

EMPATHY AND GROUPANALYSIS AN INTEGRATIVE APPROACH

Ana Sofia Nava

Ana Sofia Nava is a psychiatrist, with a Master's Degree in mental health. She is a group analyst in the Portuguese Group-Analytic Society, a Full Member of the Group-Analytic Society, and Founder Member of the International Neuropsychoanalytic Society.

Summary:

With the aid of the most recent neuroscientific and psychological investigations, the author proposes an integrative approach of empathy.

Employing this referential she explores the characteristic way that, in groupanalysis, empathy is an investigative agent and, as such, opens a very special pathway to the analysands' intra-psychic lives. Stemming from very recent neuroscientific data (2000/2004), she also proposes that this instrument of investigation is amplified in the groupanalytic and psychotherapeutic group contexts.

The author, subsequently, reflects on the manner in which, in groupanalysis, empathy is also integrated in the therapeutic process itself.

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1. INTRODUCTION

The natural human ability that we have that enables us to perceive another person's emotions and feelings, and to go in their assistance, is usually called empathy.

Ickes (2003) metaphorically named it "every-day mind reading". In fact, it is an innate ability, which greatly eases life in society and inherently the intersubjectivity. It makes sense that for the social animal that man is, natural selection has privileged it as an indispensable tool.

The original German word, *Einfühlung*, literally means, "feel inside of" (Wispe, 1986). *Einfühlung* would be the result of a process in which the observer would project himself into the perceived object.

It's important to take into account that, for some authors, there are various forms of empathy that may roughly be divided into aspects that are more emotional and others that are more cognitive.

Preston e de Waal (2002) clearly set out the following definitions:

1. **emotional contagion** - the subject's emotional state is the direct result of the perception of the object's state, there is no distinction between the self and the object and there is an inability to help the other.
2. **sympathy** – The subject feels sorry for the object, the focus is directed more towards the situation than to the physical state of the object, there is a distinction between the self and the object and the ability to help may, or may not, exist.
3. **empathy** – the subject's emotional state is a result of the perception of the object's state, with the distinction between the self and the object, the ability to help the other is present and increases with the familiarity, similarity and exuberance (relevance).
4. **cognitive empathy** – the subject represents the object's state, through a top to bottom process, there is a distinction between the self and the other and it may, or not, culminate in assistance. This process is also known as "taking into perspective".
5. **pro-social behaviour** – assuming attitudes in order to reduce the object's unease. There is usually a distinction between the self and the object, and the

ability to help is present.

Although various psychoanalytic authors, such as Freud, Reike, Rogers, Melanie Klein, Bion and Greenberg, used and defined the term empathy, it was, however Kohut, who investigated this matter in depth. Kohut (1984) greatly emphasised the use of the analyst's empathic capabilities, and affirmed that although empathy had not been created by the Psychology of the Self, it has broadened its applications and enhanced its theoretical importance.

Kohut (1984) proposes the following definition of empathy: the ability to penetrate, by means of thought and feeling, into the other person's inner life. Kohut defends that the only two tools, on which the therapist may rely to promote the analytic cure (the transforming internalisation), are empathy and interpretation. Therefore, we can see how fundamental and decisive the concept of empathy is for the school of Psychologists of the Self.

He clarified the concept of empathy in two levels: abstract and operational.

1) Abstract empathy:

In an Essay in 1959, Kohut defined empathy as "indirect introspection", seeing that it is from the introspection of our own experience that we can understand how the other person must feel in a similar psychological circumstance.

It is since this definition that Kohut considers empathy as a "tool", an "instrument" or a "method of observation", with which the science of psychoanalysis gathers its data. As such, empathy assumes a role in the definition of psychoanalysis as a science. Because of this, Kohut considers psychoanalysis to be the only "pure psychology", when he defines it by means of two components that are essential to any science: its field of study (the states of the individual's internal world) and its methodology (introspection and empathy).

2) Operational empathy

In his later work, Kohut proposes a clinical definition, a more pragmatic one, when he affirms that empathy is the capacity to think and feel the other's internal world. Empathy is simply that, which allows the individual to reach the other's internal world, without losing his own objectivity.

Kohut explains that empathy should not, be misinterpreted with the quality of

interaction with another person, which we normally identify as love, compassion or any other intense emotion.

The clinical use of empathy

Empathy is of use to two clinical objects: the comprehension and the explanation (MacIsaac, 1997).

Comprehension: By thinking and feeling the patient's internal world, the analyst perceives what the patient is experiencing at that moment, and communicates, in a verbal or non-verbal manner, that the patient's experience was understood.

Explanation: While the first stage is centred on communicating what was obtained from the patient's experience, the second stage uses this comprehension, accumulated over time, to explain the meaning of the patient's experience, correlating it with, past experiences, internal impulses and intra-psychic dynamics.

2. RECENT CONTRIBUTIONS FROM THE NEUROSCIENCES

Functional Architecture Model – Decety and Jackson (2004)

Decety (Director of the Cognitive and Social Neuroscience Laboratory at the Washington University) and Jackson (neuropsychologist) (2004) setting out from the humanistic perspective (empathy as an innate ability) and the psychodynamic perspective (empathy as a communication skill), they propose three fundamental components of empathy in human beings:

1. *Affective Sharing* between the self and the other, based on the perception-action liaison, that originates shared representations.
2. *Conscience of the self and the other.* Even when some temporary identification exists, there is no confusion between the self and the other.
3. *Mental flexibility* in order to, subjectively adopt the other's perspective and, *regulating processes.*

These three components interconnect and should interact with each other, in order to produce the subjective experience of empathy.

1. Shared representations between the self and the others

a) Perception-action liaison

This concept reflects the idea that the perception of a given behaviour in another

individual, automatically activates the representation of that behaviour in the self (Knoblich and Flash, 2003; Preston and de Waal, 2002; Prinz, 1997).

The neurosciences have come forth to elucidate the perception-action liaison. The studies of electrophysiological registers in monkeys, have demonstrated the presence of *mirror neuron* that discharge in the same mode, whether in situations of actions directed towards an objective, or in situations where the actions of other individuals are observed (Rizzolatti, Fogassi and Gallese, 2001). Studies of functional neuroimaging in human beings, demonstrate that the neuronal circuits involved in the execution of an action, overlap those that are activated during the observation of the same action (Blakemore and Decety, 2001)

This neuronal network involves the pre-motor cortex, the parietal lobe, the supplementary motor area and the cerebellum (Grèzes and Decety, 2001).

Other studies have demonstrated that similar cerebral areas, belonging to the same neuronal network in the pre-motor cortex and posterior parietal cortex, are activated in the following situations:

1. When the individual imagines his own action (Decety, Jeannerod, Bettinardi, Woods, Mazziotta, et. al, 1994)
2. When the individual imagines the other's action (Ruby and Decety, 2001).
3. When the individual imitates the actions performed by a model (Decety, Chaminade, Grèzes and Meltzoff, 2002; Decety, Costes, Perani, Jeannerod, Procyk, E. et al, 1997; Iacoboni, Woods, Brass, Bekkering, Mazziotta, Rizzolatti 1999).

Other neuroscientific studies use the measurement of the cortical-spinal excitability provoked by transcranial magnetic stimulation. A study by Fadiga, Fogassi, Pavesi and Rizzolatti (1995) discovered motor evoked potentials in participants whom had been asked to; simply observe the hand gestures of other individuals.

In another recent study, the participants were asked to perform three tasks; observing, imagining or imitating hand movements, while electromagnetic stimulation was present (Clark, Tremblay and St.-Marie, 2003). The following results were obtained: the greatest intensity of the motor evoked potentials was achieved when the task was the imitation of the hand movements, followed by that of observation and finally by the task of imagining. These extremely interesting results, clearly explain the need for identification models for the learning of physical skills and most likely for other types of skills, namely relational and affective skills.

On the whole, the representations shared between the self and the other at a

cortical level, were found at the level of *comprehension, pain processing* and recognition of the *emotions*. This mechanism provides the neurophysiological base for the function of social cognition, through the automatic activation of the motor or emotional representations. There is no specific cortical region, for the shared representations, its neuronal base is widely distributed, and the activation pattern varies according to the processed domain, a particular emotion or stored information.

For Decety and Jackson (2004) all this evidence offers the functional bridge that would be the base of intersubjectivity. However, the model of empathy that it commends suggests that this mechanism is necessary, but not sufficient.

2. Conscience of self/other

As previously mentioned, this model of empathy implies that there is a clear delimitation between the self and the other. The conscience of the self isn't rooted in a specific region of the brain. Quite on the contrary, it depends on the interaction of processes that are found spread throughout the brain, especially on the level of the pre-frontal cortex and the inferior region of the parietal lobe, as it is, the right hemisphere has the preponderant role (Keenan, Gallup, Falk, 2003).

The roots of the self are formed in early infancy. The representations of the actions of the self and of the other, are simultaneously overlapping and distinct (Rochat and Striano, 2000).

The developmental psychologist Vasudevi Reddy suggests, based on observation studies, of newly born, that the children are conscious of being the object of attention by others, even before they have conscience of the other (Reddy, 2003).

The conscience of one's self, needs the capacity of secondary representation of an object. These types of skills are developed during the child's second year of life. There is increasingly more evidence that substantiates that at about 4 years of age, a connection starts to take place, between the development of the capacities of mentalization and self-control (Perner, Lang, 1999). Currently, we know that the development of cognitive control is related to the development of the pre-frontal cortex (Tamm, Menon, Reiss, 2002). The inferior parietal cortex, concerted with the pre-frontal cortex, have a crucial role in the recognition of the self/other and, as such, is fundamental for empathy.

3. *Mental flexibility and auto-regulation*

The ability to take into perspective is clearly a fundamental variable for the capacity of human empathy, and obviously an essential skill for the psychotherapist to be able to enter into his patient's reality. Tomasello (1999), discusses that it is this skill that distinguishes us from the other primates, and is an essential element of intersubjective communication.

In spite of this growing ability to get into someone's shoes, human beings also have the natural tendency to deduce that the others have the same knowledge and beliefs that they themselves have, even though, rationally they know that they have different points of view (Keysar, Lin, Barr, 2003; Royzman, Cassidy, Baron, 2003).

This data is consistent with that, which was explained in relation to the mechanism of shared representations. Each one sees the other, through their own cognitions, using their own knowledge, the primary base for understanding the others. Self-perspective is the *default mode* of the human mind. Taking this kind of basic functioning into account, it is licit to equate that in order to have an empathic understanding of the other, an adjustment, of the shared representations, is needed.

We need to regulate our own perspective, which is triggered by the interaction with the other, or even just the act of imagining the interaction. In this manner, empathy requires some kind of active inhibitory mechanism, so that this type of regulation can be made, and the pre-frontal region has a decisive role in this regulatory process (Fuster, 1989). Patients with cerebral lesions in this area, demonstrate a lack of empathy, in addition to an incapacity to control their own behaviour.

The more recent advances in clinical Neuropsychology and in the neurosciences indicate that the frontopolar cortex is involved in regulatory or inhibitory processes. Decety and Jackson (2004) defend that this inhibitory process is necessary for regulating and decreasing the self-perspective, in order to allow the evaluation of the other's perspective. This regulation is necessary to the extent that the overbearing self-perspective, which derives from the automatic liaison between the perception and the action, is the normal method of functioning, and only through its regulation, does it allow cognitive and affective flexibility.

According to this conceptualization, empathy is an intentional and voluntary capacity. When there is no conscience of one's self and no emotional control, there is no real empathy. On the contrary, the mere sharing of emotions, only leads to

discomfort or to anxiety.

Empathy, is not only the resonance of the affect between the self and the other, it also involves the explicit representation of the other's subjectivity.

Preston and de Wall (2002) undertook an exhaustive study, on the manner in which empathy may be modified by experience. They carried out a revision of the literature and found various papers, by various authors, that investigated this matter in rats, monkeys, apes, human infants, human children and human adults. They concluded that overall these variables may be organised into categories: 1) familiarity/similarity, 2) past experience, 3) implicit and explicit learning. These variables produce an increase in empathy, which may be explained by the processes of perception-action.

3) REFLEXIONS CONCERNING EMPATHY AND GROUPLANALYSIS

I will now try to imagine what takes place in neurobiological terms, during a session of analysis, when empathy is in action, which in some way is equivalent to what happens when a mother takes care of her baby, using her capacity for reverie, her alpha function.

1) Through the model of perception-action, we know that there are shared representations between the patient's emotions and the analyst's respective neuronal circuits. In other words, the patient's emotion is mirrored, through the *mirror neuron*, in the neuronal circuits that codify the same emotion in the analyst. This process is automatic, the analyst doesn't need to make any conscious effort, he just has to let himself go, without being defensive. There is an immediate, natural sharing of affections, even before we have any conscience of what is taking place and, without a doubt, it is mirrored on our face, as are all our emotions (see Nava, 2003). This all, may be apprehended by the patient in face-to-face therapy and in groupanalysis. This phenomenon certainly corresponds to one of the components, which are not yet conscious, of counter-transference and, is extremely fast. The vegetative and somatic response, corresponding to the patient's emotions, is shared and activated in the groupanalyst.

2) The second step is the conscience of the self and the other, which enables a clear

conscience of the limits and makes sure that there is no confusion between the analyst and the patient. It prevents emotional contagion, and ensures that the patients' emotions do not invade the analyst, as if they were his own. Obviously, this would hinder the performance of the therapeutic capacities. This level involves conscious processes, thus, the analyst's training as a person and as a professional are very important.

3) Finally, mental flexibility permits the introduction of inhibitory mechanisms, which restrain the analyst's perspective (his life referential, based on implicit and explicit memories, somatic tracers). At this time, regulatory processes come into action, so that the analyst may assume the other's perspective. This part can be altered the most as a result of the analyst's training and, where his theoretical formation takes on a more important role. The third component doesn't imply direct aid, as Kohut stated. We are not going to solve the patient's needs directly, the analyst is going to produce an explanation of these needs.

At this point, I would like to explore further, the first component of empathy – the shared representations – in groupanalysis.

As we have previously seen, the *mirror neuron* are activated by visual perception and are immediately activated and mirrored. They mimic (imitate) what is being seen, in other words, the circuits that correspond to what is being observed, are activated. We have also had the opportunity to see that some of the investigations have demonstrated that this phenomenon is more complete and more intense when a model is being observed, but it is also activated when the individual imagines the other person's action or when he imagines his own action. In analytic terms, this data leads us to new reflections about the following particularity: in groupanalysis, the analysands see the analyst, a question that has already been mentioned by some groupanalysts (Nava, 2000; Neto, 2002).

In groupanalysis you can see – The Mirror Neuron

1) The groupanalyst has a greater capacity to understand his group-analysands because he is observing them. He is face to face with them and may look straight into their eyes. The perception-action model, allows us to conclude that the level of shared representations reach greater intensity, therefore the groupanalyst has a greater empathic capacity, precisely because he is face-to-face. The intensity of the brain processing is

greater than when the analyst doesn't see the patient, and merely uses his hearing. Nowadays we know that this is what happens, because the emotions, have a corporal component that can only be seen entirely, in a face-to-face situation and, due to the system of shared representations, it enables the group analyst to capture the emotions of his analysands, automatically and with much greater intensity.

This is the secret of the primary mother-infant relationship. It is the way that biology discovered, to enable the existence of harmonious communication between the mother and her baby, so that, without the use of words, the mother may empathically receive (by the shared representations that are mirrored), the emotions, feelings and the needs of her baby. In fact, a great part of the formation of the personality of our patients, was created in the primary relationship with the objects of the self, and probably, the best way to reach it is through an empathic investigation, recreating the same pattern, and taking full advantage of our biological capacities.

Once again, I would like to emphasise the fact that the *mirror neuron* reach their maximum power through vision. If we merely use our imagination, we can also activate the *mirror neuron*, but we are not taking advantage of their full potentialities.

2) Observation of relational phenomena in the group.

When the analysand relates an episode of his life, one that took place outside the analytic setting, his therapist may imagine what happened and, as we know, this activates the circuits of shared representations of empathy, on a smaller scale. However, when the analyst observes a similar episode within the group, through the way that the group-analysand relates to the other elements in the group, the analyst reaches a greater level of shared representations, therefore a greater degree of empathic capacity, in the sense of an increased investigative capability. Adding to this phenomenon, we shouldn't forget that when a patient relates an episode of his life, frequently and unconsciously, he distorts it, which doesn't happen when he is living it *in loco*, in the analytic group.

I believe, that this paper has also enabled us to reflect about the factors that have an effect on the analyst's empathic abilities: familiarity, similarity, learning and past experience.

As I have already mentioned, various studies, with animals, human children of various ages, and adults, have confirmed that, the greater the familiarity and similarity with the object, the representations, that the subject has of the object, are richer, by involving more associations; thus, creating more complex, more elaborate and precise patterns of activity. This pattern is encrypted based on the reference of personal experience as well as the object's experience.

Thanks to the perception-action liaison, the similarity allows the emotional expressions, of the subject and the object, to be convergent. This will originate a more direct mapping the perception-action and, a better understanding.

Based on what we have presented, we may infer that, the similarity between the analyst and his patient, is a factor that may determine an increase in the empathic capacity. I believe that this variable is especially significant during the first contacts, which, are of great importance for the establishment of the therapeutic alliance. This is especially true because this situation is bilateral. If on one hand the analyst feels more empathy towards the patient, on the other hand, the patient may also feel greater empathy towards the analyst.

This characteristic is also important in the course of an analysis, due to the fact that, the more the shared representations overlap, then, the greater the amplification of the process of understanding the other. This process become faster, more focalised, more detached from the underlying noise that is always present in a group. In this similarity, besides the more obvious variables (race, sex, age), I would like to emphasise the variables present in the specific situation of analysis: personality structure and the main defence mechanisms.

Considering my clinical experience, it's easy to perceive that I understand, with astonishing speed, the defence mechanisms that are similar to mine, and that I was able to identify during my personal analysis. On the other hand, I am rapidly contaminated with certain defence mechanisms that I use on an unconscious level, and that I'm only capable of identifying *à posteriori*, after work of elaboration.

On the contrary, I have more difficulties at identifying defence mechanisms and forms of mental functioning that are very different from my own. It may happen that I don't understand them easily or, I feel the need to defend myself (I get sleepy, lose my concentration, look for many theoretical explanations...).

Overall, there are probably certain personality structures that we understand better than others. This may be related to our own structure, or those of our parents,

with whom we dealt with for so many years.

Another perspective is that familiarity can supplant similarity, probably when a strong emotional connection exists (Zahn-Waxler Hollenbeck, Radke-Yarrow, 1984; Temerlin, 1975; O'Connel, 1995; de Waal, 1997b). In this sense, the familiarity that is created during a groupanalysis is extremely important. In fact, being with a person, three times a week, during many years (usually a minimum of six years), is extraordinary. It's quite unlikely that we can have this level of familiarity with our friends. Obviously, in a group psychotherapy, with a weekly session, this level of familiarity can't be reached and, as such, in this case, similarity is perhaps the most important factor in the empathy achieved.

The effects of past experience, can also be explained by the same principles of familiarity and simplicity. If the subject needs to accede to the representations of a certain internal state, to be able to understand the object's situation, he will be all the more empathic, if he has already experienced these situations or these states, to some extent.

From all that we have already seen, we may infer that the empathic capacities, of the groupanalyst, will be directly influenced by the degree of similarity, familiarity and past experience, he shares with the patient. This, elucidates the subjective experience that we have with certain patients, for whom we have greater empathy, and amongst those, we are able to understand, the ones that are more alike us, or those that had similar life experiences, far better.

Finally, the learning factor seems to be extremely important. It's the variable that is generally connected to the cognitive dimension of empathy, and the one that the analyst, can and should, perfect. I believe that this exercise can be achieved through the following aspects:

1. Personal Analysis:

Only by going through this process can we learn the empathic capacities in practice. Just as babies learn the capacity of reverie, and the alpha function with their mothers, and one day put it into practice with their own children, the future analysts learn analytic empathy with their own analysts.

2. Life Experiences

The analyst, completely closed in his consulting room, limits his relational pattern to the situation in which he possesses the ascendancy of the analyst, an as if,

father figure, who doesn't relate with his peers. This, without a doubt, limits his empathic capacity to one very special situation. I believe that it's important for him to continue developing his relational and empathic capacities in the real world, integrated in restricted or expanded groups – family, friends, his professional group or other social groups. If this doesn't occur, his life experiences cease to exist, and he will not be able to understand his patients' experiences effectively, since, in this case, he would only have access to distant memories.

3. Theoretical Formation,

The theoretical knowledge is essential in the moments, in which the regulatory mechanisms are being used, that enable the analyst to assume the others perspective. It is the more elaborate and specialised dimension of the cognitive level of empathy. They are used in a non-automatic way, are voluntary and conscious. They enable the explanation of the patient's emotions and sentiments, in other words, they allow the communication of the empathic understanding that Kohut conceptualised as being a therapeutic agent.

4. Supervision

The supervision is the practical complement of the theoretical training. It is the ideal “setting” to complement theoretical knowledge, but also allows the analysis of some of our blind spots. During supervision, counter-transferential aspects, and empathic flaws, that are not conscious to the analyst, may be discovered.

4. Learning from the experience of being an analyst.

We can't expect our analyst, our supervisor and the books, to do all the work to discover our faults. There is a very important amount of personal work to be done, based on learning with experience. The maintained capacity of empathic investigation, enables us to make important clinical revelations, concerning the type of patients and pathologies that reach us. In other words, our own clinical investigation, provides us with the data, with which we can deduce new theoretical conceptualizations.

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