Analysis of the Concept of Empathy: Illustration of One Approach

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NURSE SCHOLARS, recognizing nursing as an applied science, have identified concepts from the biological, psychological, social and physical sciences that fall within areas of nursing expertise. Refinement of the image of reality can occur through careful analysis of the phenomena identified in day-to-day clinical practice.

Empathy has long been considered an important concept in the nursing process. Empathy is commonly introduced in early stages of nursing curricula as an approach to the nurse-client relationship, and it has been a focus of nursing research in education and practice.[1-3]

Conceptual analysis is defined as a precise process of examining parts, operations of and the interrelated whole of a thing.[4] It requires rigor and precision, yet the end product is inexact and tenuous. It is perhaps because of this inequity between energy expended and end-product return, and because of a lack of conceptual analytic know-how, that precise concept

0161-9268/80/0022-0033$2.00

analysis has been neglected. This neglect cannot be perpetuated if nurses are committed to progressing to explanatory and predictive levels of theory development that will guide nursing interventions. The process of concept analysis can be illustrated and documented using the analytic approach described in *Thinking with Concepts.*[5]

The major techniques used in this approach to concept analysis are:

- Description and analysis of model cases, or analysis of empirical events that can be said by most observers to represent an instance or occurrence of the abstract concept;
- Description and analysis of alternative cases that represent the occurrence of contrary, related and borderline concepts;
- Review of existing literature to extract explicit or implicit meanings;
- Extraction of provisional criteria that may be used in naming the occurrence of the phenomenon;
- Examination of such factors as social contexts, underlying anxieties, and application of varying means in different social situations.

The techniques are not necessarily used in step-by-step fashion; rather, they tend to emerge simultaneously once the initial steps of analysis have been undertaken. Thus the analyst may propose model cases, define and illustrate these model cases using existing literature, and explore possible criteria in the same process. Often the analyst strikes a frustrating conceptual barrier, and then it may be helpful to leave one line of analysis and pursue another technique; for example, it may be helpful to look at dictionary definitions or to review existing literature. It is always helpful to work in conjunction with another analyst, testing in spoken words and in writing the ideas and logic of others.

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DESCRIPTION AND ANALYSIS OF MODEL CASES

Model cases of empathy are used in order to examine precisely the factors inherent in the phenomenon and, ultimately, to encourage insight into the essential nature of empathy. The cases examined in this article evolved from actual nursing experiences. It is not intended that the cases represent ideal nursing situations, nor are the cases necessarily representative of administration of high-quality care.

A 4-year-old child is hospitalized with a tentative diagnosis of blood dyscrasia. The child was accompanied by both parents. The mother remained with the child. Visiting hours are from 2 P.M. until 4 P.M. At 4 the announcement is made over the public address system that visiting hours are over. The mother rushes to the nurses' desk and, bursting into tears, she implores, "I can't leave. He has never been away from me."

N. "You are concerned about how he will react to your leaving?"

M. "Yes, and I'm afraid to leave. I don't know what will happen if I do."

At this time the nurse comes from behind the desk and, putting her arm around the woman, leads her toward a lounge area.

N. "You are afraid that something will happen?"

M. "I may never see him again. The doctor is afraid he has a terrible sickness. He told us two weeks ago we could not delay in bringing him in. Oh, if anything happens . . . "

N. "You believe you delayed and that you may be responsible for a serious outcome?"

M. (Sobs uncontrollably.)

Examination of the phenomena represented in this case reveals the following conditions (provisional criteria), which may be necessary whenever empathy exists:

1. *Consciousness*—of self, of other and of experience (one's own and the experience of another). The experience of another may be called "foreign experience," a term borrowed from Edith Stein to mean experience external to the psychophysical "I." This "I" lives in experiences of sensing, thinking, feeling and willing. Experience that appears beyond the mere physical body but is conveyed in outer perception is constituted within consciousness. Edith Stein explains the experience as follows: ". . . I may also hear someone make an indiscreet remark and blush. Then I not only understand the remark and see the shame in the blush, but also discern that he knows his remark is indiscreet and is ashamed of himself for having made it. Neither this motivation nor the judgment about his remark is expressed by any 'sensual appearance'. . . ."[6]

The mother in this model case consciously approaches the nurse, inviting her to direct her attention to her, the mother. Whatever the nurse is involved in, whether reverie or conscious thought, she is now interrupted and in the "here and now" she is consciously aware of the mother and of the mother's distraught condition. The criterion of consciousness suggests the second and third criteria: temporality and relationship.

2. *Temporality.* The "here and now" experience is important and must be responded to; otherwise changes occur in time and space. The experience becomes past as new feelings, sensations and thoughts occur. Imagine the consequences and direction of events if postponement occurred in the model case.
3. *Relationship* denotes response, interaction and reciprocity. In an act of empathy the attending and responding to the experience of another established relationship between two persons. Response implies giver and receiver. Interaction may occur by word, action or attitude. Reciprocity is the resultant movement toward wholeness of each being as the result of relationship. A response liberates us, affirms our own human essential quality as an individual. When this comes about, we no longer are alien, the world is not a threatening place in which to be and we are available one to the other.

In the model case, as the nurse attends to the words of the mother, she initiates response. She actively involves herself in the relationship by eliminating physical distance and by touching the mother.

Through verbal clarification she facilitates the probability of reciprocity.

4. *Validation*—feedback from one to the other of owning and taking responsibility of one's own feelings (experience). Buber states that "the man who experiences has no part in the world. For it is 'in him' and not between him and the world that the experience arises."[7] The point is made against object relationships in which validation cannot and does not take place. Rogers maintains that the only person who can fully know his field of experience is the individual himself; therefore, the best vantage point for understanding behavior is from the internal frame of reference of the other individual.[8(p488-524)] Validation, in the form of feedback about one's perception of the situation, becomes an important criterion.

The nurse in the model case senses the mother's distress and plea for attention. Not only does the nurse listen, but she also perceives that the mother is actually seeking comfort from her. She places her arm about mother and mother does not draw away. The nurse has validated her perception of what is occurring. The verbal interchange continues the validation process and, as the nurse clarifies, the mother owns and takes responsibility for her experience. The process of validation may be reversed as the mother may need to validate her perception of how the nurse is responding to her both cognitively and affectively.

5. *Accuracy.* Clarification of the meaning of experience may occur at different levels of accuracy. For purposes of human growth, the interpretation must be based on reality, as reality is experienced by the individual at any given moment. The question then arises how the person can differentiate between a subjective image that is not a correct representation of reality and one that is. What enables the person to separate fact from fiction in his or her subjective world? Rogers maintains that "what a person experiences or thinks is actually not reality for the person, it is merely a tentative hypothesis about reality.... The person suspends judgment until he puts the hypothesis to a test.... The test consists of checking less certain information against more direct knowledge."[8 (p484-486)]

In responding to the mother's words "Oh, if anything happens" with "You believe you delayed and may be responsible for a serious outcome?" the nurse focuses in on the vulnerability of the mother who may be experiencing some guilt. At least her uncontrollable sobbing suggests that the nurse may be accurately assessing the situation. It appears that behavior may be best understood by gaining, as far as possible, the internal frame of reference of the other person, and seeing the world of experience as nearly as possible through his or her eyes.[8]

6. *Intensity.* Energy varies within the individual from low to high. It may move from a superficial empathic reflection of the expressed feeling, to a more intense empathic understanding of vulnerability, and subsequently to life and death concerns.

The Carkhuff scale for measurement of empathic understanding in interpersonal processes is further support of intensity as

a criterion for empathy.[9(p174-175)] Carkhuff and his associates have arbitrarily determined that responses that are interchangeable with the client's feeling and content are at the 3.0 level and are termed "minimally facilitative." The higher levels of empathic responses, 3.0 or above, are termed "additive." Additive responses reflect that the helper has to go beyond what was expressed by the client and add to the client's self-understanding and exploration. Responses that fall below the 3.0 level are termed "subtractive," that is, they have a detrimental effect on the client. A helper whose responses are subtractive does not facilitate a person's growth.

Analysis of the selected model case revealed six provisional criteria as listed above. To gain further knowledge about these criteria, to test whether they are typical as opposed to essential features of empathy and to extract other criteria, additional techniques of analysis were pursued. One such technique is the examination of alternative cases, which may include contrary, related and borderline cases.

DESCRIPTION AND ANALYSIS OF ALTERNATIVE CASES

Contrary Case

The situation is the same as in the model case. Mother rushes to the nurse at the desk and bursts into tears.

M. "I can't leave. Paul has never been apart from me."

N. "Visiting hour is over. Sorry, there are no exceptions."

Examination of this contrary case of empathy was productive only insofar as it validated the negative aspect of each of the criteria as explicated in the model case. Whatever empathy is, this is certainly not an instance of it. The criteria of temporality, relationship, validation, accuracy and intensity are all denied.

Same scene:

M. "I can't leave. Paul has never been apart from me."

N. "I know what you mean. I had the same experience. My Johnny was a mess when he had his tonsils out. But everything went just fine. There was nothing to worry about."

In this example, the nurse has disregarded the feelings of the mother. She has related to her own past experience and allowed her experience (object) to come between herself and the other, so that although there is conscious presence, there is no relationship, no sensitivity, no attending and certainly no empathy. Essentially, this is a case of discounting or disconfirmation in which the nurse communicates no awareness of even the most obvious expressed feelings of the mother.

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Related Cases

In the analysis of empathy it is important to consider other related concepts. In nursing, because of the implications of empathy to effective relationships in terms of therapeutic outcome, it is essential that

we differentiate between empathy and its related concepts of sympathy, pity and compassion.

SYMPATHY

The situation is the same as in the model case.

M. "I can't leave. Paul's never been apart from me. His father doesn't care. He probably is out with his mistress right now. I must stay with Paul."

N. (who is in the process of divorce herself). "Oh, I know what you mean." (Dissolves into tears as she holds the mother close.)

This is clearly not a case of empathy. It is related, but definitely different and might be labeled an instance of sympathy. It fits some conditions of empathy, namely, it is a conscious process and involves an object relationship. It is an "I-it" response rather than 'I-thou' relationship experience between the nurse and another person. It differs in that the focus is not on the feeling but on the content of what each is saying. The response of the nurse comes from a preconceived internal frame of reference that excludes the pain, fear and hostility of the mother. These are discounted; moreover, the nurse adds to the burden by giving the mother more to deal with. Her underlying anxiety about her own personal situation becomes a factor in creating distance between the two, even as they share feelings of sympathy, pity, or compassion. They are sharing a oneness, an identification. Empathy does not involve oneness, nor is it identification. Empathy is different from sympathy: the two processes are mutually exclusive. In sympathy, the subject is principally absorbed in her own feelings as they are projected into the matter. Sympathy bypasses real understanding of another, and the other person is denied her own sense of being. This related case of sympathy brings into evidence the following condition for empathy:

7. *Objectivity.* To become subjectively involved in the feelings of another puts one in the position of needing help also.

According to Rogers,[8(p515-524)] experiences inconsistent with the self are perceived as threats and evoke anxiety. To protect the integrity of the self-concept, these threatening experiences are denied symbolization or are given a distorted symbolization. This is expressed in defensiveness, which affects interpersonal relationships. Conversely, these experiences may be objectively perceived, tested, and assimilated. As this process of integration occurs, the individual becomes less rigid, accepts others more readily and enhances himself.

An additional criterion related to objectivity is:

8. *Freedom of evaluation.* Sympathy implies two people who have agreement of value judgment and similarity of experience. When this is so, it interferes with dealing with the accurate assessment of the other's point of view. Accurate assessment is weakened because the assessor tends to avoid the dissonance that may occur when we tend to see ourselves as similar to others in some respects and not in others.[8(p503-524)]

PITY

Another related case is pity. Pity may be said to be deep sympathy. It differs from sympathy, however, in that it has a connotation of demeaning or diminishing the

humanity of another. Pity is not seen as a positive growth-supportive feeling, as illustrated in the expressions "Pity the poor slob" or "There but for the grace of God go I." Consider the model case with a change of scene to include two other nonparticipant nurses who are standing within hearing distance. The one nurse turns to the other and says, "Poor woman, I feel for her."

The second nurse says with sorrow, "I would hate to be in her shoes." The criterion of relationship is not essential to pity.

COMPASSION

Compassion may also be said to be related. It connotes sorrow or pity excited by the distress or misfortunes of another. A case may involve the young student nurse with the geriatric patient. The young student, feeling compassion for the older person, visits on weekends to provide family for the lonely. In this instance, there is a pervasive long-term condition that evokes pity or sorrow. It does not have the quality of growth potential that empathy does even though in many cultures compassion is a high value characteristic of maturity in persons.

Evidence from these related cases gives us a better understanding of empathy by indicating how empathy fits into the network of concepts of which it is a part. These related cases illustrate major differences relative to the type of relationship and to the subjectivity-objectivity criterion.

Borderline Cases

Another very helpful technique is the examination of borderline cases in which one cannot be sure whether an instance of the phenomenon in question exists.

CON ARTIST

The con artist is a case in point. Consider the protagonist in The Music Man. *His fast musical patter about his understanding and concern as he attempts to coerce his audience into buying his wares is a questionable instance of empathy.*

The case of the undertaker who goes through ritualistic postures to convey his empathic understanding of bereavement may or may not be an example of genuine empathy.

UNDERTAKER

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MANIPULATOR

The case of the manipulator who attempts to avoid social obligations by appealing to the empathic nature of his friends may be said to be a case of pseudoempathy. The appeal may be a familiar one of "I can't come; I have a headache" to "I can't serve on the committee; my schedule is overbooked," or "I would like to join, but I don't have the money."

These borderline cases meet only a few of the criteria for empathy. It is obvious that there is not a point-by-point match. Rather than a person-to-person relationship, a person-to-object relationship appears to be in place.

Validation, accuracy and relationship are

TABLE 1
Comparison of Observed Criteria of Related Concepts with the Essential Criteria of Empathy

Provisional Criteria	Empathy	Sympathy	Pity	Compassion
Consciousness	X	X	X	X
Temporality	X	X	X	X
Relationship "I-thou" objective	X	X	X	X
Validation	X			
Accuracy	X			
Intensity	X	X	X	X
Objectivity	X			
Subjectivity		X	X	X
Freedom from value judgment	X			

not essential in these cases as they are for empathy. Subjectivity, however, appears to be a common criterion in the other cases that are cited as related and borderline. Table 1 shows the comparison of the observed criteria of related concepts with the essential criteria of empathy.

REVIEW OF EXISTING LITERATURE

An essential component of any conceptual analysis is the review of existing literature on the concept, including theory, research and philosophy. Literature from a broad range of fields of inquiry is sought to test the consistency—or lack of consistency—of conceptualizations in various fields. Existing tools used to "measure" or "test" the concept are examined to extract subtleties of meaning conveyed in test questions.

A review of existing literature has been made on a selective basis throughout this analysis. The review does not represent an exhaustive search, but reference is made to authors who have facilitated extraction of both explicit and implicit meanings of empathy. A more inclusive bibliography, written by the author for "Exploration of Empathy in Nurse-Client Interaction," may be referred to.[10]

EXTRACTION OF PROVISIONAL CRITERIA

Provisional criteria that may be used in naming the occurrence of empathy were identified through exploration and deliverance of model and alternative cases. They were previously listed in piecemeal fashion as they were identified. For purposes of clarity the total list is presented as follows:

1. Empathy occurs in consciousness.
2. Empathy implies relationship.
3. Empathy involves validation of experience.
4. Empathic understanding exists in variable degrees of accuracy.
5. Empathy has temporal dimensions restricted to the here and now.
6. Empathy involves energy, which varies in intensity.

7. Empathy requires objectivity.
8. Empathy requires freedom from judgment or evaluation.

These criteria represent conditions that must be present to determine that an instance of empathy is occurring. Moreover, when an instance resembling empathy does not satisfy these criteria, it is logical to conclude that a related or borderline case of the concept is being used. This sensitivity contributes to a more definitive meaning for the concept of empathy.

EXAMINATION OF SOCIAL CONTEXTS AND UNDERLYING ANXIETIES

Empathy in everyday usage is defined in such a way that one cannot differentiate it from its related concepts. It is, more often than not, used interchangeably with sympathy. Dictionary definitions are seldom helpful in reaching explicit meanings for abstract concepts.

Within contemporary nursing a concern is perceived by many nurses about the part that empathy plays in establishing therapeutic nurse-client relationships. Differences in essential criteria for empathy and for observed criteria of related concepts were identified through the techniques applied in this conceptual analysis. A question of value arises in this area. Would not nurses attempt to improve their empathic ability if they understood the differences? Would not nursing educators be more effective in teaching nurses to be empathic? What is the relationship of education and empathic ability? Is empathic ability considered as a condition of admission to helping professional programs? Might it not become a criterion for admission when its limits and implications to practice are understood and accepted?

One question of underlying anxiety that needs to be addressed by nurses has to do with power. Patients ascribe expertise and reward power to professionals whom they perceive in control. Nurses have the potential to accept this power with or without actually earning it. To earn it would require active sharing of oneself in every interaction. Does the organizational structure of nursing allow for this patient contact, or is the nurse busy with other than patient concerns? To say that nurses do not have time to be in an "I-thou" response relationship with patients is, in effect, an acknowledgment that nurses do not give therapeutic or empathic care.

Another related underlying anxiety revolves about the relationship of professional satisfaction and retention of nurses in the profession. Does professional burnout occur more rapidly with low empathic experiences and ability? What happens to the empathic ability of newly graduated nurses? Does it increase or decrease with clinical practice?

Empathy needs to be investigated in the broadest possible social context to include ordinary and professional usage. It is difficult to switch into various personality behaviors without experiencing dissonance and resultant energy drain. Would not it be more congruent to understand empathic behavior and develop it for both professional and nonprofessional roles?

The general method of approach described here does not provide a complete answer to conceptual analysis. It does provide a methodology for initiating conceptual thinking. In opposite instances,

when one believes one has nothing to say or that one has said all there is to say about a concept, this approach has been productive. It is easily followed and can be used by individuals and groups. Increased understanding and use of this approach by nurses would help to advance nursing science by providing an organized methodology for describing phenomena important to nursing practice.

REFERENCES

1. Kalish, B. "Experiment in the Development of Empathy in Nursing Students." *Nurs Res* 20:3 (May-June 1971) p. 202-211.
2. Mansfield, E. "Empathy: Concept and Identified Psychiatric Nursing Behavior." *Nurs Res* 22:6 (November-December 1973) p. 525-530.
3. Zderad, L. *A Concept of Empathy.* (Georgetown University: unpublished doctoral dissertation 1968).
4. Chinn, P. and Jacobs, M. "Theory Development in Nursing." Tape Series, Nursing Sciences Tape Library, Texas Woman's University, Denton, Texas 1975.
5. Wilson, J. *Thinking with Concepts.* (London: Cambridge University Press 1963).
6. Stein, E. *On the Problem of Empathy.* (The Hague: Martinus Nijhoff 1970).
7. Buber, M. *I and Thou.* (New York: C. Scribner's Sons 1958).
8. Rogers, C. *Client-Centered Therapy.* (Boston: Houghton Mifflin 1951).
9. Carkhuff, R. *Helping and Human Relations,* Vol. 2, *Practice and Research.* (New York: Holt, Rinehart, and Winston 1969).
10. Forsyth, G. L. "Exploration of Empathy in Nurse-Client Interaction." Ph.D. dissertation, Texas Woman's University, Denton, Texas, May 1977 (Ann Arbor, Mich.: University Microfilms International 1977).