Empathy Series

**Towards a definition of “therapeutic empathy”: The philosopher’s view**

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In this paper, as part of our empathy series, we will introduce the notion of empathy and attempt to define “therapeutic empathy”. While the concept of “empathy” is an umbrella term that involves many different (and sometimes opposing) components, clinical or therapeutic empathy implies more specific characteristics. From a methodological point of view, we will use phenomenological notions and definitions to explore these. From a practical perspective, we will propose features which clinicians may utilise in order to practice therapeutic empathy.

1. Introduction: What is empathy?

Coined by R. Vischer, the term *Einfühlung* originally meant the projection of “…my own life into the lifeless form (artworks)” [[1]](#endnote-2) and was later translated into “empathy” by E. Titchener. Originally used in art, the term was adopted by the philosopher and psychologist Lipps, who described it as the ability to grasp other’s feelings in and with the other, immediately and non-inferentially [[2]](#endnote-3). This umbrella term has since assumed different meanings according to context such as philosophical domains, phenomenology [[3]](#endnote-4) [[4]](#endnote-5) [[5]](#endnote-6) [[6]](#endnote-7) and clinical settings[[7]](#endnote-8) [[8]](#endnote-9) [[9]](#endnote-10). In Verducci´s account, there are three kinds of empathy[[10]](#endnote-11):

1. *Aesthetic empathy*: “I am able to ‘feel into’ works of arts and into nature”. Aesthetic empathy can be considered as the original definition of empathy, and relates to the link between the perceiver and the artwork. In *Aesthetik,* Lipps develops the notion of aesthetic empathy by closely linking our aesthetic perception and that of another embodied person as a minded creature. In his view, the nature of aesthetic empathy is always the “experience of another human”[[11]](#endnote-12)**.** For example, we appreciate another object as beautiful because empathy allows us to see it in analogy to another human body. Similarly, we recognize another organism as a minded creature because of empathy. Empathy in this context is more specifically understood as a phenomenon of “inner imitation”;
2. *Sympathetic empathy:* ‘I understand other’s feelings, but there is still some emotional distance[[12]](#endnote-13).’ This type of empathy has also been described as cognitive empathy, it is centered on understanding rather than feelings and attempts to keep emotion at a distance. It is consistent with the professional approach of adopting a ‘detached concern’ for the patient.
3. *Compassionate empathy*: ‘I perceive and internalize the other’s state.’ In this kind of empathy, there is less distance among the subjects, who, on the contrary, are bound to each other and moved by pity to help the other. This type of empathy has also been described as affective empathy, it recognises the central role of feelings and emotions.

In the clinical setting, which of these matters? It seems that it cannot be either aesthetic empathy, nor simply sympathetic or compassionate empathy. In fact, the clinical encounter is a complex experience where subjectivity itself is conceived as a multilayered entity (a living and suffering psyche, a biological malfunctioning body, a peculiar consciousness with a specific life-world and habits that are changed and disrupted by illness). Therefore, the clinical encounter requires a multilayered intersubjective approach. For these reasons, we add a fourth kind of empathy, specific to the clinical setting which we call *therapeutic empathy.*

As argued by J. Howick et al.[[13]](#endnote-14) , therapeutic empathy is a peculiar kind of empathy which involves three key features: *understanding* what a disease means to a patient, *communicating* that understanding and *acting* on that shared understanding in a helpful way. In order to be useful, therapeutic empathy requires both *affective resonance* (like in compassionate empathy) *and* emotional *distance* (like in sympathetic empathy).

To characterize therapeutic empathy, we need to take into account the dimension of feelings and the importance of those pre-reflective components that are perhaps undervalued in the clinical setting, such as the patient’s experiences, emotions and habits. Phenomenology—a specific philosophical tradition that gives much importance to empathy and the different kinds of intersubjective understanding— is useful here as a theoretical starting point for characterising an empathy suited to patient care. First, we have the notion of *Leib—*living body— which is helpful to understand as the patient being much more than a malfunctioning machine. Rather it is a suffering subjectivity that the clinician may hear and understand. The empathetic clinician will therefore see the patient as an individual human being, not as a number on a production line.

After briefly characterising the role of the body in empathy and in the clinical encounter, we will now move towards underlying other features of empathy to try to understand how empathy can be concretely used in the therapeutic setting. Furthermore, we specify how therapeutic empathy should go beyond the already existent accounts to involve different phases where the innateness of the feeling coexists with the development of higher cognitive components, without being in contradiction. In other words, the heart and head must work together.

**2. Phenomenology of empathy**

Phenomenology— a distinct philosophical tradition is particularly helpful for understanding empathy. Indeed, many authors (Stein, Scheler, Walther, Schutz etc.) used phenomenology to offer their definitions of this peculiar phenomenon. In the semester between 1928 and 1929 Husserl—the “father” of phenomenology— held his final class, “*Phänomenologie der Einfühlung in Vorlesungen und Ǘbungen*” on the topic of empathy. Within the vast production of Husserl, it is possible to find numerous definitions—or attempted definitions—of this concept. What we would like to emphasise here is the role of the body, which seems to be central in the empathic act of perceiving the other. In fact, Husserl claimed that the similarity of the other’s body motivates the analogy through which we attribute other subjects a *Leib* (a living body, essentially intertwined with the psyche) like our own, albeit different from it. We perceive the other not just as a mere object, but as a *subject* in turn.
Translated to a clinical setting, we argue that the body of the patient is not only an object that the clinician should analyse and observe, but also a feeling subject, who can in turn perceive, feel and observe, actively participating in this mutual recognition.

However, the recognition of the other as a subject like me is merely formal; it does not concern the *contents* of experience. Husserl’s main purpose is, in fact, a theory of empathy through which we can have access to the other while keeping a primary differentiation between our flows of subjective experience. The physical body is collectively available, but the psychic elements do not remain directly accessible. Perceiving the existence of another living body also involves the decentralisation of the self: ‘I realize that my perspective is not unique, but one among many.’ How can we conceive of a similar relationship in the medical encounter, where the body of the patient is usually a sick, altered body, often considered in its mere biological and organic features? In this case, it seems to us that what is needed is not simply a so-called “emphatic concern”, but an empathy *specifically* shaped for the clinical setting.

 Firstly, from phenomenology we can borrow a notion of *experiential* empathy: while a definition of empathy as a mere cognitive ability does not involve the need to *feel* what others (in this case, patients) feel; an experiential account of empathy is necessarily linked with the lived dimension. We need to feel patient’s experiences, even if it is impossible to feel exactly the same. In phenomenology, this feature is called “*opacity*”: in my encounter with the other, I will never grasp exactly what s/he is feeling, since we are two different entities, two different lived bodies with unique perspectives. This is important for self- awareness as well: after the empathizing act, the subject is destabilized because he understands he is just one orientation among others and not the only one. In medicine, we can affirm that there is still a sort of divergence and dialogical breakdown between the illness lived from within by the patient and the illness analyzed by the clinician. The doctor, simply as a human being, can empathise with the patient’s experience, knowing what it is to be in pain or be disabled and understanding the illness as a disruption that involves not a single organ, but a self.

Furthermore, from a phenomenological approach empathy is a *pre-conceptual experience,* which definitely needs the experiential, lived, feeling dimension. Taking into account this feature and the concept of opacity, and applying them to the clinical environment, we can reason that therapeutic empathy is a balance between a subjective, intuitive grasp of otherness, and an objective analysis of her/his condition. In addition, opacity allows for maintaining a more professional type of empathy and is consistent with clinicians being able to remain self-aware of their own responses to the predicaments of their patients: on the one hand clinicians do not want to appear dispassionate, but on the other hand there are limits to the emotions that can be comfortably expressed within the professional setting of the consultation.

In this view, the patient's body becomes an "expression of life”, and not just a biological support. The unity between the somatic region and the psychic one is indivisible, and, therefore, the therapeutic relationship is configured as a process that involves an enlargement of assistance interventions, which are transformed from an *organic cure* into a *holistic care*. Accordingly, *to cure* is synonymous with healing by means of specialized medical technologies, which refer to the body like an organic *Körper*; on the contrary, *to care* means taking care of the sick in a global sense, with an emphasis on the educational and relational dimensions of the clinical process. Considering the patient a *Leib*, whereby the disease afflicts not only the single organs, but the body in its whole existence, implies a sense of cure that stresses the complexity of the person and reveals the necessity of a holistic and not merely biological therapy.

The result is an emphasis on the everyday world, on things and their function in the clinical encounter, which takes the form of an exchange of perspectives, a blend of two different lived bodies, of two different *life-worlds* (that is, two different ways through which the world is immediately or directly experienced in the subjectivity of everyday life, as sharply distinguished from the objective “worlds” of the sciences): the medical activity has found its own way in this intersection, in the complexity of shared perspectives. The phenomenological approach seems to be suitable to describe a similar encounter also because it emphasizes that this type of sharing will never be completed: the commonality goes hand in hand with individual uniqueness, so that first and third person perspectives will never be reduced to one another.

**3. Concrete application of therapeutic empathy**

At this point, it is legitimate to ask: how can we practically use therapeutic empathy in the clinical setting?

The Society of General Internal Medicine (SGIM) defined clinical empathy as “the act of correctly acknowledging the emotional state of another without experiencing that state oneself”[[14]](#endnote-15); on the contrary, others have argued that clinicians’ “emotional attunement greatly serves the cognitive goal of understanding patients’ emotions”[[15]](#endnote-16). But can we point out an emotional *and* a mere cognitive kind of empathy? Especially if we take into account the clinical setting, it seems that empathy is a complex experience that needs a multilayered definition.

In our opinion, a characterisation of therapeutic empathy must account for the following features:

* It must recognise that both the patient and clinician are two living subjectivities, unique and specifically characterized;
* It should take into account the patient as a *Leib*, and not as a mere biological organism;
* It should be pre-reflective, immediate and intuitive for what concerns its emotional components, such as the immediate recognition of the other as another person;
* It involves *self-awareness and self-other awareness*;
* It involves an *emotional and cognitive* distance and not an unqualified identification with the patient (speaking in Husserlian terms, the “opacity”);
* It is an *intentional* act (it is directed towards the other);
* It has a *moral* value since its aim is making people feel better and showing them they are not alone and that their suffering is being witnessed. This is a specific feature of clinical empathy since in “general empathy” we can also have negative aims. This happens, for instance, in the case of the sadist, who feels pleasure because he empathizes with whom he tortures.

In order to account for a concrete “empathic” relation in the clinical setting, our proposal consists of two different phases. In essence the clinician must strive to achieve two distinct, but interwoven, aims:

1. *contemplate and feel* other’s emotion (which we can also call “*empathic grasping”,* and can be described as a mere emotional, experiential, intuitive phase);
2. transform it into an *empathic attitud*e towards the patient (which involves the development of cognitive *and* emotional capacities).

For these reasons we believe that while empathy, in a broader and mere experiential sense, is innate and cannot be learnt, *therapeutic empathy as an attitude* (phase two), can be taught. Accordingly, we can speak of “empathic training” which can be exercised at different levels, from the receptionists to the doctors.

In Howick’s words, “the doctor is the best medicine”[[16]](#endnote-17), implying that physician empathy can sometimes have more efficacy (and certainly less side effects) than the drugs the doctor prescribes. The benefits of empathy have been reported previously[[17]](#endnote-18) through systematic reviews and meta-analysis with results suggesting that it reduces pain and anxiety and improves some physical outcomes such as bronchial activity in asthmatic persons. Of course, for empathy to have a therapeutic utility the patient needs to know that they are actually in receipt of it. The physician can communicate empathy through considerate words matched with appropriate non-verbal attributes like attentive listening, eye contact, smiles or simply the use of silence. Evidence tells us that communication skills like these are teachable, especially through the experiential training including the use of role play[[18]](#endnote-19) [[19]](#endnote-20). In fact, the existential aspect of the disease implies the necessity of compassion on the part of the doctor, who must not only understand the illness but also *empathize* with the patient. In this view, the clinical relationship could be considered an *ethical relation* between two subjectivities, a “form of affiliation”[[20]](#endnote-21).

**Conclusion**

Therapeutic empathy is a complex notion: despite frequent attempts to define it, there is still confusion about its real nature: is it affective or cognitive? Can it be taught?

In this paper we use a philosopher’s perspective to delineated the essential features of clinical empathy, and we proposed an account which goes even further, defining it as a *therapeutic experience* that involves both cognitive components and affective features. Accordingly, we described it as a process which implies two stages —one intuitive and one attitudinal. The attitudinal aspects of empathy require the types of communication skills that can be nurtured through effective teaching and training. In the medical setting, we need to establish not only an interaction and an emotional resonance with the patient, but also a concrete understanding, which requires the construction of narratives that situate the patients’ experience in the real world. In the health care context there are limits to empathy and to the intensity of feelings that can be professionally expressed: here the concept of *opacity* is central to establishing an empathy that is compassionate but maintains a professional detachment required for clinical judgement.

To conclude, we can affirm that human beings are essentially intersubjective (dialogue in his own essence); pathology involves the disruption of such dialogue, and therefore clinicians may restore this dialogue, through empathic caring and a dialogical or communicative approach[[21]](#endnote-22).

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