

Compassion, Hope, and Forgiveness in the Therapeutic Dialogue

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Abstract

Compassion, hope, and forgiveness in the therapeutic dialogue are essential aspects of a relationally focused integrative psychotherapy and are instrumental in healing the psychological wounds from neglect, stress, shame, and abuse. Each concept is defined, examples are given, and therapy illustrations provided that link the three concepts.

Keywords: Compassion, empathy, forgiveness, hope, integrative psychotherapy, presence, psychotherapy, relational psychotherapy, therapeutic dialogue

Compassion. The word conjures up images of Jesus healing the sick and Buddha's suffering because others in the world were suffering from hunger or oppression. The word "compassion" comes from Latin: "com," which means "with," and "passion," which means "to suffer." Compassion thus means to suffer with the other, to suffer together.

Compassion involves both a physiological and an emotionally sensed experience

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of the suffering that others endure. It is a total sense of the other, a moving out of our own experience by being fully aware of the pain of others. Compassion is selfless. It is about the welfare of others. It may involve putting the welfare of another person above our own—as when a hero jumps into cold water to rescue a stranger.

In psychotherapy, compassion begins with ethics. We are compassionate when we practice our profession with a constant awareness of ethics. In my view, the most significant ethic of all is the commitment to our clients' welfare. That is what guides us in all we do and say. All other ethics emerge from this central one, which involves our commitment to make our clients' welfare most important in all of our actions.

Compassion is a central element in psychotherapy and what may have motivated some of you to become psychotherapists. It is that felt sense of experiencing other people's suffering and a simultaneous desire to relieve their pain, anguish, or loss. Compassion is what motivates us to put our arm around individuals who are grieving. We want to comfort them, to alleviate their grief. Compassion motivates us to attune to clients' affect, rhythm, and relational needs, to fully connect with them.

In my practice of psychotherapy, compassion emerges from the conviction that each person is of value in his or her unique way. Carl Rogers (1951) called this valuing of the other "unconditional positive regard" (p. 144). Martin Buber (1923/1958) described how this aspect of compassion is based on what he called an "I-Thou relationship." He used the Biblical word "Thou" to reflect the spiritual nature of a fully contactful relationship, one that is without preconceived notions of the other, that is built on continually discovering the other's uniqueness, and that attends to the other's affect and relational needs (Erskine, Moursund & Trautmann, 1999).

When we foster such a relationship, we are naturally empathic because empathy is based on compassion. Although the words "compassion" and "empathy" are often used interchangeably in the English language, empathy usually refers to the emotional connection with a specific person, whereas compassion is often associated with a response to the suffering of all human beings. Empathy refers to our ability to feel the emotions of another person, to experience those feelings as though they were our own. This is echoed in a saying attributed to Native Americans: "You cannot really know another unless you have walked a mile in his moccasins."

Empathy is about being deeply connected to another person's affect and experiencing what it is like to be in his or her skin. Carl Rogers (1951, 1975/1980), in defining the theory and practice of client-centered therapy, elaborated on this idea when he defined empathy as our capacity to feel the other person's affect,

such as sadness, fear, anger, or joy.

Psychoanalyst Heinz Kohut (1977), in writing about self psychology, referred to empathy as a form of listening to the other person's phenomenological experience without any preconceived notion or judgment. For him, empathy was about wanting to understand others' subjective experience without imposing his ideas on them. In psychotherapy, this kind of empathy occurs automatically if we have the attitude that "I know nothing about the other person's experience, and so I must continually strive to understand the subjective meanings of his or her emotions and behaviors." As psychotherapists, it is essential that we have both forms of empathy as described by Rogers and Kohut: to feel others' affect and to strive to understand how they experience themselves.

Although empathy usually refers to the ability to feel the emotions of another as well as to understand his or her reasoning, compassion generally refers to the desire to help. This is the type of compassionate psychotherapy I described in *Beyond Empathy: A Therapy of Contact-in-Relationship* (Erskine et al., 1999) and in *Integrative Psychotherapy: The Art and Science of Relationship* (Moursund & Erskine, 2004).

We go beyond empathy when we attune ourselves to our clients. Attunement is our yin to the client's yang. Affect attunement provides the necessary reciprocity that the other needs to feel emotionally whole. The important concept of reciprocity refers to the way others need something from us in response to their affect. Here are four examples of reciprocity:

- When our client is sad, we provide expressions of sensitivity, warmth, tenderness, and acceptance.
- When our client is angry, we respond by taking what he or she says seriously.
- When our client is afraid, we feel protective and may act protectively.
- When our client is joyful, we meet him or her with our vitality and celebration.

Recently, I was typing up a transcript of the video of a therapy session and trying to describe the compassion, empathy, and attunement that the client required in order to heal from the emotional wounds of neglect and abuse. I realized that the words I was using only slightly conveyed my compassion and empathy because the most important component of compassion was in my nonverbal behavior: my sustained eye contact, the muscles of my face, my hand gestures, and the tone of my voice. All of these conveyed my full presence.

Therapeutic presence requires that we be fully with our clients' experience as well as being there for them, decentered from ourselves. To be fully present, we make our own concerns not important. Yet simultaneously we draw on all of our personal and professional experiences as a resource to further our attunement and

connection with our clients. It is our presence and attunement that allows for an authentic person-to-person connection. Our clients' capacity to heal from the wounds of neglect, ridicule, or abuse directly depends on the quality of interpersonal contact and attunement that we provide.

Confronted by Compassion

One spring day, after returning from lunch, I discovered a woman sitting on the stairs to my office. She was dressed in a rumpled skirt and blouse and appeared to be in her mid-fifties. Her stringy gray hair hung over her flushed face, and her eyes were swollen from crying. I asked her if she needed anything, and she responded that she was waiting for the psychologist whose name was on the sign. I said I was that person and asked why she was waiting. She said that she was confused and needed to talk to someone who could help her.

It was apparent that she was distressed, confused, and did not know how to phone for an appointment. I did not want to leave her crying on the stairs, but I also did not want to talk to her. The brief encounter was unsettling. I had intended to use the half hour before my next client to take a nap. Yet the way the woman conveyed her anguish and confusion touched my heart, and I could not ignore her request to talk. I decided to give her a few minutes before my next client and perhaps refer her to a colleague. I asked her to step into the waiting area of the office and tell me why she wanted to see a psychologist.

Agatha rapidly told me fragments of an entangled story about her husband dying of pancreatic cancer, her wanting a divorce, her care of him during his painful illness, his physical abuse of her throughout their marriage, and her children's anger at her for staying in the marriage. She punctuated each part of the story with "I'm so confused." Although I was empathic, I too was confused by the profusion of information as she went from one part of her story to another and back again. It was too much information too fast. It was difficult to stay attuned to her changing affect and discombobulated story.

She continued to talk for the full 30 minutes until my next client arrived. Unexpectedly, I was drawn to her emotion-filled story in some way I did not understand. As a result, I offered to see her the next day but added that we could only have six sessions because I would be leaving in seven weeks for Europe. I knew it was not the time to begin a psychotherapy relationship with anyone, yet I spontaneously offered her the six sessions.

Later that day I wondered how I had become ensnared in such a countertransference trap. That evening I arranged to see a trusted colleague to talk about my encounter and how, against my better judgment, I had arranged for

the six sessions. As I told the story, my eyes fill with tears. I talked about how I wanted to comfort the woman, even though we did not yet have a relationship. It seemed necessary to explore my countertransference.

In our conversation, my colleague used the word “compassion” a few times to explain my intense reactions to the woman on the stairs. We talked about the meanings and significance of compassion as well as our professional commitment to the welfare of our clients. My colleague’s discussion of the concept of compassion opened a new awareness for me. That night I had an enlightening dream about protecting a woman from being physically attacked by a man. I was filled with a desire to protect and help. It was as though compassion had a deep hold on me. I had felt a similar sense of deep interpersonal connection several times in both my personal and professional life, but I had never thought of it as compassion—a deep desire to provide the other person with relief of his or her suffering.

The next day Agatha and I began our limited series of therapy sessions. I soon realized that I was again experiencing compassion via my intense affect attunement when she told me more details of her story. This was the beginning of a significant therapeutic relationship that eventually transformed her life.

Hope

The word “hope” reminds me of a children’s book entitled *The Little Engine That Could* (Piper, 1930). “I think I can, I think I can, I think I can” was the motto of the little engine. Some of you may know this story, as I do, from reading it over and over to your young children. In the story, the Little Engine was eventually able to climb the hill and finally exclaim: “I knew I could, I knew I could.” This story is a delightful way to teach children about the importance of hope.

Merriam-Webster (n.d.) has two definitions of hope: first, “a desire with anticipation” and second, “desire accompanied by expectation of or belief in fulfillment.” I like the second definition because it is central to the process of psychotherapy. Our clients come to us because they expect to change and grow and they are looking for some form of fulfillment. This is why transactional analysts often begin therapy with a clear contract defining clients’ expectations and how they will know when those goals have been fulfilled.

Hope is optimistic, a state of mind based on anticipation that something good will result and that events and circumstances in life will turn out well. One of my mother’s important teachings was about hope. When things were bleak and I was discouraged, she frequently said, “Life always turns out, not necessary the way you expect, but it always turns out.” More than 70 years later, I realize how

instrumental my mother's message of hope has been in my life. Her message has served to keep me enthusiastic and enjoying the adventure of life.

Several writers on psychotherapy have commented on the sense of hope. Alfred Adler saw hope as central in our mental health when he described the importance of goal seeking (Ansbacher & Ansbacher, 1956). He encouraged clients to make plans and find various way of making those plans come true. Lawrence LeShan (1994) described his research with people who were diagnosed with terminal cancer. He encouraged them to dream big, to make big plans for what they always wanted to do, and then to implement those plans. The patients who activated their dreams, who dared to follow their desires, lived from 2 to 5 years beyond their expected time of death (L. LeShan, personal communication, 20 May 1993).

Donald Winnicott (1964) saw hope in a child's disruptive behavior, which he viewed as an unconscious desire to make an impact on the adults in the child's life. If we expand on Winnicott's idea, perhaps our clients' "resistance" reflects their desire to make an impact on us. What would happen in your therapy practice if you viewed your clients' reluctance as an unconscious desire to influence you, to encourage you to see the world from their perspective?

Psychologist Charles Snyder (1994) described the connection between hope and mental will power. In my personal experience, hope emerges most strongly when there is a crisis because it is hope that opens me to new, creative options. My client may be despairing about the circumstances in his or her life, and in that moment of crisis I am often propelled to find some important way of connecting with that person. The crisis in our therapy relationship propels me forward with a new hope, with courage to experiment with different ways of our being together.

Hope offers us a challenge. It is much more than wishful thinking or passively longing for something to happen to us. True hope is realistic and must include real possibilities, with a clear plan about how to reach what is hoped for. An important aspect of psychotherapy includes helping clients to identify their aspirations and then to find the step-by-step ways to achieve their hoped for goals. However, psychotherapy may also involve helping the client to be realistic about what may never happen, for example, to let go of the illusion that someone else will change.

If the loss of hope results in depression, then hope must be an essential element in psychotherapy. Not only is it instrumental in recovery from the psychological effects of neglect, abuse, and humiliation, hope is central in all psychotherapy. It helps people recover from physical illness and may even prevent illness from developing in the first place because our beliefs and expectations can stimulate the body's hormones to enhance recovery.

Alexander Pope (n.d.) wrote about how people are blessed because "hope springs eternal in the human breast." I think he meant that hope gives us a sense of liveliness filled with a desire to achieve something. It is hope that gives sparkle

to our lives. This zest for life has been emphasized by sages for millennia. As St. Paul said, "For we are saved by hope" (Romans 8:24 King James Version). All of the world's religions emphasize hope as a necessary aspect of overcoming life's drudgeries.

Agatha's Hidden Hope

Over the first few weeks we met, Agatha told me many of the details of how she had been "trapped in a disastrous marriage" with a husband who both physically and sexually abused her. She had finally gone through the arrangements for a divorce when her husband was diagnosed with pancreatic cancer. Agatha gave up on the divorce and instead nursed him devotedly for the next 11 months while he continued to criticize and verbally abuse her. After he died, she had a "strange mixture of missing him" and being "free of the bastard." She was confused by her "mixed-up feelings." She described how over the years she had often wanted to murder her husband but was scared to because it would have had "a disastrous effect" on her two children.

I discovered that I was the first person she had ever told about the abuse she had lived with for 33 years. She felt guilty about wanting to kill her husband and about the murderous fantasies she had from the time she was first pregnant. Her self-criticism and guilt were intense.

Providing her with some relief from the intense internal criticism seemed important before we went further in our psychotherapy. I used the word "hope" to describe her fantasies of killing her husband: "hope to have some relief from the pain your husband repeatedly inflicted on you." At first she did not understand and continued to feel guilty. In the following session she was again confused about why she had "wanted to kill him all these years and yet I carefully nursed him to the end."

Again I described both her fantasies and actual caring behavior as hopeful, as "a way to have relief at a time when you did not have the internal resources to terminate a disastrous marriage." She told me how she would "lie in bed imagining him dead ... with a knife in his balls" and would fantasize getting a divorce "if I only had the money to do so and a place to go." I explained how hope is often the unconscious motivation in people's fantasies and how it provides us with some relief from discomfort. Agatha began to think of her fantasies as a significant desire to be free of her abusive marriage and no longer as though something was evil in her.

Our conversations about the significance of hope helped her to realize that throughout her married life she had longed to return to university to finish what had

been interrupted when she became pregnant. In our next session, she told me how she had begun to imagine finishing her university degree.

As our sessions came to an end, she was not confused. She had spent several sessions telling me the details of her painful story, things she had never revealed to anyone. She was still embittered about her abusive marriage, still resentful about her children's anger at her for staying in the marriage, but she was no longer self-criticizing or feeling guilty. Agatha was hopeful about returning to school. We decided together that we would continue our psychotherapy sessions when I returned in September.

Forgiveness

Forgiveness is letting go of resentment and finding an end to our angry reactions and bitterness toward someone who has offended or injured us. It is about freeing ourselves from the physical and mental pressure that occurs when we continue resenting someone. Forgiveness frees us to move out of the past and into the present and future with a new and different perspective.

Resentment results from holding on to old angers; it involves living in the past. It is often accompanied by fantasies of getting even or withdrawing. Resentment involves the fantasy that we hold some power over the other person, but in actuality it distracts from the disappointment and pain that occurs when there is a disruption in relationship.

When we hold on to anger at someone, the body is stimulated to produce cortisol and adrenaline, two primary stress hormones that have a major effect on our behavior (Cozolino, 2006; Damasio, 1999). Our body may then become addicted to living with an overproduction of stress hormones. This addiction is one reason some of our clients hold on to old resentments for many years, perhaps even after the resented person is dead. The prolonged release of stress hormones within the body often interferes with both physical and mental health. That is why forgiveness is so important in psychotherapy: It brings peace to both body and soul.

With my clients, I find that the first step in forgiveness involves consciously deciding to let go of the resentment. The second step occurs when they examine their own behavior and attitude toward the resented person. I guide my clients into challenging themselves with the question, "How did I possibly contribute to the conflict?" Answering this question involves soul searching, facing truths about ourselves, and examining our attitudes, fantasies, and behaviors toward the person we resent. This soul searching is a central part of the Alcoholics Anonymous 12-step program. The AA literature describes this step as "taking a searching and fearless moral inventory of ourselves."

Some people think that forgiveness is about forgetting, that is, no longer remembering what occurred. But that is not the case. Forgiving involves both being fully aware of what occurred and taking some responsibility for it. By responsibility, I do not mean self-blame but, rather, being soberly aware of my part in the conflict. Forgiveness does not mean that we excuse the other person for what he or she did. That person is responsible for their behavior. But central in forgiveness is taking responsibility for what one believes and feels. Forgiveness is based on our attitude toward the other person and one's self.

The third step in resolving resentment includes not only telling the truth to oneself, as in step two, but also telling the truth to an interested other. Truth telling to an emotionally attuned other is essential in achieving forgiveness. When confessing, we not only hear our own words and explanations but also observe the facial expressions and hear the other's tone of voice and words. Such intersubjective communication often helps to calm resentment and restore internal peace.

To help clients maintain an attitude of forgiveness and not lapse back into resentment, I try to convey the idea that at any moment we each do what we think is best given our limited perception of options. Later we may realize that our choice of behavior was a poor one, but, at the moment, what we said and did often seems like the only choice.

Forgiveness does not mean that we have to reconcile with the other and make everything OK. It means letting go of the false idea that we have some control by remaining resentful. We can engage in the process of forgiveness even if we never talk to the other person again. Forgiveness may take a long time. It is a process of self-awareness and learning that "this resentment and anger that I feel hurts me as much, or even more, than it hurts the other."

In a 1973 article entitled "Six Stages of Treatment," I described the last stage of therapy as forgiveness of others. After publication, I became concerned that some therapists might push clients into forgiving prematurely and their clients might merely adapt or that some people might push themselves to forgive before they were internally ready. For example, some clients are quick to say, "My parents did the best job they were capable of doing." Sometime this might be true, but sometimes it is not. The parents may have been drunk, intentionally critical, inflicted physical pain, or were sexually abusive. In such situations, forgiveness based on excusing the other is not transformative and growth producing. It is merely avoiding realizing and accepting the impact that the other had on the individual.

Resentment Is Killing Me

When we resumed our therapy sessions, Agatha agreed she would come weekly until the end of May. She was excited about having enrolled in university in a special course designed to reorient older students who were returning to study. As our work evolved, she said she experienced my being supportive and how it gave her courage to rage at her husband's many acts of abuse.

At first it seemed important that I witness her intense rage and resentment. But as the months went on, Agatha's resentment not only did not dissipate but seemed to intensify. Her anger was not an interpersonally contactful form of anger. She was just enraged and unaware of what she might have needed in a healthy marriage. Whenever I could, I talked about the caring qualities that she had needed, and that were absent, in her marriage. Periodically she ignored my opinions of what she needed and would again express her intense resentments. It was as though the rage and resentment were providing some form of self-stabilization.

Eventually, she began to cry about what had never occurred in her marriage and how her husband was not only abusive to her but neglectful of and abusive toward their two children. I talked to her about the tension I could see in her face and neck when she was resentful. She angrily said, "You want me to forgive the bastard, but I will never forgive him." I explained that forgiveness was not about forgetting the abuse but about letting go of her husband's influence over her and that as long as she remained resentful she was under his domination. She cried and said that she had always felt so controlled by him. As she wept, her whole body relaxed.

The next session began by Agatha saying, "My resentment is killing me. If I am going to survive I need to forget all the awful things he did. I need to make a new life for me." We talked about the difference between forgetting versus not letting what occurred influence us any longer. Over the next few sessions, we talked both about making a conscious decision to stop the resentments and various ways of "letting go." We talked at length about Agatha's hurt and anger at her husband as well as her responsibility in provoking some of the physical fights that they had had. She concluded that she should have ended the relationship the first time he raped her, that she protected him and never told his family about the physical abuse or reported him to the police. She wept as she described how she spent "half a lifetime waiting for him to change." She added, "Now I am going to change. I am going to stop my hatred of him because this resentment is killing me. I will make a new life."

In the late winter, Agatha met a man who attended the same university course. They quickly developed a respectful and caring relationship. She was excited about her "new life." She then told me that she had a confession to make. She

described how for a few years she had walked past my office twice a day and would look at the “psychologist” sign on the door and “hope.” She had tears in her eyes as she talked about crossing the street to look into my window so she could see what I looked like, hoping that I would be sympathetic, kind, and able to understand her and help her create a new life. She described the importance of expressing her anger and how I had never criticized her for her rage. She added that the most important thing was to let the anger go because the “resentment is killing me.” Agatha had a sense of renewed hope that she said she had not felt since she was an adolescent.

Conclusion: Compassion, Hope, and Forgiveness

Compassion, hope, and forgiveness are central in a relationally focused, integrative psychotherapy. These three areas are frequently in my mind when I carefully listen to my client’s narrative. I am continually monitoring my expressions of empathy and desire to be compassionate so that I am affectively attuned to the client’s internal experiences. I want to emotionally connect with my client but I am also cautious that my expressions of compassion not overwhelm the person by invoking more emotional stimuli than he or she can internally process. Affect attunement is always a challenge because it requires a moment-by-moment balance of my affect in resonance with my client’s affect.

I want to infuse my clients with a sense of hope, which is the antidote to despair because it provides direction and enthusiasm. Yet I want to make sure that I am not offering hope as a panacea but that the hope we share together is realistic and vitalizing. Hope, and the accompanying sense of well-being, is based on realizing that a fully lived life is a process of learning and growing.

Forgiveness is an important ingredient in a relationally based psychotherapy. I want to make sure that with my clients, any expressions of forgiveness come from a desire and readiness to let the emotionally consuming past be over. I do not want to suggest that they forgive before they are internally ready. The desire to forgive must come from their sense of hope to be relieved of the burden of resentment. Forgiveness is transformative when the impetus for change is the result of clients’ realization that their resentment harms them more than anyone else.

Compassion, hope, and forgiveness: These three important elements of a psychotherapy relationship are instrumental in the healing of the psychological wounds from neglect, stress, shame, and abuse.

Acknowledgments

Portions of this article were presented by Richard G. Erskine as the keynote address entitled “Compassion, Hope, and Forgiveness in the Therapeutic Dialogue” at the Manchester Institute for Psychotherapy Conference, 15–17 November 2019, Manchester, United Kingdom.

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