

ON EMPATHY: FUNDAMENTAL ISSUES REGARDING ITS NATURE AND TEACHING

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To be able to "demonstrate empathy" is one of the stated objectives of the South African Nursing Council (S.A.N.C.). In their teaching guide for the subject "Nursing Dynamics", it is the compulsory subject for all post-basic clinical programmes (S.A.N.C. 84/M89 dated 1989-02-17). The prominence accorded to empathy in the curriculum would lead one to expect clarity among nurse educators and professional nurses regarding what it is and how it may be taught. Yet this does not appear to be the case in practice. Empathy as a phenomenon remains elusive. Much ambiguity surrounds it and the term is used in different ways by different people. At times empathy and sympathy appear to be used interchangeably, and many factors no doubt contribute to this confusion. Educational programmes of the majority of practising nurses and nurse educators did not include training in the development of empathy skills. Nursing textbooks in general present only brief references to empathy and do not address rigorously the question of its nature and whether and how it may be taught and evaluated. Publications of scholars and researchers which address these issues are not readily and freely available in nursing colleges and clinical areas, and in essence, if empathy is to be demonstrated in nursing and if research in this area is to advance, issues relating to empathy need clarification. It is the purpose of this paper to analyse theory and identify fundamental issues regarding the nature and teaching of empathy and its place in clinical nursing practice.

THE NATURE OF EMPATHY

Origin and development

The historical roots of the word empathy date back to the early part of this century when Edward Titchener, an English psychologist at Cornell University introduced the word in the English language as an equivalent of the German word "Einfühlung". The latter term was coined about 1885 by Theodor Lipps, a German psychologist (Mackay et al 1990: 29). Einfühlung literally means "feeling into" and was used for describing a person who is very understanding (Universal Readers Digest Dictionary 1987: 505). Evidently "empathia" was an early Greek word meaning affection and passion with a quality of suffering. Bar-

ABSTRACT

In nursing empathy is generally regarded as an essential component of nurse-patient interaction, but there appears to be a lack of clarity among nurse educators and professional nurses regarding its nature and how it may be taught and measured. This paper focuses on an analysis of selected theoretical works related to the nature and teaching of empathy, and an attempt is made to identify fundamental issues regarding the phenomenon "empathy" and its place in clinical nursing practice.

ABSTRAK

In verpleegkunde word empatie in die algemeen as 'n wesenlike komponent van verpleeg-pasiënt interaksie beskou. Dit blyk egter of daar heelwat onduidelikheid onder verpleegdosente en praktisyne bestaan met betrekking tot die aard en onderrig van empatie. In hierdie studie word 'n analise van geselekteerde teoretiese werke oor empatie gemaak en 'n poging word aangewend om fundamentele vraagstukke ten opsigte van empatie en die plek daarvan in kliniese verpleegpraktyk te identifiseer.

rett-Lennard (1981: 91) points out that the "em" means in or into, and there is the idea at least of going into a strong feeling or connection with another. The Latin equivalent largely borrowed from the Greek, was *pathos* which can mean feeling/perception.

In ensuing decades the meaning of empathy evolved further to include perceptual and interactional events as well. Its importance in helping relationships increasingly was recognised. Psychoanalysts and therapists developed the skill "to understand the client", to see with his eyes and listen with his ears" -to put themselves in his shoes and to obtain in this way an inside knowledge, that is almost firsthand (Freud 1957: 40; Katz 1963: 13; Barrett-Lennard 1981: 92). Carl Rogers (1957) a psychotherapist well-known for his work in defining the characteristics of a help-

ing relationship identified empathy, warmth and genuineness as the three qualities of a therapist that provide the necessary and sufficient conditions for therapeutic growth to occur.

By the 1950's empathy began to have some influence in nursing. In the nursing literature Peplau, an interaction nurse theorist speaks indirectly about empathy in her comments about nursing care. *Understanding* of the meaning of the experience to the patient is required in order to function as an educative therapeutic maturing force (Peplau 1952: 41). Sperry published an article in 1956 entitled "Empathy is important in nursing". Henderson (1964) wrote of the nurse's requirements to know and understand the patient, to get inside his skin. In subsequent years many more nurses put forth empathy as a critical component of helping relationships and an essential part of nurse-patient interaction (Travelbee 1964, 1971; Ludeman 1968; Zderad 1969; Ehmann 1971; Kalisch 1973; Leininger 1978; Watson 1979; La Monica 1981; Dage-neis & Meleis 1982). Most of these writings reflected the influence of Carl Rogers.

CONCEPTUALISATION AND DEFINITIONS

An analysis of conceptualisations and definitions of empathy in contemporary publications of scholars and researchers reveals a wide divergence of thought with regard to the nature of empathy. Empathy has been identified as an innate ability or personality predisposition or trait; a learned skill; an emotional phenomena in which one person experiences the feelings of another person; a cognitive understanding of the situation of another person, a state and a process. (Rogers 1957; Travelbee 1966; Ludemann 1968; Kalisch 1971; Forsyth 1979; Watson 1979; La Monica 1981; Dage-neis & Meleis 1982; Janzen 1984).

These variations are reflected in the definitions of the writers. For Rogers (1957: 99) empathy means "to sense the client's world as if it were your own, without ever losing the 'as if' quality. This is empathy and this seems essential to therapy". Travelbee (1966: 137) sees it as the ability to share in the other per-

son's experience. Ludemann (1968: 277) describes it "as entering into the spirit of another and becoming aware of being nearly identical with him or her". Kalisch (1971: 203) describes it as "the ability to enter into the life of another person and to accurately perceive his or her current feelings and understand their meanings. To Watson (1979: 28-30) empathy is the ability to experience and thereby understand the person's perceptions and feelings and to communicate these understandings. La Monica (1981: 398) considered empathy to be a sequence of perceptual and interactional events (state empathy) which involves both verbal and non-verbal behaviour on the part of the helper. She provides the following definition: "Empathy signifies a central focus and feeling with and in the client's world. It involves accurate perception of the client's world by the helper, communication of this understanding to the client and the client's perception of the helper's understanding". Forsyth (1979: 55) describes empathic individuals as "those who possess keen insight, imaginative perceptiveness and social acuity about other persons". Dagneis and Meleis (1982: 415) identify a personality dimension they entitle empathy which has as subdimensions adaptability, sociability, consideration and sensitivity. Janzen (1984: 3) defines empathy as "a psychological process of a nurse feeling into a client's thinking; sensing, comprehending and sharing his/her internal frame of reference."

THE EMPATHIC PROCESS

The trend to examine empathy as a process occurring in stages or phases has been spelt out by several writers. Zderad (1969) describes a psychological process of empathy comprised of three phases. First the nurse vicariously experiences another's private world by constructing "a mental image of him/her including his physical appearance, affects, life experiences, modes of behaviour, attitudes, defences, values and fantasies". The nurse's ego then splits into an observing and observed part, with the observed part remaining in sympathetic resonance with the other person. The third phase of the process involves the nurse's detachment, her ejection of the other's ego and her examination of the internalised content.

Layton (1979) describes a psychological process of empathy made up of three components; the empathic state of the nurse, the communication of empathy from nurse to client, and the perception of a nurse's empathic state by the client. Empathy therefore involves a personality predisposition (sensitivity), an experienced emotion (sensing and feeling the client's predicament) and a cognitive and behavioural aspect (understanding the client and communicating this understanding in a language attuned to a client's current feelings, and the client's perception of this feeling).

In 1981 Barrett-Lennard, a psychologist delineated "a sequence of distinct stages involved in empathic interaction". This sequence encompassed a five-step empathy cycle as follows:

- (1) A actively attends B who hopes A is receptive (empathic act).
- (2) A resounds to B so that the latter's experience becomes known to A (empathic resonance).
- (3) A shows felt awareness of B's experience (expressed empathy).
- (4) B has a sense of A's understanding (received empathy).
- (5) B continues expression which provides A with information to confirm perception of B's experience and to confirm B's perception of A as understanding. The cycle then reverts to step two (Barrett-Lennard 1981: 91-94).

DIMENSIONS OF EMPATHY

Schwartz et al (1983) presented a three dimensional model on empathy for nurses which includes three discrete approaches to empathy.

- 1 **The predictive approach**
Here the nurse possesses the ability to predict accurately the thoughts and feelings of others, that is take on their role, even if their attitudes are different from her own. In other words, to be empathic, the nurse takes on the role of the patient and accurately knows how he/she thinks and feels, even if he/she is very different from her.
- 2 **The achieved approach**
This is an interactive client-centered approach. Here the thoughts and feelings of the other, while not becoming the nurse's, need to be perceived by the other as being understood. Instead of focusing on accurate understanding (as in the predictive approach) the focus in this approach is on whether the other person feels understood. In other words the nurse is empathic if the patient thinks she understands him/her. The nurse has achieved empathy because the patient believes that she understands.
- 3 **The behavioural approach**
Behaviours which promote understanding characterise this approach and not the perceived understanding by the other. In other words the nurse is empathic if she can make appropriate statements in response to the patient.

These divergent views expressed by writers on the nature of empathy, the empathic process and dimensions of empathy naturally hold grave implications for nurse educators. The assessments of whether the students are able to demonstrate empathy necessarily will differ according to the conceptualisation of

empathy in nursing schools and clinical practice.

CHARACTERISTICS OF EMPATHY

Several characteristics appear to be essential in facilitating empathy in nurses. Both Zderad (1969) and Tyner (1985) cite self-confidence and the ability to listen as basic empathy promoting characteristics. Tyner is furthermore of the opinion that empathy requires self-disclosure, a nurse's full attention, her authenticity, honesty, truth and a non-judgmental approach (1985: 393-401). Zderad points out that the ability to empathise is influenced heavily by maturity and experience. With experience the nurse builds up a storehouse of knowledge, feelings, attitudes and learning to help understand the experience of others. Empathy also requires a healthy psyche, flexibility and ready access to feelings. It is thought that the nurse who knows herself well is best able to empathise (Rawn-sley 1980: Griffin 1983).

Travelbee (1984) regards courage as an important characteristic to enter empathic like relationships. La Monica (1981) in her research on empathy solicited descriptions of a highly empathic person from female psychology graduate students, nurses and university professors and found that perceptiveness and compassion showed the highest loadings in a factor analysis of descriptions she gathered. These findings raise further questions for the nurse educator. Is there a critical point in a scale, which could be developed to assess characteristics stated to be essential in empathic relations, below which a person cannot be properly trained to offer genuine empathy?

EMPATHY VERSUS SYMPATHY

Even though it is generally accepted that empathy is different from sympathy, there appears to be considerable ambiguity in the use of these terms in the literature and the distinction maintained by some writers is not necessarily accepted by others. Bradley and Edinberg's summary of the differences between these terms probably represents the majority view. According to them the sympathetic nurse is subjective, as opposed to the empathic nurse who maintains a sense of objectivity. The sympathetic nurse offers condolence and pity, whereas the empathic nurse offers support and understanding. The sympathetic nurse "takes on" client's feelings whereas the empathic nurse "borrows client's feelings". The sympathetic nurse loses self-identity, whereas the empathic nurse maintains self-identity" (Bradley & Edinberg, 1986: 89).

Empirical evidence of a distinction between empathy and sympathy is offered by Gruen and Mendelsohn (1986) who found empathy to be a stable personality factor, whereas sympathy depended on an interaction between the

personality of the observer and the plight of the individual in the observed situation.

THE GOALS OF EMPATHY

Differences in opinion exist, too, with regard to the goals or the desired endpoints of empathic relationships. In the nursing literature two main ideas regarding the goals of empathic relationships emerge. Some writers hold that the goal is to analyse objectively another's experience and thereby effect therapeutic change (Zderad 1969; Kalish 1971; Mansfield 1973). Others maintain that the goal of empathy is to share another person's pain or distress in order to relieve him or her carrying it alone. (Travelbee 1964; Tyner 1985).

The difference in these ideas is significant and again raises questions about the nature and place of empathy in nursing.

EMPATHY AND CARING

Despite the divergencies regarding the nature of empathy there appears to be agreement among the nurse writers referred to so far, that empathy is a necessary or core condition in helping relationships and an essential part of the nurse-patient interaction. It has in fact been postulated that through empathy nurses reach the essence of care but this view is not supported unanimously within the literature. A number of contributors to the literature have called it into question. In 1965 Eysenck published results of his research of the effectiveness of psychotherapy and found the importance of empathy on the part of the therapist small or nonexistent. In 1983 Gladstein on the basis of his research, maintained that despite claims for the positive effect of empathy on client outcomes, the evidence in this regard was equivocal. He stated: "It appears as though empathy in counselling/psychotherapy can be helpful in certain stages with certain clients and for certain goals. However, at other times it can interfere with positive outcomes (Gladstein 1983: 467).

In nursing, La Monica (1979) pointed to the need to investigate whether nurses being empathic make a difference to what she terms 'nursing care outcomes'. This need still appears applicable today.

Griffin does not see a place for empathy in her philosophical analysis of caring in nursing. She maintains that empathy is wholesale immersion in the feeling of another and that the intensity of this involvement is not feasible in nursing practice. Instead of empathy Griffin uses the notions of attunement and perspective to conceptualise caring practices (1985: 289-295).

Benner (1984) performed extraordinary examinations of the actual caring practices of nurses, using clinical episodes, critical incidents and exemplars from practice as a data base. Empathy is however, not a term Benner

chooses to describe caring behaviour. She uses "compassion", "presencing", "inspiring hope", "comforting", "touch", "support" and "mediating" among her descriptions of caring. In Benner's accounts of actual practice, there are no descriptions of nurses sensing a patient's experience as if it were their own, or of vicariously experiencing a patient's world. Rather, expert nurses have a storehouse of experiences that allows them to understand a patient's lived experience without necessarily experiencing it themselves. There are no examples of a nurse being the observer and the observed simultaneously, or of objectively analysing a vicarious experience. In addition Benner offers no examples of nurses consciously and deliberately using expert caring to achieve a specific planned goal. From the work of Benner, previous notions about the role empathy plays in successful nurse-patient interaction and the way nurses "use" empathy to effect therapeutic change seems called into question.

TEACHING OF EMPATHY

There is considerable agreement in the literature that empathy is a human potential, which must be developed and not left to chance. Aspy, (1975) a counselling psychologist, thinks our entire society would benefit from learning the application of empathy to human relations. He recommends that empathy training be a part of every service-oriented profession. Writers however, differ in how empathy should be developed. Rogers (1957) thinks empathy is best taught by being around other empathic persons. He believes the empathic climate itself teaches others to be empathic. On the other hand there are writers, for example Gazda et al (1987) who suggest empathy be directly taught as a skill as other skills are taught and to this end, developed the Human Relations Training (H.R.T.) model to teach empathy as a skill. Nevertheless they consider a respectful attitude as a prerequisite for obtaining the skills necessary for communicating empathic understanding, and view this attitude in the context of psychosocial development. Developmentally, to be empathic, individuals must have reached a stage where they have a sincere interest in others, they must have matured beyond thinking of themselves, so they are capable of understanding another's point of view. In the H.R.T. model a respectful attitude means that human nature is trusted so much that we are comfortable allowing people to be themselves. When we judge, control, give advice and have expectations for others, we violate respect. Furthermore when we lack respect, we do not work with others, but do things to or for them and such actions are said to prevent a facilitative relationship from developing. In H.R.T. terms, if we are not able to view life from another person's viewpoint and have sincere interest in him/her, we are not capable of empathy.

The H.R.T. model attempts to teach empathy throughout our lifetime. As we master one developmental stage we are able to advance to the next level of interpersonal functioning. With H.R.T. we begin to learn empathic attitudes and skills at their most teachable moments and progress according to our psychosocial development.

The H.R.T. model uses a group format in teaching empathy. The training requires a minimum of 12 group hours and the optimal group size ranges between 10-18 members.

A major function of the group is to allow trainees the opportunity to practise the skills they are learning. With each skill component there are exercises that allow group members to practise and successfully master the skills. Once a skill is mastered, group members move on to the more advanced skills. The H.R.T. consists of three major skills:-

- recognising and classifying types of requests
- attending behaviours
- giving empathic responses

The first set of empathy skills to be mastered in the group is recognising and classifying requests. Technically a patient can make four kinds of requests to a health professional. Each request requires a different response. The first two requests, "request for information" and "request for action" involve professional and technical expertise. The third kind of request, "request for understanding and involvement" requires skill in interpersonal function. The fourth type of request, the caregiver may encounter is "an inappropriate request". Care-givers must be able to assess the type of request which is being made.

Upon mastery of identifying these different forms of requests, group members advance to learning attending skills. There are non-verbal behaviours used for listening to another person. These behaviours include tone of voice, posture, eye contact, facial expressions and other physical behaviours.

Upon mastery of attending skills, group members are ready to develop the ability to give facilitative responses. A facilitative response is one that perceives accurately the speakers feelings and conveys that understanding to the speaker. These responses can be measured for their empathic content on Gazda's empathy scale.

Several other empathy training models exist of which those of Carkhuff and Truax are probably the first ones to have been designed. Truax and Carkhuff (1967) translated empathy into an observable and measurable behaviour and developed scales to measure this behaviour. These two scales were developed later into human relations training models.

Several interpersonal skill development programmes conducted with nurses in which em-

pathy is a dominant focus have been described in the literature (Kalish 1971; Farrell Haley and Magnasno 1977; La Monica, 1983; Anderson and Gerard 1984; Bradley and Edinberg 1986; La Monica, Madea and Oberst 1987; Mackay et al 1990). Most of these are based on the training models already described. These programmes range in length from six to forty-five hours and include the common features of didactic instruction, experiential learning, modelling behaviour, rehearsal and feedback. Teaching strategies include role-playing, video-taped vignettes, work-books and small group discussions.

Bradley and Edinburg (1986: 90-103) advocate four verbal and four non-verbal skills which nurses should learn in order to increase the likelihood of developing an atmosphere of trust and empathy through the therapeutic use of self. The four verbal skills are the use of "I" statements, reflection, sharing feeling and verbal reassurance while the four non-verbal skills are non-verbal reassurance, attending to the client, active listening and the use of silence.

There seems ample evidence to show that participants in the Empathy Training programmes increased their abilities to offer empathic responses at a helpful level, but, the application of empathic skills in the practice fields remains a problem which has yet to be solved.

THE MEASUREMENT OF EMPATHY

Numerous instruments purporting to measure empathy have been developed, but there is little agreement among researchers on exactly what should be measured and how it should be measured. Each of the measurement approaches stem from a different view of empathy as a concept. Instruments are categorised as self-report, client observer measures, peer judgment or independent observer judgment.

The Truax Accurate Empathy Scale (1961, 1963), Carkhuff's Empathic Understanding in Interpersonal Processes Scale (1969) and Gazda's Empathy Scale (1984) probably are the most frequently used observer empathy rating scales. According to these scales, an empathic response is determined by how well we communicate understanding of a speaker's feelings and the meaning attached to those feelings. Truax developed an 8 point empathy scale, while Carkhuff developed a 5 point scale. Carkhuff's Scale is a simplification of the Truax Scale. Gazda's Empathy Scale is a seven-point scale with 3.0 being a facilitative response. A 1.0 to 2.5 response does not convey understanding and respect for an individual. These responses range from a hurtful to a neutral response, whereas a 3.0, 3.5 or 4.0 response is empathic, conveys respect and forms a facilitative relationship.

Defined on the empathy scale, a 3.0 response is one which communicates the primary feelings made by the client and includes the meaning the client attaches to these feelings. In essence, a 3.0 response conveys understanding of how the client feels (affect) and the meaning (content) attached to those feelings. On all these scales empathy is rated by judges (independent observers) and several investigators have found that inter-judge reliability is a problem with these measurements (Layton 1979; Janzen 1984).

A frequently used measure of empathy derived from the client's, perspective is the empathy subscale of the Barrett-Lennard Relationship Inventory or B.L.R.I. (1962). The empathy subtest of the B.L.R.I. is a 16-item 6 point questionnaire rating scale, which may be used for self-rating or rating by clients.

Of particular interest to nursing is an instrument developed by La Monica (1981) called the Empathy Construct Rating Scale (E.C.R.S.). La Monica developed this instrument for use among nursing and other health professionals who are in a position of giving help and who are in positions of authority relative to the recipients of care. The E.C.R.S. is an 84 item 6 point questionnaire rating scale, and is similar in format to the B.L.R.I. It offers great flexibility in view of its potential as a self-report, client or associate/observer measure of empathy.

Several problems have been noted with regard to client perception measuring instruments. Gagan (1983) summarises these problems as follows:

- (1) Patients perceive nurses as empathic whether they are or not, evidenced by high correlations with patient satisfaction and low correlation with empathy training.
- (2) The B.L.R.I. assumes the professional-client relationship to be sustained over time, whereas in nursing, especially in hospital nursing, relationships are often of short duration so that the patient does not know the nurse well enough to respond to the questions asked on the B.L.R.I.
- (3) Patients are a captive group and may be deterred from offering candid responses through concerns for their subsequent care.

A self-rating scale using a personality perspective which has been employed in nursing studies (Forsyth 1979; Brunt 1985) is Hogan's Empathy Scale. This scale consists of 64 statements which respondents claim to be true or false relative to their self-appraisals. Hogan (1975) developed this scale to distinguish the person who is socially perceptive and aware of impressions made on others, from the one who relates to everyone in the same way in socially desirable or conventional terms.

The major criticism of self-report scales is that most depend on an intellectual self-appraisal of ability which may not be borne out behaviourally. To substantiate this criticism Kunst-Wilson and Associates (1981) can be cited. They found no agreement between self-reports of empathic ability and observer ratings of actual ability in their study on empathic ability and observer ratings of actual ability in their study on empathic perceptions of student nurses.

Two Instruments which have been used in nursing studies to measure general emotional responsiveness are Stotland's (1978) Fantasy Empathy Scale (F.E.S.) and the Mehrabian (1972) Emotional Empathy Scale (M.E.S.). The M.E.S. measures general emotional responsiveness to a variety of interpersonal situations. The scale is conceptualised as a measure of general empathic tendency or trait empathy and consists of 33 items on an 8 point scale ranging from +4 to -4. The F.E.S. measures the tendency to respond emotionally to fictional and/or dramatic characters. The scale consists of three items on a 5 point Likert-type scale ranging from strongly agree to strongly disagree.

Close examination of available instruments measuring empathy suggest that they are not confined to empathy but may measure several caring components and interpersonal skills. As an example, scale items on La Monica's E.C.R.S. include commitment, concern, availability, presence and genuineness. This may suggest that these conditions have an interlocking nature or interact in such a way as to increase and complement each other and makes it difficult to pinpoint empathy. In 1984 Janzen conducted a thorough review of literature dealing with empathy and found that established empathy rating scales did not correlate with each other and that measurement processes based on empathy offer variable interpretations. This may indicate that each one of the scales may measure different constructs which do not necessarily include empathy. It is clear that the accurate and valid measurement of empathy is a formidable research goal not yet fully achieved and this has grave implications for nurse educators who have to measure empathy. Without a dependable measure they will not be sure of the reliability or validity of their assessment. Lack of consensus on the means of measuring empathy blocks the progress of research into the effect of the care-givers use of empathy in nurse-patient interactions on the subsequent well-being of the patient.

CONCLUSION

The exploration of empathy as discussed in this paper has revealed several issues which stand out as particularly important. Firstly, there is no doubt that conceptual agreement concerning empathy as a phenomena is lacking. There is a lack of consensus on the na-

ture of empathy, how it may be defined and how it can be measured.

Secondly, there are unanswered questions concerning the validity of a number of measures published which purport to assess empathy, which restricts opportunities for investigators to build upon the work of others.

Thirdly, it seems that nurses have problems in operationalising empathy as it has been described in the nursing relationship and there is a lack of consensus whether empathy is a valid concept for practice.

These issues have clear implications for nurse educators. As there is still much uncertainty with regard to various aspects relating to empathy, and as it is currently unknown whether helper empathy, in fact makes a difference in positive patient outcomes, the question arises whether there is justification for educators to include empathy skill attainment in programmes for the preparation of nurses. Should not the emphasis rather be on the development of caring relationships of which empathy is but one component? The close association between the various caring components suggest that it is somewhat artificial to separate them and focus only on empathy, particularly when conceptual agreement on the phenomenon is lacking. Furthermore since the application of empathy in practice appears to be problematic, should attention not first be given to supportive environments and clinical role models? If there is no reinforcement for using facilitative empathy from role models or other practitioners, is it cost-effective to teach it in the classroom?

It will be important for our future understanding of nursing to answer all the questions raised. The need for further research is indicated. Research evidence needs to include both quantitative and qualitative documentation of results and to include multicultural implications of the findings.

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