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Basic Empathy:

Developing the Concept of Empathy from the Ground Up

Abstract

Empathy is a topic of continuous debate in the nursing literature. Many argue that empathy is indispensable to effective nursing practice. Yet others argue that nurses should rather rely on sympathy, compassion, or consolation. However, a more troubling disagreement underlies these debates: There's no consensus on how to define empathy. This lack of consensus is the primary obstacle to a constructive debate over the role and import of empathy in nursing practice.

The solution to this problem seems obvious: Nurses need to reach a consensus on the meaning and definition of empathy. But this is easier said than done. Concept analyses, for instance, reveal a profound ambiguity and heterogeneity of the concept of empathy across the nursing literature. Since the term "empathy" is used to refer to a range of perceptual, cognitive, emotional, and behavioral phenomena, the presence of a conceptual ambiguity and heterogeneity is hardly surprising.

Our proposal is simple. To move forward, we need to return to the basics. We should develop the concept from the ground up. That is, we should begin by identifying and describing the most fundamental form of empathic experience. Once we identify the most fundamental form of empathy, we will be able to distinguish among the more derivative experiences and behaviors that are addressed by the same name and, ideally, determine the place of these phenomena in the field of nursing. The aim of this article is, consequently, to lay the groundwork for a more coherent concept of empathy and thereby for a more fruitful debate over the role of empathy in nursing.

In Part 1, we outline the history of the concept of empathy within nursing, explain why nurses are sometimes wary of adapting concepts from other disciplines, and argue that nurses should distinguish between adapting concepts from applied disciplines and from more theoretical disciplines. In Part 2, we show that the distinction between emotional and cognitive empathy—borrowed from theoretical psychology—has been a major factor in nurses' negative attitudes toward emotional empathy. We argue, however, that both concepts fail to capture the most fundamental form of empathy. In Part 3, we draw on and present some of the seminal studies of empathy that can be found in the work of phenomenological philosophers including Max Scheler, Edmund Husserl, and Edith Stein. In Part 4, we outline how their understanding of empathy may facilitate current debates about empathy's role in nursing.

Keywords

Empathy; Concept Development; Nursing; Philosophy; Phenomenology

Contribution of the Paper

What is already known about the topic?

- Empathy is widely considered key to effective nursing, but there is no consensus on how to define the concept of empathy
- Nurses have borrowed concepts of empathy, such as concepts of emotional and cognitive empathy, from psychology and cognitive and affective neuroscience
- Many nurses believe that cognitive empathy is of central importance because it allows one to understand the other's experience while maintaining a detached, objective stance

What this paper adds?

- A critique of the concepts of emotional and cognitive empathy, which demonstrates that neither concept accurately captures the most basic nature of empathy
- An account of how basic empathy—a concept developed by philosophical phenomenologists—is a precondition for more cognitive ways of understanding others
- An account of how the concept of basic empathy is relevant for nursing practice

Basic Empathy:

Developing the Concept of Empathy from the Ground Up

Empathy is a topic of continuous debate in the nursing literature. Many argue that empathy is indispensable to effective nursing practice. Yet others argue that nurses should rather rely on sympathy, compassion, or consolation. However, a more troubling disagreement underlies these debates: In the field of nursing studies, the concept of empathy remains “immature”—that is, there’s no consensus on how to define it (Morse et al. 1996). This lack of consensus is the primary obstacle to a constructive debate over the role and import of empathy in nursing practice. And the fallout from this state of affairs is perhaps most acute in the nursing education literature, much of which laments how the lack of conceptual clarity stifles our ability to develop effective training for nurses and other healthcare professionals (Brunero, Lamont, and Coates 2010; Williams and Stickley 2010).

The solution to this problem seems obvious: Nurses need to reach a consensus on the meaning and definition of empathy. But this is easier said than done. Take, for example, the numerous analyses of the concept of empathy, which were especially common throughout the 1990s (see, e.g., Kunyk and Olson 2001; Sutherland 1993; 1995; White 1997; Wiseman 1996). These analyses reveal a profound ambiguity and heterogeneity of the concept of empathy across the nursing literature. Since the term “empathy” is used to refer to a range of perceptual, cognitive, emotional, and behavioral phenomena, the presence of a conceptual ambiguity and heterogeneity is hardly surprising. Some researchers have attempted to resolve the challenge by simply identifying the specific phenomenon that they take to be of greatest relevance to nursing practice. But this only gives rise to another question: Which empathic phenomenon has the highest clinical relevance?

Our proposal is simple. To move forward, we need to return to the basics. We should develop the concept from the ground up. That is, we should begin by identifying and

describing the most fundamental form of empathic experience—the form that other concepts of empathy, as well as related notions such as sympathy and compassion, presuppose. Once we identify the most fundamental form of empathy, we will be able to distinguish among the more derivative experiences and behaviors that are addressed by the same name and, ideally, determine the place of these phenomena in the field of nursing. The aim of this article is, consequently, to lay the groundwork for a more coherent concept of empathy and thereby for a more fruitful debate over the role of empathy in nursing.

The article proceeds in four parts. In Part 1, we outline the history of the concept of empathy within nursing, explain why nurses are sometimes wary of adapting concepts from other disciplines, and argue that nurses should distinguish between adapting concepts from applied disciplines and from more theoretical disciplines. In Part 2, we review some of the conceptual distinctions that nurses have adapted from theoretical psychology, neuroscience, and the cognitive sciences. We show that the distinction between emotional and cognitive empathy has been a major factor in nurses' negative attitudes toward emotional empathy. We argue, however, that both concepts fail to capture the most fundamental form of empathy. In Part 3, we draw on and present some of the seminal studies of empathy that can be found in the work of phenomenological philosophers including Max Scheler, Edmund Husserl, and Edith Stein. In Part 4, we outline how their understanding of empathy may facilitate current debates about empathy's role in nursing.

1. Nursing's Ambivalence About Empathy

Within nursing, the most influential account of empathy can be traced back to the work of Carl Rogers, a psychotherapist famous for his work on the therapeutic relationship between client and therapist. Rogers gave a keynote address at the American Nurses Association in 1957. His client-centered approach resonated with the patient-centered approach that nurses

were already familiar with, and his concepts—including his concept of empathy—were quickly transposed into the nursing literature (Gunter 1962; Morse et al. 1992, 275–76).

Rogers' initial definition was quite simplistic: “To sense the client’s world as if it were your own, but without ever losing the ‘as if’ quality—this is empathy” (Rogers 1957, 99). He elaborated this definition as follows:

The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain hitherto as if one were the person, but without ever losing the ‘as if’ condition. Thus it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is *as if* I were hurt or pleased and so forth. If this ‘as if’ quality is lost, then the state is one of identification. (Rogers 1959, 3:210–11)

Over the next two decades, Rogers became more critical of his initial definition, but this is the one that directly influenced the field of nursing.

Rogers' account was not, however, universally accepted in the nursing literature. Morse et al., for example, point out that Rogers developed his concept of empathy with the explicit aim of clarifying and facilitating the relationship between a psychotherapist and his client. But psychotherapists and nurses have quite different aims and carry out their work in different contexts. Morse et al. therefore argue that Rogers' therapeutic concept of empathy is not an obvious fit for nursing (Morse et al. 1992, 277–78). They say,

Nursing as a profession is perhaps more unique than we have previously recognized, and this uniqueness has both advantages and disadvantages. One of the disadvantages is that we must develop our own practice (including our own interventions) cautiously and wisely rather than mimicking the therapeutic strategies of other professions.

Conversely, the development of unique nursing theory and practical knowledge must

be considered an advantage and essential as we develop as a distinct discipline.

(Morse et al. 1992, 279)

Morse et al.'s cautionary note is well placed. It is true that applied disciplines may implicitly incorporate their practical aims into their conceptual foundations. Often their concepts were not meant to be applied outside the practical contexts in which they were developed.

However, there are other disciplines, such as philosophy and theoretical psychology, that have a rather different set of aims. In most cases, researchers working in these fields do not set out to resolve a practical problem. They do not typically ask, for instance, "How should we understand the empathic relationship between psychotherapist and client?" or "How do nurses think about empathy?" Rather, they ask more general questions, such as "What is empathy?" or "What are the key components of empathic experience?" A shortcoming of this more theoretical orientation is that it might not be immediately clear how to apply these concepts in practical settings. But an advantage of this approach is that, at least in principle, the concepts should apply more broadly. A philosophical or psychological account of empathy might, for instance, identify a universal capacity or feature of human experience, rather than one that is particular to nurses, psychotherapists, and so on. If nurses have clear, practical ends that they want to use empathy toward, then they should be able to take these broader and more foundational concepts and apply them to their own particular concerns and contexts.

2. From Psychology to Nursing

Which disciplines might nurses turn to for conceptual clarifications and foundations?

Historically, nurses have made considerable use of the psychological literature, adapting a range of concepts for their clinical aims. In the case of empathy, nurses often appeal to a popular distinction in psychology, namely the distinction between emotional (or affective)

empathy and cognitive empathy. Whereas the former is seen as an innate capacity, the latter is considered a learned skill (Alligood 1992; Walker and Alligood 2001).

Cognitive empathy refers to higher-level intellectual processes used to understand the other's experience, such as methods of perspective taking, critical thinking, or inference. Within the nursing literature, it is often referred to as "state" or "clinical" empathy. It is this concept of empathy that often receives the most attention from nursing educators, not only because it is understood as involving clinical skills that can be trained and developed, but also because cognitive empathy is said to allow the nurse to understand her patient while maintaining distance and objectivity. Some (e.g., Alligood and May 2000) argue that nurses can also train "intrapersonal" empathy, which refers to the innate capacity. But this is a minority view. In fact, most would argue that one ought not to rely on this supposedly innate empathic capacity since it is an emotional experience, which hinders effective clinical care (e.g., Morse et al. 1992). To empathize in this way would supposedly require the nurse to take on and share the feelings of her patient, which, depending on the patient's situation and state of mind, may be overwhelming. Even if such an experience did provide an accurate understanding of the patient, the emotional toll might outweigh any benefits.

This worry about the emotional cost of empathy is not unique to nursing. In a target article entitled 'Against empathy' from 2014, Paul Bloom, a psychologist and cognitive scientist at Yale, argues that "if you want to be good and do good, empathy is a poor guide" (Bloom 2014). Bloom offers a variety of arguments for this view, but one of them bears directly on the definition of empathy. For Bloom, empathy is basically a matter of affective sharing. To empathize with somebody in pain or distress is to feel what the other is feeling. But if the empathizer suffers as a result of empathizing with your suffering, this is not to your obvious advantage. If you seek help from a physician or therapist, you don't want them to relive your pain and distress; you don't want them to be overwhelmed by negative emotions;

rather, you want them to remain calm and to respond with care and concern and help (Bloom 2014).

Whereas a more detached form of perspective taking, which Bloom calls cognitive empathy, can support rational, objective decision making, emotional empathy should be avoided because feeling as someone else feels can be harmful by not facilitating effective medical care. Here in Bloom's own words:

As I write this, an older relative of mine who has cancer is going back and forth to hospitals and rehabilitation centers. I've watched him interact with doctors and learned what he thinks of them. He values doctors who take the time to listen to him and develop an understanding of his situation; he benefits from this sort of cognitive empathy. But emotional empathy is more complicated. He gets the most from doctors who *don't* feel as he does, who are calm when he is anxious, confident when he is uncertain. (Bloom 2014)

In light of Bloom's characterization and assessment of empathy, we might conclude that, despite some enduring conceptual confusions, much of the nursing literature is on the right track: Nurses should not rely on their innate capacity for emotional empathy; instead, they should develop intellectual techniques for understanding their patients in an objective manner that provides distance from their patients' emotional distress.

But this conclusion is too quick. As we will argue in the following section, the very distinction between emotional and cognitive empathy is based on a misunderstanding of how we come to know and experience others (see also Zahavi and Michael 2018). While these two concepts do refer to ways that we engage with the experience of others, they both presuppose a more fundamental form of empathic experience that has been neglected in much of the nursing literature.

3. A Phenomenology of Empathy

How do we come to know and understand others in day-to-day life? On the proposal currently under consideration, either by using intellectual processes that rely on imagination, reason and inference, or by affectively sharing the other's mental states. Consider, however, the following example. You walk into a patient's room. He scowls, yells at you, and flings his food tray against the wall. You immediately experience the patient as angry, even enraged. This happens so fast that there is hardly time for the cognitive machinery of detached perspective taking to run its course. Are we then dealing with a more immediate form of affective sharing? To answer this question, let us consider how you feel in this situation. You might feel consternation, surprise, or fear. Perhaps you might also feel anger. But should we really think that you only understand that the patient is angry if you also feel anger? This is hardly plausible. But what is it then that allows you to understand how the patient is feeling? We can find an answer if we turn to phenomenologists such as Edmund Husserl, Edith Stein, and Max Scheler who were among the first to develop a proper philosophical account of empathy at the beginning of the 20th century. One reason why the work of these classical thinkers has recently been taken up again is due to developments in cognitive neuroscience. The discovery of the so-called *mirror neurons* or *mirror neuron systems* has been interpreted as lending support to the existence of a low-level form of empathy—one that explains the ease with which we understand the behavior of others. And one of the leading proponents of this approach, the Italian neuroscientist Vittorio Gallese, explicitly references Stein's account of empathy, as well as Husserl's and Merleau-Ponty's discussion of intersubjectivity (Gallese 2001), and is quite explicit in arguing that his own notion of embodied simulation is akin to, and a further development of, the phenomenological proposal (Gallese, Keysers, and Rizzolatti 2004, 397; Zahavi 2012).

But what is then the view of the early phenomenologists? They argue that empathy is a basic, perceptually based form of other-understanding, one that more complex and indirect

forms of interpersonal understanding presuppose and rely on. They consequently often used the term “empathy” interchangeably with terms such as “other-experience” or “other-perception” (Husserl [1931] 1960, 92; Scheler [1923] 2008, 220). In their view, one can obtain an acquaintance with the other’s experiential life in the empathic face-to-face encounter that is direct and immediate. When I see the anger in another’s face, I do not infer such experience from the precise configuration of the other’s facial muscles, nor do I ascribe it as a result of an elaborate process of imaginative perspective taking where I attempt to put myself in the shoes of the other. The phenomenologists are not denying that we, in some cases, draw on imagination, memory, or theoretical knowledge when attempting to understand others. They do insist, however, that empathy is the basic experiential source for our comprehension of foreign subjects and their experiences and that this is what more complex kinds of social cognition rely on and presuppose.

Scheler famously writes,

For we certainly believe ourselves to be directly acquainted with another person’s joy in his laughter, with his sorrow and pain in his tears, with his shame in his blushing, with his entreaty in his outstretched hands, with his love in his look of affection, with his rage in the gnashing of his teeth, with his threats in the clenching of his fist, and with the tenor of his thoughts in the sound of his words. If anyone tells me that this is not ‘perception’, for it cannot be so, in view of the fact that a perception is simply a ‘complex of physical sensations’, and that there is certainly no sensation of another person’s mind nor any stimulus from such a source, I would beg him to turn aside from such questionable theories and address himself to the phenomenological facts. (Scheler [1923] 2008, 260)

Empathy, according to the phenomenologists, gives us the experiencing other directly, non-inferentially, as present here and now (Stein [1917] 1989, 7). But there will always and by

necessity remain a difference between that which I am aware of when I empathize with the other and that which the other is experiencing. Empathy is *not* about me having the same mental state, feeling, sensation, or embodied response as another, but rather about me being experientially acquainted with an experience that is *not* my own. Empathy targets foreign experiences without eliminating their otherness. In empathy, I am confronted with the presence of an experience that I am not living through myself. If I empathize with your sadness, I have a sense of what it is like for you to be sad without being sad myself; I lack first-person access to the sadness in question. To empathically grasp another's joy is not to be joyful oneself, but to recognize the joy as belonging to the other. This is, of course, why phenomenologists have standardly rejected proposals according to which empathy should entail that the other's experience is literally transmitted to me or require me to undergo the same kind of experience that I observe in the other.

According to the phenomenologists, empathic other-experience is not about getting *inside* the other's experience. Not only do we perceive the other's emotions, intentions, or desires expressed directly through their bodily expressivity. We also perceive their experiential world. Consider the following example. You take your child for a walk in the park. As you turn a corner, your friend's dog runs up to you and barks. Your child cries out in alarm and jumps behind you. You perceive your friend's dog as excited and anxious to play. But your child perceives the dog as fearsome and dangerous. In the moment that you see your child leap behind you to avoid the dog, you immediately understand how your child perceives the dog. You see what the dog means to the child—you understand the sense that it has in your child's lived world. Yet at no point are you yourself afraid of the dog. Perhaps you've never felt afraid of a dog. Nevertheless, your immediate empathic understanding of the psychological significance of your child's bodily expressions grants you an understanding of how they experience their environment and the objects within it.

Rather than seeing empathy as being about identification, fusion, or similarity, basic empathy must be seen as an experiential engagement with the other that recognizes and preserves the self-other difference. Indeed, rather than blurring the distinction between self and other or leading to a sense of fusion or of merged personal identities (Cialdini et al. 1997), basic empathy is distinctive precisely because the empathized experience is located in the other and not in myself: “The subject of the empathized experience . . . is not the subject empathizing, but another. And this is what is fundamentally new in contrast with the memory, expectations, or the fantasy of our own experiences” (Stein [1917] 1989, 10). In this respect, basic empathy differs from Rogers’ concept of empathy, which amounts to something akin to perspective taking, in which you attempt to put yourself in the place of the other, yet abstain from fusing or fully identifying with them.

Perhaps some might object to this and argue that the only way we can truly understand others is by having (or by having had) the same kind of experiences as they do. To truly understand what it is like for a woman to give birth, one must have given birth oneself. But is that always an advantage? Imagine having had an easy birth, and then witnessing a woman who is in a lot of pain because of a difficult birth. Will the fact that one has given birth oneself necessarily make one more appreciative of her experiences, or might it on the contrary make it more difficult to grasp what it is like for her, since one might be inclined to generalize from one’s own case, and therefore assume that it is probably not as hard as it seems? All of this is not to deny that imagining what it must be like for the other, i.e., engaging in imaginative perspective taking, might occasionally help one appreciate someone else’s experience. But the imaginative exercise supplements the more basic understanding of them that you already achieved through your empathic perception. More comprehensive accounts of both classical and contemporary phenomenological analyses of empathy can be found in Zahavi (2010; 2011; 2014; 2017; 2019). Let us emphasize that the

direct and immediate character of basic empathy doesn't entail any claim regarding its infallibility. Basic empathy is fallible. Indeed, just as you can be mistaken about an object that you perceive, you can be mistaken about a person that you empathize with. In the case of misperception, it wouldn't be right to say that you didn't have a perception at all. Rather, you simply had an inaccurate perception, which is likely to be corrected by other perceptions that you have of the same object. In much the same way, you can have an inaccurate empathic understanding of the other, which may be corrected as you continue to engage with them.

4. Re-Applying Empathy in Nursing

With this formulation of the phenomenon of basic empathy, we see that the understanding of others' experiences requires neither affective sharing nor imaginative perspective taking. But how does this new formulation guide our understanding of empathy's role in clinical practice? At first glance, it may seem that basic empathy is so fundamental and automatic that it is entirely outside of our control. Perhaps I can choose whether or not to care about someone, whether or not to feel compassion for them; but I can't choose whether or not to empathize with them in this basic sense—that is, I can't help but to see their body as expressive of their experience and subjectivity. If this is the case, then each and every nurse already employs basic empathy. It is an indispensable guide in daily interactions with colleagues, patients, and their family members. But if it is not something that one has any control over—if it is not something that one can develop in any meaningful sense—then why focus on it?

Basic empathy is direct and immediate. But it can still be obstructed or facilitated in a variety of ways. Much of the literature on the phenomenology of illness laments how clinicians engage with a patient's body as a mere material thing—a natural object to be manipulated in order to restore natural function (Leder 1984; Toombs 1993). Kevin Aho,

drawing on his own experience of illness and recovery, says, “What became clear in the aftermath of the heart attack is that the physicians and surgeons rarely encountered me as a person. I was reduced to numerical data, to numbers and sets of numbers revealed through various diagnostic instruments. [...] There was little attempt to listen to the person behind the symptoms. I was simply a corporeal thing, an object of measurement” (Aho 2018, 190). To see a human body as, first and foremost, a natural object—rather than an expressive embodied subject—is an acquired and highly artificial way of perceiving and understanding others. In some cases, such as in the midst of surgery, the clinician must perceive the patient’s body in this way in order to provide effective care. But this kind of encounter constitutes a very small slice of a patient’s day-to-day interactions with healthcare professionals.

In fact, despite Aho’s critical remarks about his physicians, he recalls his interactions with nurses and nursing assistants in a completely different light. They saw him first and foremost as a vulnerable, suffering individual—and they engaged him as such: “The fact that those who listened to and affirmed my experience were mostly nurses (or nursing assistants) reveals something about the instrumental and transactional nature of modern doctoring, where the aim is not to listen and tend to a particular person but to manage and treat malfunctioning body parts” (Aho 2018, 199). Since nurses are, by and large, concerned with properly empathizing with their patients, they may be considerably less likely to perceive their patients as mere bodies with physiological dysfunctions. So, admittedly, the traditional phenomenological critiques of bodily objectification may apply more easily to physicians than to nurses (Zahavi and Martiny 2019). In the case of nursing, perhaps a more significant concern is with the nurse’s ability to be open to and appreciate the individuality of each patient. In some cases, it may be all too easy to approach a patient as yet another instance of a particular disorder or injury. But effective care requires more than accurate diagnosis and

appropriate interventions. It also requires that the clinicians understand and appreciate how the patient is coping with their condition within the particular context of their life circumstances. To genuinely empathize with a patient requires not only that one perceive them as an experiencing subject. It also requires that one appreciate the particularity, even the uniqueness, of their experience and subjectivity. Some healthcare researchers have drawn on the phenomenological concept of basic empathy in order to understand not only how to see patients as more than biological bodies, but also how to see them as unique individuals with specific sets of desires and needs (Morgan 2017; van Dijke et al. 2020).

Consider Alastair Morgan's (2017) work on hybrid empathy. Morgan's primary concern is with the dehumanization of patients, which may occur when we feel disgust rather than compassion toward the person we're meant to care for. He suggests that such dehumanization may occur when a patient differs too much from us, such as patients with severe psychiatric disorders or those "suffering from dementia and loss of control over bodily functions" (Morgan 2017, 4). Responding compassionately to these patients is not always as simple or straightforward as it is with patients who are more easily understood. To overcome this challenge, Morgan draws on Matthew Ratcliffe's phenomenological account of empathy (Ratcliffe 2012; 2014). He proposes a hybrid notion of empathy that consists of immediate, direct understanding (i.e., basic empathy), supplemented by "a more developed cognitive concept of empathy that is concerned with a projective imaginative response to another's experience" (Morgan 2017, 3).

We find promise in Morgan's approach to supplementing the other-understanding provided by basic empathy. However, there is an ambiguity and even potential danger in relying on what Morgan calls a "projective imaginative response." Consider the following situation. A patient has recently been paralyzed as a result of a traffic accident. In order to be able to offer proper care, it is crucial for the nurse to be able to understand what it is like for

the patient to live with this new life situation. How should the nurse go about doing that? The nurse could engage in imaginative perspective taking and consider what it might be like for her or him to be bound to a wheelchair for the rest of her or his life. But is this really the most optimal approach? Consider the phenomenon known as the “disability paradox”. As has been repeatedly observed, although most external observers—including trained clinical personnel—judge individuals with serious and persistent disabilities to live undesirable or even miserable lives, when asked themselves, those very individuals often report that they experience a good or excellent quality of life (Albrecht and Devlieger 1999). This mismatch is a stark reminder of not conflating empathy with imaginative perspective taking. To insist that I can understand the other by simply putting myself in his or her position is often nothing more than an imposition of one’s own view upon the other; it is precisely something that risks violating or doing away with the other’s perspective altogether.

Morgan’s use of projective imagination seems to fall into this trap, insofar as “projection” implies the imposition of one’s own experience on another. Thus, projection risks covering over the unique features of the other’s experience with what I draw from my own life. However, Morgan’s characterization of projective imagination is ambiguous because he also appeals to a process of narrative reconstruction. He suggests that, when trying to understand some patients, it is better to solicit their narrative, either from the patient or from their friends and family. Such narrative reconstruction may provide a context within which the clinicians can more easily feel and express compassion toward their patient. This is certainly a higher-level cognitive form of empathic understanding. But it does not involve the imposition of one’s own beliefs or experiences upon the other, so to avoid misunderstandings it is better to clearly distinguish projective imagination from narrative solicitation.

Jolanda van Dijke, Inge van Nistelrooij, Pien Bos, and Joachim Duyndam (2020) share similar concerns to Morgan, which they address from a slightly different angle. Rather

than arguing for a hybrid approach in which basic empathy is supplemented with higher-level cognitive processes, such as narrative interventions, they stress the relational aspects of empathic engagement. They argue that we shouldn't think of empathy as something that is purely a capacity of the empathizer. With basic empathy, we access the other's experience through his bodily expressions. Again, we cannot help but to perceive him as expressive. However, what we perceive him as expressing also depends on his own expressive skills and capacities. They say, "When patients fail to express themselves, caregivers may still empathize with their patients' situation, but the inner world of experiences and meanings remains hidden" (van Dijke et al. 2020). Drawing on the work of care ethicist Nel Noddings (2013), van Dijke and her colleagues argue that the empathizer and the empathee have differing, but complementary, obligations in the caring encounter. The empathizer ought to maintain an attitude of openness and attentiveness to the empathee; the empathee, by contrast, ought to make a concerted effort to express himself genuinely and accurately, whether through bodily or verbal expression. This highlights the active role of the empathee in the caring relationship. van Dijke and her colleagues point out that this understanding of the empathic relationship goes beyond communicative theories of empathy, which merely require the empathee to confirm or deny the empathizer's understanding of their own experience (van Dijke et al. 2020, 6). While confirming and denying the accuracy of the empathizer's understanding is obviously important for effective communication and care, the empathee has considerably more power than the communicative account of empathy acknowledges.

By thinking of empathy in this relational way, we are better able to identify some of the challenges to accurate and effective empathy. A lack of trust may, for instance, undermine one's ability to accurately know the other's experience (van Dijke et al. 2020; Reynolds and Scott 2000). On the one hand, an empathee who doesn't trust a potential

empathizer may be less likely to exhibit expressive behavior. On the other hand, an empathizer who doesn't trust his empathee may be more likely to perceive the empathee as purposefully misleading them by expressing something other than what they actually feel.

Considerations like these also open potential avenues for empathy training programs. Some researchers have pointed out that the success of empathy education is hindered by a lack of conceptual clarity (see, e.g., Brunero, Lamont, and Coates 2010). By clearly distinguishing among the types and levels of empathic experience, we can better facilitate the design and evaluation of such programs. Moreover, although basic empathy may not be something that one can develop, it can certainly be obstructed or diminished in cases of inadequate communication between empathizer and empathee. A successful training program may, therefore, teach clinicians how to identify obstacles to basic empathy and also teach them techniques that supplement basic empathy, such as the solicitation of patient narratives.

The work of Morgan and van Dijke et al. provide excellent examples of how we may facilitate and supplement basic empathy in the clinical encounter. However, before we conclude, we would like to express a brief word of caution. Morgan and van Dijke et al. do not simply describe how various emotional, cognitive, or behavioral processes relate to or build upon basic empathy. They also aim to establish a more complex concept of empathy by integrating the concept of basic empathy with other concepts. Morgan proposes a hybrid concept of empathy, which combines the concept of basic empathy with the concept of projective imagination; van Dijke et al. propose a relational concept of empathy, which highlights how the accuracy of empathic understanding is, in large part, dependent on the expressive capacities of the empathee. In some cases, the formulation of more complex concepts such as these may be useful. But this also risks creating a new set of partially overlapping concepts, sowing new confusions to replace the old. If our aim is to provide order and coherence for discussions of empathy in the field of nursing, then we suggest that

the concept of basic empathy should be retained in its original and simplified form. We can, and should, explore how basic empathy might be facilitated or supplemented by other human capacities. But we should do this while maintaining a conceptual framework that applies as broadly as possible, rather than establishing a new concept in response to each new problem.

Conclusion

The role of empathy in nursing has been the subject of considerable and ongoing debates. These debates have, however, been hindered by a lack of clarity over the concept of empathy in the nursing literature. To provide some clarity and structure, nurses have borrowed concepts from a variety of disciplines, including psychotherapy, psychology, and cognitive and affective neuroscience. We argued that the most common distinction drawn from this literature—that between emotional and cognitive empathy—mischaracterizes the most fundamental form of empathy. Empathy in its most basic sense offers a direct and immediate form of other-understanding—one that doesn't require us to reproduce or share the other's experience. By identifying this fundamental form of empathic understanding, we hope to establish a clearer conceptual foundation that will allow nurses to better identify and clarify the forms of interpersonal understanding that they are concerned with in research and practice.

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