An offprint from *The Psychoanalytic Study of the Child*, vol. 41/1986
Edited by Albert J. Solnit and Peter B. Neubauer

Yale University Press

The Empathic Wall and the Ecology of Affect

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Affect Theory

MODERN AFFECT THEORY BEGINS WITH THE WORK OF SILVAN TOMkins (1962, 1963). Observing the face of his newborn son, Tomkins saw what looked like "emotion" displayed on the face of an organism with none of the history, none of the life experience we have always considered necessary for the development of emotion. "Certainly the infant who emits his birth cry upon exit from the birth canal has not 'appraised' the new environment as a vale of tears before he cries" (Tomkins, 1982, p. 362). Nonetheless, the crying infant looks quite like a crying adult—this cry of distress must have been *available* to the infant courtesy of some preexistent mechanism triggered by some stimulus acceptable to that mechanism.

Tomkins sees nine of these mechanisms, a group of primarily facial responses which he calls "innate affects," as operating from birth. The positive affects are *interest* or *excitement, enjoyment* or *joy,* and *surprise* or *startle.* The negative innate affects, also present from birth and visible on the face of the newborn, are

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Portions of this paper were presented at the International Symposium on Denial, Jerusalem, 30 January 1985.

I am deeply indebted to Dr. Léon Wurmser for his constant support and encouragement and for the many theoretical discussions which allowed clarification of my ideas.

distress or *anguish, fear* or *terror, shame* or *humiliation, dissmell,*[1] *disgust,*[2] and *anger* or *rage.*

Tomkins assumes that the affects are triggered by the way information comes into the brain through neural pathways—it is the number of neural firings per unit time, what he calls the "density" of neural firing, which is responsible for affect activation. Once activated, the subcortical program then begins to produce affect, which itself triggers more affect. It does not matter whether the stimulus comes in on the auditory, visual, or kinesthetic track—in this theory the affects are essentially neutral with respect to their activators. Thus he postulates that a stimulus which begins at a low level and increases gradually produces the affect *interest,* which affect at its higher levels of intensity is experienced as *excitement. Distress* is activated by stimuli which are at a relatively constant but higher than optimal level, and *anger* by stimuli which are constant but at a still higher nonoptimal level. *Enjoyment* accompanies the sudden reduction of any stimulus, and *surprise* will be activated when the stimulus gradient is sudden and upwards, as with a pistol shot. Babies are thus equipped from birth with perceptual and protective systems which allow them to react to stimuli that they will not "understand" for quite some time.

Affective behavior patterns are inherited programs available to the infant. These may be combined with each other and with the experiences which triggered them to form complex patterns, just as the letters of our alphabet may be combined to form words and words combined to form sentences. Memory, for instance, can produce the shock of recognition, which involves

1. The sense of smell allows us to evaluate a distant entity by its emitted odor. What functions initially as a drive auxiliary, protecting us from unchecked and therefore potentially dangerous hunger, becomes an affect later in development. This is seen in such expressions as "turning up one's nose at" and calling the object a "stinker."

2. Taste is the final sentinel of the gastrointestinal tract, allowing us to "spit out" something before it gets into the gut. Tomkins also views disgust as an affect which developed from a drive auxiliary. Nausea, vomiting, and diarrhea are the other mechanisms protecting the gut from noxious substances—although presenting frequently as emotion equivalents, they are not displayed on the face and do not rank as primary affects in Tomkins's system.

an affective response to the suddenness with which various higher cortical systems presented an association. These affect programs involve a host of bodily systems, including of course what we have always called the "muscles of expression" in the face, but also the endocrine and exocrine glands and nearly any group of odors, postures, and colors. Basch (1976, 1983a, 1983b) has suggested that we use the term "affect" to refer to biological events, "feeling" to our awareness of these events, and "emotion" to the complex interrelationships formed by the experience of an affect and our associations to it. "Emotion," he suggests, "when developed, is evidence of neocortical activity of a highly sophisticated sort" (1976, p. 770).

Buck (1984) suggests that the emotions evolved in three phases. Arising first as subcortical mechanisms concerned with bodily adaptation and the maintenance of homeostasis, they operated completely out of awareness (Emotion I). In the second phase, the affects became expressed in externally accessible behaviors as spontaneous expressions of internal states, perhaps useful for the coordination of behavior in a species (Emotion II). The final phase of development (Emotion III) involves the direct subjective experience of the state of certain neurochemical systems. It is this last adaptation which has allowed the linkage of the phylogenetically earlier subcortical affect mechanisms with higher cortical function to form the type of emotion with which we are most familiar in psychoanalytic thinking.

Psychoanalytic Concepts

The historic focus of psychoanalysis on cognitive, intrapsychic function has tended to underemphasize the importance of affect expression and affective communication. Yet, as Modell (1978) has said, "assuming that psychoanalysis is a study of meaning, meaning itself is determined by the communication of affects" (p. 170).

It is in the nature of evolution that existing systems are recruited for new functions—we should not be surprised that the affects evolved into a quite sophisticated communication system. That the affects are displayed on the signboard of the face is not limited to man, as any dog owner can testify. Our pets convey

messages of the most remarkable complexity by a combination of intentional gesture and affect display. Affective communication in the human is of even greater complexity, and nowhere is this more important than in the relationship between mother and infant.

Although it suited the purpose of previous generations of theorists to view the infant as entirely self-involved, it has become clear that the baby spends a considerable portion of his time observing mother with rapt attention. To Winnicott has been attributed the comment that there is no such thing as a baby—there is only the baby and his mother. Mother and infant are linked in a dyadic relationship. Lichtenberg (1981) states, "The overwhelming weight of evidence from infant research indicates that the neonate begins life in an interactive dialogue with his mother. From the beginning, for both partners, this dialogue has models of perceptual organization that activate the responsiveness of the other. Within this dyadic communicative exchange there is no distinction between affect response and perceptual-cognitive ordering" (p. 333). From the moment of birth the infant is delivered into the climate of mother's affect. Any competent theory for the development of the infantile ego must include systems for the processing of affective communication.

Anna Freud (1936) may have alluded to this when she wrote, "The efforts of the infantile ego to avoid 'pain' by directly resisting external impressions belong to the sphere of normal psychology. Their consequences may be momentous for the formation of the ego and of character, but they are not pathogenic. When this particular ego function is referred to in clinical analytic writings, it is never treated as the main object of observation but merely as a by-product of observation" (p. 71). In this communication I wish to refocus our attention on such ego functions, and to demonstrate their relevance to our clinical work.

Empathy

The term for an affective linkage forged during psychotherapy is "empathy." As Basch (1983a) has so convincingly demonstrated, while it is affect which is transmitted in empathy, we

experience this empathic perception as emotion because of our associations to the particular affect transmitted. We never really share the other person's emotion because each of us has lived too complex a life, has formed associations to these innate affects based on experiences which are different despite their general similarity. Your experience of shame is not mine, your anger is not my anger. Yet through empathy I may clench my jaw when you feel angry, and look away in embarrassment when you are shamed. Many clinicians are loathe to diagnose depression in a patient who does not make them *feel* depressed; similarly we accept without comment that mania is infectious.

The psychoanalyst is a paradigm of the "good" audience. Indeed, for many people, therapy provides the first life experience in which they feel heard, in which they feel real. So highly do both therapists and patients value this feeling of being known on an affective level that a significant underlying truth has been obscured. We consider the absence of empathy normal, and the presence of it special. The most mature among us do not live in a world of shared emotion. Maturity implies a certain degree of isolation from the emotions of others.

The Empathic Wall

Rather than asking how the message of happiness, grief, resentment, anger, or distress is *transmitted,* we should consider how such transmission is *blocked.* How is it that we are not more often taken over by affect so broadcast? When infectious disease was the frontier of science, such transmission was called contagion of affect (Scheler, 1912; Sullivan, 1954). One has only to watch dispassionately the flow of laughter through an audience, or the flow of anger through a mob, to wonder how the normal human develops immunity to this contagion; how do we learn to remain ourselves in the presence of the affect of the other?

These and many other questions may be answered by the introduction of a new ego mechanism to which I have given the apparently paradoxical name the "empathic wall." The empathic wall allows us to monitor our affective experience and determine whether the affect of the moment is generated from within or without, thus defining the difference between self and

other. It may be the root mechanism for a host of normal and pathological defensive operations of the ego.

Rather than considering all experience of affective transmission to be synonymous with empathy, I would agree with Basch (1983a) that *mature* empathy involves the intentional acceptance of such transmission. It is my feeling that mature empathy can occur only in a person with a healthy empathic wall mechanism, who is in addition capable of relaxing this ego function in order to merge briefly with the affective broadcast of the other. In our analytic work this lapse into primary process, which is analogous to other examples of the creative process, is followed by a return to secondary process accompanied by data about the other learned during the empathic link. In the remainder of this paper I will focus on the development of the empathic wall and its relationship to denial, projection, and the phenomenology of certain psychopathological conditions.

Infant Research

That infants reward the smile of the mother with a smile of their own is an indication of the relationship between mimesis and affective transmission. Emde et al. (1976) have written extensively about affect mutualization between mother and infant. The infant's smile makes the mother feel good, which sense of pleasure may be communicated to the child; conversely, the infant's cry of distress activates distress in the mother. Demos (1982) describes the infant as scanning his environment with interest, accepting it as a provider of stimulation. When this stimulation begins to produce distress, "he will attempt to decrease the level of stimulation by turning away from the object" (p. 565). One form of stimulation is, of course, the affect available in his environment; I believe that such activity of turning away represents the early beginnings of the empathic wall.

Beebe and Sloate (1982) describe the attempts of an infant to handle the affective onslaught of a psychotic, intrusive mother. By 3 to 4 months the child had lost her fascination with mother's face and demonstrated extensive gaze aversion. "It can be hypothesized that the pattern of extensive looking away was already being used by this infant to help modulate inappropriate

stimulation that was experienced as aversive" (p. 606). At 8 months, "She tuned out and withdrew from mother's attempts to engage her in play, turning her back, looking out the window, behaving as if she did not hear her mother" (p. 616). Adequate data are given in this case material to allow the conclusion that the infant was avoiding mother's affect, using what I believe to be the blocking function of the empathic wall mechanism. Beebe and Sloate explain this by reference to Rubinfine's (1962) comments "on the child's use of denial to conserve the object relation in situations where the mother has taken on the properties of an aversive stimulus" (p. 616).

Selma Kramer (1983) has suggested that, in the normal child, the appearance of stranger anxiety marks achievement of an ego mechanism which can allow him to recognize the difference between the affective transmission of mother and of anybody else. Awareness of the difference between such transmission sets may be one way the infant learns to recognize individuals; more important for our purposes here, it certainly may provide the analogue for recognizing the difference between self and other on the affective level. Emde et al. (1976) note that by this time the "transactions between mother and infant have differentiated to the point where both are 'tuned in' to a mutually specific attachment. . . . As a stranger approaches [the infant] looks with an expression of interest which then becomes one of sober perplexity. This is followed by what is rated as a fearful expression, with frowning and then crying . . . accompanied by gaze aversion and a turning away of the head and body" (p. 145).

Denial and Projection

Both denial and projection involve application of skills learned in the formation and operation of the empathic wall mechanism. The child has learned to evaluate intense experiences of affect by checking to see whether a feeling has arisen from within self or other. In the face of intense, perhaps unacceptable affect broadcast by the mother, the empathic wall allows the child to succeed in the struggle to maintain affectional ties while *separating from the feeling*. Proper use of the empathic wall allows the child to remain self while leaving broadcast feelings outside the

self. The case of Beebe and Sloate (1982) cited above represents an extreme example of the affect blocking provided by the empathic wall mechanism. Thus, denial and projection are part of the normative functioning and not limited to being in the service of pathological defense mechanisms.

Here, then, is a mechanism which allows the individual to sample his own affective state and determine its source, a mechanism valuable for an organism whose perceptual and communicative apparatus are not developed adequately to allow symbolic communication. If such a mechanism can allow the child to wall off external affect, to feel that this affective state comes from outside the self and rightly should remain outside the self, then that mechanism is capable of being recruited for further use when unpleasant affect derives from *inner* conflict. The child can wall off the feeling, even to the extent that the feeling is viewed as an intrusion from the outside, the result of affective transmission. Denial utilizes the affect-blocking portion of the empathic wall, while projection makes use of its ability to perform a "vector analysis"—to determine from which direction a particular affect originated.

Useful as this mechanism may seem in allowing the individual to disavow some portion of the meaning of an event or a percept in order to reduce the associated painful affect (Weisman and Hackett, 1961), it alters rather than solves the problem. As Waelder (1951) said, even if projection shifts the focus from self to other, "the denied instinct remains in the limelight; he who projected his aggressiveness onto others has his mind occupied with aggressiveness, albeit somebody else's" (p. 174). The noxious affect is still being experienced, but it is attributed to the other.

Projective Identification

Kernberg (1967) comes close to my understanding of the empathic wall mechanism in his discussion of projective identification; he states that the patient's aggression, although projected onto the object, remains active. "This leads such patients to feel that they can still identify themselves with the object onto whom aggression has been projected, and their ongoing 'empathy' with

the now threatening object maintains and increases the fear of their own projected aggression. . . . In summary, projective identification is characterized by the lack of differentiation between self and object in that particular area, by continuing to experience the *impulse* as well as the fear of that impulse while the projection is active, and by the need to control the external object" (p. 669; my italics).

But it is affects, not impulses which are projected. Further, in the language developed here, it is through a defensive misuse of the empathic wall mechanism that one has attributed an affect to the object and decided that one is experiencing this uncomfortable affect by affective transmission from the object. What Kernberg calls "empathy," I see as affective transmission, which by its nature is a transient or reactive state; identification, which implies a move toward likeness to another person including the adoption of interests, ideals, or mannerisms of the other, is therefore a much more lasting phenomenon. It would appear, in view of our current understanding of affect, that the term "projective identification" is a misnomer at many levels. Perhaps the actual phenomena involved would be described better by the terms "subjective naming" and "objective naming," to take into account the situations where our idea of the other derives from our own, subjective sources, or from the object seen clearly.

Interpersonal Aspects of Denial

An often ignored yet supremely important matter is the interpersonal aspect of denial—what denial does in and to a relationship. We take it for granted that in a good, healthy object relationship the participants share reality. But as Dorpat (1983) has said so well, "The dynamic defensive function of denial is carried out by the active exclusion of information from focal attention, i.e., explicit conscious awareness" (p. 48). What if, through denial, one member of a dyad acts as if some piece of information, taken for granted by the other, and the competent subject of focal attention by that other, does not exist?

Our observation is that each belief system produces its own characteristic affective display—i.e., we wear on our faces the feeling state, or mood which derives from the sum of our knowl-

edge, whether conscious, preconscious, or unconscious. When the intimate other senses, by affective transmission, the disparity between the two belief systems, anxiety is produced. This anxiety causes interpersonal tension which must be resolved if the relationship is to endure at the previous level of intimacy. Each relationship has a characteristic mode of tension resolution, ranging from friendly inquiry to open hostility and fighting. Denial seems to work better in the privacy of one's defenses. Thus denial in the subject causes anxiety in the object, verifying again Waelder's (1951) observation that, at least in a relationship, there may be no such thing as "successful" denial unless there is a fit of one person's denial with the needs or tolerances of the other person in the close relationship.

Clinical Illustrations

case 1

Karen, a 24-year-old graduate student, entered therapy in an attempt to interrupt a recurring cycle of unhappy romantic liasons. Men flocked around her in bars and at parties; she was courted impulsively by suitors who responded to her with a degree of sexual intimacy and openness one might expect in a more developed relationship. She remarked, "They seem to be turned on, ready for sex when I am just getting to know them. The first couple of guys who said 'Come on, I know you want it too' made me furious. But enough men have said something like that, and I thought I should bring it up here."

What excited those men? Karen noted with some interest that although in intercourse she experienced a considerable degree of vaginal anesthesia, and that she did not look forward to intercourse, she was aware of nearly constant vaginal wetness unassociated with conscious sexual ideation. That she had disavowed sexual excitement as a compromise settlement of oedipal conflicts became apparent to her much later; what helped her at this stage in treatment was the recognition that men were sexually aroused by her denied arousal. Knowing that her body was responding to unconscious forces with which she was not yet ready to deal, she was better able to integrate relationships with men

now that she understood that portion of their behavior deriving from her denied arousal. Late in her fourth year of therapy, when she was well on her way toward healthy object relatedness, beginning to be involved in genital sexuality with a loved and loving partner, she commented that during sexual excitement she was aware that her facial expression was reminiscent of the facial set which, before therapy, she had displayed nearly constantly.

Sullivan (1954) commented that lust appears as a drive in early adolescence. It is during this period in development that sexual ideation becomes connected to its affective component. Parents of adolescents know this best, for children previously unsuspected of sexual ideation "suddenly" are seen as being "sexy." "Sexiness" is an affective broadcast. I have confirmed this observation in clinical practice on countless occasions—men and women who are read by others as sexually exciting are themselves, at that moment, involved in their own sexual excitement. This is normal affective transmission, handled, as Anna Freud said, by the ego functions which monitor external impressions.

The hysteric is decidedly uncomfortable with the oedipal ideation which has produced her sexual excitement, and has used the affect-blocking portion of the empathic wall mechanism to keep this complex of affects out of awareness. The fact that she is condemned by this defensive decision to be the object of sexual pursuit confirms Waelder's observation that denial is not freedom.

Finally, this case illustrates the relationship between denial, projection, and the empathic wall, for Karen's denial does not eradicate her own sexual excitement, which is still being triggered, but now by forces of which she is not aware. This affect remains in the interpersonal field, where it may be confused with normal affective transmission from the object. Both the hysteric and the paranoid see the disavowed, unacceptable affect as emanating from the object. The difference lies in the competence of the vector-analyzing portion of the empathic wall mechanism. The hysteric has blocked the feeling, and remains relatively free of it—the sexual excitement and ideation are attributed to the object through a defensive misuse of the empathic wall. The paranoid, whose empathic wall is weaker than that of the

hysteric, continues to experience the affect, but blames the object for "influencing" him.

CASE 2

Any ego function can be eroded in the schizophrenic process—indeed, study of the schizophrenias has taught us much about the range of normal ego functions. If a breach in the empathic wall has been forced by illness, the patient may complain that the feelings of others are being experienced as an unwelcome intrusion. Wurmser (1981) reports the statement of Blanche, 3 years before an overt schizophrenic psychosis, trying to defend against terrible discomfort in the presence of others, "I try consciously to get to know them, but it's as if I lack empathy" (p. 140). Later, during the worst of her illness she reported, "I'm so dependent on what other people think. I wanted to get away from people—to be myself, to feel my own feelings. Why do other people affect me that much?" (p. 140). This failure to block broadcast affect also may be interpreted by the patient as fantasies of telepathic power, or delusions that one is the subject of messages broadcast from another's space ("outer space").

Failure of the empathic wall ego mechanism is seen in "psychotic insight," which involves involuntary empathic acceptance of affective and gestural communication otherwise denied by the sender. Such insight is considered psychotic because the patient either is unable to use the empathic wall to return to self, or cannot use other ego mechanisms to integrate this new information about the other for the purposes of normal interpersonal relatedness.

CASE 3

Another patient, Jocelyn, complained bitterly that in the company of others she was unable to maintain her own emotions. If a friend seemed upset about something Jocelyn had said, she too would begin to feel upset; if a companion were to be gleeful, she would feel inappropriately gleeful, then confused and angry as she felt a loss of her own identity. The experience of affective resonance was quite unpleasant for her. Concomitantly she was extraordinarily restricted in the display of her own emotions. I

will take up two facets of her relationship with her mother in an attempt to explain the development of what she regarded as her most uncomfortable symptoms.

Jocelyn avoided contact with her mother, whom she described as an affective steamroller whose rages and sulks dominated the family. The family dog was severely beaten whenever it soiled a floor or rug, despite the fact that no attempt at housetraining was ever made. The patient was often awakened to hear her mother screaming at her father. In dreams the mother usually was represented as a dark figure, frequently a witch, always an object of terror. Such a parent provided an environment overloaded with unmodulated affect, depriving the growing child of the opportunity to develop an adequate empathic wall, rendering the child susceptible to external impression.

By age 11 Jocelyn had discovered lying, which gave her some sense of distance from her mother. Later she learned to control her own affective output around her mother, developing first a sort of facial flatness and then a number of elaborately conceived and practiced pseudoemotional behavioral entities which we came to call "affective modules." By maintaning (initially consciously, later unconsciously) her facial musculature in a masklike state, she reduced the affective resonance which so upset her, for the face is the major display board of the affect system. This served another function, for, as she described interactions with her mother, "Unless I am in complete control of my emotions when I am around her, she takes over my emotion. I can't be in a bad mood, or she will not only be in a bad mood, but it will be her bad mood, and she will tell me what I should do. After I am around her for a little while when one of these things is happening, I feel crazy because I can't even remember why I was in a bad mood to begin with, let alone what I was really feeling." I suspect that this mother's problems with affect modulation bear some relationship to a defect in her own empathic wall mechanism.

In treatment Jocelyn gave up the defensive flatness only when she had thoroughly and repeatedly tested my ability to maintain a calm, warm manner despite her attempts within the transference to see me as volatile. A breakthrough of enormous importance came in the third year of therapy when she decided to

stand before a mirror experimenting with facial expression. As she mimicked the expressions of anger, distress, shame, joy, surprise, and disgust, she felt herself flooded with feeling which she could now control by turning off the expression. Through a year-long series of exercises she worked through a wide range of affects, building her ability to tolerate emotion. Growth in therapy strengthened her ability to handle her own affect as well as that broadcast by others. Now, in her fifth year of treatment, she has begun to develop a good sense of self and a healthy need for privacy appropriately bounded by shame.

Integration with Other Theories

In his microanalysis of the mechanism of denial, Dorpat (1983) determined the following "four phases of denial reactions: (1) preconscious appraisal of danger or trauma, (2) painful affect, (3) cognitive arrest, and (4) screen behaviour" (p. 47). He explains that "cognitive arrest is brought about by unconscious fantasies of destroying or rejecting whatever he considers to be the cause of his psychic pain (or what I have termed 'the painful object')" (p. 47). I believe that it is the normal function of the empathic wall to sense that the pain one is experiencing derives from the object by affective transmission. Dorpat has come quite close to my concept in his suggestion that an affective state deriving from inner conflict has, through denial, been attributed to pain caused by another.

Basch (1982) points out that *Verleugnung* is properly translated as disavowal, rather than denial, for disavowal implies the vernacular use more central to Freud's meaning—the unconscious version of the self-serving socially acceptable evasions of everyday life, in which there is no hint of psychotic distortion of thought process. He shows that Freud meant to designate disavowal "as the mechanism which defends against traumatic external reality, whereas repression deals with unacceptable instinctual demands" (p. 135). "Disavowal," he continues, "prevents the union of affect with percept, without, however, blocking the percept from consciousness" (p. 147).

Finally, Basch states that "conceptual clarity would be served if the term 'denial' was used as a collective term for those psychotic or nonpsychotic mechanisms that actually interfere with the per-

ceptual interpretation of sensory signals, while following Freud, using the term 'disavowal' only to describe that situation in which the affectively toned meaning that a percept would be expected to have for the self is unconsciously repudiated" (p. 146). Both senses of *Verleugnung* fit well with the concept that they are preceded by skills learned in the use of the empathic wall mechanism. The empathic wall conforms to Basch's requirement for a mechanism which "interferes with the perceptual interpretation of sensory signals" as long as one understands that affective resonance is a sensory analogue.

The relationship between affective transmission and the repudiation of the "affectively toned meaning of a percept" requires further discussion. Just as affect display can be mimicked—as it is normally in affective resonance and intentionally in the experiment of Ekman et al. (1983)—it can be mimed for the purpose of conveying a false communication. The "confidence man," the salesman, and the seducer pull us into a trusting relationship by their use of the verbal tone and facial affect display of affection and caring. The mature person ignores these messages in order to focus better on the verbal, symbolic content of the communication. It is the ability to resist affective transmission which protects us from such sales techniques. Philosopher Alan Watts (1970) called this "ig nor' ance," the healthy ability to ignore. Disavowal of an affective percept is initially the function of the empathic wall.

As the head turns and the eye blinks to shield the retina from intense light, so the growing ego is protected by a host of mechanisms from overly intense affect, whether generated from within or impinging on the child from the interpersonal environment. The mental mechanisms are not some sort of refuge for the weak. They are a group of protections built into the organism itself, protective systems inherent to the nature of man, defenses accumulated through the ages of evolution, recruited even today in the life of an organism struggling for survival.

Summary

The nature and significance of affect and of affective transmission are examined, and a new ego mechanism, called the empathic wall, is described to explain the organism's adaptation to

affective resonance. The earliest form of communication is the sharing of affect; the infant needs some way of differentiating between affect experienced as the result of (maternal) transmission and that resulting from purely inner sources. The empathic wall mechanism provides a primitive form of affect blocking and allows attribution of experienced affect either to subject or object, thus providing the substrate on which both denial and projection are formed. The psychoanalytic understanding of empathy is reviewed in terms of the empathic wall. Clinical material is provided to demonstrate the use of this concept in our understanding of patients and in therapy.

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