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Towards a Theory of Emotional Autonomy

Abstract

The author challenges the emotional contagion theory and proposes an alternative of emotional autonomy. He critiques how the contagion theory is faulty logic because it assumes different individuals may experience identical emotions, rather than each having their own phenomenological experience even though the outward signs may look similar. A way of ascertaining individual experiences of emotions is suggested, followed by an example of the experiences of pain, before the conclusion that we should adopt within the literature the assumptions of emotional autonomy.

Key words

transactional analysis, emotional contagion, emotional autonomy, phenomenological experience, projective identification

Introduction

This paper is intentionally written to be challenging because I believe we need more emphasis within transactional analysis (TA) on what I am calling emotional autonomy theory (EAT) instead of the current focus on how emotions are being presented within the psychological literature on the basis of emotional contagion theory (ECT). My argument with ECT is that it appears to be a collection of beliefs ranging from one believing they can be infected by other's feelings and they can feel other's feelings, to those who subscribe to the idea that mimicry of another's body posture will result in them experiencing the same emotions that the original person is having, whereas I believe that we can only ever understand and know our own emotional experience. As soon as we experience a feeling it is our feeling, in our body, and not somehow transported as an emotional experience from one person to another. When mimicking another person's body language, we can never know if the copier is having the same or different feelings as the person being copied.

I cannot recall ever having the experience where I had thoughts and feelings that were not my own. Indeed, I would say that in usual circumstances, if a client started to report that they were having thoughts that were not their own and experiencing emotions that felt like they were someone else's that would be indicating diagnostic signs of a delusion or some kind of thought disorder.

I am challenging ECT because it appears to contain some contaminated Adult thinking about feelings. I am proposing EAT in an attempt to present clear Adult ego state thinking about how emotions and feelings are experienced and understood. I now contrast how emotional contagion tends to be presented within the literature, and how this needs to become a focus on emotional autonomy.

Emotional Contagion versus Emotional Autonomy

Examples of ECT in the literature include Olszanowski, Wrobel and Hess (2020) who write "The transfer of affective states between people has been given different names, such as emotional contagion, emotional transfer, affective linkage, or the social induction of affect." (p.367). Hsee, Hatfield, Carlson and Chemtob (2008) state "This study explores two questions: Do people tend to display and experience other people's emotions? If so, what impact does power have on people's susceptibility to emotional contagion?" (p.327).

Decety and Ickes (2009) say "Primitive emotional contagion is a basic building block of human interaction, assisting in "mind reading" and allowing people to understand and to share the feelings of others." (p.19). Additionally, Rothschild (2023) concludes "Thinking of the transmission of moods as akin to the transmission of social viruses, it seems reasonable to suppose that some people … stand especially vulnerable to contagion." (p.92).

As one can see, this view is that emotions can be contagious the same way that a virus can, and that somehow one person's emotions can transfer into another person and then they experience that other person's emotions. This is the core of the ECT. This view is also stated in the transactional analysis

literature, especially in discussions of projective identification.

Tilney (1998) states “Projective identification: expelling part of the internal world (self or object) into another person (external object) so that they identify with the projected feeling or thought as if it was their own. This constitutes projection *into* the other while simple projection is projection *on to* the other. This is particularly important with babies where verbal communication is absent. If the mother is able to take in the baby’s feelings she can be intuitively aware of its needs and be attuned.” (p.95) (italics in original). Also in discussing projective identification Tenconi(2020) states “In other words, I was feeling her needy C1 (Child in the Child ego state), and I could finally feel the shame and worthlessness about her other C1, angry, spitting food and sabotaging herself.”(p.106) and “This may allow a more mature transforming transference in which the therapist, through projective identification, feels and experiences something deep on behalf of the patient that cannot yet be thought or expressed in words.” (p.109-110).

Additionally, Heath and Oates (2015) say the concept of projective identification was developed “to describe the way someone may unconsciously disown and project unwanted and unbearable aspects of self into another.” (p.98). Speaking of Bion they also state “Bion insists that projective identification is not only a fantasy but a manipulation of one person by another and thus an interpersonal interaction. His work manages to capture some of the strangeness and mystery that characterise the experience of being involved as the recipient of a projective identification, which he suggests, is like having a thought that is not one’s own.” (p.98).

However, Ray Little (2012) clearly understood the limitations of ECT when, in his discussion of projective identification, he notes “the client exerts pressure on the therapist to act or to feel in a certain way. I would add that the feelings the client has pressured the therapist to feel are the therapist’s own feelings, which in some manner are similar to even though different from the client’s fantasy. The client is eliciting a mirrored response in the therapist. These responses consist of the therapist’s own feelings.” (p.261).

It appears that Little felt the need to clearly state a therapist can only have their own feelings and not someone else’s. That in the process of projective identification the client may project their feelings onto the therapist but any feelings the therapist may feel are the therapist’s own feelings and not the client’s. That feelings cannot be contagious where you may transfer a feeling from one person to another. This forms the basis of what I am proposing as EAT. As stated in the introduction, our emotions are autonomous. They are discrete things that are felt and experienced only by self. It is not possible to feel another person’s emotions or have someone project their emotions into me such that I can experience them. As soon as one feels a feeling or has some kind of phenomenological experience then that is that person’s experience and feeling not anyone else’s. It is quite possible to have a feeling in reaction to another person, but that reaction is an autonomous event where the individual has their own emotional reaction to another person.

In the original quotes above, phrases such as these were used: transfer of affective states between people; people tend to display and experience other people’s emotions; allowing people to understand and to share the feelings of others; therapist, through projective identification, feels and experiences something deep on behalf of the patient. In EAT these are seen to be the result of faulty or even magical thinking. One can only ever have their own phenomenological experience and never have another person’s such experience.

Mimicking emotions

In discussing the process of how emotions are contagious, Olszanowski, Wrobel and Hess (2020) state “First, the receiver imitates the sender’s emotional display in emotional mimicry. Second, facial feedback from such mimicry elicits the corresponding emotional state in the receiver … As such, mimicry is a cause of emotional contagion.” (p.367). Van der Schalk, Fischer, Doosje, Wigboldus, Hawk, Rotteveel & Hess (2011) also describe a two part process, “First, perception of emotional expressions leads to automatic imitation of these expressions, a phenomenon referred to as emotional mimicry … Second, it is presumed that the perceiver begins to experience the emotion that is being mimicked through a mechanism of afferent feedback, a phenomenon we refer to as emotional contagion.”(p.286).

As you can see, this whole process is based on an invalid assumption - the assumption that the perceiver experiences the same emotion as being mimicked. First to be clear, the emotion is not being mimicked; instead it is the behaviour and emotional expressions that are being mimicked. Second, ECT assumes that because two people have similar emotional expressions, then they must be having the same emotional experience of the feeling at that time. An interesting hypothesis but one that is untestable as you can never know if two people are having the same emotional experience. You can never know the experience of another person’s emotions. You can see their facial expressions, body language, hear them describe an emotion but you

can never understand their phenomenological experience of that emotion. You cannot see and hear another person's emotional experience. One cannot mimic something that you cannot see, touch or hear, such as an emotional experience. So, you can never know if one person is having the same feeling experience as another person. If one person's feeling of sadness feels the same as another person's feeling of sadness, there is no way to measure or understand that. This is the core of EAT.

Individual experience of emotions

One could seek to find evidence that emotional experiences of individuals are in fact different and not similar. First, any therapist who works in a gestalt or cathartic kind of way uses an existential phenomenological philosophy where you do not try to understand the other; you simply react to them and be open to subjective experience. Using this approach in therapy one finds people report very individualistic body experiences for their feelings. Any therapist that encourages the cathartic expression of feelings in clients will have noticed that clients describe the bodily sensations of their feelings quite differently. In the clinical setting, such as with redecision therapy and many of the body therapies, when working with emotions we ask the client to understand their feeling or emotion in a bodily sense. For example, the following dialogue may occur:

Therapist: *What are you feeling now?*

Client: *I am feeling angry at my mother.*

Therapist: *Where do you feel that anger in your body, describe it.*

Responses

Client 1: *I feel it as a tingling sensation in my arms*.

Client 2: *I get a hot feeling in my head like I am getting a headache.*

Client 3: *I feel it like a clenched fist in my stomach*.

The majority of clients can answer these questions quite easily and the responses will be varied and highly individualistic. When asked to describe the same feeling of anger in their body the responses will vary widely from person to person.

From this one could argue that one person's experience of anger is quite different to another person's experience of anger. One feels it in their arms and another feels it in their stomach. So the reported phenomenological experience of it is different. A person cannot mimic another's tingling sensation in their arms because you cannot see that in the other person. You will never know it is there unless the other person tells you and in most situations that would not happen. Even if the one can mimic the facial expression of anger of another, to some degree the bodily sensations reported above are usually going to be different, so the experience of the anger will be different, indeed quite different. One could then argue that it is not possible to mimic or understand another person's phenomenological experience of anger.

Whilst this is a nice hypothesis it is also an untestable hypothesis. EAT says you can only ever understand your own experience and never understand the phenomenological feelings of another person. Therefore, you can never compare your experience to another's and discover if it is the same or different. It may be the same or it may be different - we can never know. Even if one reports that their anger is like tingling in their arms and another says it's like a hot headache you can never compare those to see if they feel the same or different. There is no measuring device that can compare one phenomenological experience with another.

The Experience of Pain

Our feelings and experience of pain are dependent on a wide variety of psychological factors. In one way this is testable, as one can compare their own experience and feelings compared to self under different psychological conditions. There is significant evidence that shows this to be true with the phenomenological experience of pain, for example Akdeniz, Pece, Kusderci, Dogru, Bulgar, Suren & Okan (2023). In another study of the psychology of chronic pain, Main, Foster and Buchbinder (2010) state "Patient beliefs are a core part of pain perception and response to pain." (p.216). For example, the more a person believes they have a good approach to and management of their pain the less pain they will feel, the more they have good self-efficacy beliefs regarding pain the better as well. Linton & Shaw (2011) state "The experience of pain is shaped by a host of psychological factors. Choosing to attend to a noxious stimulus and interpreting it as painful are examples of two factors involving normal psychological processes. To be sure, pain is a subjective experience, and although it is certainly related to physiological processes, how individuals react to a new episode of pain is shaped and influenced by previous experience." (p.701).

As we can see, people who believe they manage their pain well have good self-efficacy regarding the pain, do not attend to the cause of the pain and will experience less pain than those who do these things. Other factors which effect the experience of pain are known to be: catastrophizing; experiencing anxiety or depression can lead to more intense experiences of pain; distracting may reduce the pain experience; negative thoughts can increase the feelings; and positive emotions can decrease the experience of

pain (Linton & Shaw, 2011). These factors reject the mimicry theory of emotional contagion. One can mimic the body posture and facial cues of a person experiencing pain but one cannot mimic the person's level of catastrophizing, their level of anxiety, their distractibility and so forth. Therefore, even though the body mimicking will take place, their experience of pain will be different so one does not know what that feeling is like for that person. Emotional contagion cannot occur in this way.

Conclusion

However, like in the example given above, from this one could argue that it is not possible to mimic or understand another person's phenomenological experience of pain. Whilst this is a nice hypothesis it is also an untestable hypothesis. EAT says you can only ever understand your own experience and never understand the phenomenological feelings of another person. Therefore, you can never compare your experience to another's and discover if it is the same or different. It may be the same or it may be different, we can never know. Even if we know that a person who catastrophises a lot feels more intense pain than another who does not, we can never compare them to know if that is true or not. There is no measuring device that can compare one phenomenological experience of pain with another.

I invite readers to consider whether to work on the assumptions of ECT or EAT. Can we be infected and feel other's feelings, or can we only ever understand and know our own emotional experience?

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