Defining Empathy to Better Teach, Measure, and Understand Its Impact
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Abstract

No consensus on the definition of empathy exists. Empathy has been described as emotional and spontaneous, cognitive and deliberate, or some combination of the two. Attentive nonverbal reactions, feeling reflections, reassurance, sympathy, and compassion all have been conflated with empathy, making it impossible to differentiate empathy from other communication skills. This confusion over the definition of empathy has affected its measurement. For example, the authors of the Interpersonal Reactivity Index see empathy as multidimensional, involving both emotional and cognitive aspects, while the authors of the Jefferson Scale of Physician Empathy see empathy as a predominately cognitive process. Researchers, such as Yamada and colleagues in their study in this issue, then must straddle these conceptualizations, which is a limitation to their work.

To address this problem, the author of this Invited Commentary proposes adopting the cognitive definition of empathy, noting that it allows physicians to distinguish between empathy and other communication skills and is the most consistent with counseling psychology descriptions. Empathy—the Jefferson Scale of Physician Empathy (JSPE) and the Interpersonal Reactivity Index (IRI). Both measure self-assessed, intrapersonal experience and use subscales to capture different dimensions of empathy. It is important to note, however, that the authors of the IRI see empathy as multidimensional, involving both cognitive and emotional aspects, while the authors of the JSPE see empathy as a predominately cognitive process. Although there may be overlap, the JSPE and IRI do not measure the same thing.

Yamada and colleagues concluded that “the JSPE is a more sensitive measure of changes in empathy than the IRI.” Supporting this conclusion, they found that changes in scores for two of the four IRI subscales, Personal Distress and Fantasy, from baseline to the three-month follow-up, were not significant. They further explained this finding by saying that these subscales may be capturing sympathy rather than empathy. Because we do not have consensus on a definition of empathy, one could argue the reverse. Perhaps their intervention, a two-day communication skills training workshop, failed to elicit the intrapersonal reactions in participants that are expected of empathic growth—reactions the JSPE did not measure. Furthermore, how can we trust that our teaching interventions are valid and precise? Yamada and colleagues’ workshop emphasized providing reassurance. Although reassurance has a role to play in comforting patients, those who hold a cognitive view of empathy would argue that providing reassurance is not a form of empathic communication. Unfortunately, we cannot study, let alone master, what we do not clearly define, a problem that continues to plague studies of empathy.

In my opinion, affectual or emotion-based conceptualizations of empathy, those that lean heavily on “experience sharing,” conflate empathy with an array of emotional reactions (e.g., distress, compassion) and responses (e.g., feeling reflections, reassurance, attentive nonverbal reactions). As a result, they cannot explain how empathy is unique. Although cognitive-based definitions do not discount affectual responses as a component of empathy, they lean more heavily on the thinking aspects of the empathic process. As a result, for them, empathy is distinguishable from other listening skills. In this Invited Commentary, I discuss further this cognitive-based definition of empathy, which is teachable, measurable, and consistent with counseling psychology descriptions.
What Empathy Is and Is Not

Let me begin with a few differentials. Empathy is not a basic listening skill; it is a master listening skill, requiring more than reflective listening techniques. Empathy is not compassion—the “heart that trembles in the face of suffering.”6 Compassion motivates individuals toward altruism, while empathy enables self-understanding. Empathy is not sympathy. Sympathy is the disclosure of a physician’s feelings to a patient (“I am sorry to hear about …”), while empathy is the process by which a physician identifies her feelings, then withholding them from her response to a patient. Finally, empathy is not “putting oneself in another’s shoes.” If I put my feet in your shoes, I will not understand you better. What is tight on me may be loose on you. What I consider worn you might find comfortably broken in. My feet distract me from understanding you.

Empathy is a conscious, strenuous, mental effort to clarify a patient’s muddy expression of her experience using a soft interpretation of her story. Employing the empathic process involves the distilling or connecting of feelings and meanings that are associated with a patient’s experience while simultaneously identifying, isolating, and withholding one’s own reactions to that patient and her experience. To this end, there are four aspects of empathy that are rarely noted in the medical literature but that are fundamental to understanding its practice: (1) the “as if” condition, (2) the use of soft interpretation, (3) the primacy of cognition, and (4) the relevance of reflection.

The “As If” Condition

To sense the client’s private world as if it were your own, but without ever losing the “as if” quality—this is empathy.7 When we think of empathy as putting ourselves in another’s shoes, the “as if” condition is easily lost. Imagine the scenario in which a young physician tells an 87-year-old patient that she is going blind. The patient says: “I can’t go blind; I have nine grandchildren and I have made quilts for all but the youngest. I have to finish!” A nonempathic response would be: “I know this is scary. You want to stay as independent as you can for as long as possible.” This attempt at empathy, likely adulterated by how the physician might feel if she were in the patient’s shoes, does not accurately capture the patient’s struggle. An empathic response would be: “It’s unfair. Blindness is cheating you out of leaving your legacy to your grandkids.” Perhaps we can say that empathy is putting yourself in another’s shoes, as if you had her feet, but the emphasis must be placed on the “as if” condition.

Let me offer a second example of an empathic versus a nonempathic response in a patient–physician encounter. A patient is told that he has HIV. He says: “I have sex with men, occasionally, but I’m not gay. Now I’ll have to tell my wife, and everyone will know.” This is just the sort of dense reaction, full of meaning and complex feelings, that empathy can help unpack. An empathic response would be, “You’re afraid everyone will think that you’re gay.” This response clarifies the patient’s almost articulated fear. The physician in this scenario might instead have responded, “This is difficult news to hear, but being gay is not something you need to fear.” The physician knows this statement is true for himself because he is nonheterosexual and coming out was therapeutic for him. Although well intentioned, this is a nonempathic response because the physician formed his response based on his experience rather than the patient’s experience. He failed to attend to the “as if” condition. Thus, the empathic process requires self-awareness of one’s own reactions to another’s circumstances. This awareness is necessary to avoid entangling one’s own experience with that of another person when formulating an empathic response.

Humanistic psychology, from which conceptualizations of empathy have largely evolved, holds that people are inherently good and will move toward health and happiness when barriers to growth are removed. Humanistic physicians nurture growth by offering careful listening and unconditional positive regard, thus creating a safe space for patients to vigorously explore the thoughts and feelings that might impede their growth. They accept patients where they are on their journeys, even when they appear lost and seem to be moving in the wrong direction. (Because the patient sets the course, the physician cannot anticipate the direction.) The humanist tolerates diversions and bumps in the road, because she believes that the journey, this self-guided process, is ultimately healing. The patient-centered approach embraced by medicine is foundationally humanistic. In medicine, we do not cut the path for patients. Instead, we use listening skills, such as empathy, to illuminate the path. Illumination requires being acutely aware of the long shadows cast by white coats and staying off the path and out of the patient’s way.

The Use of Soft Interpretation

Empathy requires soft interpretation, which is like a pencil line drawn between feelings and experience that completes the picture and reveals meaning. Karl Menninger,8 one of the fathers of psychiatry, implied this style of interpretation when he said, “One tells a patient what the patient almost sees for himself.” Likewise, Carl Rogers, founder of the humanistic psychology movement, wrote:

[Empathy] involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living in his/her life, moving about in it delicately without making judgments, sensing meanings of which he/she is scarcely aware.…9

From Menninger’s and Rogers’s use of the words “delicately,” “almost,” and “scarcely aware,” we can conclude that empathy is careful work. The physician pulls the threads of feelings and experiences together, revealing the fabric’s pattern. These threads, the material used in the empathic response, are drawn directly from the patient’s immediate disclosure, not from the physician’s extended analysis of the patient’s story.

The Primacy of Cognition

Empathy is primarily a cognitive task.10 Although it may be motivated by compassion and enhanced by intrapersonal awareness, the type of work involved in rendering a truly empathic response is largely mental, not emotional. Think of what I discussed above: identifying one’s feelings, then removing those feelings from one’s soft interpretation of the patient’s...
experience. The head checks in with the belly but is in charge. When engaged in the empathic process, the physician is aware of both her feelings and reactions as well as the patient’s feelings and reactions. The physician joins the patient in her confusion, but that confusion is ameliorated by the physician’s careful, cognitive work—work that the patient cannot quite achieve on her own.

This is not to say that the empathic listener is entirely cut off from the patient. As the psychoanalyst Heinz Kohut11 said, “Empathy is the capacity to think and feel oneself into the inner life of another person.” Through emotional resonance, we can explore another person’s feeling world. Through imagination, we can vicariously move about in emotional worlds we have never inhabited. When formulating our empathic response, the feelings we feel about another person’s experience and the feelings we imagine we might feel feel are filtered by our intellect. Emotional observations that clarify the patient’s experience might be used in the empathic response, while unhelpful projections are withheld.

The Relevance of Reflection
Identifying one’s emotional reactions during the empathic process requires deep reflection. In fact, to master empathy, physicians must make reflection a daily part of their mental life. Rigorous self-reflection is necessary because feelings and thoughts that are left unacknowledged or unaccepted will be the same feelings and thoughts that inhibit or contaminate empathic reasoning. When undertaken with an attitude of unconditional positive regard, reflection allows for fearless self-discovery. The connection between empathy and reflection goes beyond the diligent use of reflection to enable empathy. The process of reflection is like turning the warm light of empathy inward and the process of empathy like turning the warm light of reflection outward. Reflection and empathy are two sides of the same coin.

Conclusion
Empathy has been associated with decreased patient distress, increased patient satisfaction, and decreased physician burnout.10,12 Could it be that separating self from other, a step necessary for empathic reasoning, insulates against burnout? Although emotionally intelligent physicians may learn empathy more quickly, all physicians need training. Empathy can and must be taught. Like any procedural skill, the empathic process needs to be explained, in a step-by-step fashion, and practiced. However, before we can teach empathy, we must first agree on a distinct and precise definition. To that end, I recommend we adopt the cognitive definition of empathy so that we can move forward and truly teach, measure, and better understand the impact of empathy on physicians and patients.

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