What Is Empathy, and Can Empathy Be Taught?
Carol M Davis
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Empathy is a commonly used, but poorly understood, concept. It is often confused with related concepts such as sympathy, pity, identification, and self-transposal. The purposes of this article are to clearly distinguish empathy from related terms and to suggest that the act of empathizing cannot be taught. According to Edith Stein, a German phenomenologist, empathy can be facilitated. It also can be interrupted and blocked, but it cannot be forced to occur. What makes empathy unique, according to Stein, is that it happens to us; it is indirectly given to us, "nonprimordially." When empathy occurs, we find ourselves experiencing it, rather than directly causing it to happen. This is the characteristic that makes the act of empathy unteachable. Instead, promoting attitudes and behaviors such as self-awareness, nonjudgmental positive regard for others, good listening skills, and self-confidence are suggested as important in the development of clinicians who will demonstrate an empathic willingness. [Davis CM. What is empathy, and can empathy be taught? Phys Ther. 1990;70:707–715.]

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Distinguishing between empathy and similar interpersonal actions such as sympathy, pity, identification, and self-transposal is a difficult task. To further add to the confusion, these terms are often used interchangeably, both in the literature and in common conversation. In considering whether empathy can be taught, a clear definition is in order. This article utilizes the phenomenological description developed by German philosopher Edith Stein in her work *On the Problem of Empathy*[1] to support the premise that the skill or behavior of empathy cannot be taught. Rather, the process of empathy can be facilitated by developing other attitudes and behaviors that are important to achieving a high quality of health care.

The Nature of Empathy

Counseling psychologists have attempted to operationally define the "skill" of empathy in order to recognize it in the counseling interaction and to teach counselors how to empathize with clients.[2] Carl Rogers,[3] a well-known humanistic psychologist and founder of client-centered therapy, described empathy as central to the success of his therapy. Rogers claimed that empathy occurs when therapists view clients with "unconditional positive regard" and when they actively listen to clients, feeding back thoughts and feelings with sensitivity and accuracy. Healing in a psychological sense would then result.

Rogers's[3] early work described empathy as a skill that can be taught. In his later work,[4] he conceded that empathy was not so much a skill, as a way of being. One person who strongly influenced this shift in understanding of the process of empathy was Jewish theologian Martin Buber. Buber[5] described the importance of the "I-Thou" relationship to the health of human beings and described a process he termed "dialogue" as central to this relationship. In dialogue, two people embark on an unfolding conversation, the outcome of which is not known. When the process of "crossing over" occurs, a person finds herself or himself very closely connected to or aligned with the other person in a moment of shared meaning.[5] Buber[5] wrote of the thera-

CM Davis, EdD, PT, is Associate Professor and Associate Director for Curriculum, Division of Physical Therapy, Department of Orthopaedics and Rehabilitation, School of Medicine, University of Miami, 5915 Ponce de Leon Blvd, Coral Gables, FL 33146 (USA).

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peutic value of this process, and Rogers[6] claimed that dialogue was identical to empathy. Buber disagreed by claiming that the moment of crossing over could not be made to happen; it had to be allowed to happen.[6] In sum, Rogers[3] emphasized that empathy occurred willfully, when one cognitively made it happen through careful listening and mirroring of words and feelings. Buber[5] maintained that psychological healing did not occur as a result of a cognitive process that one could control, but resulted as a part of a special alignment that took place spontaneously in certain kinds of conversation.

Edith Stein,[1] a phenomenologist and a student of German philosopher Edmund Husserl, described empathy as a far more complex process. Stein claimed that empathy is absolutely unique and distinct from related intersubjective processes in that it occurs in three overlapping stages and is given to us "nonprimordially," or after the fact, somewhat like a postevent realization. A common example of a nonprimordially given experience, something that catches most of us unaware, is "falling in love." We can want to fall in love, want to be in love with someone we know well, but when the moment of enrapture hits us, often it catches us unaware. We find ourselves experiencing it, rather than causing it to happen directly. Finally, Stein[1] maintained that empathy is not so much a behavior as it is a "happening" that we can either facilitate or block. This description of empathy will be examined in more detail, but first it would be useful to examine the four interactive processes that are most often confused with empathy.

Processes Most Often Confused with Empathy

Four interactions most often mistaken for empathy are sympathy, pity, identification, and self-transposal. Each will be described according to the phenomenological literature.

Max Schleler[7] described sympathy in great detail, identifying several variations of the central process. Wyschogrod[8] describes sympathy as "fellow feeling." You and I are "at one" with our feelings and ideas about something outside of us, for example, the results of a football game or the weather. When you feel joyful with me over my success, you are in sympathy with me. In a sense, we stand side by side sharing a common feeling related to something that happened in the past or that is happening outside of us now (Fig. 1). No feeling of crossing over is identified, but the experience of sympathy is stronger than simply being in agreement with another.

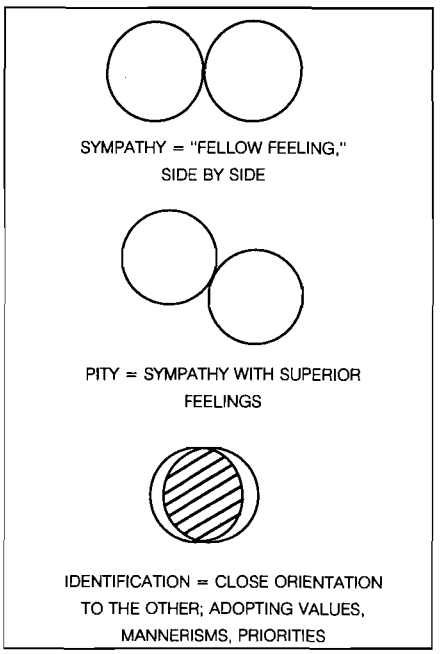

Figure 1. *Graphic representation of three intersubjective processes.*

Pity is described as a form of sympathy, a kind of sympathetic sorrow, but the side-by-side, shared nature of sympathy is replaced with a superior-inferior relationship (Fig. 1).[8] When I pity someone, I feel sorry for that person and thus I feel (perhaps subconsciously) more fortunate or superior.

Identification is an interpersonal process wherein the self aligns or orients itself closely to another person (eg, a mentor) or a group (eg, members of a certain religion, a political party, or a country club) with a resulting strong emotional tie. When I identify with a person or a group, I may adopt identical values, mannerisms, priorities, and dress. Identification is made more possible when one is not aware of one's unique identity and is searching for a way to be in the world. At the extreme of identification, one's ego is replaced by the mores of the group or person. In this situation, cult behavior can develop (Fig. 1).

Self-transposal is the phenomenon most commonly thought of as empathy. It is the process whereby I "think" myself into the place (or "shoes") of another person.[9] Rogers[3] actually defined empathy this way in his early work. Psychologist Robert Carkhuff[2] developed a training program wherein skill development emphasized this primarily cognitive behavior of accurately mirroring words and feelings of the client. Empathy, however, is far more complex than thinking and feeling oneself into the place of another, as Stein[1] suggests.

Sympathy, pity, identification, and self-transposal, therefore, are not precisely understood and are thus often confused with empathy. All are similar to each other in that each can be described as a one-stage, intersubjective process that one can cause to occur at will. Empathy, on the other hand, is more complex in that it is a three-stage process, the second stage of which cannot be made to occur at will, but happens to us when we allow it.

An Example of an Experience of Empathy

In a phenomenological research study conducted for my doctoral dissertation,[10] 10 physical therapists recounted their experiences with patients wherein they believed empathy (including the unique crossing-over phenomenon) took place. A summary of one of the many experiences follows:

> My patient, David, just ready for discharge within the next week, wheeled himself into view in the rehab gym

where I was finishing up a treatment with another patient on the mat. I had gotten to know David and his whole family quite well over the previous 4 months that he had been my patient. He was excited and scared about going home, but was quite hopeful for a good life, especially since he was engaged to be married. I smiled to him and said, "Hi, David. Go ahead and transfer to the mat and I'll be with you in a moment." I continued with my patient. David didn't move. I repeated my suggestion that he transfer, but he looked at me and said, "I don't need therapy; I need a drink!"

I knew this was strange behavior, so I told him I'd be right with him. In a few moments, I wheeled him to a private area and closed the door. I kneeled down beside him and looked at him and asked, "David, what's wrong?" He began to cry, and said that his fiancée and his brother had just told him that they had fallen in love and were getting married.

At that moment, I, too, felt terribly sad and hurt and angry, and I reached out to him and felt the tears in my eyes as well. I said to him, "Oh, David, I'm so sorry."

At this point in the interview with the physical therapist, I would ask that the therapist return to the moment that he or she felt that the crossing over took place and describe it to me as if it were taking place in slow motion.

In this instance, the therapist said she felt a kind of "lining up" of herself with the patient when she kneeled down to listen carefully to what was bothering him. Then, when he told her his bad news, she said it was as if she had been punched in the stomach. It was such a blow. I believe that, for a moment, she felt her crossing-over response so deeply that she forgot that this was not her problem, that it was her patient's problem. She reached out to touch his hand to offer support, and, I contend, to also remind herself physically that she was separate from him. The therapist and the patient then shared the feelings of sadness and hurt and anger. In other words, in the third stage of this total process, they felt in sympathy with one another.

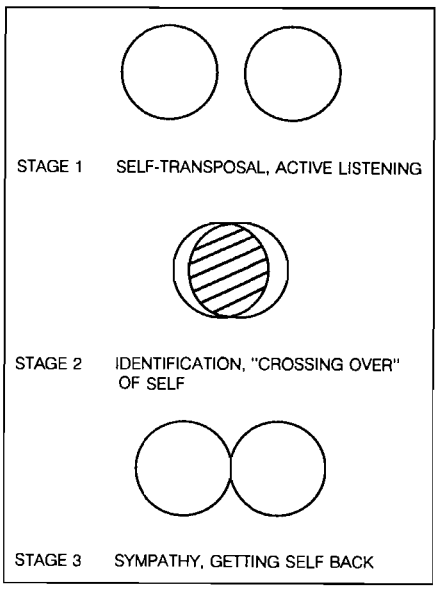

Figure 2. *Three stages of empathy as described by Stein.*[1]

Each of the 10 physical therapists recounted three or more experiences, and in each example, three stages could be identified: 1) a kind of listening and cognitive attempt to understand, or self-transposal, followed by 2) an emotional deepening, a kind of crossing over or merging of self with the other person, which is much like identification, followed by 3) a strong feeling of "at-oneness" with the person, or sympathy (Fig. 2).

The Unique Experiencing of Empathy

Stein[1] maintained that two characteristics make empathy unique, that is, distinct from all other interactions: 1) It is given to us *after* the fact, or we realize it after it has occurred, and 2) it takes place in three overlapping stages.

First, empathy happens to us; it is given to us after the fact, somewhat like falling in love happens to us after the fact. We find ourselves experiencing empathy. Empathy catches us after it has happened. We seem to look back on it and realize what just occurred. In philosophical terms, it is nonprimordially given; we realize it only after it has occurred. In one sense, this characteristic of empathy can be compared not only to falling in love, but also to what happens in forgiveness. We can want to forgive someone, but often when forgiveness is actually felt, only then do we realize it was given to us. Essentially, we help forgiveness to happen, but the final letting go of bad feelings comes as a gift of a sort.

Second, empathy takes place in three overlapping stages (Fig. 2). The first stage—self-transposal—takes place when we listen carefully and attempt to put ourselves in the place of the other person. In the second stage, we suddenly feel a crossing over, an emotional shift from thinking to feeling, wherein we experience a deepening of understanding and awareness. This stage has been termed a "shared moment of meaning"[10] and is often described as occurring like a "blow to the stomach." We feel deeply connected to another person, so deeply connected that a form of identification occurs. For a moment, we are at one with the other person and we may forget that we are separate, that really there are two of us. Finally, in the third stage, we seem to get our "self" back, and we stand side by side with the other person in sympathy about the experience just shared (Fig. 2).

The second stage—the crossing over—seems to hold the greatest significance of the three stages. Certainly, it is the most extraordinary of the three stages. Although ordinarily quite risky, I believe that such a total sharing of lived experience is viewed as positive and is desired by most people. From my perspective, this is what many of us are searching for in a life partner, someone who will share with us the meaningful moments of life at the deepest levels. To feel totally alone and unrecognized is very often an alienating and despairing feeling. I contrast this to feeling listened to, to being really understood and at one with another person. This is a positive, powerful experience sought after by most of us throughout life.

When health care students say, "I resist feeling empathy with my patients because I fear I will lose my therapeutic objectivity," I contend it is not empathy they fear but *identification*. When students are taught never to sympathize because it is demeaning to patients, what is meant is that *pity* often strips a person of dignity and self-worth, and the concurrent feelings of judgment interfere with the healing relationship. When we hear, "I can empathize with you on that point!" what is meant is, I can *sympathize* with you. Empathy catches us in its process. My contention is that we can facilitate it, and we can prevent it from happening, but we cannot make it happen. The question then arises, "Can we teach students to empathize?"

Can Empathy Be Taught?

Acknowledging the importance of Rogers's[3] work to effective counseling, Carkhuff[2] developed a rather elaborate theory and process of training that identified empathy as a skill, the accuracy of which could be evaluated on a continuum. The most skilled counselor listens to the client and responds accurately to both words and underlying feelings. Responses are graded from 0 to 5 in accuracy. Elaborate counselor-training programs have been established to train people in the skill of empathy. However, according to Stein's[1] description and to the experiences recounted by the physical therapists in the previously mentioned research study,[10] Carkhuff[2] is teaching self-transposal, not empathy. If we accept that empathy happens to us, we must also accept that it cannot be taught. Empathy seems to be a communication process that develops as we mature. Cognitively and emotionally mature people should be capable of experiencing empathy, because it seems to develop along with cognition and emotions during puberty.

The first and the third stages of empathy—self-transposal and sympathy—can be taught and developed in others, because we can cognitively create them. However, in order for the second stage of empathy—crossing over—to occur, 1) one must allow the experience of coming outside of oneself, a characteristic that requires a secure sense of self, and 2) cognitive development to the stage of formal operations or abstract thought (as in the experiencing of being in another's place) must be present, which Piaget[11] characterized as occurring around the time of puberty. With puberty comes the ability to envision what it might be like to be in another's shoes. Thus, adolescents begin to make more meaningful plans for a career because they can envision more clearly what it would be like to be a journalist or a lawyer. Likewise, adolescents begin more fully to realize the effects of their behavior on others and can feel the hurt another feels as a result of their own actions, and thus are able to be genuinely sorry for what they say and do that is hurtful.

One might erroneously assume that a baby crawling across the floor, grasping a blanket to offer to a crying child, is experiencing empathy. This is not possible. Instead, this might be an example of primitive trial-and-error learning to extinguish a noxious stimulus.

Intellectual and ethical development in the college years has been described by Perry[12] as unfolding from a concrete, outer authority base found in first-year college students (eg, "All older people are rigid and resistant to the changing times. My father told me that.") to an inner frame of reference found in those ready to graduate 4 years later (eg, "Resistance to change has less to do with age and more to do with how in control of the change the person feels.").

The more concrete a person's intellectual and ethical development, the more similar to another person he or she must be to allow empathy to occur with that person. For example, a person with very concrete intellectual and ethical development would say that it would be impossible for a white person to empathize with a black person because they would have so little in common. The more mature a person is, the more the imagination can see even the smallest of similarities. In fact, maturation can be, in part, charted by an increasing feeling of at-oneness with all human beings. Those with creative imaginations and a genuine interest in people of all types will experience this realization more.

In the phenomenological research I conducted with other physical therapists,[10] I questioned a young, but mature, physical therapist athlete about his experience of empathy for his patients. He recounted an experience with a patient in intensive care to whom he was administering pulmonary percussion and drainage. He described experiencing the crossing-over stage of empathy as his patient, an elderly, homeless person, rolled her eyes back into her head in sheer physical exhaustion. I asked him how he, a strong athlete, had even noticed this frail woman's response, let alone felt empathy for her. He smiled and said, "I run the Boston Marathon each year. I know what it's like to feel exhausted and out of breath." In this way, this mature professional illustrated that, by virtue of the fact that we all breathe, we have the capacity to experience the breathlessness of another person, no matter how different that person appears.[10]

In my view, adolescent striving to be just like those one admires and to be accepted by others is eventually replaced by the struggle for individual autonomy and self-worth. This struggle, I believe, often takes place during professional education for physical therapy.

The more aware one is of one's identity and personal values and boundaries, the easier it is to retain one's identity in interaction with others and the easier it is to not mistake patients and teachers for parents or grandparents. The more self-aware one is, the greater the ability to feel at one with fellow persons and the greater the likelihood of this occurring. Therefore, although we cannot directly teach others the behavior of empathy, we can teach exercises in self-

awareness such as values clarification and awareness of one's strengths and weaknesses in communication. We can also facilitate the shift from black and white, or concrete, thinking to more abstract, nonjudgmental perspectives.

What About Empathy Can Be Taught?

My contention is that, although empathy, as a process, can be facilitated to occur, the behavior itself cannot be directly taught as a skill. Certainly, teachers can help develop it in students by offering experiences that increase self-awareness, listening skills, awareness of the commonalities of all human beings, and respect and tolerance for the differences. Empathy can be facilitated by teaching humanistic interviewing skills, by helping students identify their prejudices and fears, and by developing students' confidence in their therapeutic skills so that they can be free of anxiety and thus more likely to establish a therapeutic presence for others. Empathy can be facilitated by modeling these behaviors and then reflecting on them with students so that learning occurs.[13]

Anxiety, self-doubt, prejudice, and low self-esteem focus one's attention inward, making it difficult to establish a therapeutic presence for others, and thus these behaviors can prevent empathy from occurring. Teachers who treat their patients and their students with compassion and then reflect on that process do a great deal to develop this awareness of compassion at work in students.[14]

The theoretical framework for the psychosocial development of students, often termed *professional socialization,* can be viewed as logically progressing from experiences and theory that lead to a clearer understanding first of oneself alone, one's values and needs, and the influence of one's family on the desire to be in the helping professions. Next, the exercises might progress to theory and experience with other people in interaction. Such topics as the characteristics of an effective helping relationship, active listening skills, use of "I statements" to express one's feelings, assertiveness training, ethical dilemma resolution, therapeutic presence with dying patients and families, and patients who have questions about the physical restrictions on sexual expression would be examples. In sum, the teaching experience in professional socialization should be centered on experiential learning of self-awareness and effectiveness in communicating a therapeutic or healing use of oneself with patients and colleagues. In this way, empathy will be facilitated to occur, along with the therapeutic presence.[13]

Conclusion

The art of healing is, in part, made up of a therapeutic use of oneself or a therapeutic presence for patients. This presence is more than knowledge and skill alone; it is also composed of a compassionate understanding of the patient and a communication that the therapist is worthy of the trust that the patient has bestowed. Empathy enhances the therapist's therapeutic presence and deepens the patient-practitioner interactions without fear of losing one's self in the process. This shared meaning seems to enhance the patient's process of healing.[14]

Empathy is a process that eludes teaching.[1] However, developing students' therapeutic presence through professional-socialization experiences and through modeling compassion and allowing empathy can facilitate empathy to occur. Likewise, helping students identify any negative, fragmenting behaviors such as prejudice, self-preoccupation, excessive nervous talking, poor listening and poor assertiveness skills, and low self-esteem will assist students in taking responsibility to change these behaviors that block empathy and interfere with healing. The role of the clinical instructor is paramount in helping students to become aware of behaviors that can block empathy.

We can no longer simply hope that our students will become mature professionals with compassion and empathy for patients. We must create experiences to develop these attributes, and we must take responsibility for modeling these behaviors and reflecting on them with students, to raise their consciousness about the nature of a mature healing presence.

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