Pity, Suffering, and Psychotherapy

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Every day psychotherapists are called upon to assuage and give meaning to human suffering. This report examines the ways in which therapists' and patients' attitudes towards giving and receiving "pity" can advance or interfere with the realization of these goals. Clinical observations, introspective analyses, interviews, and questionnaires are used to investigate the following questions: What feelings and thoughts are encompassed by the state of pitying a person or an aspect of a person? What are the similarities and differences between pity and compassion? How do pity and empathy interact in the therapeutic situation? When is taking and showing pity therapeutically beneficial? Is pity a force that brings people together, or is it a way of distancing ourselves from those whom we regard as "other?" Based on the phenomena brought to light by investigating these questions, the author proposes that pity is an inevitable and integral component of our reactions to the ordeals suffered through by individuals facing tragic situations. As a background, an overview of the two radically different conceptions of pity that coexist in our culture is presented.

> Pity is a rare and fleeting virtue
> whose essence is freedom, to be freely
> given, it must remain unsought or
> accidental, even fought against.
> Leslie Farber (1996, 23)

Psychotherapy holds the promise of helping people come to terms with their traumas and tragedies. Great responsibilities are inherent in this promise. The primary aim of this paper is to bring into sharp focus the ways in which patients' and psychotherapists' attitudes toward "pity" influence therapists' attempts to fulfill these responsibilities.

First, I will present an overview of the varied and contradictory meanings pity has acquired over time and circumstances. Then I will consider the distinctions and connections between pity, compassion, and empathy. I believe that a clarification of the relations among them would

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advance efforts to provide our patients with optimally effective forms of "caring concern" (Geller, 1994; Pope & Vasquez, 1998). Following that, I will distinguish between the bondage imposed by non-productive forms of self pity and the occasions when self-pity is the first step taken toward helping victims of traumas and tragedies feel empathy for themselves. My basic assumption is that anxieties about experiencing and expressing pity exert a restrictive influence on the capacities required to assuage and give meaning to human suffering.

In order to study pity and its place in the therapeutic situation, I have relied on a variety of methods—interviews with therapists, a questionnaire survey of therapists (1994), and my own clinical and introspective reflections. The motivational roots of my concern with this topic are both professional and personal. My family became the target of pity, and I fell prey to self-pity, when my youngest daughter was diagnosed as profoundly deaf. I have written about these experiences in *Thank You for Jenny* (1996).

I have also drawn heavily upon the insights of theologians, (e.g., Augustine, [trans. 1958; Houlden, 1984; Noueman, 1976; Boteach, 1995), ethical philosophers, (e.g., Aristotle, trans. 1961; Boleyn-Fitzgerald, 2003; Cioran, 1963; Goldstein & Kornfeld, 1987; Worthour, 1991), poets, (e.g. Bishop 1983; Dante, trans. 1954; Yeats, 1959; Stevens, 1982,), literary critics (e.g. Scheff, 1979; Slatoff, 1985; Ulrich, 1989) and social historians (e.g. Jackson, 1994; Reiff, 1966), in preparing this paper. From ancient times to the present, written works have explored the modes of relatedness that lead to the arousal of pity, the feeling aspects of pity, the functions which pity serves, and the moral judgments it implies. The themes of these works are varied and include the intimate linkages that exist between pity and the inevitability of death, pity and forgiveness, pity and status, pity and shame, pity and love, and pity's relationship to acts of kindness.

Given this extensive history, it is surprising to find that pity has been largely ignored in the psychotherapy literature. There are only a few brief and incidental references to the cognitive, affective, and motivational properties of pity as they manifest themselves in the therapeutic situation. Moreover, on the few occasions when pity is mentioned at all, the emphasis has been decidedly negative. Representative of the opinions expressed is Horney's (1937) notion that neurotic patients use "appeals to pity" in a covertly hostile fashion to disclaim responsibility for their actions, or to demand affection from others, as illustrated by the directive "You ought to love me because I suffer and am helpless" (p. 141).

By way of contrast, I will give special attention to the occasions in

which pity may have some unique therapeutic value. I shall advocate the view that recognition and constructive use of what Farber (1996) chose to call "unsolicited pity— pity that is not sought after, or that is even resisted—can make a vital contribution in helping traumatized patients address the tragic aspects of their lives and undo the maladaptive consequences of aspiring to a radical lack of pity for the self. As a background, let us first consider the drastic and remarkable changes the notion of pity has undergone since it was first introduced to Western thought.

PITY: A HISTORICAL OVERVIEW

Pity is a word with many meanings. It has been variously regarded as a feeling, a capacity, an attitude, a state of mind, and a moral stance. Like the notion of piety, pity comes to us by way of *pietas*, the Latin term for "due respect for Gods and man" (Hainsworth, 1991). Original users of the word pity intended it to mean sorrow felt for another's suffering or misfortune, and the attendant desire to be of help. For the ancients, pity in the strict sense of the word meant to "suffer with."

My readings suggest that up until the early part of the twentieth century, serious authors used the word pity to refer to the feeling states and modes of relatedness that the ancients had in mind when they brought the word into common usage.

In the teachings of Judaism and Christianity, pity has always been presented as a precious ideal to which a good person should aspire. At the heart of Rabbinic Judaism is an all-forgiving form of pity known as *rachmones* (Boteach, 1995). Rachmones denotes a constellation of feelings and thoughts expressing compassion, mercifulness, respect and a wry sense of humor about human frailty and corruptibility.

In the Old Testament, "Job is the suffering servant of God" (Jung, 1965). In the New Testament it is Jesus. Job cries out, agonizingly, "Have pity on me, Have pity on me, Oh you my dear friends" (New Standard Version of The Bible, 1984). Pity is repeatedly referred to, in the New Testament, as the originating source of Jesus' efforts to bear the sufferings of all humanity in his body, as if all of mankind's were his own. According to the Gospels (New Standard Version of the Bible, 1984), it was this universal pity that motivated Jesus to heal the blind, to cleanse the leper, to teach the ignorant, to feed the hungry, and to raise the dead.

This is very different from ancient Greek dramas, where the objects of pity were tragic heroes, kings, and noble individuals who possessed qualities equal to or greater than that of the imagined audience. Aristotle (1987) describes these larger-than-life figures as "innocent victims" who

brought about their own downfall "by some error or frailty" and as somewhat "better" but not too much better than the implied spectators in their efforts to face moral choices. One can perhaps feel the greatest pity for those who are not essentially pitiable – or so it seemed to Aristotle. In ancient Greece, as in the Christian and Jewish religious traditions, pity was regarded as a deep source of humanitarian inclinations, and that like the classical "virtues" – courage, wisdom, justice and temperance – one couldn't have too much pity.

Michelangelo's sculptural image of the Virgin Mary supporting the body of her dead son, Jesus, in her lap, is widely regarded as the ultimate artistic representation of Christianity's positive valuation of pity (Tonay, 1956). It is known in America as The Pieta, the French call it *"la virge de pitic."* Since the Renaissance, Mary's posture and facial expression have been interpreted as signifying not only maternal grief and love, but as embodying an empathic appreciation that her son's suffering offered mankind the hope of redemption. Among poets, the intermingling of love and pity continued to be a common theme up until the middle part of the twentieth century. For example, Heine (1848/1996) wrote "To be wholly loved with the whole heart one must be suffering. Pity is the last consecration of love, or is perhaps love itself" and Yeats (1959) wrote "A pity beyond all telling is hid in the heart of love (p. 40).

Today, pity is rarely used when seeking to express pure and deep feelings of tenderness for the suffering of those whom we known *personally*. On the contrary, contemporary usage indicates that there is a strong pull in our society toward thinking of pity as being primarily expressive of a condescending, or even contemptuous, form of feeling sorry for another, especially those who have brought misfortune upon themselves. At this moment in history, pity is predominantly spoken in phrases of censure. Consider the affective meanings of the following colloquial sayings. A misanthropic conception of pity can be heard in "I pity you." It is usually uttered in a disdainful fashion, and directed toward persons who are regarded as pathetic, inferior, or reprehensible in some way. Impatience and indignation are carried by the phrase "for pity's sake. . ." The television character Mr. T. popularized usage of "I pity the fool" as a way of expressing contempt. In recovery-speak, alcoholics are told to get off "the pity pot" when seeking to use their "poor me" stories as an alibi or as an excuse for a relapse.

In brief, deep differences separate the core of ideas the pre-moderns intended when they spoke of pity, and our culture's understanding of what it means to have or to take pity on the self or another. Pity is still very much

a part of our living language, but its original positive meanings have receded into the background, and they have been superceded by essentially mean-spirited uses of pity.

It is not the purpose here to trace the changes in the meaning of pity into more modern times. The reasons for the progressive devaluation of pity, like its neglect in the literature on psychotherapy, are undoubtedly complex and over-determined. My own readings suggest that Nietzche (1885/1996) may have been among the first authors to give published voice to the view that giving and receiving pity was undesirable. For Nietzche, pity, whether arising from Christian motives or otherwise, was a vulgar and shameless intrusion into the lives of others. "Pity is obtrusive,—you, O Zarathustra, whether it be God's pity or man's—pity offends the sense of shame" (p. 123). Consequently, he objected strongly to receiving pity, "Verily, I like them not, the merciful ones, whose bliss is in their pity: too destitute are they of bashfulness. If I must be pitiful, I dislike to be called so: and if I be such, it is preferably at a distance." (p. 124) As a psychotherapist, my primary concern is with the ways in which the existence of two disparate and contradictory conceptions of pity complicates efforts to provide patients with benignly influential caring concern. Let us next turn our attention to these matters.

BEING THE RECIPIENT OF PITY

For some time now, I have encountered only one patient who consciously and unashamedly wished to be pitied. He was a 73-year-old, retired Catholic school teacher of English. In response to his worsening Parkinson's disease, he had become very depressed. On those occasions when he wished to both express and take some distance from his worries, he would quote a line from *Dante's Inferno* (1954, "Have pity on me." The line is spoken to the Three Beasts of the Wilderness who are meant to symbolize the sins of lust, violence, and fraudulence (Durling, 1996). At our last session he read to me from Milosz' (1995) poem,"Body": The final stanza is:

> Julia, Isabel, Luke, Titus!
> It's us, our kinship and mutual pity.
> This body so fragile and woundable,
> Which will remain when words abandon us. (p. 60)

A week doesn't go by when I haven't heard someone objecting to or refusing to be pitied. How often do therapists hear, either in session or in a non-clinical context, a person say "Don't pity me under any circum-

stances!" or "I hate being pitied"? Antipathy toward pity and self-pity are recurrent themes in the movies, on television, and in the autobiographies of individuals who are physically challenged in some way. For poet David Wright, who is deaf pity ". . .is a sentiment that deceives its bestower and disparages its recipient. . .Its acceptance not only humiliates, but actually blunts the tools needed to best the disability. To accept pity means taking the first step towards self pity, thence to the finding, and finally the manufacture, of excuses. The end product of self-exculpation is the failed human being, the "victim" (1969, p. 8). Helen Keller (1990), an archetypal sufferer, simply wrote "I hate pity" (p. 53).

PSYCHOTHERAPISTS' ATTITUDES TOWARD PITY

Public expressions of pity's original meanings can still be heard in two present-day contexts. These meanings survive in declarations of pity for humanity. For example, Bertrand Russell (1951) claimed that "Three passions simple but overwhelmingly strong have governed my life: The longing for love, the search for knowledge, and the unbearable pity for the suffering of mankind (p. 23)." This form of pity is impersonal, an abstraction. Pitying the millions of Jews who died in the Holocaust has far less immediacy and palpability than pitying the specific sons and daughters of the survivors of Auschwitz whom we know personally.

Echoes of sorrowful pity can also be heard when people speak about the victims of the devastating catastrophes lawyers refer to as "Acts of God"— fires, earthquakes, famines—whom they have witnessed from afar. But what about the feelings and thoughts that accompany a therapist's pitying a patient in the privacy of his/her office?

Remarkably, there have been no systematic empirical examinations of therapists' attitudes towards pity and the roles it plays in therapy. As a first step in this direction, I constructed a self-administered interview that asks therapists to describe their personal definition of pity, to list their immediate associations to the word pity, to specify the frequency with which they experience pity toward their patients, and to indicate their opinions about the meanings and functions of pity on various Likert scales. This investigation (Geller, 1994) of 40 psychotherapists (23 women, 17 men, all psychologists from a mid-size city in the northeast) revealed that therapists' attitudes toward pity are remarkably diverse. Although the small size and geographical limitations of this sample preclude any definitive conclusions, the patterning of the findings (see Table 1) nonetheless suggests that therapists differ in their attitudes towards pity in ways that mirror and reflect those found in the wider culture. These preliminary findings, then,

are consistent with the hypothesis that no single definition of pity can encompass the spectrum of contradictory ways in which therapists conceive of this concept. Replication is obviously required to establish the reliability of all the preliminary normative data presented in this report.

When asked to estimate the frequency with which they felt pity for the pain and misfortune of their patients, 10% reported never, 30% reported rarely, 43% reported sometimes, and 17% reported often. The arousal of pity is not a low-frequency event. Interviews with therapists-in-training indicate that they are reluctant to tell their supervisors when they feel pity for patients, including those who have suffered traumas and tragic events. One supervisee told me that his reticence derived from the fear that his pity would be interpreted by his supervisors as serving to defensively distance him from his patients. Another traeed the origins of his secrecy to the belief that he would be criticized for excitedly and excessively overidentifying with his patient's suffering. Whether or not these supervisees' expectations were justified, I believe that their anxieties about experiencing and expressing pity exerted a restrictive influence on their ability to empathize with their patients' suffering. I also believe that their divergent motives for not self-disclosing point to pity's confusing relationship to the central human dramas of closeness and distance, sameness and difference.

Once aroused, rarely is pity and pity alone experienced in relation to psychotherapy patients. Only 5% of the participants reported that they experience pity in the absence of other co-occurring emotions. Sixty percent of the therapists reported that for them, pity is typically experienced in combination with negative emotions, e.g., anger, anxiety, lack of respect, frustration. Aristotle (trans.1961) anticipated these findings when he wrote that viewing tragedies gives rise to variably ambivalent blends of pity, horror, and fear.

Although very much in the minority, there are therapists (17%) whose overall attitude toward pity is positive. Thirty-five percent indicated that they tend to experience pity primarily in combination with positive emotions, e.g., sympathy, loving kindness, generosity, and especially compassion. Parenthetically, it is noteworthy that Farber (1966) seems to have come to his positive view of pity as a result of receiving the pity of a patient who was unable to speak and was hospitalized with schizophrenia and whom Dr. Farber had been treating unsuccessfully for many years. After many years of remaining silent, the patient inexplicably began speaking to Dr. Farber. Several months later, the patient explained that he began speaking because he felt pity for Dr. Farber when he saw how despairing Dr. Farber was of never being able to reach him.

Standard dictionaries (e.g. American Heritage, 2000) and the thesaurus (1996) continue to define pity as closely equivalent in meaning to compassion, especially when pity is deeply felt and accompanied by strong feelings of wanting to alleviate pain and suffering. But pity and compassion are no longer used interchangeably in everyday speech, or by a majority of psychotherapists. Sixty percent of the therapists in my sample emphasized the differences, rather than the similarities, between pity and compassion. These therapists were inclined to think that compassion always favorably connotes broad or profound feelings for the misfortunes of others, an emotional sharing of their distress, and a desire to aid them. For them, compassion has come to be equated with "suffering with" another, and pity with merely "feeling sorry" for another.

These divisions are based on the following types of comparisons. First, they tend to interpret compassion, symmetrically, as evidence of fellow feeling among equals, and pity, asymmetrically, as offered to those whom

Table I. THERAPISTS' ATTITUDES TOWARD PITY

	% (n = 40)	
Attitude*	Agree	Disagree
1. Pitying a patient places him/her in a one-down position	80	20
2. A therapist who lacks the capacity for pity cannot empathize with his/her patients	43	47
3. I am inclined to think of pity as encouraging patients to surrender to the role of "victim"	48	52
4. Pity is a counter-therapeutic emotional reaction that must be "overcome"	35	65
5. All human beings need both to pity and to be pitied throughout their lives	25	75
6. I have difficulty receiving pity	75	25
7. I equate psychological health with a lack of self-pity	70	30
8. Inequality is an inherent aspect of the relationship between the giver and recipient of pity	63	37
9. Pity impedes or hinders productive understanding of a patient and the ongoing process of therapy	45	55
10. I tend to react negatively to "appeals" for pity	75	25

*Note. Respondents expressed their opinions regarding each statement using the following scale: 1 = strongly agree, 2 = agree, 3 = mildly agree, 5 = mildly disagree, 6 = disagree, 7 = strongly disagree. Reproduced from Geller (1994), presented at the Society for Psychotherapy Research 26th Annual Meeting.

we regard as "other" or as somewhat inferior in worth or quality to ourselves. In their imaginations, the voice of compassion says "I suffer too, it is part of our life," while the voice of pity says "Oh that poor person over there is suffering." As reported in Table I, 80% of the sample holds the view that pity implies a relation between someone who is "one up" and someone who is "one down." This conviction tends to be correlated with two other interpretive biases. The first is that compassion dignifies suffering whereas pity is condescending, insulting or degrading. The second is that compassion is empowering while pity symbolizes futility and impotence. According to this view, compassion holds out glimpses of hope to those who are suffering, while pity carries with it somber forebodings, such as the prediction that one is condemned to a horrible fate.

In short, the positive qualities once ascribed to both pity and compassion are now attributed solely to compassion by the majority of the therapists' surveyed. Several colleagues recommended that I should only use the word compassion when writing about the feeling states and modes of relatedness the ancients had in mind when they spoke of pity.

This terminological solution recommends itself for a variety of reasons. In non-Western cultures, compassion played (and still plays) the same roles that pity and rachmones played in the Christian and Jewish religious traditions. Cultivating compassionate feelings and knowledge is an essential aspect of Buddhism (Goldstein & Kornfield, 1987). Some sectors of the therapeutic community have already begun to use the vocabulary and practices of Buddhism (e.g., meditation) (Safran, 2002). In some places "compassion fatigue" (Figley, 2002) has replaced "burnout" as the fashionable way to refer to the long-term consequences of listening daily to the suffering caused by rape, fatal or incurable illnesses, child abuse, the death of a child, etc. I was surprised to learn that pity is also being systematically replaced by compassion in recent translations of the Bible (personal communication, Lancaster, 1999). But the problems posed by pity's linguistic ambiguities will not disappear by banishing pity from our vocabulary or by finding a more acceptable name for the capacity to "suffer with" others.

COMPASSION AND EMPATHY

The data and concepts of Attribution Theory (Heider, 1958, Kelley, 1967, Weiner, et al. 1982) indicate that people, generally speaking, are likely to distinguish between sufferers who are deserving of compassion and those who are undeserving of compassion. Compassion appears to be reserved for those who cannot be held responsible or accountable for their

suffering, and withheld from those who are seen as bringing misfortune upon themselves because of their vices, or other deficiencies of will. At best, people "feel sorry" for individuals who look as if they ought to be in control of the activities that led to their suffering. This is a way of saying that people are more likely to feel compassion for a hemophiliac who contracted AIDS during a blood transfusion than an IV drug user.

Withholding compassion from those among our patients whose suffering was perceived as being "caused" by their own actions, or was perhaps, avoidable, runs counter to the ethical principles and clinical concepts of scientifically-based psychotherapy. Indeed, some of the most difficult moments in therapy revolve around the question: "How do I hold a patient responsible for the life he/she created, yet join with him/her in agreeing that he or she was harmed—, perhaps unalterably—by crippling influences that could neither be altered by doing something nor avoided by not doing something?"

We therapists must be simultaneously attentive to the damage caused by destructive forces that were beyond our patients' power to control and to the ways in which "reality" has been exploited to justify apparent helplessness. My efforts to resolve this dilemma are strengthened by maintaining a commitment to understanding patients, empathically (Schafer, 1983).

Empathy, as I understand it, is a call to transcend blame-based systems of morality, and it offers a way of achieving this ideal. As used here, empathy refers to a mode of relatedness that enables a therapist to enter into and share a patient's needs, thoughts, and feelings on a moment-to-moment basis. An empathic grasp of a patient's situation presupposes a setting aside of one's own prejudices and the values one holds for oneself. To be with a patient empathically means aspiring to a non-judgmental, or at least merciful, moral stance regarding patients who appear to have brought misfortune upon themselves. The empathic therapist does not demand "reasonable grounds" for supposing that a patient's suffering is deserving of caring concern. Doing so would constitute a failure to honor the ethical responsibilities of "caring" (Pope and Vasquez, 1998). The point here is that being deeply empathic widens the circle of compassion to include acceptance of, and a readiness to, "suffer with" patients whose actions do not conform to one's sense of how they *should* behave.

For the ethical and empathic therapist, compassionate concern potentially arises from two reliable sources. The first involves imagining oneself in a patient's place or summoning up personal memories that are of a sort similar to the experiences he/she is describing. A therapist need not,

however, identify with a patient in the sense of the feeling that "he/she is like me" in order to gain access to the empathic mode of knowing. Compassionate concern can also be inspired by contrasting one's good fortune with the "undeserved misfortunes" that befall individuals with exceptional qualities. Both of these sources of caring were activated when I listened to the ordeals and suffering endured by a patient who was facing an imminent death.

My patient was a 43-year-old musician who was dying of a rare heart disease. He was a proud, dignified human being—someone who was deeply imbued with a tragic view of life, long before his illness. During the course of therapy he rarely complained or expressed feeling unjustly singled out by a cruel fate. I imagined that he identified with the restraint and manliness of Humphrey Bogart on the tarmac at the end of the film Casablanca. He asked "Why me?" ruefully, not ragefully.

Placing myself "in his shoes" awakened in me pity that he did not seek, and put me in touch with my most vulnerable selves. Sitting face-to-face with him bent my thoughts to a terrifying awareness of my own mortality. [If one accepts Freud's (1930) view that every person is convinced, unconsciously, of his/her own "immortality," we all die prematurely].

On the one hand, learning that he was dying, stirred in me strong feelings of wanting to alleviate his pain and suffering. On the other hand, his deteriorating condition served as a constant reminder of the impossibility of being able to affect the outcome of his fatal illness. Contrasting my blessings with his "underserved misfortunes" also provoked the feeling, "There for the grace of God go I," which in turn led to reflections on basic spiritual and philosophical questions."Why not me?" "Why have I been lucky, so far?""How much control do I *actually* have over my destiny?"

What I am trying to convey are the unwanted burdens, unanswerable questions, and deep ambivalences that can accompany empathizing with suffering of tragic proportions. I can feel both attracted to and repelled by the suffering of someone I genuinely care about. With this dual potentiality in mind, Nietzsche (1851/1996) wrote of his relationship to beggars "Verily, it annoyeth one to give to them, and it annoyeth one not to give to them" (p. 94).

Aristotle (1961) would have predicted that my bearing witness to my patient's suffering would give rise to blends of pity, fear, and horror. My experience is also congruent with the finding that therapists typically experience pity within the context of a network of co-occurring positive and negative emotions. Pity's essence depends on whether the balance is tipped in the later or former direction.

Sometimes pity aimed me toward sympathizing with and feeling compassion for my patient. There were other moments when pity potentially awakened problematic or conflictual emotional reactions such as shame and despair. Psychologically, it is quite possible for one reaction to precipitate a compensatory reaction in the other direction. In other words, compassion can sour into pity, or pity can be transformed into compassion. Broadly speaking, a therapist can struggle against or suppress the inner experiences brought to awareness by pity or acknowledge and work non-defensively with them. The direction taken will have a decided effect in determining whether subsequent interventions will benefit a patient, prove ineffective, or in the worst cases, augment harm. As long as a therapist is open and alert to the meanings of pitying a particular patient, pity can be used as a valuable source of information, like any other emotional reaction. What is of utmost importance is adopting an investigative attitude toward one's experience of pity whether or not one regards pity as an untoward countertransference reaction that needs to be "overcome."

A CLINICAL EXAMPLE

The following vignette (Moses, 1988) illustrates the lost opportunities that arise in therapeutic dyads in which both therapist and patient unquestionably agree that giving and receiving pity is inherently undesirable and to be avoided.

During the first year of a psychoanalytic psychotherapy, a female patient, communicating in a detached style, tells her male therapist:

> My mother went to give me some medicine, but the bottle was not my medicine, it was some enamel paint for the kitchen appliances. I tried to tell her it was paint, but she refused to listen to me and made me take a teaspoon. I was afraid to tell my father about it because he might get angry at her and then I'd get in trouble again, but I didn't feel much else. I know when I'm telling it to you now I don't feel much either except my heart is beating very quickly. (p. 578)

The therapist tells us that in response to hearing this he "conveyed to her how terrifying, helpless, and hopeless it *must* have been for her" (p. 579). Contrary to his expectations, the patient did not feel empathetically understood. Instead she "scolded him" as she felt he was "pitying her." His reflections upon this incident included the following question: "Should I have inquired as to her motive for demeaning my observation and diminishing my response to one of pity?" (p. 579).

By contrast, I would have assumed that I was not listening, empatheti-

cally if I had not been "brought to" pity and outrage by the magnitude of her calamitous experience,. From the empathic vantage point, pity is natural, appropriate; perhaps inevitable component of our emotional reactions to hearing patients describe severely traumatizing experiences. What I am suggesting is that pity is not aroused by some calculation concerned with its utilitarian consequences, as is the commitment to being with a patient empathically. Therapists strive conscientiously to be empathic because of a belief in its beneficial effects. Not so with pity. For me, pity arises spontaneously or is to some extent not directly subject to volition, once I have made the decision to listen, empathically. I further believe, that in some instances, (e.g., hearing of the death of a beloved infant), not to feel pity signals a loss of humanity, as is implied by pity's antonym. Pitilessness continues to be linked with indifference, cruelty, disrespect and ruthlessness. In other words, those who are pitiless are incapable of empathy.

This perspective on pity opens up a wide range of exploratory possibilities. What did the therapist do or say that led the patient described above to believe that her therapist was feeling pity and not compassion, or sympathy, or empathy? What meanings did she, consciously and unconsciously, ascribe to being pitied? There are many reasons why she might assume that receiving pity is undesirable, e.g., because for her pity implies being damaged beyond repair; or because it implies unfavorable judgments about one's strength of character? Did she believe that the acceptance of pity meant taking the first steps toward self-pity? In our culture, expressions of pity have somehow become associated with the idea of reinforcing "learned helplessness" (Seligman, 1975). The following stanza of a poem by Wallace Stevens (1982) expresses the belief that accepting even Jesus' pity can undermine one's sense of personal agency.

> If only he (Jesus) would not pity us so much,
> Weaken our fate, relieve use of woe both great
> And small, a constant fellow of destiny,
> A too, too human god, self-pity's kin
> And uncourageous genesis. . .(p. 315)

Yet another possibility is that she was antagonized by the sense of certainty carried by his use of *must*. For supportive utterances to be experienced as supportive, they must be accommodated to a patient's communicative requirements (Geller, 2003). Perhaps the patient would have been more receptive if Dr. Moses had spoken in a style that was more tentative. In a similar vein, I have found that the use of impersonal diction

increases the probability that a prideful individual will take in and benefit from expressions of caring concern. For example, I will say "It's a pity;" or "It's a shame;" or "It's too bad;" to convey my appreciation of the magnitude of their suffering.

I also wondered whether the patient took issue with her therapist's caring concern because she was unable to recognize whatever genuine differences separate expressions of pity and compassion. My clinical experience suggests that an important, often undetected, source of a patient's prevailing capacity to accept offerings of genuine caring concern are related to individual differences in this regard. Among the most difficult patients to treat are those who interpret all expressions of caring concern as "evidence" that their therapists finds them pitiful, and who hold the view that pity is an unsympathetic form of emotion that is felt towards a person who is to "blame" for his or her misery.

Systematic studies have yet to examine the extent to which pity and compassion can be differentiated by observers on the basis of contextual nuances and expressive cues or "meta-messages." I am moving toward the conclusion that such studies would reveal that all expressions of caring concern, irrespective of how they are intended, are ambiguous with respect to the presence of pity. In my experience, subtle stylistic differences separate the facial expressions and vocal qualities that accompany and reflect the emotional states of pity and compassion.

In my opinion, systematic studies will also be required in order to determine the extent to which pity and compassion are introspectively distinguishable. My introspective observations suggest that they interact and interpenetrate in complex ways, and that the experiential boundaries which separate pity and compassion are neither clear nor fixed.

As for the therapist, did his prejudices against pity render him prone to avoidant forms of countertransference? Did he have the inner freedom to feel sorry for his patient? If he didn't, the therapeutic dyad was deprived of a potentially valuable source of information, and an important avenue of exploration. Did he feel that bringing "science" to bear on her suffering required him to take distance from a concept with religious overtones?

According to Reiff (1966), Freud refused even to ask the religious question, "How are we to be consoled for the misery of living?"and consequently as he put it, "There is no theology at the end of Freudian therapy" (Reiff, 1966 p. 372).

In a similar vein, pity may have fit uneasily into Dr. Moses' lexicon because he associates it with earlier stages of cultural development. The introduction of pity as an ideal into Western civilization clearly advanced

communal efforts to deal with life's "inequities." The role relations that pity implies were laid down within the context of tightly and hierarchically organized economic and political institutions. As such, appropriating pity may feel like a betrayal of the democratic and egalitarian values that Interpersonalists like Dr. Moses uphold. My hunch is that the failure to give scholarly attention to pity in the literature on psychotherapy derives from these same interrelated sources.

THE THERAPEUTIC USES OF SELF-PITY

The object of pity can be the self or another. In our culture to be called self-pitying is one of the worst criticisms one can receive. It's often assumed that it means one is wallowing in suffering, neurotic, and unwilling to take initiative in bringing about improvements in one's life (Stöber, 2003). Therapists are not immune to this interpretive bias. Groves (1978) included the "whining self-pitier" in his system for classifying hateful patients. In the psychoanalytic literature, self-pity has been variously described as a "narcissistic orgy tinged with masochism" (Milrod, 1973), as a manifestation of "depletion depression" (Wilson, 1985), as a subtle but potent expression of "self-righteous rage" (Horowitz, 1981) and as a means of adopting a martyr's persona for the purpose of "exhibitionistic display" (Kahn, 1965).

Along with most of my colleagues I believe that psychological health, like genuine spirituality, is marked by an absence of self-pity as a *dominant* part of one's characterological adaptation, and by a deep gratitude for one's blessings (Goldstein & Kornfeld, 1987). I also believe that when self-pity becomes a *modus operandi*, or a characterological mechanism, it can serve as a resistance to self-exploration in certain stalemated therapies. However, I do believe that a one-sided negative view of self-pity can obscure the maladaptive consequence of aspiring to a radical lack of self-pity.

Despite the current emphasis on "victimization" in the popular media, most of the patients I have treated hold themselves "accountable" for their suffering. It is not even uncommon for incest survivors and rape victims to somehow "blame" themselves for having been traumatized. This conviction is often coupled, consciously and unconsciously, with the "pathogenic belief" (Sampson & Weiss, 1986) that they are undeserving of caring concern.

My work with patients such as these has led me to the hypothesis that helping them to develop the inner freedom to feel self-pity may be a fundamental first step toward developing self-care, self-concern and em-

pathy for themselves. One of my patients, the daughter of survivors of the Holocaust, is prone to severe agitated depressions and has a markedly diminished capacity for pleasure. Nevertheless, she ridicules and trivializes her own suffering and idealizes the ordeals her parents suffered through in concentration camps. She experiences all expressions of personal pain as histrionic or melodramatic. The trivialization of her distress is further reinforced by an overdeveloped sense of irony. Even when it is tempting or would be relieving to do so, she will not cry. She stifles any hint that she is surrendering to feeling sorry for herself, and responds with intense shame and guilt whenever there is a suggestion that she is doing so. At the same time, she maintains her suffering because of unconscious identifications with her parents' "survival guilt," and as a strategy to avoid future calamities. She especially resists interventions that are intended to diminish her avoidance of gratification. As we are coming to understand, the dominant aim of her "moral masochism" (Berliner, 1947) is not the idealization of the role of suffering martyr but rather a persistent search for the love of her parents. Both of her parents, she now realizes, demanded suffering and the renunciation of pleasure as the price for their love.

Another patient maintained his Spartan stoicism even during the acute stages of grieving the death of a beloved friend. He experienced being depressed as immoral and self-indulgent. He grew up in a home in which there were strong prohibitions against crying, whining, whimpering, and other expressions of distress. His parents, also survivors of the Holocaust, regarded all expressions of distress as "childish." Like the previous patient, he considered it disrespectful and unfaithful if he questioned his parents' values or their internalized representations, to which he responded with loving submission. His father taught him that the sharing and comparing of vulnerabilities, even with friends, weakens one's efforts at survival. Like Maya Angelou (1994), he came to believe that "Whining is not only graceless, but can be dangerous. It can alert a brute that a victim is in the neighborhood" (p. 87). He was haunted by the image of pleading with a Nazi soldier to "Have pity on me."

The idea of receiving the pity of others was also repugnant to my patient. A very prideful man, he analogized pity to a "cheap gift" that is given to "losers," and to the "consolation prizes" given to "failures." Although Jewish, his assumptions about what constitutes being "pitiful" or "pitiable" were primarily derived from the imagery found in the Gospels. It will be recalled that Christ's pity was directed toward the blind, lepers, the destitute, the terminally ill and the dead. My patient also confused the wish to rely on me for support and understanding with being a "beggar."

As a result of having internalized their parents' views, neither patient is able to avail themselves of the cathartic relief of "complaining." For decades they suffered alone and in silence. Moreover, by aspiring to a radical lack of self-pity, they have stifled the development of the capacity to have empathy for themselves.

To counteract their taboos against "complaining," I devote much attention to identifying the occasions when they disguise or deny their "disappointments" in my lapses of understanding and empathic failures. Alternatively stated, I give complex consideration to the defensive styles they adopt in order to protect themselves against the perceived and imagined dangers of speaking truthfully about the ungratifying aspects of therapy.As I have discussed at length elsewhere (Geller, 1986), helping patients to become more eloquent critics of the process of therapy can serve a variety of therapeutic ends. This means that I express consistent caring concern not only for the misery suffered outside of therapy, but also for the frustrations, difficulties, and sacrifices imposed within the therapeutic situation. Throughout this process I am attentive to a piece of advice found in the Bible: - "Take pity on them, who cannot take pity upon themselves." (New Standard Revised Version of the Bible, Luke, X, 1989). My hope is that our explorations will lead to the insights the shipwrecked Robinson Crusoe achieved as depicted in Elizabeth Bishop's (1983) poem "Geography":

> Do I deserve this? I suppose I must. I wouldn't be here otherwise. Was there a moment when I actually chose this? I don't remember, but there could have been: What's wrong with self-pity anyway? With my legs dangling familiarly over a crater's edge, I told myself "Pity should begin at home." So the more pity I felt, the more I felt at home (p. 162).

CONCLUSION

My inquiries suggest that therapists' attitudes toward pity reflect and mirror the range of views found in the culture. Those who report feeling a blend of tender and loving feelings when experiencing pity are in the minority, and those who report experiencing pity primarily in combination with negative emotions are in the majority. Like the psychoanalyst Greenson (1967), members of the latter group are more likely to regard the arousal of pity as a conflict-laden countertransference reaction. Either set of attitudes can impede or facilitate productive understanding of a patient and the ongoing process of therapy. Giving and receiving pity are dense with meanings.

To encourage inquiry, I will leave with some questions that might help to think about resistances to acknowledging and appropriating pity into therapeutic work.

- What obstacles do you encounter in your efforts to "stay with" and use as interpretive resources personal reactions to giving and receiving pity?
- What forms of suffering do you turn away from in aversion?
- Who are your "exemplary sufferers?"
- How do notions of accountability, responsibility, free will and determinism enter into your decisions about whom to pity?
- What is your reaction to patients who present themselves, initially, as passive and helpless victims of circumstances?
- In order to empathize with a patient who uses illegal substances to get "high" do you have to lower your superego standards?
- How do you know if you are experiencing compassion or sympathy rather than pity?

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