, Bakker et al. (2000) found that contact with demanding patients produce a lack of reciprocity in the general practitioner-patient relationship. This asymmetric relationship was shown to initiate the burnout syndrome as the general practitioner's emotional resources were depleted.

## Clarifications on the Term “Empathy”

The concepts in Kohut and Neff’s theories will be defined and clarified in relevant detail in the conceptual framework in chapter 3. However, given the ambiguity and varied use of the term “empathy,” a few words of clarification are in order. Aware of how this term is used differently across disciplines, I will in this thesis use the term in accordance with Kohut.

As a therapist and a professional caregiver himself, Kohut was especially concerned with the developmental origins of empathy, and its impact and significance for his profession in particular. He understood empathy in two ways. First and foremost, Kohut thought of empathy in an epistemological sense, as an *observational stance* that is definitive for the field of psychoanalysis. Introspection (self-reflection) and empathy (vicarious introspection) were for Kohut the main tools that allowed him to gather data about the inner life of his patient.

[I]t is the capacity to think and feel yourself into the inner life of another person. It is your lifelong ability to experience what another person experiences, though usually, and appropriately, to an attuned degree (Kohut, 1984: 82; cf. Kohut, 1959 for more elaboration).

Kohut viewed this form of empathy as “an informer of appropriate action” (Kohut, 1981). However, Kohut also stressed that empathy in itself does not necessarily include well-meaning intentions. The knowledge you gain by thinking yourself into the life of another person can be used for the purpose of kindness or utter hostility. One needs to know the other in order to be helpful, as well as one needs to know the other’s vulnerable spots in order to be hurtful. Emphasizing that our ability to understand what another person experiences will never completely capture the experience of the other, Kohut also theorized that one’s introspection, one’s access to one’s own subjectivity, is the very source of the therapist’s ability to “vicariously introspect” his patients’ minds in order to gain knowledge that can inform him of what is appropriate action (Kohut, 1977: 251). If you cannot access your own subjectivity, you cannot vicariously access someone else’s subjectivity.

Secondly, and increasingly important for Kohut as his theory took shape, was empathy as a therapeutic act, empathy as *responsiveness*, not just as an observational stance. Believing that an empathic human milieu is a necessity for psychological survival, like oxygen is for biological life, Kohut became increasingly aware of the healing power inherent in it.

Empathy is so many things: empathy is biological survival. Unless there is an empathic environment, a child does not survive. Empathy is emotional survival because unless you have

empathy in your surroundings you feel you cannot show what you are and who you are. You know, in the beginning empathy is the reliability of the world, its predictability. Will responses be human? (Kohut, 1996: 28)

In “Forms and Transformations of Narcissism” (1966) Kohut argued that narcissism can be transformed in development into empathy, as well as wisdom, humor, acceptance of transience and creativity, a development he further elaborates in his three main publications (1971, 1977, 1984) as conditioned by this empathic responsiveness.

As mentioned in the introduction, this is a point taken up by Arne Johan Vetlesen in his emphasis of empathy as a precondition for moral performance. According to Vetlesen (1994: 7) moral perception is often taken for granted in moral theories, whereas he believes that a prerequisite for moral perception is one’s capacity for empathy, a capacity dependent on the extent to which one has experienced empathy from others. Because this thesis is not an inquiry into the moral performance of professional caregivers, I will not dwell any further on Vetlesen’s exploration.

Kohut’s understanding of empathy will be relevant for the interpretation in chapter 4 in two ways. First, the extent to which the caregivers themselves understand empathy will be viewed in light of Kohut’s understanding empathy as an *observational stance*. Secondly, we will look at the professional caregivers own need for certain experiences of being empathically understood, approaching their own need for *empathic responsiveness* in their surroundings.

## **Disposition**

In this introductory chapter I have presented the research theme, placed it within a field of research and made some initial clarifications about my use of the concept of empathy. In the next chapter I will present the methodology and the rationale for choosing this particular approach, trying to clarify potential benefits, but also problems and limitations. The conceptual framework is then spelled out in relevant detail in the third chapter with special attention to Kohut’s understanding of narcissistic maturation, orientation towards selfobject needs, and Neff’s understanding of self-compassion.



The fourth chapter contains the abductive redescription of the interviews in light of Kohut and Neff's constructs, illuminating the way in which professional caregivers relate to themselves as they are faced with the call for emphatic engagement in their practices. In that chapter the interview data is examined diachronically, in the order in which the respondents were interviewed.

In the fifth chapter I will report and evaluate the SONI self-report scores, exploring the extent to which they support and further illuminate the findings from chapter 4. In the final chapter I summarize the findings in light of Kohut's understanding of empathy, narcissistic maturation, orientation towards selfobject needs, and self-compassion. I conclude with some brief reflections on practical implications the findings might have for professions that involve intensive caregiving, as well as for other dimensions of human society.

## Chapter 2. Methodology

In this chapter I outline the methodology of the thesis, attending to the potential benefits as well as problems and limitations of the chosen research design and strategy. The last section of this chapter also deals with ethical issues relevant to the research process.

Following the terminology of Ole Riis (2009: 241) this thesis utilizes a “methodological combination,” i.e., it combines both qualitative and quantitative methods in order to illuminate a complex social phenomenon more adequately. This is similar to what Alan Bryman (1992) calls “mixed methods.” In a broad sense the research is “qualitative” insofar as the goal of the investigation is describing, discovering and understanding, rather than predicting and confirming (Danermark et al., 2002: 162). However, in the collection of data I combined a qualitative method, conducting semi-structured interviews (cf. appendix B), with a quantitative self-report scale (cf. appendix C and D).

According to Riis (2009: 242) using different methodological tools is particularly important when attempting to collect information on a complex subject or phenomenon and to interpret it in a convincing manner. Riis further explains that if the different methods give divergent conclusions, the researcher is given the opportunity to consider whether the two sets of information contradict each other, or simply clarify different aspects or dimensions of the phenomenon. A combination of methods can thus contribute both to better control of the validity of the findings as well as to their further illumination.

As I will explain below the overall structure of the argument is *abductive*, which means to “interpret and recontextualize individual phenomena within a conceptual framework or a set of ideas” (Danermark et al., 2002: 80). Because the approach I have chosen is not primarily inductive, I am not focused primarily on the extent to which the findings can be

generalized to other similar cases (Bryman, 2004: 29). However, the approach is not simply deductive either, that is, I am not trying to derive logically necessary conclusions from pre-accepted premises. Rather I attempt to understand the phenomena of how professional caregivers relate to themselves as they are faced with the call for empathic engagement in a new way, by reconceptualizing the professional caregivers' own reflections in light of the conceptual framework to be outlined in chapter 3.

### **Philosophy of Science Issues**

The data to be interpreted and recontextualized in this thesis are the results of six qualitative in-depth interviews, and the results of a quantitative self-report scale. This decision for a mixed methodology was guided by several background issues outlined in recent literature in the philosophy of science.

Following the criteria for evaluating social research, two potential challenges are especially relevant for the internal validity of the thesis, one of a conceptual, another of a hermeneutical character (cf. Bryman 2004: 273). The conceptual challenge concerns the use of experience-distant and experience-near concepts. Even if it is possible to distinguish two kinds of languages to talk about social phenomena, the separation of the two is neither desirable nor possible when conducting social research. According to Anthony Giddens' "double hermeneutics" the social researcher must go beyond the social actors self-perceptions, but not completely lose touch with them. There will therefore always need to be a dialectical move between the two. In this case that means that Kohut's experience-distant concepts must be made recognizable to the respondent, and so also, the answers given in the experience-near concepts of the respondent must be translated back to fit Kohut's rather abstract concepts (cf. Gilje & Grimen, 1993: 146).

The hermeneutical challenge involves both the respondent and me as a researcher. My background and interests will lead me to pay more attention to some issues than others. I have my reality, shaped by my experiences, resulting in a particular horizon of understanding, and the respondent most likely has a very different one. With exception of the doctor I interviewed at the interreligious conference in Melbourne, all of the other respondents were Norwegian, which means they share my general context in terms of cultural background. This

has the advantage that I have a greater precondition to know what lies underneath their answers, because of our shared horizon of understanding through common social experiences. Even if there are differences in terms of gender, age, beliefs, or other factors, the shared national, linguistic context makes it easier for me as a researcher to understand the person I am interviewing.

This shared context might also be a potential limitation if it hinders me from noticing what which Michael Polanyi calls “tacit knowledge.” That is, if certain elements of our preconceptions are taken for granted without further reflection, it might bias the interpretation (cf. Gilje & Grimen, 1993: 151). Whereas these preconceptions are likely to block me from noticing certain details, they will hopefully also help me illuminate others. Being aware of this challenge also helped me take on a wider perspective. Even if the main focus has been on issues treated by Kohut and Neff, I continuously reminded myself to be open to the complexity of factors playing a part in every respondent’s thinking, feeling, and acting (cf. Gilje & Grimen, 1993: 150).

The insider vs. outsider perspective is also a hermeneutical challenge. I am not a professional caregiver, so how can I understand how they feel? On the other hand, keeping Polanyi’s tacit knowledge in mind, if I was a professional caregiver there might be things I wouldn’t notice because I might take them for granted. Although the insider vs. outsider observational stance is important to notice, most of the time there is a little bit of both. Whereas no neutral interpretation can be found, the mere awareness of this problem helps me stay attentive to the limitations of my interpretations (cf. Knott, 2005).

Another challenge is the possibility that there is not always exact correlation between what people say they do, and what they really do (cf. Gilje & Grimen, 1993: 200). However, it needs to be made explicit that this thesis is not an attempt at psychoanalyzing the professional caregivers, because neither my background knowledge nor my methodological approach allows for this. Applying the conceptual framework built on Kohut’s developmental model, and Neff’s conceptualization of self-compassion, I will interpret the professional caregivers at their current state. Although I believe this approach might be illuminative, the method for data collection and the method for interpretation will necessarily be limited in its ability to accurately assess orientation towards selfobject needs, or their level of self-compassion. Being aware of this I have tried to find a balance between trusting the respondents and staying attentive to possible inconsistency in their answers.

With these reflections on philosophy of science issues, I turn now to an elaboration of the abductive argumentative approach selected for this thesis.

## **Abduction**

A growing number of scholars are combining methods for data collection, challenging the harsh distinction between deductive and inductive inference, which have often been traditionally correlated strictly to qualitative or quantitative approach (cf. Danermark et al., 2002; Riis, 2009). Moreover, the combining of methods results in approaches with elements of different modes of inference, including abduction and retroduction. In this thesis I am relating theory to data by way of *abduction*. According to Danermark et al. the fundamental structure and the thought operation specific for abduction is:

To interpret and recontextualize individual phenomenon within a conceptual framework or a set of ideas. To be able to understand something in a new way by observing and interpreting something in a new conceptual framework (Danermark et al., 2002: 80)

For this thesis it means that I seek to give new meaning to the interview material (data) by interpreting and redescribing it in light of Kohut's self psychology, complemented by Neff's conceptualization of self-compassion (theory). By using a different frame of interpretation I seek to discover connections and relations that might help us understand and explain an already known phenomena in a new way (Danermark et al., 2002: 91-92).

In the next two sections we will take a closer look at the two different ways of collecting data, conducting semi-structured interviews and having the respondents complete a psychological self-report scale.

## **Qualitative Interviews**

The rationale for choosing semi-structured interviews as the main method for data collection was to gather data with as much detail, complexity and nuance as possible, allowing me to interpret the person I am interviewing with a greater knowledge of his or her context.

The respondent sampling has been guided by two criteria only. The first criterion was that the respondents on a daily basis are confronted with patients call for emphatic engagement. Secondly, in order to get at their capacity for balancing idealization with realism,

an important dynamic in Kohut's theory, I also included the criterion of at least five years of experience in their respective fields. This was to increase the likelihood of the respondents having experienced disappointments in their work situation, allowing me to talk to them about their emotional and cognitive coping strategies related to frustrated idealization.

I have not used potential respondent's professional or institutional belonging as sampling criteria, but I acknowledge that certain institutional structures may facilitate or diminish each professional caregiver's chance for dealing with emotional challenging experiences in their practice. I therefore have respondents from different institutions: a hospital, a retirement home, a medical clinic, and a psychiatric residential treatment facility. With one exception, a doctor I met at a conference in Melbourne, all the respondents volunteered after reading the information letter given to them by their respective division managers, etc.

In conducting the interviews (cf. appendix A), which lasted between 45 minutes to one hour and 45 minutes, I started off with questions of a general character to get the conversation going, asking about their background and current working situation. The questions were for the most part about the respondents' sense of self-attunement, values, their understanding of empathy, and questions trying to get at how they experience empathic engagement in different areas of their life. Some of the questions were phrased like hypothetical cases; the respondents were asked they would respond in such a situation. Other questions were formulated more directly.

After having carried out and transcribed the interviews I read through them several times looking for the dynamics described by Kohut and Neff. The answers I found to be most interesting in light of the three main components of my conceptual framework (chapter 3) was subjected to further reflection in chapter 4. As indicated earlier, this process was supplemented by the collection of data using a quantitative methodology.

### **SONI Self-Report Scale**

The *Selfobject Needs Inventory* (SONI self-report scale) was originally designed for the purpose of empirically testing some of Kohut's key concepts (Banai, et al., 2005). The SONI consists of 38 items constructed to tap the avoidance (denial of selfobject needs) or approach

orientation (selfobject hunger) towards the selfobject needs for mirroring, idealization and twinship. These concepts are explained in detail in chapter 3. In filling out the SONI, a respondent rates the extent to which each item is self-descriptive on a 7-point scale, from “not at all” (1) to “very much” (7). Each question is part of a set of questions tapping a certain orientation. The five factors the self-report scale measures are:

1. Approach orientation towards twinship (hunger)
2. Avoidance orientation towards idealization and twinship (denial)
3. Approach orientation for idealization (hunger)
4. Approach orientation for mirroring (hunger)
5. Avoidance orientation towards the need for mirroring (denial)

I gave the self-report scale inventory to my respondents after each interview, asking them to fill it out and mail it in at their convenience. However, I purposefully did not calculate the scores until after I had finished interpreting the interviews. My initial idea was to use the SONI as a supplement to the interview material, evaluating both the sets of data at the same time. After consulting my advisor Dagfinn Ulland and psychologist and researcher Steven Sandage it became clear to me that a better approach would be letting the self-report scores rest until after finishing the interpretation to avoid the potential bias seeing the scores ahead of time might bring upon on the interpretation.

One of the limitations of the SONI self-report scale is that it can only directly tap a person’s conscious appraisal of selfobject needs. Whereas this method for data collection might be illuminative, like all self-report measures, it may be subject to conscious distortion as well as implicit cognitive and motivational biases. As mentioned in the first section of this chapter the quantitative self-report scale was utilized as a way of potentially confirming or challenging the findings from the interpretation of the qualitative interviews (cf. Riis, 2009: 168; Bryman 2004: 273). As we will see in chapter 5, the SONI self-report scale findings do in fact support and further illuminate the initial intuition that key aspects of Kohut’s theory helps us reconceptualize and better understand the dynamics of empathic engagement among professional caregivers.

## **Ethical Issues**

Because this thesis involves talking to people about issues that might be experienced as sensitive and private, certain ethical precautions have to be taken into consideration. As a researcher I have an ethical responsibility both for the individuals I am interviewing, but also for the institutions they are indirectly representing. Even if this study is not primarily concerned with the respondent's institutional belonging, but with the respondents' own experience of themselves in that specific context, the institutional belonging will inevitably have an influence on their experience of caregiving.

All but one of the interviews was conducted in Norwegian, so I have translated the respondent's answers into English. The interviews typically were conversational in style and relaxed in tone, which meant that the original transcriptions were characterized by interjections, intermittent pauses and incomplete sentences. In some cases, I do not include such interruptions within the transcribed text reported in the analysis of the interviews in chapter 4, but in such a way that I am careful to portray their intended meaning.

The ethical precautions taken in this study include obtaining informed consent from the participants and securing their anonymity throughout my work with this thesis (cf. Bryman, 2004: 511-513). The identities of the professional caregivers I have interviewed have been disguised, and aspects of their life not relevant to the points I make have been altered to hinder the possibility of recognition. Having received information about the project ahead of time, the respondents were all informed of their right to withdraw from participating. The interviews were audio-recorded and transcribed, and after the thesis is finished the audio recordings will be deleted. During my work with the thesis, the transcribed interviews have been stored separately from personally identifiable information, and only I have had access to the material. This strategy was evaluated and approved by Norsk samfunnsvitenskapelig datatjeneste (cf. appendix E).

Having presented the methods for data collection and interpretation, along with reflections on the strengths and limitations of this approach, I turn now in chapter 3 to outlining the conceptual framework that will be used to reinterpret the material from the interviews (chapter 4) and SONI reports (chapter 5).



## Chapter 3. Conceptual Framework

In this chapter I spell out the conceptual framework that will be used to analyze and interpret the data I have collected in interviews with professional caregivers across different disciplines (in chapter 4). The framework is primarily derived from two interrelated concepts within Heinz Kohut's self psychology. First, I pay special attention to his theory about the "maturation of narcissism," which results in greater self-regulatory capacities. A second and closely related concept is Kohut's understanding of a person's "orientation towards selfobject needs," which occurs along three "axes," to be explained. These will be combined with Kristin D. Neff's conceptualization of self-compassion, which will serve as a resource to complement Kohut's ideas.

A full integration of Kohut's and Neff's complex theories, whereas it would have been interesting, is not within the scope of this thesis, nor is it necessary for achieving its purpose. My goal here is more modest: to identify points of connection between their ideas and approaches, linking them in a way that is mutually reinforcing and that provides a framework through which I can reinterpret and reconceptualize the phenomenon of empathic caregiving in my data. In general, Kohut tends to focus on the developmental progression of empathy while Neff is more concerned with a person's current situation. I will suggest that the state of self-compassion described by Neff is the *product* of the *process* Kohut outlines as the maturation of narcissism in the orientation of selfobject needs. These are inseparable of course, and cannot be understood apart from one another; each scholar attends to both, despite emphasizing one over the other.

Spelling out these conceptual relations is the task of this chapter as a whole, but let me begin with a couple of examples that hint at the potential for their interconnection. In a recent

empirical study, Neff and McGehee (2009) found that parenting behaviors appear to contribute to the development of self-compassion. The study found that while maternal support, secure attachment and harmonious family functioning predict higher levels of self-compassion among teens, developmental factors like adolescent egocentrism negatively predicted self-compassion. These findings by Neff and McGehee are reminiscent of Kohut's claim that the ways in which one is met by one's caregivers conditions narcissistic development.

We can also see that both scholars theorize a correspondence between their proposed criterion for health (mature narcissism and self-compassion) and very similar personal and behavior characteristics. For example, Kohut (1966) argued that healthy maturation of narcissism would lead to qualities like empathy, creativity, humor, wisdom and acceptance of transience. Without referring to Kohut, Neff's empirical research (2009) has demonstrated that self-compassion is strongly associated with emotional intelligence and wisdom. Connections such as these have not been observed in the literature, and my goal is to link them into a framework that will then be used to clarify the relation between empathy for self and empathy for others in the experience of caregiving professionals.

### **Narcissistic Maturation Along the Three Axes**

One of Heinz Kohut's most significant contributions to psychoanalysis was his reformulation of the concept of narcissism (1971, 1977, 1984). Freud theorized that narcissism was a character structure to be outgrown and eliminated in order to experience object love, assuming an oppositional relationship between the two. Kohut rethought this relationship and claimed that narcissism and object love develops side by side rather than in opposition to one another (Kohut 1971: 219; Kohut 1984: 47, 185, 208).

When most people hear the term "narcissism" they have a pre-conception that it is something bad that needs to be eliminated, an assumption reinforced by Freud's view. Kohut, however, viewed narcissism as a vital personal resource that needs nourishment, not elimination. Appropriate nourishment then ensures the development of mature narcissism, and its transformation into capacities like creativity, wisdom, acceptance of transience, humor and

*empathy* (Kohut, 1966; Kohut 1971: 299).

Already in his 1959 article *Introspection, Empathy and Psychoanalysis: An Examination of the Relationship between Modes of Observation and Theory*, Kohut was breaking new ground by redefining the psychological task as one of understanding and explaining from the patient's perspective, rather than just from the vantage point of the therapist. He advocated and expanded this view throughout his authorship.

In addition to a vast number of articles, Kohut's most important books were *The Analysis of the Self* (1971), *The Restoration of the Self* (1977), and *How Does Analysis Cure?* (1984). In these publications Kohut develops the "selfobject" concept, explains the maturation of narcissism through selfobject experiences in development or in therapy, outlines the role of introspection and empathy (vicarious introspection) as observational stances to gain access to the inner life of the patient, and describes the curative power of empathy through understanding, echoing, affirming, and explaining.

In the two first publications Kohut explains the development to occur along the axes of grandiosity and idealization (1971, 1977). In his last book he adds the axis of alter ego connectedness (1984). According to Kohut the goal of development is the maturation of narcissism. This process takes place as psychological needs are met in accordance to the three dimensions of the self. These dimensions, which are also called axes, are:

- *Grandiosity*
- *Idealization*
- *Alter-ego connectedness.*

Corresponding to these three dimensions of the self Kohut suggest three specific psychological needs:

- *Mirroring*: the need for recognition and acceptance
- *Idealization*: the need to be connected to a greater, ideal other, providing an experience of a sense of calming and soothing, safety, and strength
- *Twinship*: the need to feel an essential likeness with other people and to be included in relationship with them

Kohut more often referred to these psychological needs, as *selfobject needs*.

In Kohut's last book he defined *selfobjects* is as "the dimension of our experience of another person that relates to this person's functions in shoring up our self" (Kohut, 1984: 49). So, a selfobject is not necessarily another person him or herself, but the function the

person is providing that contributes to uphold our sense of self, or what Kohut called our *cohesive sense of self*. The cohesive self is referring to a feature of one's self-experience, "the secure feeling of being an unit in space, a continuum in time and a center for initiation of action and for the reception of impressions" (Kohut, 1977: 156). Whereas our self-cohesion in early years is dependent on our caregivers' functioning as selfobjects for us, if the selfobject needs are optimally responded to, the capacity for self-regulation is gradually internalized (Kohut, 1971: 278; Kohut 1977: 139).

As indicated above, Kohut theorized that every individual is born with a need for relatedness with others for psychological survival and growth, and that particular types of relational experiences are required for optimal development. The vulnerable young child needs help to fulfill psychological needs, as well as physical needs. She needs to feel affirmed and recognized, to feel accepted and appreciated. This is called "mirroring." She also needs to feel linked to an idealized other to experience a sense of calming and soothing, strength and safety. Kohut calls this "idealization." And thirdly, she needs to experience an essential likeness with others in order to feel that what she experiences is part of a common human experience. This is the idea of "twinship." Kohut further theorized that the caregiver's provision and meeting of these psychological needs is what enables the child to eventually learn to provide them for herself.

This process of transition, where the selfobject needs are empathically responded to and optimally frustrated, Kohut calls *transmuting internalization*. These experiences are then transmuted into healthy, tension-regulating, *psychic structures* (Kohut, 1971: 28). The latter are psychological capacities and abilities that enable the individual to choose her own values and goals and commit to them, leaving her with more autonomous and realistic perceptions, providing a sense of inner security and resilience leading towards a psychologically more healthy way of relating to herself and others.

However, if the infantile narcissism is challenged too brutally, or if the unresolved needs from childhood are too comprehensive, it can create "faults" or "weaknesses" in the psychic structures that hinder further development. The individual might then remain stuck with what Kohut calls *archaic needs*, hindering the internalization of psychic structures that reliably can regulate self-confidence and calm the self, leaving the individual dependent on others to provide these functions.

Kohut's reformulation of the idea of narcissism also includes an acknowledgement and an affirmation of the enduring need for mirroring, idealization and twinship experiences throughout an individual's lifespan. He viewed a person's striving for absolute autonomy as a

sign of archaic narcissism, rather than of maturity. In *How Does Analysis Cure?* Kohut introduces part II, “The Nature of the Psychoanalytical Cure” like this:

Self psychology holds that self-selfobject relationships form the essence of psychological life from birth to death, that a move from dependence (symbiosis), to independence (autonomy) in the psychological sphere is no more possible, let alone desirable, than a corresponding move from a life dependent on oxygen to a life independent of it in the biological sphere. The developments that characterize normal psychological life must, in our view, be seen in the changing nature of the relationship between the self and its selfobjects, but not in the self’s relinquishment of selfobjects. (1984: 47)

Kohut often compared the need for selfobject experiences for emotional life with the need for oxygen for biological life, in order to emphasize that one does not grow out of the need. But, depending on the development of healthy psychic structures, one can grow from an archaic to a mature way a relating to those needs, allowing them to be met in a number of ways (Kohut, 1984: 220).

So, according to Kohut, we all relate to the world through narcissism, but the *quality* of the narcissism we have is either mature or archaic, or somewhere in between, and is conditioned by the way our psychological needs have been and continue to be met within our selfobject matrix. The firm, healthy, resilient self is less dependent on external sources of self-regulation, tolerates less than optimal selfobject experiences without significant loss of self-cohesion, and has the capacity to relate to others without demanding that they fulfill selfobject functions.

## **Orientation Towards Selfobject Needs**

In the previous section we looked primarily at the *process* Kohut refers to as the maturation of narcissism. This process will be relevant in the next chapter’s interpretation, as we will look in the data for dynamics related to the three axes of grandiosity, idealization and alter ego connectedness. In this section we will take a closer look at the *product* of the narcissistic development. By making the distinction between a mature and an archaic narcissism I will try to spell out how the maturation of narcissism has consequences for the ways in which one

deals with self-other relations, conceptualized by Kohut as the way one is *oriented towards one's selfobject needs*.

In making the distinction between archaic and mature narcissism, it is important to underscore that it is not necessarily one or the other. Kohut himself said that “there is not one kind of healthy self – there are many kinds” (1984: 44). However, the distinction might help us notice things we otherwise would miss. A person might have a stronger tendency towards a narcissistic orientation that is archaic or mature. Moreover, the distinction will also help me further spell out the features of the three axes along which Kohut theorizes the self develops. In addition, the idea of mature narcissism will be the point of connection to Neff’s conceptualization of self-compassion to which we will return in the next section. All these concepts will later help us illuminate how professional caregivers relate to themselves as they are confronted with the call for empathic engagement in their practices.

According to Kohut’s theorizing, people with *mature narcissism* will have a greater capacity to self-regulate and so will have less need for other people to function as selfobjects for them in order to uphold their cohesive sense of self. As their healthy grandiosity, idealization and connectedness have been strengthened, the self becomes the main agent of regulation, and the person will be less dependent on others to reflect back a sense of recognition, affirmation and admiration. Keeping Kohut’s notion about the enduring need for selfobject experiences in mind, this does not mean that these affirmative reflections are not still appreciated, and also needed, but they are no longer playing the role of constituting the self.

In relation to the idealization axis, those with a mature narcissism will have internalized a capacity for self-regulation in terms of calming, soothing, safety and strength. They might also have a greater capacity for balancing idealization with realism, making them less vulnerable to the feeling of failure, confident that even if they try their best; sometimes they don’t reach that idealized goal they set out for. The ability to balance idealization with realism affects the way those people relate to their own values and goals, but also the way in which they judge and relate to others.

The need for twinship, which is related to the alter ego connectedness axis, refers to the need to feel similar to others and to be included in relationships with them. People with a mature narcissism often have an increased capacity to adapt to community codes and develop the social skills necessary to stand in healthy, emphatic relationships without feeling that this connectedness is threatening or that their connectedness to others in the community is what constitutes the self.

People with an *archaic narcissism*, on the other hand, might experience problems maintaining healthy feelings of grandiosity, idealization and connectedness, because they are dependent of their selfobjects functioning for them to uphold their sense of cohesion. In general they might have trouble balancing idealization with realism, coming to expression as extreme vulnerability to criticism and failure, a focus on deficiencies, often becoming overwhelmed by negative emotions and having experiences of alienation and loneliness. Along the grandiosity axis they might have unrealistic ambitions, either too low or too high. In relation to the idealization axis they might have a poor capacity to self-soothe in emotionally challenging situations. Finally, along the alter ego connectedness axis they might experience difficulties communicating feelings to other people and commit in intimate relationships, afraid to show their needs and afraid they will not be accepted by others.

Broadly speaking, Kohut theorizes that this archaic narcissism is a result of the unresolved needs and empathic failures in childhood, manifesting itself in certain ways of being oriented towards selfobject needs. While those who have a mature narcissism have relatively balanced selfobject needs and do not attempt to deny these needs, those with an archaic narcissism might have overly strong object needs, what Kohut called “hunger” for selfobject experiences, others attempts to deny and avoid these needs (Banai et al. 2005).

People with high levels of *object hunger* will tend to need other people to continuously validate them, often due to parents failing to serve as selfobjects providing mirroring and opportunities for idealization and twinship. In relation to the alter ego connectedness axis and the twinship need they might act inappropriately clingy to the people and the groups they are bound to, at any cost trying to keep them as close as possible. This also results in frustration when the selfobjects think, feel and act in contradiction to what the person with the archaic narcissism believes.

On the other hand, a high level of *selfobject denial* is often the result of unresolved experiences with rejection and loss. Persons high on selfobject denial often appear strong, but this is more than anything an unstable facade aimed at reducing negative self-related feelings. This also influences their ability to empathize with others. Over-idealization might be a cause of reoccurring disappointments, both by themselves and others, because they never reach the idealized goals they set for themselves and other people, resulting in a lack of trust because their idealized reality keeps letting them down.

According to Kohut (1971, 1977, 1984), the state of *archaic narcissism* in adulthood is, as we have seen in this section, an attempt either to secure the provision of selfobject experiences or to protect the self from further injuries. Whereas persons with high levels of

selfobject hunger at their extreme are overly dependent and quickly adapt to others because they not comfortable enough to trust their own abilities, persons who deny their selfobject needs tend to be compulsively self-reliant, trusting themselves completely, denigrating their own needs in order to appear strong and independent, a repressive strategy that only makes them more vulnerable in times of crisis.

One could say that people with a *mature* narcissism, however, are on a completely different frequency. Such people have found a balance, a more resilient way of facing difficulties, having internalized a sense of direction, and they have the ability to both give and receive while maintaining a cohesive sense of self.

In this section I have made the distinction between an archaic and a mature narcissism using the extremes of each to illustrate their characteristics. Because the respondents in my interviews are well functioning professional caregivers, however, one would not expect that they are likely to fit into either of these rather extreme polarities. Nevertheless, the distinction between archaic and mature narcissism, developed along three axes, applies to us all, and my task will be to explore the ways in the professional caregivers are oriented towards their selfobject needs, and how this might influence the way they relate to themselves as they are faced with the call for empathic engagement in their practices.

These dynamics are discovered and discussed not only through the interviews (chapter 4), but also through the SONI self-report scale measures (chapter 5). First, however, I need to outline the third component that will guide my reinterpretation and reconceptualization of the phenomenon in relation to the data.

## **Self-Compassion**

With Kohut's notions of mature narcissism and orientation toward selfobject needs in the back of our minds, we now turn to Dr. Kristin D. Neff's helpful and complementary conceptualization of "self-compassion." In this section I will explain self-compassion as theorized by Neff and link her construct to Kohut's understanding of narcissism.

Neff does not refer to Kohut; nor does she say exactly the same thing as he does. Nevertheless, it seems to me like Neff's conceptualization of self-compassion can be used as



a resource to complement Kohut, suggesting that the state Neff describes is similar to the development envisioned by Kohut, the *product* of the *process* he describes as narcissistic maturation. Neff (2003a) connects her understanding of self-compassion to a more general definition of compassion; in addition to feelings of openness to others pain, without avoiding and disconnecting from it, compassion also includes the desire to help alleviate their suffering.

Drawing on the writings of Buddhist scholars, Neff has defined self-compassion as having three main components:

- *Self-kindness*: being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical
- *Common humanity*: perceiving one's experience as part of the larger human experience rather than seeing them as separating and isolating
- *Mindfulness*: holding painful thoughts and feelings in balanced awareness rather than over-identifying with them

(Neff, 2003a: 85)

The three components of self-compassion will be used in chapter 4 to complement Kohut's concepts for the interpretation of how the professional caregivers relate to themselves as they are faced with the call for empathic engagement in their practices.

Proposing self-compassion as an alternative conceptualization of a healthy attitude towards oneself Neff argues against the previous use of "self-esteem" as the primary measure for psychological health. She observes that high as well as low self-esteem can be linked to several negative psychological outcomes. Whereas low self-esteem has been linked to lack of motivation, depression and suicidal ideation, some psychologists argue high self-esteem might be linked to self-centeredness, self-absorption, and a lack of concern for others (Neff, 2003a). A primary characteristic of self-esteem is that it is constituted by judgment and comparison. The self is primarily judged and evaluated in comparison to others, and will also look to others' evaluations in order to determine how much one likes one's self (Neff, 2003a).

This can be linked to Kohut's understanding of mature narcissistic development, or lack thereof. On the one hand, "we need others to become ourselves" (Kohut, 1985: 238). On the other hand, if the selfobject needs necessary for the maturation of narcissism have not been met, the self remains stuck in the same patterns in which one's sense of self-worth and regulatory capacities are still dependent on the sense in which one's grandiosity is reflected back by idealized others.

It seems to me that the characteristics of self-compassion correlate with the mature narcissism where the self-regulatory capacity is internalized in the individual (Kohut, 1971: 278; Kohut 1977: 139). For Kohut this does not imply that one is then completely independent of other people, but that in relating to one's enduring need for selfobject experiences, one can comfortably acknowledge one's dependence on others. Whereas Kohut envisions a mature way of relating to the self in terms of being able to self-regulate, not needing other people to function as selfobjects for the individual to feel emotionally balanced, Neff makes explicit certain ways in which this self-regulation might come to expression.

In the next chapter's interpretation I will make use of the components of self-compassion as presented by Neff to further illuminate how the professional caregivers I have interviewed relate to themselves. Are they kind and understanding towards themselves, or harshly self-critical? Do they feel alienated, or do they feel like their suffering and personal failures are part of a common human experience? And are they able to "stand in" their pain, do they cut off from it, or do they over-identify with painful experiences and feelings?

Implicit in Kohut's idea of a mature narcissism and in Neff's conceptualization of self-compassion lies the notion of a good kind of selfishness, a sense of concern for the self without repressing others, a sense of self-awareness that actually makes the individual more empathic to others. As one's healthy grandiosity, idealization and connectedness are strengthened the cohesive self becomes the main agent of self-regulation. Because a person with a mature narcissism has less need for her selfobjects to uphold a sense of self, she will have more to give because as she has become less dependent on optimal selfobject responses, she does not have to struggle to get her own needs met.

If, on the other hand, one's energy is mainly directed towards securing the provision of one's selfobject needs, or avoiding additional frustrations by denying those needs, then having empathy for others becomes increasingly difficult. Both Kohut's notion of a mature narcissism and Neff's state of self-compassion include the idea of an attitude towards the self that enhances one's ability to cope in time of stress, as well as actually increasing one's ability to feel and show empathy toward others. Throughout the following chapters, I will explore some of the ways in which mature narcissistic development and compassionate attitude towards one's self may affect one's capacity for empathy toward others in the context of professional caregiving practices.

## **“Placing the Bag on Yourself Before Attending to Those in Your Care”**

As I mentioned earlier, Kohut often compared the need for selfobject experiences for emotional survival with the need for oxygen for physical survival, in order to underscore the necessity and centrality of these experiences throughout the lifespan for the formation and shoring up of a healthy self.

This section’s heading refers back to the quote from the Malaysian Airline security instructions<sup>2</sup>, with which I introduced my thesis. I now want to follow up this analogy and make more explicit an idea that I believe lies implicitly within Kohut’s theory. This is the idea that one’s lasting capacity for empathically caring for others is conditioned by the extent to which one’s selfobject needs have been and continue to be met within one’s selfobject matrix; caring well for others requires that one is able to receive psychological oxygen for oneself.

If the archaic narcissism of the young child has been ideally met, empathically responded to and optimally frustrated, the transmuting internalization is allowed to take place, and healthy, tension-regulating psychic structures are internalized. This means that the individual is less dependent on their selfobjects to function for them, resulting in a more resilient and healthy way of relating to the self. As we have seen in previous sections, this does not mean that as one’s narcissism matures one becomes totally independent; rather, it means that one is able to comfortably acknowledge one’s dependence on others. This process involves growing from a dyadic regulation to increased self-regulation; that is, from an archaic to a mature dependence.

According to Kohut optimal selfobject experiences are necessary for narcissistic maturation and the development of highly valued capacities like wisdom, humor, creativity, acceptance of transience and *empathy* (Kohut, 1966). Ongoing selfobject experiences are also necessary for the maintenance of these same capacities. That is to say, if you want to maintain your capacity to empathically care for others, you need to make sure that your own oxygen bag is securely strapped on.

According to Neff (2003a) a balanced integration between concern for oneself and concern for others is essential to optimal psychological functioning. Being maturely narcissistic, or having self-compassion, you can recognize that you are about to fall to the

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<sup>2</sup> “Place the [oxygen] bag on yourself before attending to those in your care” - Malaysia Airlines security instructions, January 2010

floor from lack of oxygen. You can take hold of the bag and place it on yourself before attending to those in your care.

## Summary

In this chapter the ideas embodied in Kohut's model of narcissistic maturation were linked it to Neff's conceptualization of self-compassion, suggesting that the state Neff describes is the *product* of the *process* Kohut outlines.

The development from an archaic to a mature narcissism is, according to Kohut, a development from being dependent on selfobjects for regulating self-confidence and self-cohesion, to having internalized these self-regulation capacities. He also theorizes that the early provision of positive selfobject experiences are essential for the maturation of the self, and that the need for such experiences remains throughout the lifespan. The three enduring needs Kohut's points out in his developmental model were:

- *Mirroring*, the need to feel affirmed and recognized.
- *Idealization*, the need to feel linked or connected to an ideal other, providing an experience of a sense of calming and soothing, safety, and strength.
- *Twinship*, the need to feel an essential likeness with other people and to be included in relationship with them.

Whereas mature narcissism comes to expression as a balanced orientation towards selfobject needs, an archaic narcissism (at its extreme) might come to expression as either an overly dependent *selfobject hunger* or a compulsively self-reliant *selfobject denial*. Although these extremes are not likely to be found in our respondents, we can use the distinction in order to illustrate the difference between tendencies toward one or the other way of being orientated to one's selfobject needs.

In this chapter, I have described the three main components of my conceptual framework – narcissism, orientation toward selfobject needs, and self-compassion – with special attention on the connection between the enduring need for having one's selfobject needs met and one's lasting capacity to empathically care for others. I turn now to the interview material, which will be abductively interpreted and reconceptualized in light of this framework.

## **Chapter 4. Interview Material and Interpretation**

Having presented the conceptual framework, we now turn to the interpretation of the interview material. Instead of organizing the presentation around themes, I have decided to report on the respondents diachronically, i.e., making a separate interpretation, in a linear order, of each of the six interviews. One reason for this is that it better maintains the sense of each respondent's narrative, making it easier to keep in mind the contextual differences that make his or her response unique. This approach also leads to a less fragmented presentation and interpretation, making it easier to feel the coherence of each interview. In chapter 6, however, I will briefly summarize the findings synchronically – in light of the themes outlined in chapter 3.

In carrying out the interviews I focused on questions concerning the respondent's own understanding of empathy, encouraging them to give me examples of situations in which they think it is more or less difficult to be empathic (cf. appendix B). I also asked more direct questions, trying to approach their orientation towards selfobject needs, getting at how they experience lack of recognition and affirmation, and whether they are able to balance idealization with realism, and their need for others to be like them.

Throughout the process of interpretation I was especially attentive to the professional caregiver's own reflections on empathic engagement, points of connection to narcissistic maturation, their orientation towards selfobject needs, and the extent to which they show signs of self-compassion, as conceptualized by Neff (self-kindness, common humanity and mindfulness).

## **Mr. A**

Mr. A has been a psychologist for 14 years working with clients as well as doing further training for other therapists. Of the respondents, Mr. A was the one who was most knowledgeable about Kohut's theory. Throughout the interview he showed a strong interest in the curative power of empathy, but he was also attentive to the limitations of empathy, defending an approach to therapy that combined psychological and philosophical insights.

When asked in which kind of situations he finds it most easy to have empathy, Mr. A immediately replied that he always has empathy for his patients. He asserted he has no difficulty sustaining this empathy because of the explicit goal of helping, which is inherent in the therapeutic context. Mr. A's answer made me curious how he feels with others, such as with his colleagues, and I asked whether it is different in other contexts. He said that for him it very much depends on what is the main focus of the specific situation, observing that empathy requires attention, mindfulness, and enough time and space to process, qualities not present in all situations.

Following up on the question concerning situations in which empathic engagement is easier to sustain, I asked him if he could remember situations in which he felt insufficiently empathic, or which in retrospect he viewed as overreacting.

... I am probably almost over-focused on empathy, knowing how to read people's faces, read their feelings from their faces. Also, having the perspective that all people have been children, and that children are very sensitive and needs to be affirmed for their feelings and experiences, and to be valued for who they are in order to develop a good sense of self. If you assume that perspective it is very easy to have compassion even with terrible people, they probably had poor conditions for developing a good sense of self. But what I also would like to say, the worst problem of modern psychiatric health care is that there is not enough time, which often feels devastating. The patient needs time, and sometimes I don't have enough time to give them the treatment they need. In those situations I myself need empathy and support, and/or help to find solutions.

Responding to the first question Mr. A had mentioned that he experiences his empathic engagement as conditioned by context. His role as a psychotherapist, with its overarching goal of helping the patient, helps him stay empathic and attentive to the patients. In response to the follow up question, however, he acknowledged that certain situations or contexts have characteristics that make it more difficult for empathy to emerge.

In light of the conceptual framework outlined in chapter 3, several aspects of his responses are interesting. For example, he acknowledges his own need for empathy and support when experiencing that his ability to help his patients is being hindered by factors beyond his control. On the one hand, this recognition suggests that Mr. A has access to his own subjectivity, an ability Kohut saw as necessary condition for a person's empathic capacity. On the other hand, his humble acknowledgement of his own needs, not attempting to deny them, indicates a mature orientation towards his selfobject needs.

In the next question, trying to approach Mr. A's self-regulatory capacities, I asked him whether he remembers situations where he has been disappointed, angry and/or frustrated with himself, colleagues or patients. He answered that he most often experiences being angry and frustrated with himself, then colleagues, and least of all with his patients. Wishing for him to elaborate his answer, I asked him how he handles these situations.

Well, I am very much influenced by newer self psychological theory, and they are almost masochistic in their focus on the therapist empathy. Therapists influenced by these theories I think rarely are frustrated and angry with their patients. The old theories on the other hand, there are studies that show that therapists that work by Kernberg's model often get frustrated and angry with their patients. Therapists working in accordance with the theories of Kohut, Stolorow and Jeffrey Young seldom do. They feel more care and compassion towards their patients, and often they have very high demands for themselves. This of course can lead to feelings of inadequacy. A high sense of responsibility often leads to self-condemning feelings, not being good enough. I think therefore, and that is my experience too, that it is the best therapists and the best psychiatric nurses, the most empathic are the ones that are in most danger of burnout and compassion fatigue. And it is these therapists and nurses that the patients have most use for. Then support becomes very important, collegial support or networks, or ideally become so good at what you're doing that your patients actually gets well, that is an enormous award, a win/win situation. Like when a mother is empathic towards her crying child. If she comforts the child and the child is content and calm, also the mother feels good. It is a win/win situation, everyone involved feels good, and the same is true for therapy...

Again Mr. A is attentive to his own need for emotional support. He mentioned different arenas in which these needs could be met, including collegial support and networks. The most affirming experience for Mr. A, however, is seeing patients getting well.

If we take a look at his answers in light of Neff's concept of self-compassion, we can notice that Mr. A also mentioned feelings of inadequacy and self-condemnation, especially

experienced by professional caregivers that have a high sense of responsibility. The ones that are the most empathic, Mr. A notices, are the ones most in danger of burnout and compassion fatigue. If Mr. A is right, this might indicate an imbalance between the ways the caregivers care for themselves and the way they care for others. According to Neff, a balanced integration between concern for oneself and concern for others is essential to optimal psychological functioning. Being kind and understanding towards oneself when faced with experiences of suffering and personal failure are more likely to generate healing and growth than will being harshly self-critical.

The next question was about his likely reaction to a colleague getting praised for a job Mr. A was responsible for doing. This was intended to approach his need for mirroring experiences, his need for others to see and acknowledge, and even praise his accomplishments. He answered:

I think I have experienced that. Generally speaking, it is kind of annoying; it depends also on how one can explain it. It also depends on what kind of value system we have; some might be jealous, some annoyed or bitter. And shame psychology, just to mention that, if you are very engaged in something, and you are in some way hindered, if you are doing an effort and not being met, that you don't get our "award", one might feel wounded. I don't feel like that is a part of my life, that I feel bad when other people receive, I like to share as much as possible. I guess I have received enough to develop a good enough self-confidence after getting feedback from patients. At least I would not think it was a problem, but a little annoying I guess, from an ego point of view. It depends on how deep rooted that self-confidence is. If it is rooted in the ego, it will feel differently than if it is rooted in like a mission, that one wishes to contribute to a warmer and more caring society or something.

Kohut theorized that children who experience traumatic frustration of the mirroring selfobject need might try to compensate by trying to be perfect because they assume that the lack of mirror responses are caused by their inadequacy. If frustrated in a traumatizing way the child might later in life have a hunger for this need, trying to secure the provision of selfobject experiences or to deny the need, in order to protect the self from further injuries (Kohut and Wolf, 1978). Mr. A's answer indicates that he has a balanced orientation towards this selfobject needs. He acknowledges (rather than denying) his need to be seen and praised for what he accomplishes.

The next set of questions are about significant persons in Mr. A's life, trying to get at idealization and twinship experiences in his childhood and adolescence. He cheerfully started



his response by mentioning that of course years of therapy have already been spent thinking and talking about it. He further reflected:

I think that a part of my script is a need to be kind, to help people, and I can easily feel like I am not good enough, have high demands for myself. Many therapists have that, high demands and expectations for themselves, I have had that too. I can easily get a feeling of guilt, and shame, that I am not doing a good enough job in all areas, at least I am sensitive to those feelings. But then there was this guy in my adolescent peer group, who had a lot of influence on me, and who opened up many doors for me, to philosophy and psychology, but also teachers at the University. The nice thing about Kohut was that he noticed that having an idealized relation to someone was not necessarily bad; in a way he legitimized it. He legitimized my kind of childish need to idealize. When criticized for not saying what I meant as a newly educated psychologist I could say that I wanted to learn from the ones that were more experienced than me. So Kohut's psychology helped me allow myself to be humble and look up to more experienced others.

Again Mr. A mentioned his high expectations for himself, his experience of not being good enough. Although this answer can be thought of as showing his need for idealization, they can also be interpreted in light of Neff's conceptualization of self-compassion. His answers then indicate that his self-evaluation to a certain extent is constituted by judgment and comparison, rather than understanding and patience. He still seems to have a certain need for experiences of recognition and acceptance from an idealized other, providing soothing, safety and strength. Mr. A is aware of these needs and seems to relate to them in a healthy way.

Mr. A mentioned psychological theoreticians that have served as ideals, but also characters such as His Holiness The Dalai Lama, Nelson Mandela, and similar great personalities. I will get back to the idealization experiences, but first let's look at how his answer can be thought of in terms of twinship experience. In adolescence the twinship experiences with other people outside the family system help the adolescent differentiate from his or her family, an experience also important for identity formation (cf. Lessem, 2005: 52). For Mr. A this need seems to have been met by the man in his peer group who helped him discover philosophy and psychology, disciplines that Mr. A has found so inspiring that they has become his occupation.

Returning to the question regarding idealization and how he relates to his idealized others, I asked Mr. A if he feels his idealized others as failing when displaying signs of imperfection. His answer can be seen to illustrate an example of what Kohut would call having found a balance between idealism and realism.

No, because they have certain fundamentals, and then you can see. I have heard this humoristic observation from a female Buddhist meditation master. She said that she was so disappointed every time she really got to know one of the other masters. But the greatest disappointment was when she herself was renowned as a master herself (laughter). I have felt that. If I can be approved there must be a low standard...

I feel that after all it is part of the master level, acknowledging your own insufficiency, that we are just humans doing the best we can. If we can manage to be empathic and caring, understand and have care for, and try to be of help that is good. Looking around me I don't feel like I should have to lack self-confidence, but I also see that there are others even better than me, but we are all human, nobody is perfect.

Mr. A's feelings toward and understanding of his idealized others as fellow humans, not just as omnipotent others with which he wants to merge, illustrates not only the balance between idealization and realism, but also the importance of twinship experiences in which he recognizes others, including those he looks up to, as being like him. In Neff's terms his answer illustrates the common humanity component of self-compassion, especially when he compares himself to other people and recognizes it as a common human experience to feel inadequate in some way.

All in all, Mr. A's answers give us several examples of the dynamics exemplified by both Kohut and Neff. For me the most interesting dynamics are not only related to his own development, but also to the way in which he experiences the fruitfulness and limitations of Kohut's model for treatment of severe personality disorders. Several times throughout the interview Mr. A mentioned the importance of having self-empathy, the fundamental right for everyone to be allowed to experience exactly what they experience, and the enormous healing power of being understood and acknowledged. He sees the effect it has on his patients, how good it makes them feel, and that it makes them "less crazy." He often refers to Stolorow who says that empathy is conditioned by our horizon of understanding, and the extent to which we have integrated our sense of self, our affects, and our emotions. This supports, but also expands, Kohut's assumption that a person's capacity for empathy is dependent on the extent to which she has access to her own subjective experience.

Mr. A strongly expressed his belief in the curative power of love and humor, emphasizing the qualities of understanding, acceptance, recognition and care immanent in love. In his article *Forms and Transformations of Narcissism* (1966), Kohut theorized humor and empathy to be two of the capacities growing out of a healthy narcissistic development. Further reflecting on Mr. A's interview as a whole, it seems to me that his knowledge, his

experience, and also his wide horizon increases his empathic capacity as it provides him with concepts and frameworks helping him understand both himself and other people. His experience allows him to discover patterns more easily, and his wide horizon of understanding allows for the recognition of a wide range of possible ways of thinking and living.

Leaving Mr. A for now, I turn to the interpretation of Mrs. B who works as a midwife at a town hospital.

## **Mrs. B**

Having worked as a midwife for twenty years, Mrs. B is still very happy with her job. She likes being challenged and she likes working with people, but she also admits it is demanding at times because of the responsibility that comes with it. Potentially being a matter of life and death, it is likely to be very traumatic when something goes wrong. Early in the interview she mentioned an experience she had several years ago, at a time the institutional follow-ups after traumatizing experiences were not as good as they are today. Looking back she realized that this experience led her into a mild depression lasting about a year. Later she got a chance to process it with others, and she thinks that this experience was of great importance for her own mental health.

On the question regarding her understanding of empathy Mrs. B's answer corresponded with Kohut's understanding of empathy as an observational stance.

It is about putting yourself in someone else's situation, without being drawn into it. It is a difficult concept, but basically showing compassion, understand the situation, but still keep it on a professional level, and not let it destroy you.

“Vicarious introspection” was the term Kohut used to describe the empathic process in a therapeutic setting: “one person's (attempt to) experience the inner life of another person while simultaneously retaining the stance of an objective observer” (1984: 175). Based on my reading of Kohut I take him here to mean “objective” in the sense of non-judgmental, not that the therapist has a vantage point that is more objectively true than the patient.

As mentioned in the introductory chapter, according to Kohut a person's introspection, i.e., her ability to access her own subjectivity, is a source of her ability to empathize with

someone else's experience. On a follow-up question regarding whether she thinks empathy mainly is about recognizing and understanding someone's feelings, or whether it also concerns the capacity to acknowledge and understand their worldview, Mrs. B answered:

I would say it concerns everything; it concerns everything in my work. So, both in understanding the experience they are having, sometimes I see how much pain they are in, other times I see that they are experiencing being in much pain. I can see a difference. But still I have to understand how this person experiences it, and meet them in the experience they are having. I think that is very important in our work. If the feeling is not real, it is real for the person experiencing it like that. I have often thought about this.

Both these answers indicate that Mrs. B is capable of acknowledging another person's experience as well as her own. Her comment on keeping it at a professional level, not letting it destroy her, can be seen to indicate an experienced danger inherent in empathy, i.e., not being able to balance one's concern for others with a concern for oneself.

I wondered if Mrs. B, like Mr. A, experienced that it is easier to have empathy with her patients. I asked her if she feels more easily frustrated with people closer to her.

I think it has to do with my personality. I rarely get irritated. Of course, my children (laughter) probably think I don't understand enough. And I might be a little tougher on them actually. But I rarely get irritated. I think I in most cases can show empathy. When you have a certain amount of life experience you know to distinguish between what is mine, and what is someone else's problem. For instance at work I can easily handle people who are in a bad mood, hard to please and doesn't want to work. I can see that it is not my problem. It is their problem. Then I can also imagine what lies behind it, that there is things happening at home, things bothering them... I think my life experience makes this easier, I don't think it is that difficult.

Again, this answer indicates that Mrs. B is able to see both her own reality and other people's reality, which seems to be an advantage when engaging with her colleagues. Instead of only seeing herself and get offended and upset when colleagues display some kind of unpleasant behavior, she is able to see them in their subjectivity. Most likely, her ability to see and empathize with her colleague makes her more able to calm their anxiety as well, whatever it is about.

I also asked her about her background and the ways in which she has experienced being met earlier in life. Mrs. B responded that she especially values the safety, love, and understanding that her parents were able to carry over to her; despite the things they couldn't do because of their own psychological problems (anxiety, depression). In addition to giving

her the love and affirmation she needed, Mrs. B notes, reflecting on their problems gave her a wider horizon of understanding, making it easier for her to understand other people's problems. She also mentioned how moving out and living by herself when studying to be a nurse helped her find herself, to discover her own platform.

Viewed in light of Kohut's theory Mrs. B's answer indicates that she had experiences of both being optimally responded to, and being optimally frustrated during her childhood and adolescence. Mrs. B's experience of her parents as providing safety can be seen to correspond with the need for idealization, and the experience of love and understanding as corresponding to Mrs. B's need for mirror experiences. Moving away from her parents also seems to have contributed to her development of a healthy, secure self or, as she describes it, of the positive experience of discovering her own platform, her own identity.

Further inquiring into how Mrs. B is oriented towards her selfobject needs, I asked her what she thinks is important in a work environment to uphold the employee's motivation. She answered:

I think it is very important to be met in the right way, that someone sees you, and it is important that you are able to cooperate, and that you feel you can say when enough is enough, and I think how it is here most of the time. It is important that we feel like we can trust each other... it is hard to find the right words... but to feel you are allowed to be yourself, and to be accepted for who you are. Some are turbo midwives, some are calmer, to be accepted for whom you are, and that is how I experience the atmosphere where I am currently working... I guess there are many others things that are important too... It is important that there is a sense of structure in the work we do, we have experienced this structure lacking here sometimes, because of continuous changes in management. If everything is up in the air, it is hard to relax. I think it is important to have clear instructions for who does what, who is responsible, and that there is someone over you deciding these instructions. I think that means a lot for a work environment, having leadership, someone in charge.

Mrs. B's opinion of what she perceives as an empowering work environment echoes Kohut's belief in an enduring need for selfobject responsiveness, necessary for our well-being in adulthood as well as in infancy and childhood. Throughout our lives, Kohut asserted (1984: 47), one needs to experience being recognized, understood and affirmed for who one is, as well as experiencing a sense of security and stability.

In this example we can also see the selfobject needs coming to expression in Mrs. B's thoughts on the need for structure, the need for a stable leadership attentive to their responsibility of leading the employees in their work. On the one hand, Mrs. B acknowledges

that she needs to be affirmed for who she is, i.e., in Kohut's terms, to be mirrored, which helps to build and maintain self-confidence. On the other hand, she says she needs someone to lead the way, someone responsible and secure in his or her decisions, i.e., in Kohut's terms, the need for idealization. This can also be seen as an example of the type of nourishment Kohut suggests one needs to have throughout the lifespan. That is, one continuously needs certain psychological functions supported for one to feel a sense of energy and direction.

Next I presented Mrs. B with a hypothetical problem concerning having empathy for someone with a different worldview, a dynamic we touched on earlier in the interview. The question for reflection was how she would feel if confronted with parents deciding against blood transfusion because of their religious belief, even if it might mean that the child and/or the mother wouldn't survive.

It is actually a relevant problem for discussion, even if it doesn't happen that often, and even if it is not directly my problem to deal with. If a child is so sick that it needs blood transfusion it is transferred to the newborn unit, and then a doctor makes the decision. But I have to get into it though, with the mother, and that is difficult. I have to admit that in those cases it is hard to be empathic, I think it is hard to accept that they would let the child die. But we wouldn't do that. I don't think anyone would let a child die, and if they do I think it is right to oppose the parent's will. I can understand that they are convinced this is the right thing to do, and that they think it is a tough decision to make, but still, I cannot accept it. And of course, I do have problems with other cultures too, and I believe that is because I don't know enough about them, what they do and why. Often we just end up accepting the things they do, just let them do it their way, there is probably a cultural reason why they do it this way. It is interesting though; I often think that I would like to learn more about how they think. Like you are saying, it is about their perception of reality. The world is like this, my world is like this, but that is not your world.

As a follow-up question I ask her whether she generally experiences empathic engagement as more challenging when other people's understanding of reality is too different from her own perception of reality.

Yes, I think it is challenging, but I try not to step on, not to damage, because I accept that the world is experienced differently for others. But it can be challenging, it can be hard to know how to meet them. What, and how much you should get into, how much we should try to explain how we do it and why, and why we think that is the right way to do it. At the same time it is not possible, we don't have the right to demand of others to do it in a special way. It is very challenging, the situation you mentioned regarding blood transfusion, we also have

women in labor choosing to bleed to death, they want to, but if we let them do it is a different discussion. But it is not my responsibility, and I am very glad it is not. But it doesn't happen very often, most of the time everything works out fine, we are happy that is the case

Both her answers show the ambivalent feelings that arise when she meets different perceptions of reality. On the one hand, Mrs. B wants to respect other people's right to govern their own lives. On the other hand, she experiences it as problematic to accept decisions that go against the very core of her values.

Approaching questions about burnout and compassion fatigue Mrs. B returns to what she hinted at in the beginning of the interview, the traumatizing experience she had early in her practice, which she did not realize she needed to process until much later.

Yes, I have had experiences causing a mild depression, more or less throughout a whole year without me being able to put it into words, without talking to anyone about it, but in retrospect I can see that I was depressed that year. A child died during labor. And this is a long time ago, so no one helped you process it; we had no conversations about it. In retrospect I can see how wrong that was. In situations like this we all think about what we might have done differently, and maybe if someone else were responsible this would not have happened. And I know if I meet someone else having experienced the same, they would be thinking that too. And if you can't put it into words, it becomes this heavily load you have to carry. I remember going to work as usual, but I think it has shaped the way I relate to my work, that experience is always in the back of my head. I have worked through the experience now, but it would have been better if I had done it sooner. Yes, and I have also had periods while working as head of the ward, where I experienced it too stressful and I had to take a couple of months off. Sometimes I think that this occupation is too tough, too demanding. If anything goes wrong here, it is a matter of life and death. But most of the time I am having fun at work. It also happens I feel drained by always having to care for others; you are supposed to give all the time. You do get the reward of other people's gratitude, but it is an occupation of caring, you have to give of yourself all the time, both here and there. So sometimes I feel... Then I have to go home to a bunch of kids... Sometimes I need something too, and then it is very important that I can ask for it. And I more and more can as the years go by. But yes, it is a very demanding occupation.

From Kohut's perspective, Mrs. B's traumatic experience can be seen as an example of a situation so psychologically challenging that her need for selfobject experiences becomes increasingly decisive for her maintained belief in her own competence and her sense of stability and security in the world. This points to the need for nourishment, or in different terms, for psychological oxygen. Not getting those psychological needs met resulted in a mild

depression, or what Kohut might have called a mild fragmentation of the self.

According to our Kohutian informed conceptual framework, it is possible that this could have been avoided if Mrs. B had been given the opportunity to process the traumatic experience earlier, while also having her selfobject needs for mirroring, idealization and twinship met. Collegial support and sharing stories about similar experiences could have both provided a mirroring function, to help her maintain her belief in her own competence, and also twinship experiences that would have helped her escape the feeling of alienation often following experiences like this.

Another issue illustrated in Mr. B's answer is the dynamics of her own need to receive in order to have something to give. Mrs. B clearly acknowledges and affirms her own need for care. From what she has told me in the interview it seems to me that Mrs. B is capable of "placing the bag on herself before attending to those in her care." Her previous answer suggests that she is aware of her own need for care, and that she can actually go ask for it. We can also understand this in terms of Neff's three components of self-compassion. Mrs. B's answer indicates first that she is able to be kind to herself, instead of harshly self-critical, secondly, that she feels herself as part of a common humanity and, finally, that she can express her need for care instead of feeling isolating and ruminating.

From interpreting the experiences of a midwife working at a town hospital, we now move on to the interview with Mr. C, a psychiatric nurse at a psychiatric residential facility.

## **Mr. C**

After twenty-six years of working at different psychiatric residential facilities as a psychiatric nurse and therapist, Mr. C is still convinced that he chose the right occupation. He believes that his uncle's hospitalization at a psychiatric institution (while Mr. C was in the middle of his military service) was one of the main factors contributing to his decision. Mr. C grew up in an upper middle class neighborhood, his mother worked as a physiotherapist, and his father in the military. He recalls having identified more with the warm and caring qualities of his mother, but also acknowledging the warrior-like qualities of his father residing in him. He



strongly believes that carrying both these tendencies within him has increased his ability to identify and empathize with a wide range of patients. This is how he understands empathy:

It has to do with being sensitive, understanding other people, trying to be sensitive to how they experience the situation, to understand what the other understands, as precisely as possible, that is what it is all about. I would put empathy on a scale ranging from zero to a hundred, where you have sympathy in one end, and antipathy in the other. Then you have empathy in the middle. There is a difference in neutrality. Empathy is being sensitive to what they are experiencing, without judging in a way. You are not judging if this is good or bad, you are just trying to understand.

Mr. C's answer can be seen to correspond with Kohut's understanding of empathy in the sense of being a value neutral observational stance. In addition to introspection, empathy, understood as vicarious introspection, is seen by many contemporary therapists to be one of the most important tools for gathering information about the inner life of the patient. Mr. C also notes that for the appropriate empathy to emerge there must be a balance between closeness and distance. This is similar to a dynamic earlier mentioned by Mrs. B explaining her understanding of empathy to be "about putting yourself in someone else's situation, without being drawn into it."

If something is experienced as being too close, either in terms of being someone you actually know, or someone reminding you of someone you know, there might a danger of coming too involved, Mr. C asserted. You then might experience having too much sympathy, getting more than professionally involved. On the other hand, if you are distancing yourself too much, either because you don't recognize the situation, or you are not interested in entering into it, you might not have the same chance to help the patient. In a couple of situations Mr. C has felt himself becoming too personally involved; for example, seeing the reflection of his own daughter in a young patient struggling with drugs and other serious problems. In these situations he notices the danger of becoming too involved.

This is exactly what I am interested to discover: what intersubjective dynamics underlie Mr. C's professional life, and whether or not this influences his empathic engagement with the patients. Next I ask Mr. C if there are situations where he experiences the call for empathic engagement as being more challenging than others.

Treating patients with extensive drug problems, patients who never succeed in dealing with it represent a challenge to me. I try to tell them that as long as they keep using drugs we will not get any further. Then I can experience negative countertransference. Also with very depressed

women, who never stop complaining, sometimes I think that is all they want to do. They are not interested in doing anything to solve the situation, that is kind of frustrating, and discouraging.

I am curious how he handles these feelings, and so I ask him whether he is able to hide these feelings and give the patient what they need.

Yes, and that is where one has to be professional. When you notice your own negative reaction, you have to avoid letting it show, you have to contain it... Containing the countertransference, not let it play out, not show your frustration. But the patients are very sensitive to my reactions, so sometimes they notice my frustration even if I try to hide it, it is hard to control and hide.

This is consistent with Kohut's emphasis on the value of the therapist maintaining an empathic stance towards the patient, even if he also thought it impossible to uphold in every situation. Rather than causing regression in the treatment, Kohut thought of these empathic failures to be unavoidable and also contributing to the patient's growth. Later theorists (Wolf, Bacal and Thomson, Fosshage, and Orange) have criticized Kohut on this point, especially because the lack of attention paid to the analyst's own subjective reactions has contributed to self psychology's neglect of countertransference as a potential source of information about the patients experience (cf. Lessem 2005: 76).

Whereas these are relevant issues for discussing the empathic caregiver's professionalism, as I mentioned earlier our primary interest is the intersubjective dynamics underlying Mr. C's professional life, an issue he further commented on while talking about the psychological challenges facing professional caregivers.

Introspection is very important. That's a concept we haven't mentioned yet. It is very important for all therapists, and it can be very tough, because many therapists have their own issues. They are worried about unknown sides of themselves, blind spots, or what to call it. As a therapist you should be aware of these things, and then you need advice and guidance, self-therapy, which is an important part of the further training within psychotherapy. Self-therapy is mandatory.

Here Mr. C touches the theme of having access to ones own subjective experience, which is for Kohut one of the prerequisites for a therapist's being able to empathize with the patient. Mr. C acknowledges the importance of introspection for his ability to empathize with his

patients. Affirming the challenges connected to discussing themes like introspection and countertransference, Mr. C further reflected:

When the therapist projects his own unconscious material onto the patient, like when I get frustrated with a patient. That is a warning sign; a red light should be flashing in my mind. It is important to be aware of what is happening, why am I this frustrated, and that it is my frustration. It is important to sort out and separate what is mine, and what is the patient's issue. In therapy this needs to happen continuously.

Again Mr. C touched on something similar to Mrs. B. She also mentioned this sorting out and separating of what are your own from what are other people's issues. For instance, this was particularly important for her ability to see and imagine what lies behind her colleague's mood swings and negative attitudes.

Both Mr. C and Mrs. B are aware of this and they do not seem to judge themselves for it. They acknowledge it as a real danger, without being too harshly self-critical. To use Neff's concept of mindfulness and common humanity, they are able to distance themselves from their own experience and so better understand themselves, seeing their struggles as part of a common human experience.

On a question regarding what he perceives as important to maintain his motivations for doing a good job Mr. C mentioned:

I need time to reflect, between sessions, so I can finish the session in my mind before moving onto the next, what was important in the conversation, and then having some time to breath. Secondly, I need counseling, good counseling, for me to have a good day myself, so there is not things from my private life disturbing. Then, I need to get the chance to stay up to date professionally, attending seminars, reading articles on topics relevant to therapy. And good colleagues I can stop by and discuss things more ad hoc, when I need it. I think those are the most important things.

It seems to me like Mr. C's response indicates a balanced orientation towards his selfobject needs, which allows him to recognize when it is time for him to take action to secure his own emotional survival.

On a question concerning whether Mr. C has experienced burnout during his long period of working as a psychiatric nurse I get further support for this interpretation.

I have never experienced burnout, knock on wood, I don't think I will either, I have become too good at taking care of myself. It is a road you have to travel though, figure out yourself. I

actually had to take 20% off work for a period, in relation to my own divorce ten years ago. I handled it pretty well I think, I have gone to therapy myself, of my own free will, not because I had to, but because I wanted to. I needed it. I have experienced that as a privilege, but no, I have never experienced burnout. I think I have been good at taking care of myself, to seek counseling and advice, to talk about my private matters if I feel like they are interfering with my work.

Viewing this answer in light of both Kohut and Neff, Mr. C's self-compassion in relation to his divorce can be seen to illustrate a connection between his ability to care for himself and his lasting capacity to care for others in his work as a therapist.

In the next question I asked him to reflect on people and experiences that he thinks have contributed to shape his identity.

Shaping experiences for me. Person's important for me becoming the person I am today. I have to say my mother. She was a good person. Undisputable she is the one that has shaped me the most. Also being a Christian, I still am, even if in a moderated sense. I think that has meant a lot. And my mother's brother, who I also take after, I really cared about him. He got angst and psychological problems; he was around fifty years old when hospitalized. In retrospect I can see how much that affected me.

Further reflecting Mr. C remembered his support of politically radical groups in adolescence, in terms of saving the environment and changing the society, and how it became his way of opposing the elitist groups he felt his own neighborhood represented. In the wake of this he joined a charismatic Jesus movement, further encouraging his commitment to work towards societal change. Still being a devoted Christian, Mr. C told me that psychology became an increasingly important way for him to further his societal commitment.

Like the two previous respondents Mr. C also mentioned people outside the family as forces shaping who he is today. On the one hand, these twinship experiences can be seen as contributing to his differentiation from the elitist groups he felt his neighborhood represented. On the other hand, they can also be seen to have contributed to the societal commitment he now sees as a part of his identity. As we saw in our discussion of Kohut, identity formation is related to twinship experiences.

Later in the interview, reflecting on how his religious commitment affected him as a therapist, Mr. C mentioned the call to service as important to him. He noted the commandment to love your neighbor as yourself, stressing the importance of loving yourself

in order to be able to love your neighbor. I told Mr. C that I had not often heard people emphasizing the love of self. He responded:

Yes, I don't think it is possible to love others without loving yourself, I think that would result in burnout in the end, or it becomes this kind of shallow care. Love can only be given of excess I think. So in a job like the one I have, it is very important to get power supplies, empowerment they call it in English. You need to have sources for empowerment, I am very aware of that. So I don't hang around with draining people, in those cases I can be pretty rough. Even though I am a Christian I can be very serious and down to earth in these matters, and also a little bit tough. I need to take care of myself. There is no reason or purpose of me being drained of energy. I have even gotten rid of some friends, because they were draining me. Have you done that? It is not fun, but sometimes you just have to do it.

In a follow-up question I asked him where he finds his empowerment.

Good friends, who are fun to be with, and to do things together with, with whom I can cultivate my interests. I have several things I am particularly interested in. Music, culture, literature... And I love sailing!

In summary, Kohut's theory has helped us redescribe Mr. C's answers. In terms of the experienced dynamics he reports, it seems that he is aware of his selfobject needs and that he is able to set his own boundaries. His answers also indicate that his selfobject needs have matured as he mentioned a wide variety of sources, providing him with positive selfobject experiences. In addition, his answers can be seen to illustrate Neff's theory in so far as he acknowledges that a balanced integration between care for self and care for others are essential to optimal psychological functioning. We will get back to Mr. C, but for now let us turn to the next respondent.

## **Mrs. D**

Two years ago Mrs. D and her family moved back to Norway after living for about ten years in a foreign country. Mrs. D currently works as a midwife, a profession for which she was trained immediately before moving from Norway. She admits it has been a real challenge

moving back; especially it has been hard to get used to the work situation. Leaving Norway immediately after finishing her training she felt like she never got a chance to become familiar with her own profession. She feels like her title and her age makes people expect her to be an experienced midwife, while in fact Mrs. D herself feels overwhelmed, still struggling to find her identity as a midwife. Mere coincidence, she tells me, was what made her end up as a midwife in the first place.

Mrs. D was originally more interested in following a profession that would allow for more artistic and creative expression, but after missing the closing date for applications, she later got admitted to a course in health and social work. As she reflected on how she originally wished for a more creative line of work, however, she said that she did not regret the path she ended up taking. In part this is because it would have been hard to combine such a career with a family life; moreover, she would probably never have met her husband in the first place if she had taken a different route. She now finds an outlet for her artistic and creative skills outside of work.

After talking for a while about her work and family situation I asked Mrs. D how she understands empathy. She answered:

Assuming another person's situation, and show compassion. When you show empathy you always understand the other in light of what you have experienced yourself, and it is both, it can swing back and forth. If you have experienced something similar yourself, you have more empathy, more understanding. If you have not experienced similar things it is harder to understand how it feels.

Here Mrs. D notes her limitations for empathizing with something she herself has not experienced, drawing our attention to the way in which her experience of empathy is conditioned by her own horizon of experiences.

One way of thinking about her reflections is in terms of Gadamer's hermeneutics, especially his point that you will always bring your own experiences with you as you are trying to understand the other, and that what you bring with you when trying to interpret the other will always condition your ability to recognize and enter into another person's horizon of understanding. In trying to interpret another, one will always be an outsider, but as Kohut asserted, having access to one's own subjective experience makes it more possible to enter into someone else's experience. This is reflected in Mrs. D's experience, or in this case lack of similar experience in relation to those in her care.

Mrs. D also mentioned two situations in which it is especially challenging for her to

engage empathically. The first example concerns stillbirth. She has three healthy children herself, and knows it would feel terrible to lose one of them. Still she acknowledges that the fact that she has never experienced losing a child makes her unable to fully understand how it feels. In these situations Mrs. D thinks it is important to be honest with her patients about her lack in experience. For her that is a way of being there for them authentically, because she thinks that pretending to know what it feels like would only make them feel worse.

The second situation she mentioned as especially challenging was being confronted with lesbian couples who are expecting a baby. Even though she thinks this is personally challenging, she respects their right to make their own decisions, she assured me. She treats them professionally, but because of her religious beliefs she finds these situations are very difficult. Because God created us to live together man and woman, it feels very wrong for Mrs. D when people do not live in that way.

In the first situation Mrs. D recognized her limited capacity to fully understand another person's feelings because of the fact that she hasn't had the same experiences herself. However, there did not seem to be the same willingness to try to understand the lesbian couple expecting a baby. It seems obvious to Mrs. B that empathy is what the patients who are experiencing pain need, and she believes she can empathize with this pain even if she cannot empathize with their worldview.

In response to a later question concerning having empathy for people across cultural and religious backgrounds, Mrs. B mentioned that she had a very good friend who was a Muslim. Her friend had lived and worked as a computer engineer in Norway. As Mrs. D said herself, she would have thought that would create a boundary between them. Nevertheless, they had a great relationship. So rather than being about religious boundaries per se, it seems that the hindrance to empathy in her case has more to do with shared values. For Mrs. D it seems like the main creator of boundaries is experiencing people who are too unlike herself in terms of values, rather than with people who are not associated with her religious group. Through the lens of Kohut's theory one way of understanding this is in terms of selfobject experience; in this case the twinship experience seems to transcend religious affiliation because of their shared values.

Mrs. D mentioned that one of the main influences on her identity was her parent's generous way of meeting her and her siblings in their childhood and adolescence. Especially she mentioned the ways in which they were able to communicate to her that even if they might get disappointed in something she did, they would still love her and help her. This is a

value she also tries to carry over to her children. When I asked her how she believes this may have shaped her identity, she answered:

Yes, it has had an impact on me. The positive side of it is the security I feel, that who I am is OK, that has later been transferred to a security in that God loves me; I believe there is a connection there. Children who grow up with a father who hits and drinks and are mean to them will have a harder time understanding that God can be a loving father who want the best for them, right? The other side of it is that I have a hard time believing my opinion counts, right? That is the negative side of it. No one would ask me, because I never said anything, my mother didn't think I would ever get anywhere, but then I got further than the rest, so yes, it has definitely had an impact on me. Everything I have experienced in the past affects me in the present.

In light of Kohut's theory, Mrs. D's answer might be seen as an example of the way in which experiences with her caregivers provided her with a sense of affirmation and security. She also displays an ability to balance idealization with realism when she notes:

No parents are perfect, neither am I, so therefore everyone carries both, but in general I have always felt safe and good. I always knew there was someone who loved me.

Asking Mrs. D if she has experienced burnout, she answered:

Yes, I have, but it had to do with me being completely exhausted after we came back to Norway, I was all out of energy. After being away for so long the experience of not mastering what I was expected to, because I felt that I didn't know enough, didn't make it very pleasurable to go to work. And now, when going to work knowing there will be at least five women needing you at the same time, I don't really want to go to work, because I know it demands more of me than I am able to give.

We can see here that Mrs. B mentions the same thing as the previous respondent's, namely, that it is hard to give when you lack energy yourself. Professional caregivers are continuously faced with other peoples call for empathic engagement; they are confronted with other people's call for them to function as selfobjects. Giving other people the security, affirmations and understanding they need inevitable takes a lot of energy from caregivers.

I further asked Mrs. D to reflect on the things she herself needs in order to uphold her motivation to do a good job. She mentioned the value of meeting other people outside here immediately family (her husband and children), and the value of achieving new knowledge. She enjoys learning new things and attaining the feeling that she masters them. She likes



going to work because she feels like she is growing as a person, experiencing a growing confidence in her own skills. I ask her to think about what experiences specifically give her the safety and confidence in her own skills, and she answers that being affirmed, especially by people she respects, on the things that she have done right is what motivates her the most. Then she feels like she is contributing, and this encourages her to stay attentive and alert, and to do her job well.

In light of Kohut's theory this last reflection can be seen as an illustration of the need for selfobject experiences. It also shows how mixed together these selfobject experiences are. The twinship experience is exemplified by her appreciation of meeting other people outside her family. Her need for affirmation to maintain a sense of self-confidence is an example of the need for mirroring experiences. The idealization need is brought into the picture by Mrs. D's comment that it is important exactly who it is that is giving the affirmation. When the affirmation comes from someone she trusts and looks up to, it makes the mirroring experience all the more empowering.

By the end of the interview I return to questions concerning religious beliefs, and the extent to which she thinks it affects her capacity for empathic engagement.

That is actually a difficult question to answer. It is easy to just say yes, but I think, I don't really know. On the one hand I think personality plays an important part, if you are able to listen. Many non-Christians have an exceptional capacity to understand other people, to put themselves in the other person's situation, so you can't categorically say yes. Still I think I have been affected by the fact that I believe Jesus will listen to everything I feel like saying. The fact that I have this security, that there is always someone there with me, might make it easier to see someone else's situation, but it is difficult to answer.

I then asked her whether stories from the Bible have served as ideals, as leading her to see the task of helping others as a kind of vocation.

I don't really know. It is hard to say because I don't know how I would have been if I was not a Christian... I think that the sense of being safe and loved makes me happy, even though it is hard to feel it in my stomach. It is easy to understand with your mind that God actually loves me just the way I am, but to actually feel that feeling in your stomach, I still think is hard, it is not an easy task, but I think it affects me. Not because I read about the Good Samaritan, deciding I should act like him, because many times one is not like them. I am not always empathically engaged, sometimes I choose not to. I think everybody does that sometimes, I don't think I am the only one; I don't always have the energy to take on board what other people are experiencing

I also asked her how this makes her feel, and she answered that she does feel bad about it, but one has to acknowledge one's own limitations, that one can't carry around everyone else's problems. Sometimes the right thing to do is to protect your self. On the one hand, this answer can be seen as an example of her acknowledgement of her own needs. On the other hand, in light of Neff's conceptualization of self-compassion, this answer indicates that she is not too harshly self-critical, and that she recognizes her experiences as part of a common human experience.

### **Mrs. E**

Certified as a seamstress it was very hard to get a job in Norway, so Mrs. E went back to school to be a nurse after years of settling down and being at home with her kids. In the past she had good experiences working as an assistant in a retirement community. She especially recalls one of her section managers telling her that just as everybody has a hand to hold as they enter the world upon birth, they should also have a hand to hold when leaving. This made quite an impression on her and inspired her to become a nurse and work with people approaching the last days of their life. As well as being a source of inspiration for Mrs. E, this acknowledgement of human vulnerability and relational needs can also be seen as another compelling example of Kohut's understanding of empathy as responsiveness, and the enduring need for such responsiveness throughout our lives. Mrs. E also expressed to me that she understands her job in terms of serving as a fellow human being. Moreover, because of her education and experience, she can provide additional care to the people she meets in her practice.

When asked about her understanding of empathy Mrs. E told me how her understanding had changed recently after learning about the lack of empathy often experienced by people who suffer under the same condition as her son.<sup>3</sup> She was puzzled to hear about a particular person's apparent lack of empathy because this seemed to suggest that he was insensitive, something she knew him not to be. However, she had recently come to

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<sup>3</sup> For the sake of anonymity, and since it is not directly relevant for the point made, I will not name the condition from which her son suffers.

understand empathy as having to do with the extent to which you can “live yourself into” another person experience. (It is interesting to note that such an understanding is closer to Kohut’s description of empathy as an observational stance, and not simply showing sympathy or compassion for a person).

Reflecting on this experience, and her new perspective on empathy, Mrs. E described it as acquiring an extra set of legs to support her, providing her with a new outlook that was helping her in several areas of her life. In the more or less strange situations with which she is constantly confronted as a healthcare worker, she now sees that even if she can’t always have compassion or sympathy, at least she can have empathy. Having compassion, Mrs. E asserted, is not always that easy. It depends on the situation in which you find yourself, the individuals involved, and of course your relation to your self. She said that this extended understanding of empathy had helped her a great deal.

I further asked her to what extent she thinks empathy also can be thought of in relation to one’s understanding of other people’s worldview, or whether it is mostly about understanding another person’s feelings.

I often use the term “experience”; often how it feels has to do with how they experience it. I can’t separate it, but maybe my expanded understanding of empathy can make it easier. I guess I have been in situations where I have had to pretend, because I don’t understand why they feel this way. But because I now am able to imagine how this is experienced for this person it is easier to understand.

In Mrs. E’s case, it seems like her newfound understanding of empathy has contributed to her ability to understand the people she meets in her work, as well as in her private life. Her new understanding seems to allow her to see other people in a more differentiated way.

When asked if there are situations that she experiences as more or less easy to be empathic, she answered that she thinks it is easier with people she has found some kind of connection with.

When the chemistry is right, it is easier for me to be empathic, something I am aware of in my work. It is very sad I think, that with some people you immediately have the connection, and others you have to spend a lot of time, and some people you never reach in to, people that are completely locked in their own perceptions. I have a significant amount of empathy for the people who have to welcome me as a healthcare worker, but not having any chemistry with me. It is hard for me, but even harder for them; they are in the vulnerable position. Fortunately this doesn’t happen very often, and often I, as a health care worker, can attend to it

constructively. That is, my own issues, breaking the barrier, because often it is about a barrier. But as I said already, it is much easier when they have the experience that we are there to help them, and much more challenging when they don't, and it is often the last category of people who needs the most help.

Mrs. E here described one of the challenges facing professional caregivers as they are empathically engaging their patients. Their job is to help and care for the people they meet, but not everyone wants help. Mr. A mentioned the award inherent in a situation where you are actually able to help, like the mother that is empathic towards her crying child. Seeing the child settle down and feel better, the mother will also feel good. When, on the other hand, the person one is trying to help completely rejects your attempts to help, collegial support seems to be increasingly important.

Mrs. E further told me about another challenge in her work, negotiating the gap between the expectations of the patient's relatives, the amount of care she can give as a professional caregiver, the amount of care the patient wants, and the amount of care she thinks the patient needs.

I often experience that I have to advocate the patient's best interest, and it is hard to find a balance. Often the patient's relatives want something we cannot provide. I understand them. I can see how difficult it is. I know they worry and wish certain things for their close ones. Maybe they experience their old mother or father as living under what they would consider unworthy conditions. Maybe they don't have the same level of personal hygiene they might wish, maybe because their mental capacities are not what they have been. In those situations I have to choose what is in best interest for the patient. It is a hard to keep this balance, but I have to choose the patient. I can have empathy for both, but I have to prioritize the patient.

I asked her if she means that the relatives are trying to control the way she cares for their relatives. She answered:

Yes, they would like to. And most of the time I really sympathize with their wishes. On the other hand we see the patient from another perspective, and sometimes more often than the relatives. That means that we can see that even if the patient doesn't thoroughly wash herself every day, we can see that she is ok after all. We have a different threshold for judging what is sufficient for the patient to be ok. Sometimes I think that the relatives experience us as not being on their side, but I also think many relatives forget that even if their mother has reach eighty-five they cannot overrun her wishes. I experience this as a demanding situation because you see and understand their frustration.

She also told me about relatives pushing pretty hard to have it their way, which can result in an enormous pressure on the nurses who have their own guidelines to follow. This situation might be seen as very challenging to Mr. E because she has to trust her own judgment to evaluate the work she does. It also makes the affirmations she gets from her colleagues and patients even more indispensable. She added that if she ever gets burned out she is sure it will not be because of the patients, but from being worn out by the system she is part of.

After a while you realize you have to protect yourself because it is impossible to just give and give and give on the little amount of time we have for each patient, then you will not be able to put the job aside when going home to your family. On the other hand, it is a very special job we have, we really care for our patients, but we lose them all as time passes. The other day I was clearing up some papers in the office I found a list of the patient's who died last year. That is strange experience. We often remember them for many, many years. We establish close bonds to them as we are working with them.

Mrs. E tells me that both the experience of relative's expectations and the strain of experiencing their patients dying are processed on a daily basis with her co-workers. She here emphasizes the value of an open work environment where everyone is allowed to express how he or she feels. She also mentioned that her manager was especially helpful in times of need, always welcoming them to come talk to him if they have something on their mind. She especially pointed to his capacity to not just enforce what his superiors decide, but also to advocate for the nurses concerns as well.

In addition Mrs. E pointed out her manager's confidence in them, and his constant affirmation of the work they are doing, as contributing to an increase their motivation. The open, inclusive work environment described by Mrs. E can on the one hand be seen as an illustration of the need for mirroring experiences, the need to feel accepted for who you are. On the other hand, it can illustrate the need for twinship, both in sharing experiences with one another and in the manager's capacity to empathize with the nurse's situation. It is also likely that the manager can serve as an idealized other.

When asked to reflect on past and current role models or ideals Mrs. E found it hard to point out only one; rather, she felt like inspiration is carried over from nearly everyone she works with. She also mentioned people and experiences that have made her see ways in which she does not want to be. For example, she remembers experiences she had while being a student, feeling that there was an enormous focus on being empathic towards the patients, but that they as students were not given any empathy. This experience of not being understood

made her realize how important it is to also have empathy for the students. Well aware that the students are under a lot of pressure to perform all the time, Mrs. E spends a lot of time getting to know the students and helping them lower their anxiety level.

Viewing her reflections on her ideals and her experiences of not being empathized with in light of Kohut's theory it seems that Mrs. E has the ability to balance idealization with realism. People who do things she values can inspire her, and she can also sort out the things people do that she doesn't like. Having experienced the frustration of not being seen and now being a nurse herself who remains attentive to how this frustration felt, indicates that she has access to her own subjectivity.

Approaching Mrs. E's need for mirroring I ask her how she would respond if a colleague got credit for a job she was responsible for doing.

If I don't get any response, I would get a bit annoyed, especially if it is related to my area of expertise. However, with age and experience I see that it evens out. Next time it is might be me. What I try to do in these situations are to point out everyone involved, I think it is important for people to be seen. Because I think, not being seen might feel demotivating. What we also experience is that the patients praise us to our colleagues. And even if I know the praise is a result of changes we have made together I want to praise them too. It is better for the whole department when the patients are content, and it contributes to uphold the relationship of trust between the patients and the professional caregivers.

Mrs. E's answer can be seen to illustrate her experience of the importance of being mirrored, and her enduring need for recognition and acceptance. Her experience has been that this generates motivation for her colleagues, and for her self, as well as contributing to the patient's well-being.

Having friends and a husband with a different background than her own, Mrs. E experiences it as challenging to understand and have empathy with people who pass judgment on others without knowing them.

Yes, especially because we have several people working with us who are not either born or raised in Norway. When they experience that they are not allowed into people's house, then I get pretty... you know what... I feel like I can't accept that. Especially when I know the person is a very competent and skilful colleague. It is all about the color of their skin, coming from a foreign culture with a different religion. Then it is hard for me to have any empathy, and that goes for both compassion and my capacity to recognize how they experience it. It just feels terribly wrong.

Mrs. E perceives herself as a person open to different cultures and religions, an openness she traces back to the way her parents, especially her mother, who allowed her to be herself.

My parents allowed me, even if I grew up in a very traditional Norwegian home, there was not that many things we were not allowed to do. I was allowed to be myself, and think for myself. Within reasonable boundaries, of course, not allowing us to do drugs and stuff like that. But for example, it was never a problem that I had a boyfriend who wasn't Norwegian.

She told me about how she had experienced her mother as wanting to give her and her siblings the possibility of choosing differently than she herself could.

... I think she feels good to see us, even if she doesn't agree with everything we do, take on a set of qualities allowing us to think further while standing on our own. Also seeing that they have given us the freedom to make mistakes, as well as an opportunity to set things straight again ourselves.

From Mrs. E's answers it seems that she has experienced her parents as contributing to the sense of responsible independence she feels today. Moreover, this also indicates that her parent's acknowledgements and affirmations have helped her ability to value other people's unique qualities across cultural and religious backgrounds.

## **Mrs. F**

I ran into Mrs. F at an interreligious conference in Melbourne, Australia. She was attending a session on how to approach environmental challenges from a religious perspective. When I realized that she was an MD and therefore qualified to fit the respondent criteria, I asked her if she would be willing to do an interview. Hesitating at first, after a few minutes she decided to say yes. Mrs. F grew up in Malaysia, but went to Australia to get her medical degree and has now been working as a doctor in Melbourne for 24 years, first in the hospital system, later in general practice. She is currently working in general practice in the western suburbs of Melbourne (a poor social economical class area), and lives together with other women of faith in a religious community. When asked to reflect on her understanding of empathy she answered:

For me it is being able to be with a patient and listening to the patient and understanding where they are coming from, and really feeling with them, in terms of the conditions and stuff like that, and anxiety and depression, but *not* taking it on board. Sometimes I slip into the role of having to be a mentor and teacher, and give advice and make suggestions and strategies and stuff like that, but, yeah, eh, the empathy is just being able to just recognize and understand where people are coming from, that is how I understand empathy.

Mrs. F's understanding of empathy is similar to what Mrs. B and Mrs. C described, emphasizing the ability to feel other people's pain, to understand the situation they are in, but not let it become your own.

On the one hand, this can be seen to indicate mindfulness, the capacity to hold painful thoughts and feelings in balanced awareness. On the other hand, it indicates Mrs. F's ability to balance idealization with realism. Her ability to give appropriate care, while caring for herself, doing her best, but not letting her inability to save the world crush her. Following up on this question I ask her if there are times she thinks it is more difficult or less difficult to have empathy for others.

Yes, it is very hard when I am tired, that is one time I find it hard or difficult to be empathic. The other time I find it difficult is when you go through with the same patient, the same suggestions and strategies over and over again, and nothing changes. Then I use a different tactic trying to find out why things don't change. And I end up being very blunt with them. After months or years or what ever, I say to them, look, I can take the horse to water, but I can't make it drink. So, if you want help I am here to help you, but if you don't want to change, if you don't want the help, then there is no point coming because you are wasting my time, and you are wasting your time. More importantly, you are wasting your time, cause I get paid, so that is all right (laughter). So, I end up being a bit blunt with them. So those are the times I get very frustrated and find I can't be empathic. I feel like I am hitting my head against a brick wall.

Acknowledging how her own physical state (e.g. tiredness) affects her capacity to be empathic, Mrs. F also noted that the ability of the patients to receive her advice and to realize that they have to take action themselves for them to get well also has an affect on her ability to empathize. What Mrs. F describes here is similar to what Mr. C shared with me, about how draining it feels when people don't themselves take action. Similarly, Mrs. E mentioned how hard it was to help people who don't want her help; yet, she still has to give them help because it is her job.

From Kohut's perspective, in these situations, when the caregiver experiences their



attempts to help as rejected, or not taken seriously, it becomes increasingly important that the person trying to help can get understanding and affirmation from colleagues. Curious to discover more about how she experienced hindrances to her ability to empathically engage with other people, I asked her if there are other situations where she also experiences it as more difficult.

Yes, tiredness has something to do with it, and seems to, I seem to be less compassionate when I am tired. The other thing is when I am focusing on something, like I have this next session I have got to go to, I find it hard to be with a person when I feel like I have to move. I am the kind of person, like in this situation [being at a conference], that likes to be on time, I hate being late. So I find I can't stay with a person if I have to move onto something else.

Here again Mrs. F mentioned how her physical well-being can hinder her empathic engagement. Trying to get at her sense of self-judgment I ask her about how this makes her feel to set her own boundaries. For example, what if she had to break up a deep conversation because she wants to go to another session.

I go a lot on my gut feeling, if I have a gut feeling that it is genuine, then I can feel a bit guilty and stuff, but if I have a gut feeling that the person is what you I call a 'sucker', just drains the energy of you, then I don't feel bad. So, I guess you can say I have fairly strong boundaries, and I try not to take onboard what is not mine. If it is their issue, I will leave it as their issue. And I know when to take it home with me.

This answer might be seen to indicate Mrs. F's ability to recognize and affirm her own boundaries, rather than being dependent on others to affirm her right to have needs of her own (without becoming cynically self-protective). Here we see a similarity with Mr. C's experience of needing to cut off from people who he feels drain him of energy.

With the next question I try to get at her ability to self regulate in emotionally challenging situations. I start out by asking her if she recalls situations where she has been very angry or upset with herself, colleagues, family members or her friends.

Yes, easy, when I first started the job I got very angry with everyone, cause they were incompetent as far as I was concerned. So we used to have fights, now there is a healthy respect (laughter).

With doctors, or colleagues?

Staff, mainly with section staff. They don't have a sense of responsibility, like for the, they are just here to do a job, and they don't take initiative to make a difference. Reception staff. They

are very blasé about things, so I used to get frustrated with them. I had a patient with chest pain and needed a copy of ECU done urgently, and I said to them that someone can you do this urgently, that means dropping everything and doing it. Five minutes later the ambulance was waiting and she still had not done it. So I got really angry, and said this is not good enough, you work in a surgery, this is life and death we are talking about, when I say to do something urgently, you need to do it urgently, and she burst out crying. But it is, yea. After that I have realized I have to be merciful, wait a day, don't blow off your top steam too early, so I am learning.

One way to think about Mrs. F's answers is in terms of idealization. Starting in a new job it is easy to have expectations to what it will look like, and as Mrs. F told me, seeing that the section staff didn't live up to her ideals made her angry. This is not a surprising response, but a closer look at how she relates to it might give us some indications about her ability to balance idealization with realism, affecting her judgment of both self and others. In Mrs. F's case it looks like this experience if anything made her aware of her high standards, and that they are not, for different reasons, the same for everyone. Still affirming her own ideals, she recognizes that it is important that one is also understanding to other people, and that anger doesn't necessarily solve the problem.

Still interested in idealization I asked her about past and current role models or ideals she feels have been, and are, important for her.

I think it is my spirituality, my values, and my relationship with God that guides me in what I do. The female founder of my religious community, I think she was a remarkable woman who had a good balance, between fun and work, she got people to do things, she was very good at empowering people, I guess that is sort of the atmosphere I want to bring about in my work and in my home situation as well, so the ideals I suppose would be that of loving, I suppose that would be the highest ideal. And I suppose that is why I am here [at the interreligious conference].

Approaching Mrs. F's orientation towards the need for mirroring experiences I asked her how she would react if someone else took credit for something she did. She admits it would have made her really annoyed in the past, but that she now does not care as long as the task is done. Asked to reflect on what she thinks has changed, she answered:

Because I think I have just tried to change my attitude in terms of my ego and stuff like that. I got really annoyed, partly it was the justice thing, and it was not fair that I do the work and

you get the credit, and part of it was also the ego thing. Then I changed my attitude and said that what really matters is that things get done, and that people benefit from it.

Very much like Mr. A in his response to the same question, Mrs. F also expressed the view that it depends on how one thinks about motivation. If one's motivation is rooted in a mission, such as helping others, one becomes less self-aware. Reflecting further she mentioned:

I mean the reason why you do the things you do is because you care. If someone else gets credit for what I do, it is their issue. Because I think I have discovered ultimately the truth comes out anyway (laughter), so they can get the credit an all that, but ultimately people will know it is me who did it, so sometimes, not all the time, but it doesn't diminish my desire to do what I need to do. What I want to do.

Acknowledging her wish for others to affirm her efforts by suggesting that probably people will sooner or later figure out what really happened, she also asserts that other people's recognition is not her primary source of motivation.

Curious about the difference between having empathy for other's emotions vs. their worldviews I ask her if she thinks it is difficult to have empathy for people with a different cultural or religious background.

I think if I don't understand where they are coming from, I don't know their story, I think it is harder to feel empathy for them, more so with other cultures I suppose, cause I have an understanding of my own culture. But I have learnt over the years that if I can understand where they are coming from, a bit of their story, I find myself more empathic and more tolerant I suppose. But that doesn't mean I don't correct them, not correct, but not highlight different things that happened, I still do, but I think I am a bit more gentle in the way I do it. So I think for me the important thing is hearing their story. A lot of the time people are not willing to share their story. That is why I think the social side of things is so important. It is only when you go out with someone and have a drink with someone that you understand, you hear where they are coming from and understand why they behave in such and such a way, and why they can't see certain things and why they have that perspective on things.

She mentioned again how important it is to really see other people, to see them in their subjectivity. As we saw in chapter 3, this is a point also emphasized by Kohut.

Early in the interview I had asked her if she has ever regretted her decision to become a doctor. She answered:

I think like with everything else you go through periods where you think about doing something different. But I travelled around South America and had a great time instead, and so that led me more to the spiritual side of things, but I suppose sometimes I still think that maybe I could do computing instead, cause I really enjoy the computer science, multimedia and all that stuff, so. But I think that ultimately, if I go through those periods of getting frustrated and tiredness and fatigue, I am glad I have done and continue to do medicine.

Toward the end of the interview, referring back to her earlier answer, I asked her if she has had experiences of compassion fatigue or burnout.

Yes, I was burned out because I was working full time and doing a lot of hours, also studying for the physician exam as well, and most people on that stage, while studying for their exam would do less clinical work and leave it to the residents. I have this kind of guilty thing, so I can't do that, so I still spend a lot of time the ward and stuff, but you can't do both, it is hard and that is why I got burned out when I tried to do both. So I was getting tired, I was getting irritable, not only at work but at home as well, so I was burned out. I was tired.

Again Mrs. F shows her ability to care for herself, and her ability to recognize her selfobject needs.

In terms of the concept of self-compassion as outlined by Neff, it seems that Mrs. F most of the time is kind and understanding towards herself, rather than being harshly self-critical. However, some of her answers also indicate that this has been a development she had throughout her professional life. Being part of a rather strict religious community, her participation on the interreligious conference is one sign of her experience of being part of a common humanity, seeing the value of sharing instead resting comfortable in her own communities exclusiveness. Her example of the conflict she had with section staff also indicates that she is able to deal with emotionally challenging situations as they emerge, instead of ruminating for years about the "incompetence" of her co-workers.

As a closing question I asked her who or what have shaped her the most in becoming who she is today.

I think it was my relationship with God that contribute to who I am today, and I suppose having a few close friends who you can share with on a deep level, and talk through things and be challenged and all that stuff. But X (founder of the religious movement she is part of) is someone I look up to, and I guess a little of my understanding of Jesus, and the values Jesus thought, and all that stuff, has been very significant.

Like several of the other respondents, religion seems to have played a positive shaping role in Mrs. F's life.

The conceptual resources of Kohut and Neff have helped us to redescribe and interpret the dynamics reported by Mrs. F as examples of the extent to which narcissistic maturation, orientation towards selfobject needs, and self compassion have a formative effect on professional caregivers' capacity for empathy towards others.

## **Summary**

In this chapter I have abductively reinterpreted the interview material using the conceptual framework from chapter 3. As explained in chapter 2, this abductive move is an attempt to illuminate connections and relations reported by the professional caregivers' in a new way. In this diachronic overview of the interviews I have been especially attentive to the professional caregiver's reflections on empathic engagement, indications of their maturing narcissism, their orientation towards selfobject needs, and the extent to which they show signs of self-compassion, as defined by conceptualized by Neff as self-kindness, common humanity and mindfulness.

Before turning to the conclusion in chapter 6, I will first evaluate the SONI self-report scale completed by the professional caregivers after finishing the interviews.

## **Chapter 5. SONI Self-Report Scale**

In the conceptual framework chapter we saw how Kohut's understanding of the ways in which a person's narcissism can come to expression in their orientation towards selfobject needs is one of the most important elements of his theory. In the interviews I asked the respondents questions intended to get at these dynamics as they impact their experience of professional caregiving. In this chapter I evaluate the scores of the SONI self-report scales (cf. appendix C and D) in order to discover the extent to which they support, challenge and further illuminate the findings of chapter 4. I present the SONI self-report scores of each respondent, and then connect them to the findings from the abductive interpretation (chapter 4), with special attention to their orientations towards selfobject needs, which is the dimension of Kohut's theory that the scale is designed to identify. Because this orientation is intimately connected to the development of mature narcissism, and we have also demonstrated its connection to Neff's conception of self-compassion, it will also be possible to reflect on the broader concerns of the conceptual framework used throughout this thesis.

It should be noted that unfortunately I did not succeed getting the self-report scale from Mrs. F. For reasons unknown (perhaps I wrote down her email address incorrectly), she has not responded to my email request asking her to fill out the self-report scale. Therefore, I am unable to report her scores in this section.

## Mr. A

1. Approach orientation towards twinship	5,37
2. Avoidant orientation towards idealization and twinship	1,63
3. Approach orientation towards idealization	5,42
4. Approach orientation towards mirroring	3,5
5. Avoidant orientation towards mirroring	3

The SONI scores show that whereas Mr. A is balanced on both approach and denial of the need for mirroring (factors 4 and 5), he tends towards an approach orientation in relation to twinship and idealization needs (factors 1, 2 and 3).

His SONI self-report score indicates that he has a balanced orientation towards the selfobject need of mirroring. In the interview, answering the question about how he would react if a colleague got credit for a job he had done, Mr. A reported, “I like to share as much as possible. I guess I have received enough to develop a good enough self-confidence after getting feedback from patients.” In terms of orientation towards mirroring experience, this answer indicates that his main source of mirroring in terms of his professional life is his patients, or more accurately, the patients’ experience of achieving mental health.

The high scores on approach orientation towards idealization and twinship support the findings in last chapter’s interpretation. On the question about approaching idealization and twinship experiences in his childhood and adolescence, Mr. A reported: “I think that a part of my script is to be kind, and I can easily feel like I am not good enough, have high demands for myself. Many therapists have that, high demands and expectations for themselves, I have that too. I can easily feel guilt, and shame, that I am not doing a good enough job in every area, at least I am sensitive to those feelings.”

Although Mr. A clearly acknowledges his need to idealize, he also admits sometimes feeling a lack of self-confidence. Nevertheless, it seems like he is able to balance idealization with realism: “looking around me I don’t feel like I should have a lack of self-confidence, but I also see that others are even better than me, but we are all human, nobody is perfect.”

## Mrs. B

1. Approach orientation towards twinship	2,12
2. Avoidant orientation towards idealization and twinship	1,27
3. Approach orientation towards idealization	1,71
4. Approach orientation towards mirroring	3,33
5. Avoidant orientation towards mirroring	3,5

Mrs. B, like Mr. A, is balanced on the need for mirroring (factors 4 and 5). It is interesting to note, however, her scores on the first three factors. She is low on both approach and avoidant orientation towards idealization and twinship. One might expect that if she were low on avoidance (factor 2), she should be high on hunger (factors 1 and 3), like Mr. A. Our interest, however, is not analyzing the details of SONI score, but how they illuminate the extent to which her selfobject orientation bears on the internalization of psychological functions, and how this influences the dynamics of empathic caregiving.

For our purposes, therefore, the more relevant findings are factors 4 and 5 showing that Mrs. B has a balanced orientation towards mirroring. This can be seen to correspond to what Mrs. B reported in the interview, especially in relation to her comments about how her parents gave her the love and affirmation she needed. In one of her answers concerning what she perceives as a good work environment she mentioned qualities that correlate to the selfobject needs of mirroring and idealization.

In particular, she noted how important it is “to feel you are allowed to be yourself, and to be accepted for who you are.” This corresponds to the need for mirroring. She also observed that she thinks, “it means a lot for a work environment, having leadership, someone in charge.” This corresponds to the need for idealization.



## Mr. C

1. Approach orientation towards twinship	3,75
2. Avoidant orientation towards idealization and twinship	2,09
3. Approach orientation towards idealization	2,71
4. Approach orientation towards mirroring	3,33
5. Avoidant orientation towards mirroring	3,33

Of all the respondents, Mr. C's scores are those most close to balanced on every factor, indicating that, to a great extent, he has internalized self-regulatory capacities. These scores also support the findings in the qualitative interview in terms of his ability to take action to secure his own emotional survival. This is illustrated in the way he sought therapy as he was going through a tough divorce. He also stated, "I have never experienced burnout, knock on wood, I don't think I will either, I have become too good at taking care of myself".

Moreover, Mr. C's assertion that "love can only be given out of excess" indicates that he believes love for self is necessary for loving others. This case, in both the interview and the SONI scores, gives clear warrant in support of the intuition that guides this whole thesis, namely, that persons who are healthily (or maturely) narcissistic and able to show self-compassion are also able to regulate themselves as they give care to others.

## Mrs. D

1. Approach orientation towards twinship	5,37
2. Avoidant orientation towards idealization and twinship	1,63
3. Approach orientation towards idealization	2,57
4. Approach orientation towards mirroring	3,83
5. Avoidant orientation towards mirroring	3,16

As in the case of the two previous respondents, Mrs. D is also balanced on both approach and avoidant orientation towards mirroring (factors 4 and 5). This may be traced back to the love and affirmation received from her parents, which allowed her to be herself, as she reported in the qualitative interview. She also scored relatively high on approach orientation towards twinship (factor 1). This score can be seen to correspond to what she said in the interview, that one good reason to go to work is meeting other people.

Another way Mrs. D's approach orientation towards twinship comes to expression in the qualitative interview are in her answers to the question about having empathy for people across cultural or religious boundaries, and the question about situations in which she finds it difficult to have empathy. In terms of the first question she told me about her friendship with a Muslim woman. Mrs. D found, to her own surprise, that their different religious background did not create a boundary between them. Regarding the question of situations where she finds it difficult to be empathic Mrs. D first mentioned that she find it hard to have empathy when she hasn't herself experienced the same, or similar things, as in the case of stillbirth. She deals with these situations by being honest to them, instead of pretending like she understands how they feel.

As we saw, however, in response to the second question, she admitted how difficult she found it to have empathy with lesbian couples who were expecting a baby. In light of the SONI score, which reveals an approach orientation towards twinship, we find additional support for the observation made in the qualitative interview: Mrs. D's capacity for understanding and empathy is connected to the ways in which persons are similar to her.

### **Mrs. E**

1. Approach orientation towards twinship	3,62
2. Avoidant orientation towards idealization and twinship	1,27
3. Approach orientation towards idealization	2,85
4. Approach orientation towards mirroring	3,84
5. Avoidant orientation towards mirroring	3,66

As we can see from the above chart, Mrs. E is also relatively balanced on the need for mirroring. In the interview she reported, “I was allowed to be myself, and think for myself.” This indicates that as she grew up her parents acknowledged and affirmed her for who she was. The scores on factors 1 and 3 show that she is close to balanced on approach orientation towards twinship and idealization as well. These scores support what Mrs. E reported in the qualitative interview about her lack of need for others to be like her, and her ability to find inspiration in almost everyone she meets.

Reflecting on the qualities of her work environment Mrs. E mentioned qualities that all can be seen to correspond with different selfobject needs. Her manager, who is probably seen as an ideal other, sets out goals for the employees (idealization), constantly affirms the work they are doing and points out his confidence in them (mirroring). Moreover, he is also there for them as a co-worker (twinship) in times of need, instead of just staying in his office. Mrs. E also pointed to the importance of mutual affirmation between colleagues, and an open, inclusive atmosphere where everyone is allowed to be who they are (providing twinship and mirroring experiences). In the interview Mrs. E seemed to be aware of her needs and able to seek out relationships where they are nourished. Here too, the SONI scores correspond to what we found in the interpretation of chapter 4.

## **Summary**

In this chapter I have presented the SONI self-report scale scores, and evaluated them in light of the abductive interpretation made in chapter 4. I found that whereas there were some variations in how the professional caregivers were oriented towards the selfobject needs of idealization and twinship, all were close to balanced in their orientation towards mirroring. The findings presented here in chapter 5 from the quantitative data support, but also further illuminate, what was found in the qualitative data presented in chapter 4 in light of the conceptual framework outlined in chapter 3.

## **Chapter 6. Summary and Conclusion**

In chapter 3 I outlined and showed the relation between the three main components of my conceptual framework – narcissistic maturation, orientation towards selfobject needs and self-compassion. In chapter 4 I used this framework to reinterpret the phenomenon of empathic caregiving as reported in the interviews of my respondents. Their answers were reconceptualized through an abductive argument that used the conceptual framework in order to understand the data in a new way.

Going through the interviews diachronically, I was also able to show the interconnectedness of the components of the conceptual framework, illustrated in the concrete dynamics of each particular case. In chapter 5 I evaluated the SONI self-report scores in order to measure quantitatively the professional caregivers' orientation towards selfobject needs. These findings consistently supported, and further illuminated, the insights gained from the analysis of the qualitative data.

In this concluding chapter I offer a brief integrative summary of my findings in the context of an overview of Kohut's general understanding of empathy, both as an observational stance and as responsiveness, and of the three main components of the conceptual framework outlined in chapter 3. Finally, I suggest some implications that these findings might have for other professional caregivers who also face the call for empathic engagement in their practices.

## **Empathy**

As we saw in the introductory chapter, different disciplines use the word empathy in different ways. I have focused here on the two ways in which Kohut understands empathy, as an *observational stance* and as *responsiveness*, the latter being a precondition for the former. In the interviews we found that the professional caregivers' understanding of empathy was very much like Kohut's understanding of empathy as an observational stance, i.e., "the capacity to think and feel yourself into the inner life of another person... though usually, and appropriately, to an attuned degree" (Kohut, 1984: 82).

In addition, the professional caregivers I interviewed also mentioned several hindrances for their empathic engagement. Some of these hindrances were of a structural character, such as lack of time and money or excessive bureaucracy, while other hindrances were of a more personal character, such as physical and psychological exhaustion. When telling me about these experienced hindrances for empathic engagement, however, the caregivers typically also recognized their own need for care, especially when confronted by challenges that kept them from giving the care they desired to give.

The professional caregivers tended to view empathy as an observational stance. However, they also illustrated a clear awareness that empathy also involves particular qualities of responsiveness. These issues are crucial both for the health of the professional caregivers and for those in their care. In the interviews, we saw how the dynamics of responsiveness are shaped by the three components of our conceptual framework, to which we now turn in a concluding summary.

## **Narcissistic Maturation**

By showing that narcissism is a vital personal resource that needs to be appropriately nourished rather than eliminated, Kohut shed light on an aspect of human development that has often been ignored. The appropriate nourishment of narcissism, Kohut argued, is conditioned by the responsiveness of our selfobject matrix, and the way in which our

narcissism matures shapes the extent to which tension-regulating capacities are internalized. People with a mature narcissism have a greater capacity for self-regulation and are able to receive emotional support from others. They are more comfortable setting their own boundaries, and telling other people about their needs.

In chapter 4 we saw how Kohut's understanding of narcissistic maturation can illuminate the conditions that enhance the capacity for empathic engagement. The professional caregivers reported certain experiences throughout their life that can be seen as nourishing their narcissism in a way that allowed it to mature, leaving them with the ability to self-regulate. For example, Mrs. B mentioned how her parents were able to give her the love and affirmation she needed. Similarly Mrs. D and Mrs. E mentioned the experience of being seen for who they were by their parents. Such experiences, according to Kohut, are important for the internalization of a kind of self-validation.

As Kohut explains, the early experiences of selfobject responsiveness are of great importance for the development of self-regulatory capacities. But perhaps even more important for the well functioning professional caregivers I have talked to here is Kohut's insight about the enduring need for selfobject experiences throughout the lifespan. I will return to this in the section on implications below.

## **Orientation Towards Selfobject Needs**

The second component of my conceptual framework, orientation towards selfobject needs, has been illuminated both in the interviews and by the SONI self-report scores evaluated in chapter 5. Interpreting the interviews in light of the conceptual framework I found indications that later were supported by the SONI self-report scores. For example, in the interview Mrs. A acknowledge that he has high demands for himself, and that he can easily feel guilt and shame for not doing a good enough job in every area. This lack of self-confidence can be seen to correspond with his relatively high score on approach orientation towards idealization.

Mrs. D provides another clear example. In the interviews she reported having difficulty empathizing with people who are experiencing something she has not experienced herself, or who are very different from her in terms of live values (such as the lesbian couple).

The SONI scores confirmed that she had a relatively high level of approach orientation towards twinship needs.

The most interesting finding from the SONI was that whereas there was a variation in how the professional caregivers were oriented towards the selfobject needs for idealization and twinship, all of them were close to balanced on their orientation towards mirroring. It would be interesting to do additional studies exploring whether this is a shared characteristic for professional caregivers in general, and whether people who are balanced on the need for mirroring are more likely to become professional caregivers. Longitudinal studies might also be helpful, however, because several of the respondents mentioned that the need to be seen and acknowledged (mirroring) subsides as they grow older.

## **Self- Compassion**

As explained in chapter 3, Neff's conceptualization of self-compassion was used in this thesis to complement Kohut's theory. I suggested that it gives us additional concepts to talk about the *product* of the *process* Kohut outlines and explains. Whereas Kohut focuses on a developmental trajectory from being dependent on others for self-regulation toward having internalized these capacities, Neff's conceptualization of self-compassion clarifies what this internalized self-regulation might look like.

When experiencing pain or failure, a self-compassionate person is kind and understanding towards herself rather than being harshly self-critical. Such a person will also perceive her experience as part of a common human experience, rather than seeing unpleasant experiences as separating and isolating. Finally, a person who is self-compassionate can hold painful thoughts in balanced awareness instead of over-identifying and ruminating.

In chapter 4 we found that the professional caregivers reported experiences that can be seen as instances of self-compassion. For example, both Mrs. B and Mr. C were not primarily judging themselves for their own inadequacies when reflecting on the importance of sorting out and separating their own issues from those of other people. Moreover, they were able to distance themselves from their own experience, allowing them to better see other people's experience.

A major concern for professional caregivers is the danger of compassion fatigue and burnout. Mr. A observed that it is the most empathic caregivers that are in most danger for experiencing burnout and compassion fatigue; if this is right, then the imbalance between the caregivers' concern for themselves and their concern for others seems to be a topic in need for further exploration. My research suggests that there are in fact certain ways of holding on to our care for others that generate more care, whereas other ways of caring that threaten to exhaust us. When asked to reflect on their understanding of empathy, several of the respondents mentioned the importance of understanding what the patients are experiencing, without necessarily feeling their pain too much. This indicates an awareness of the dangers of becoming too involved, or becoming involved in ways that are unhealthy. What are some of the implications this research might have for others who find themselves in similar situations?

### **Implications for Professional Caregivers**

Kohut believed that the oxygen of psychological life was provided in an affirming, supportive and validating milieu. Moreover, he argued that the need for such an atmosphere remains throughout the lifespan. His theory underscores how important it is to understand the dynamics of empathic engagement for all human interpersonal and societal relations. This study, however, have been limited to professional caregivers, and how they relate to themselves as they are faced with the call for empathic engagement in their practices.

The goal of this thesis was to apply a new conceptual framework to an already known phenomenon in order to further illuminate the dynamics involved. This exercise of abductively reinterpreting the caregivers' own reflection on their empathic engagement in light of a conceptual framework based on Kohut and Neff has given us several new insights into the ways in which professional caregivers hold on to their care for others. One implication of these insights might be that an increased focus on empathy in the training of health care workers, as well as professionals in caregiving institutions in general, could contribute to a higher awareness of caregivers' own needs for empathic responsiveness by others as a condition for their ongoing ability to care for others.

The strategies for dealing with emotional pressure in professional as well as personal



life vary depending on each context. However, another implication of this research is that an increased focus on introspection, on how to gain access to one's own subjectivity, might be fruitful in the ongoing training and support of caregivers. As well as enhancing professionals' capacity for empathic engagement, it might also help them become more aware of their own needs, so that they can hold on to their care for others in a way that generate more care, instead of leading to exhaustion.

Of course it is not only professional caregivers that can benefit from understanding the conditions that enhance empathy and the importance of self-compassion. Learning how to attend in a healthy way to one's selfobject needs as well as the selfobject needs of others is important for many different dimensions of social life. It would be fruitful to explore ways in which awareness of these dynamics of empathic caregiving could be brought to bear on diverse practices such as parenting, teaching, administering organizations, governing societies and leading religious communities.

Given the importance of these dynamics in all aspects of our lives, it is important to remember the quote from the Malaysian Airlines security instructions with which we began:

“Place the [psychological oxygen] bag on yourself before attending to those in your care”

## Bibliography

- Atwood, G. E., & R. D. Stolorow (1984). *Structures of Intersubjectivity: Explorations in Psychoanalytical Phenomenology*. Hillsdale, NJ: Analytic Press.
- Atwood, G. E., & R. D. Stolorow (1993). *Faces in a Cloud: Intersubjectivity in Personality Theory*. Northvale, NJ: Aronson.
- Bakker, A. B., W. B. Schaufeli, H. J. Sixma, W. Bosveld, & D. van Dierendonck (2002). Patients demands, lack of reciprocity: A five-year longitudinal study among general practitioners. *Journal of Organizational Behavior*, vol. 21, Issue 4, 425-441.
- Banai, E., M. Mikulincer & P. R. Shaver (2005). "Selfobject" Needs in Kohut's Self Psychology: Links with Attachment, Self-Cohesion, Affect Regulation, and Adjustment. *Psychoanalytic Psychology*, vol. 22, 224-260.
- Bowen, M. (1978). *Family Therapy in Clinical Practice*. New York: Rowman & Littlefield Publishers, Inc.
- Bryman, A. (1992). Quantitative and Qualitative Research: Further Reflections on their Integration. In Brannen, J. (ed.) *Mixing Methods: Qualitative and Quantitative Research*. London: Gower (reprinted), 57-81.
- Bryman, A. (2004). *Social Research Methods*. New York: Oxford University Press.
- Danermark, B., M. Ekström, L. Jakobsen and J. Ch. Karlsson (2002). *Explaining Society: Critical Realism in the Social Sciences*. London: Routledge.
- Gilje, N., & H. Grimen (1993). *Samfunnsvitenskapens forutsetninger: innføring i samfunnsvitenskapens vitenskapsfilosofi*. Oslo: Universitetsforlaget.
- Jones, J. W., (2002) *Terror and Transformation: The Ambiguity of Religion in Psychoanalytic Perspective*. New York: Brunner-Routledge.
- Kerr, M. E., & M. Bowen (1988). *Family Evaluation*. New York: W.W. Norton & Company, Inc.
- Knott, K. (2005). Insider/Outsider Perspectives. In Hinnells, J. R. (ed) *The Routledge Companion to the Study of Religion*. London: Routledge, 243-258.
- Kohut, H. (1959). Introspection, Empathy and Psychoanalysis: An Examination of the

- Relationship between Modes of Observation and Theory. *Journal of American Psychoanalytic Association*, vol. 7, 459-483.
- Kohut, H. (1966). Forms and Transformations of Narcissism. *Journal of the American Psychoanalytic Association*, vol. 14, 243-272.
- Kohut, H. (1971). *The Analysis of the Self*. New York: International Universities Press.
- Kohut, H. (1977). *The Restoration of the Self*. New York: International Universities Press.
- Kohut, H., & E. Wolf (1978). The Disorders of the Self and Their Treatment: An Outline. *International Journal of Psychoanalysis*, vol. 59, 413-425.
- Kohut, H. (1981). On Empathy. In P.H. Ornstein (ed.) *The Search for the Self: Selected Writings of Heinz Kohut: 1978-1981*. Madison, CT: International Universities Press, 525-535.
- Kohut, H. (1982). Introspection, Empathy, and the Semi-Circle of Mental Health. *International Journal of Psychoanalysis*, vol. 63, 395-407.
- Kohut, H. (1984). *How Does Analysis Cure?* Chicago: University of Chicago Press.
- Lachmann, F. M. (2008). *Transforming Narcissism: Reflections on Empathy, Humor and Expectations*. New York: The Analytic Press.
- Lessem, P. A. (2005). *Self Psychology: An Introduction*. New York: Jason Aronson.
- Mikulincer, M. & P. R. Shaver, eds., (2007). *Attachment in Adulthood: Structure, Dynamics, and Change*. New York: Guilford Press.
- Neff, K. (2003a). Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Towards Oneself. *Self and Identity*, vol. 2, 85-101.
- Neff, K. D. (2003b). The Development and Validation of a Scale to Measure Self-Compassion. *Self and Identity*, vol. 2, 223-250.
- Neff, K. D., Y. P. Hsieh & K. Dejitterat (2005). Self-Compassion, Achievement Goals, and Coping with Academic Failure. *Self and Identity*, vol. 4, 263-287.
- Neff, K. D., K. L. Kirkpatrick & S. S. Rude (2007). Self-Compassion and Adaptive Psychological Functioning. *Journal of Research in Personality*, vol. 41, 139-154.
- Neff, K. D. (2009). The Role of Self-Compassion in Development: A Healthier Way to Relate to Oneself. *Human Development*, vol. 52, 211-214.
- Neff, K. D., & R. Vonk (2009). Self-Compassion Versus Global Self-Esteem: Two Different Ways of Relating to Oneself. *Journal of Personality*, vol. 77, 23-50.
- Riis, O. (2009). Methodology in the Sociology of Religion. In P. B. Clarke (ed.): *The Oxford Handbook of the Sociology of Religion*. Oxford: Oxford University Press, 229-244.
- Siegel, A. M. (1996). *Heinz Kohut and the Psychology of the Self*. New York: Routledge.

Stolorow, R. D. & G. E. Atwood (1992). *Contexts of Being: The Intersubjective Foundations of Psychological Life*. Hillsdale, NJ: Analytic Press.

Strozier, C. B. (2001). *Heinz Kohut: The Making of a Psychoanalyst*. New York: Farrar, Straus & Giroux.

Vetlesen, A. J. (1994). *Perception, Empathy, and Judgment: An Inquiry into the Preconditions of Moral Performance*. Pennsylvania: The Pennsylvania State University Press.

Vinje, H. F. (2007). "Thriving Despite Adversity: Job Engagement and Self-Care among Community Nurses". Bergen: Department of Education and Health Promotion, Faculty of Psychology, University of Bergen.

All sources used in this thesis are listed.

## Appendices

### Appendix A. Letter of Consent (Norwegian)

#### Forespørsel om å delta på intervju i forbindelse med masteroppgave

Jeg er masterstudent i religion, etikk og samfunn ved Universitetet i Agder og holder nå på med den avsluttende masteroppgaven. Tema for oppgaven er empati, og jeg skal undersøke helsearbeideres opplevelse av møte med ulike pasientgrupper. Målet er å bidra til økt teoretisk forståelse av vilkårene for empatisk innlevelse, og undersøke hvilke praktiske implikasjoner dette kan ha for tilrettelegging av empati på tvers av ulike skillelinjer. Tittelen på min masteroppgave er "Empathic Engagement in Caregiving Professions – In Light of Heinz Kohut's Self Psychology". Veileder for oppgaven er førsteamanuensis Dagfinn Ulland (tlf: 38142015).

I forbindelse med arbeidet med min masteroppgaven ønsker jeg å foreta et dybdeintervju med deg. På intervjuet vil jeg snakke om din bakgrunn, hvorfor du valgte ditt yrke, og hvordan du opplever det å være en profesjonell omsorgsperson. På slutten av intervjuet vil jeg spørre deg om å fylle ut et spørreskjema. Spørreskjemaet bygger på en psykologisk test som måler hvordan du opplever det å omgås andre mennesker.

Intervjuet vil ta om lag 60-80 min og spørreskjemaet 15-20 minutter. Jeg vil bruke båndopptaker og ta notater mens vi snakker sammen.

Det er frivillig å være med på undersøkelsen og du har mulighet til å trekke deg når som helst innen prosjektslutt 30.04.2010, uten å måtte begrunne dette nærmere. Dersom du trekker deg vil alle innsamlede data om deg bli slettet.

Opplysningene som jeg samler inn vil bli behandlet konfidensielt, og ingen enkeltpersoner skal kunne gjenkjennes i den ferdige masteroppgaven. Ved prosjektslutt vil lydopptakene av intervjuet slettes, og de nedskrevne opplysningene anonymiseres.

Dersom du kan tenkte deg å være med på intervjuet og spørreskjemaundersøkelsen, eller om du har noen spørsmål i forbindelse med prosjektet, ta kontakt på telefon: 47 30 60 89, eller sende en e-post til [groanita.homme@gmail.com](mailto:groanita.homme@gmail.com).

Studien er meldt til Personvernombudet for forskning, NSD.

Med vennlig hilsen,

Gro Anita Homme

#### Samtykkeerklæring:

Jeg har mottatt informasjon om studien og ønsker å stille på intervju.

Signatur ..... Telefonnummer .....

## Appendix B. Interview Guide (Norwegian)

- Kan du fortelle meg litt om din faglige bakgrunn, og hvor lenge du har jobbet her?
- Kan du si litt om hvorfor du valgte dette yrket? Er du fornøyd med de valgene du har tatt?
- Denne studien handler om empati, hvordan forstår *du* dette ordet?
- Kan du gi meg et eksempel på en situasjoner hvor du syntes det er lett å ha empati med den andre?
- Kan du gi meg et eksempel på en situasjon hvor du syntes det var vanskelig å være empatisk?

[Hypotetisk situasjon for ansatte på fødeavdelingen]

- Et foreldrepar som er Jehovas Vitner får et barn som trenger blodoverføring for å overleve. Hvordan tenker/føler du om deres valg om å ikke tillate dette?

[Hypotetisk situasjon for ansatte på gamlehjem]

- En pasient motsetter seg å få pleie av en ansatt med utenlandsk opprinnelse. Hvordan tenker/føler du om pasientens holdning?

[Hypotetisk situasjon for ansatte på psykiatrisk institusjon]

- En kollega med utenlandsk opprinnelse forteller deg at han syntes kvinnens plass er i hjemmet. Hvordan reagerer du?

[Hypotetisk situasjon, generell]

- En kollega får æren for en ekstra innsats du har gjort, hvordan reagerer du?

- Hva syntes du er den største utfordringen du har i jobben din?
- Hva syntes du er viktig i et arbeidsmiljø for å opprettholde de ansattes motivasjon?
- Kan du komme på et eksempel der du opplevde å bli veldig skuffet eller sint, enten på kolleger, pasienter eller deg selv? Hvordan håndterte du situasjonen? Hva gjorde at det ordnet seg/eller ikke? Hvordan forholder du deg til den personen nå?
- Har du hatt, og/eller har du fortsatt noen forbilder? Har du opplevd å bli skuffet over forbilder?
- De menneskene du ser på som dine nærmeste venner, er de veldig like deg med hensyn til livssituasjon, verdier, livsstil? Hvorfor tror du at det er slik?
- Syntes du det er mer eller mindre vanskelig å ha empati med noen fra samme kulturelle bakgrunn, eller med noen som er veldig ulike deg?
- Har du noen gang opplevd at du mangler overskudd til å gjøre jobben din? Har du noen strategier for å håndtere slike følelser?
- Hvordan vil du kort beskrive din kulturelle bakgrunn? Familie, oppvekst, sivilstatus.
- Er det noen personer eller hendelser som har vært spesielt viktige for deg, og hvorfor?
- Hvilken rolle spiller religion/manglende religion i hvor empatisk du er med deg selv/andre
- Har du noen spørsmål, er det noe du har lyst til å legge til? Hadde du gjort deg noen refleksjoner i forkant av intervjuet, noe du forestilte deg vi kom til å snakke om?

## Appendix C. The Selfobject Needs Inventory (English)<sup>4</sup>

1. I feel hurt when my achievements are not sufficiently admired.
2. It's important for me to be around other people who are in the same situation as me.
3. When I have a problem, it's difficult to accept advice even from experienced people.
4. Associating with successful people allows me to feel successful as well.
5. I don't need other people's praise.
6. I would just not be involved with people who suffer from problems similar to mine.
7. I'm disappointed when my work is not appreciated.
8. I seek out people who share my values, opinions, and activities.
9. I find it difficult to accept guidance even from people I respect.
10. I identify with famous people.
11. I don't function well in situations where I receive too little attention.
12. I feel good knowing that I'm part of a group of people who share a particular lifestyle.
13. I feel bad about myself after having to be helped by others with more experience.
14. It's important for me to feel that a close friend and I are "in the same boat".
15. When I'm doing something, I don't need acknowledgment from others.
16. It bothers me to be in close relationships with people who are to me.
17. I am attracted to successful people.
18. I have no need to boast about my achievements.
19. I feel better about myself when I am in the company of experts.
20. I would rather not be friends with people who are too similar to me.
21. I feel better when I and someone close to me share similar feelings to other people.
22. It's important for me to be part of a group who share similar opinions.
23. I don't really care what others think about me.
24. I know that I'm successful, so I have no need for others' feedback.
25. I'm bored by people who think and feel too much like me.
26. It's important for me to be around people who can serve as my models.
27. I feel stronger when I have people around who are dealing with similar problems.
28. It's difficult for me to belong to a group of people who are too much like me.
29. In order to feel successful, I need reassurance and approval from others.
30. When I'm worried or distressed, getting advice from experts doesn't help much.
31. I try to be around people I admire.
32. I gain self-confidence from having whose beliefs are similar to mine.
33. I need a lot of support from others.
34. I find it difficult to be proud of the groups I belong to.
35. Most of the time I feel like I'm not getting enough recognition from my superiors.
36. It's important for me to belong to high-status, "glamorous" social groups.
37. I don't need support and encouragement from others.
38. I would rather not belong to a group of people whose lifestyle is similar to mine.

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<sup>4</sup> The SONI self-report scale is used with permission from one of its developers, Professor Mikulincer.

## Appendix D. The Selfobject Needs Inventory (Norwegian)<sup>5</sup>

1. Jeg blir lei meg når mine prestasjoner ikke blir satt tilstrekkelig pris på.
2. Det er viktig for meg å omgås mennesker som er i samme situasjon som meg.
3. Når jeg har et problem syntes jeg det er vanskelig å ta imot råd fra andre, også fra mennesker som har erfaring med lignende problemer.
4. Når jeg kan identifisere meg med vellykkede mennesker, føler jeg meg også vellykket.
5. Jeg trenger ikke skryt fra andre.
6. Jeg ønsker ikke å involvere meg med mennesker som har lignende problemer som meg.
7. Jeg blir skuffet når arbeidet mitt ikke blir satt pris på.
8. Jeg søker kontakt med mennesker som deler mine verdier, meninger og aktiviteter.
9. Jeg syntes det er vanskelig å ta imot råd, til og med fra mennesker jeg respekterer.
10. Jeg identifiserer meg med berømte mennesker.
11. Jeg fungerer ikke bra i situasjoner der jeg får for lite oppmerksomhet.
12. Det føles godt å vite at jeg tilhører en gruppe mennesker som deler en særegen livsstil.
13. Jeg liker ikke å ta imot hjelp fra andre med mer erfaring.
14. Det er viktig for meg å føle at jeg er "i samme båt" som en nær venn.
15. Jeg trenger ikke bekreftelse fra andre på det jeg gjør.
16. Jeg syntes det er plagsomt å stå i nære relasjoner med mennesker som ligner meg.
17. Jeg tiltrekkes av vellykkede mennesker.
18. Jeg føler ikke for å skryte av mine prestasjoner.
19. Jeg får bedre selvfølelse når jeg er med eksperter.
20. Jeg vil helst ikke være venner med mennesker som ligner for mye på meg.
21. Jeg føler meg bedre når jeg og noen av mine nærmeste føler det samme som andre mennesker.
22. Det er viktig for meg å være del av en gruppe som deler lignende meninger.
23. Jeg bryr meg egentlig ikke om hva andre mennesker mener om meg.
24. Jeg vet at jeg er vellykket, så jeg trenger ikke andre menneskers bekræftelser.
25. Jeg kjeder meg i selskap med mennesker som tenker og føler for mye som meg.
26. Det er viktig for meg å være rundt som kan tjene som rollemodeller for meg.
27. Jeg føler meg sterkere når jeg har mennesker rundt meg som har lignende problemer som jeg har.
28. Det er vanskelig for meg å tilhøre en gruppe mennesker som er for like på meg.
29. Jeg trenger oppmuntring og anerkjennelse fra andre for å føle at jeg har lykket.
30. Når jeg er bekymret eller stresset, det ikke å få hjelp fra eksperter.
31. Jeg prøver å holde meg i nærheten av mennesker jeg beundrer.
32. Jeg blir mer selvsikker når jeg har venner som tenker som meg.
33. Jeg trenger mye støtte fra andre.
34. Jeg syntes det er vanskelig å være stolt av en gruppe jeg tilhører.
35. Mesteparten av tiden føler jeg at jeg ikke får nok anerkjennelse fra mine overordnede.
36. Det er viktig for meg å tilhøre høystatus, "glamorøse" sosiale grupper.
37. Jeg trenger ikke støtte og oppmuntring fra andre.
38. Jeg vil helst ikke tilhøre en gruppe med samme livsstil som .

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<sup>5</sup> My translation.



## **Appendix E. Approval from NSD**



Dagfinn Ulland  
Institutt for religion, filosofi og historie  
Universitetet i Agder  
Serviceboks 422  
4604 KRISTIANSAND S

Vår dato: 02.11.2009

Vår ref: 22827 / 2 / MAB

Deres dato:

Deres ref:

## TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 20.10.2009. Meldingen gjelder prosjektet:

22827	<i>Empathic Engagement in Care Giving Professions - In Light of Heinz Kohut's Self Psychology</i>
Behandlingsansvarlig	<i>Universitetet i Agder, ved institusjonens overste leder</i>
Daglig ansvarlig	<i>Dagfinn Ulland</i>
Student	<i>Gro Anita Homme</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

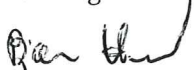
Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, vedlagte prosjektvurdering - kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, [http://www.nsd.uib.no/personvern/forsk\\_stud/skjema.html](http://www.nsd.uib.no/personvern/forsk_stud/skjema.html). Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 30.04.2010, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

  
Bjørn Henrichsen

  
Marte Bertelsen

Kontaktperson: Marte Bertelsen tlf: 55 58 29 53

Vedlegg: Prosjektvurdering

Kopi: Gro Anita Homme, Marthas vei 16, 4633 KRISTIANSAND S



## Prosjektvurdering - Kommentar

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22827

Utvalget består av ca. 10 profesjonelle omsorgsarbeidere.

Student, Gro Anita Homme, tar kontakt med avdelingsledere ved ulike institusjoner som sykehus, eldreheim etc. og ber dem videreformidle informasjon til utvalget.

Det gis skriftlig informasjon og innhentes skriftlig samtykke. Revidert informasjonsskriv, mottatt av personvernombudet 30. oktober 2009, finnes tilfredsstillende.

Det vil ikke blir snakket om tredjeperson (enkeltpasienter, kollegaer, familie etc.) på intervjuene.

Det registreres sensitive opplysninger om helseforhold, jf. personopplysningsloven §2 nr. 8 c).

Ingen enkeltpersoner vil kunne gjenkjennes i den ferdige masteroppgaven.

Personvernombudet legger til grunn at det er avklart med Universitetet i Agder at data kan lagres på privat PC.

Prosjektet avsluttes 30.04.2010. Da skal datamaterialet anonymiseres. Anonymisering innebærer at lydopptak slettes, og at direkte personidentifiserende opplysninger som for eksempel navn/navneliste, og indirekte personidentifiserende opplysninger som for eksempel alder, kjønn og navn på arbeidsplass, endres eller slettes.