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Towards a relational conceptualization of empathy

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Abstract

Empathy is a fundamental concept in health care and nursing. In academic literature, it has been primarily defined as a personal ability, act or experience. The relational dimensions of empathy have received far less attention. In our view, individualistic conceptualizations are restricted and do not adequately reflect the practice of empathy in daily care. We argue that a relational conceptualization of empathy contributes to a more realistic, nuanced and deeper understanding of the functions and limitations of empathy in professional care practices. In this article, we explore the relational aspects of empathy, drawing on sources that offer a relational approach, such as the field of care ethics, the phenomenology of Edith Stein and qualitative research into interpersonal and interactive empathy. We analyse the relational aspects of three prevalent components of empathy definitions: the underlying ability or act (i.e. the cognitive, affective and perception abilities that enable empathy); the resulting experience (i.e. empathic understanding and affective responsivity) and the expression of this experience (i.e. empathic expression). Ultimately, we propose four inter-related understandings of empathy: (a) A co-creative practice based on the abilities and activities of both the empathizer and the empathee; (b) A fundamentally other-oriented experience; (c) A dynamic, interactive process in which empathizer and empathee influence each other's experiences; (d) A quality of relationships.

KEYWORDS

care ethics, otherness, phenomenology, professional relationships, reciprocity, relational empathy

1 | INTRODUCTION

Empathy is considered to be vital to professional helping and caring relationships (Brunero, Lamont, & Coates, 2010; Douglas, 2012; Freedberg, 2007; Halpern, 2003; Hojat, DeSantis, & Gonnella, 2017; Mercer & Reynolds, 2002; Morse et al., 1992; Raudonis, 1995; Reynolds & Scott, 1999, 2000; Rogers, 1959; White, 1997; Wiseman, 2007). Nursing and healthcare literature have paid vast attention to empathy in its functions to provide knowledge and enable relationality. One of the aims of professional caring relationships is to accurately perceive patients' needs and concerns from their point of view (Reynolds & Scott, 2000). Through empathy, caregivers learn what is at stake for their patients and what their situation means to them (Vanlaere, Timmermann, Stevens, & Gastmans, 2012). These insights help to attune care to their patients' needs and individuality. Expressing empathic understanding makes patients feel valued and recognized, which promotes trust and strengthens the caring relationship (Wiseman, 2007).

Despite the interest in the relational value of empathy, it has been mainly conceptualized as the individual's ability to affectively resonate with or cognitively imagine the other's experiences or situation (Douglas, 2012; Freedberg, 2007; Håkansson & Montgomery, 2003; Main, Walle, Kho, & Halpern, 2017; Williams, 1990; Wynn & Wynn, 2006; Zaki, Bolger, & Ochsner, 2008). The relational dimensions of empathy have received far less attention and are under investigated in both theoretical and empirical research (Annells, 2006; Kunyk & Olson, 2001; O'Hara, 1997). This is problematic for at least three reasons. First, conceptualizing empathy as a one-sided activity suggests that empathy is the sole responsibility of the caregiver instead of being co-dependent on the abilities and efforts of the care receiver (Zaki et al., 2008), the quality of the relationship (Main et al., 2017) or the organizational context (Halpern, 2003). It may place unrealistic expectations onto caregivers and contribute to feelings of frustration and distress when empathy is challenged. We will argue in section 3 that such a one-directional activity does not adequately reflect the experience of empathy in daily care. Patients are not necessarily the passive recipients of their caregiver's empathy. They can be active participants who appeal to the empathy of their caregivers by being emotionally expressive or they may lead caregivers through their inner world of experiences by vividly telling them what they are going through. Empathy involves the abilities and participation of both the caregiver and care receiver, albeit in different roles. By understanding empathy as a co-creative practice, we aim to contribute to an enriched theoretical framework that more adequately represents experiences of empathy in everyday care.

Second, overlooking the relational nature of empathy, hampers a clear distinction between empathy and "false" or "pseudo" empathy, such as projection. One of the main objections against empathy is that it has sometimes been defined as a self-referential phenomenon (Noddings, 2013; Sevenhuijsen, 2014; Tronto, 1993; Zahavi, 2014a). For instance, the metaphor of "putting oneself in the other's shoes" suggests that people try to comprehend the other's perspective by projecting themselves into someone else's situation. Although such an exercise may at times be useful, it is likely to be erroneous as it does not necessarily tell the empathizer how the other experiences that particular situation. Two people may perceive a similar event in completely different ways. For instance, one person may experience a diagnosis as ultimately distressing, while another may experience the same diagnosis as a relief as it provides clarity, offers an explanation for one's symptoms and opens the way to treatment. As a consequence of projection, caregivers easily fail to recognize the other's specific needs and individuality and cannot provide adequate care (Sevenhuijsen, 2014; Tronto, 1993). In section 4, we will argue that empathy is a fundamentally other-directed experience and that a clear self-other distinction is pivotal for empathy. These fundamental characteristics help to distinguish between "true empathy" and forms of "false" or "pseudo" empathy such as projection, identification or personal distress.

Third, by conceptualizing empathy as an act of the caregiver and excluding the role of the other, the power dimensions of empathy are clouded. This is problematic, since caring relationships are inherently asymmetrical as patients are in a relatively vulnerable and dependent position (Tronto, 1993; Van Heijst, 2011; Van Nistelrooij & Visse, 2018). The power imbalances related to empathy may seriously affect the well-being of care receivers. For instance, patients may experience their caregivers' empathic expressions as patronizing or intrusive. This could happen when caregivers touch upon emotions that the patient is not yet ready to share (Morse et al., 1992), when empathy is not embedded in a trusting relationship (Reynolds & Scott, 2000) or when caregivers remain distant and disclose little of themselves (Freedberg, 2007). As a consequence of intrusive empathy, patients may feel anxious, overwhelmed and out of control (Reynolds & Scott, 2000). Although the more process-based communicative approaches of empathy include the expression, reception and confirmation of the empathizer's understanding (Barrett-Lennard, 1993), these conceptualizations still reduce the role of the empathee to either confirming or rejecting this understanding. In section 5, we will argue that empathy could be more realistically understood as a continuous, dynamic process in which both empathizer and empathee are affectively involved and constantly influence and (re)shape each other's feelings and understandings. By including the other as an active participant who can influence the caregiver, we aim to contribute to a framework that allows for a more adequate recognition and enquiry into the power dynamics of empathy.

To explore the relational aspects of empathy, it will be reconsidered against a background of theories that promote relational thinking, in particular care ethics and phenomenology. Care ethics is an emerging field of enquiry that has care practices as its main topic of interest and that considers relationships instead of personal qualities, virtues or skills to be at the heart of care and morality. Phenomenology is a philosophical discipline stemming from the 19th century that studies human experience and the structures of human consciousness (Smith, 2018). Phenomenologists, especially Husserl, Scheler and Stein, were among the first to study empathy when the concept emerged in the early 20th century. These philosophers understand humans to be connected instead of separated and have offered profound insights into the nature and essence of empathy as a relational experience. In this paper, we will mainly discuss the phenomenology of Stein (1964) and those contemporary empathy theorists who draw on her writings such as Zahavi (2008, 2014a, 2014b) and Ratcliffe (2012). In addition to these theories, we draw on qualitative studies into interpersonal, interactive and received empathy in professional caregiving.

2 | THREE COMPONENTS OF EMPATHY

Philosophy, nursing and moral psychology offer a number of definitions of empathy that form the starting point of our analysis. These definitions may consist of either one or a combination of the following components: (a) The underlying ability or act; (b) The experience that results from these activities; (c) The expression of the empathic experience. Before proceeding to the analysis, we will shortly discuss the three components in more detail (Table 1).

TABLE 1 Three components of empathy

Component of empathy	Definition	Examples (fragments) from sources
I. Empathy as an ability or act		
1. Affective empathy	The ability to emotionally attune to or resonate with the other's experiences	"(…) the capacities to resonate with another person's emotions (…)." (Oliveira-Silva & Gonçalves, 2011)
2. Cognitive empathy	The ability to imagine the other's experiences	"(…) an imaginative reconstruction of another person's experience (…)." (Nussbaum, 2001)
3. Perceptive empathy	The ability to directly perceive the other's experiences	"(…) a perceptual act, which directly brings another's experience into one's own awareness." (Meneses & Larkin, 2012)
II. Empathy as an experience		
1. Empathy as knowing	The awareness or understanding of the other's experiences	"(…) understanding another person's experience (…)." (Hodges & Myers, 2007)
2. Empathy as responding	The affective, inner response to the other's experiences	"(…) responding to another's emotion with a congruent emotion (…)." (Oxley, 2011)
III. Empathy as an expression or communication		
1. Cognitive expression	Expressing one's empathic understanding and checking its accuracy	"(…) to communicate that understanding and check its accuracy (…)." (Mercer & Reynolds, 2002)
2. Affective expression	Expressing one's empathic emotions and checking whether these are similar with or congruent to the other's feelings	"(…) accurate transmission to another of a feeling, aroused on his behalf, in verbal and nonverbal form." (Gippenreiter, Kariagina, & Kozlova, 1994)

First, empathy definitions may refer to the underlying abilities or actions that enable the experience of empathy. Academic literature offers three definitions that fit this description: (a) Affective empathy is the ability to emotionally attune to or resonate with the other's experiences; (b) Cognitive empathy or "perspective-taking" is the ability to think into or mentally reconstruct the other's experiences, mainly by using one's imagination; (c) Perceptive empathy is the ability to directly perceive the other's experiences. The latter definition is less common but can be found in phenomenological literature. The primary source of this definition is Stein's On the problem of empathy (1964). According to Stein, people may directly experience others' inner world, by perceiving their gestures, facial expressions or behaviour. Although less known, this third type of empathic ability is gradually gaining attention in nursing and healthcare literature (Määttä, 2006; Morgan, 2016; Richardson, MacLeod, & Kent, 2011).

Second, empathy definitions may refer to (the content of) the experience of empathy itself, which can again be either cognitive or affective. Moral psychologists Batson (2011) and Hoffman (2001) offer a distinction between empathy as a cognitive insight and empathy as an affective response. Meneses (2011) uses the terms "empathy as knowing" versus "empathy as responding" to mark this distinction. Empathy as knowing means people have a cognitive awareness or understanding of the other's experience or situation. This definition of empathy is found in philosophy, including phenomenology (Meneses, 2011; Meneses & Larkin, 2012). Empathy as responding refers to an affective response within the self to the other's experience. This account of empathy is dominant in moral and social psychology (Meneses, 2011). In these disciplines, empathy is essentially conceived as an affective response that is similar or congruent to the other's feeling.

Third, process-based approaches of empathy include the expression (verbal or nonverbal) of one's empathic understanding and/or one's affective response (Barrett-Lennard, 1993; Morse et al., 1992; White, 1997). Often, the focus in these conceptualizations is on the expression of the empathizer's understanding as a means to check for its accuracy (Mercer & Reynolds, 2002). These process-based conceptualizations are communicative when they include the reception, recognition or evaluation of the empathic expression by the empathee (Barrett-Lennard, 1993). The process of empathy is considered successfully completed if the subject or empathee evaluates the expression of empathic understanding as accurate. Alternatively, one may evaluate whether one's empathic emotions are similar or congruent to the empathee's experiences (Oxley, 2011) and if one's empathic expression is thus appropriate. For instance, when the empathizer expresses sadness whereas the empathee experiences relief, there is no congruence or affective match and the empathic expression may be perceived as inappropriate, mismatched or unattuned by the empathee.

In nursing and particularly in healthcare literature, empathy has been predominantly understood as a cognitive ability or act, in which the affective aspects of empathy are underemphasized (Halpern, 2003; Hojat et al., 2017; Hojat, Louis, Maio, & Gonnella, 2013; Noddings, 2013). Nowadays, empathy is gradually being defined as a hybrid or multidimensional construct that combines affective and cognitive aspects (Main et al., 2017; Noddings, 2013). For instance, in *Nursing Philosophy* Morgan (2016) calls for a rich, hybrid conceptualization of empathy in health care "that includes both pre-reflective/intuitive and cognitive/imaginative components" (p.1). In the field of care ethics, a similar tendency can be found to promote hybrid conceptualizations of empathy. For instance, Hamington (2004) defines empathy as "affective responses to an 'other' that integrates

knowledge and emotions to better apprehend their situation and feelings" (p. 62). A similar argument for an enriched, multidimensional conceptualization of empathy is the purpose of this paper. We will focus less on the affective and cognitive aspects, but rather on its relationality. The relational dimensions of the above-mentioned three components will be discussed in section 3, 4 and 5, respectively. In chapter 6, we will explore a fourth component that is far less common in academic literature: empathy as the quality of relationships.

3 | EMPATHY AS A CO-CREATIVE PRACTICE

Common empathy definitions suggest that the experience of empathy or the accuracy of one's empathic understanding rely solely on the skills and activities of the empathizer. The empathee's role, if acknowledged at all, is restricted to either confirming or rejecting the accuracy of the empathizer's understanding. An example from an empirical study may help to explain why such a view is inadequate with regard to the practice of empathy in everyday life (authors, forthcoming). In the next interview fragment, a healthcare chaplain recalls how a client invited her into his inner world of experiences by sharing what it was like having to move from a large and beautiful home to a small studio apartment in a rehabilitation centre: "Then my client says to me: 'Imagine.... Imagine that this is happening to you'. He points to the room where he sits… He says: 'This entire space is smaller than my study room at home'. And then he points to the kitchen block and says: 'That would be my kitchen. That shelf, that would be my cellar. My bathroom. Bedroom. Office.....' [Turning to the interviewer the chaplain says:] I see something happening with you as well now that I tell you this (…). What happens, I think, is that we can imagine very well what it is like." (Interview fragment qualitative research by the authors, forthcoming). This example shows how a client deliberatively appeals for the caregiver's empathy and leads her step by step through his experiential world. His vividly portraying what his situation is like has an emotional impact on the chaplain and helps her to imagine more accurately what he is going through.

Based on (empirical) research of ourselves and others, we suggest that empathy be viewed as a co-creative or collaborative practice that requires the participation of both parties (Barrett-Lennard, 1993; Wynn & Wynn, 2006; Zaki et al., 2008). Empathy, understood this way, requires that people express themselves, for instance through sharing stories or by showing their emotions (Betzler, 2019; Kupetz, 2014; Main et al., 2017; Zaki et al., 2008). Empirical research indicates that one empathizes more accurately with people who are highly expressive (Zaki et al., 2008). In health care, however, self-expression can be challenged for a variety of reasons. Patients may be aphasic or withdrawn as a result of an illness, trauma, psychiatric disease or cognitive impairment. They may be hesitant or unwilling to share what they are going through because they do not trust the caregiver or feel ill at ease. When patients fail to express themselves, caregivers may still empathize with their patients' situation, but the inner world of experiences and meanings remains hidden. In caring, it is this experiential world that caregivers ideally connect with to better attune their care to their patients' unique needs and individuality.

In the proposed relational conceptualization of empathy, patients are no longer perceived as the passive recipients of empathy. Instead, the roles are likely to be reversed. The care ethicist Noddings (2013) offers an understanding of empathy in which the caregivers are on the receiving end, by being immersed in the other's experiences through attentive listening and by allowing themselves to be affected by the other. Instead of actively entering the other's world—and thus potentially "invading" it—caregivers have an open and receptive attitude. An example of receptive affective empathy is that instead of deliberately trying to "feel with" the other's experiences by searching for emotional cues or by asking people "what it feels like," caregivers may experience the other's inner world by being open and sensitive, by listening attentively and by allowing themselves to be affected (Noddings, 2013). When thinking further along the same line, an example of receptive cognitive empathy could be that instead of trying to actively imagine the other's experience by simulating it in one's mind, caregivers listen carefully as people portray in their own words what they are going through. Thus, it is the care receiver who takes them along.

4 | EMPATHY AS AN OTHER-ORIENTED EXPERIENCE

In this paper, we argue that empathy is a relational concept in the sense that it is essentially an other-oriented experience. It is through empathy that people connect with the other's experiential world and "experience foreign consciousness" (Stein, 1964). Such an understanding is not self-evident. Empathy has in the past been criticized for being defined as self-referential, a form of projection or identification (Noddings, 2013; Sevenhuijsen, 2014; Tronto, 1993). Confusingly, some of the earliest definitions of empathy were indeed based on the idea of projection (Noddings, 2010, 2012; Zahavi, 2014a, 2014b). This interpretation of empathy has its roots in aesthetics, where the word Einfühlung emerged in 1873 to "describe the affective relation between aesthetic objects and human viewers" (Verducci, 2000, p. 67). The idea was that by projecting one's affective self into an object, people bring the object to life (Verducci, 2000). According to this early theory, subject and object merge and become a harmonious unity. The term "Einfühlung" was taken over in 1912 by the German philosopher and psychologist Lipps as a word not only explaining one's affective relations to lifeless objects such as art, but also as referring to one's understanding of others as minded creatures (Zahavi, 2014b). Lipps too understood empathy as a form of projection. According to him, people can only empathize with others if they have undergone a similar experience in the past. Such an understanding of empathy strongly limits the epistemic and intersubjective functions of empathy, since it implies people can only empathize with situations or states that they have experienced themselves (Zahavi, 2014b).

The phenomenologists Scheler (1874–1928), Husserl (1859–1938) and Stein (1891–1942), were among the first to explore empathy after it was adopted by Lipps from the field of aesthetics (Zahavi, 2014b). They rejected accounts that regarded empathy as mainly projective. For instance, Husserl preferred the term "Fremderfahrung" above "Einfühlung," stressing the experience of otherness that is in his view crucial for true or genuine empathy (Zahavi, 2014b). To highlight the focus on the other, empathy has been defined by Stein (1964) as a form of other-directed intentionality. According to Stein, it is this other-directedness or other-orientation that is the defining quality of empathy. Because of it, people are able to expand their horizon and learn something new. Nowadays, empathy is understood as a fundamentally other-directed concept instead of a self-referential one (Maibom, 2014). For instance, moral psychologists have defined empathy as an "other-oriented emotion" (Batson, 2011, p. 11) or as an "affective response more appropriate to another's situation than one's own" (Hoffman, 2001, p. 4). This other-orientation helps to distinguish empathy from related but self-referential phenomena. For instance, it is the orientation of the emotion that marks the distinction between personal distress and empathic distress (Maibom, 2014). When empathizing with other's suffering leads to distress for oneself, this is called personal distress. When it leads to distress for the other, this is called empathic distress.

The other-directedness of the empathic experience has several implications. First, to experience and acknowledge otherness, empathy entails a clear self-other differentiation (Coplan, 2011; Meneses, 2011; Pettersen & Hem, 2011; Ratcliffe, 2012; Stein, 1964). Not only is empathy other-directed but it requires an awareness that what one experiences belongs to and originates from an external consciousness (Maibom, 2014). This awareness includes a basic understanding that others have a mind of their own. It is this self-other distinction that marks the difference between empathy and related concepts such as emotional contagion. In emotional contagion, people automatically or involuntarily "catch" others' emotions and adopt them (Maibom, 2014). For instance, when people are "infected by" the other's laughter and automatically or spontaneously laugh along. Because emotional contagion lacks an awareness that the emotion originates from someone else, it is considered to be a relatively primitive or rudimentary form of empathy (Zahavi, 2014b). This is one of the reasons why it is generally not considered to be a form of true or mature empathy (Maibom, 2014).

Second, the self-other distinction entails that people do not literally share the other's thoughts or emotions. When empathizing, there is a fundamental difference between how people experience their own inner world and that of the other. Stein (1964) understands empathy as "an act which is primordial as present experience though non-primordial in content." (p10) Although empathy itself happens in the present, the content of the experience is not present for the empathizer as it belongs to someone else, to a "foreign consciousness." This fundamental characteristic of empathy has been highlighted by empathy theorists from a diversity of fields as well, albeit in different terms (Duyndam, 2010; Morgan, 2016; Nussbaum, 2001; Ratcliffe, 2012; Stein, 1964; Zahavi, 2008). For instance, the humanist psychologist Rogers (1959) famously speaks of the "as if" condition of empathy: empathizers experience the other's pleasure or pain as if it were theirs, but realize that they do not actually experience what the other is going through. The philosopher Duyndam (2010) argues that when we empathize, we do not experience the actual feelings of others, but we experience potential feelings such as potential loss or grief. The care ethicist Noddings (2013) similarly speaks of experiencing "the other's reality as a possibility for my own" (P.14) instead of as an actual reality.

Third, a strong self-other distinction entails that empathizers are connected with their own experiences as well. As Hamington (2004) explains: "Stein's concept of empathy does not negate the self but actually strengthens self-concept" (p.80). In order to experience the other's inner experiences "as if" or "potentially," the empathizer needs an awareness of the empathee as different as well as a strong sense of self (Ratcliffe, 2012; Stein, 1964; Zahavi, 2014b). In philosophy and social psychology, the ability to clearly differentiate between self and other, between self-experience and other-experience is considered to be a hallmark of mature empathy, which involves what is called "dual-perspective shifting": a shifting back and forth between one's own experiences of a situation—either imagined or based on one's past experiences with a similar situation—and the other's experiences of the situation—based on what one knows about the other or on what the other tells about the experience (Hoffman, 2001; Oxley, 2011; Slote, 2007; Van Nistelrooij, 2018). Through a process of continuous perspective shifting, the differences and similarities between self-experience and other-experience may become even more apparent as will be discussed in the next section.

5 | EMPATHY AS A DYNAMIC INTERACTION

Most academic empathy definitions do not include the role of the empathee but focus solely on the abilities and actions of the empathizer. Some scholars, however, define empathy as a communicative process that includes the expression of empathy by the empathizer and the reception and recognition of its accuracy or emotional congruence by the empathee (Barrett-Lennard, 1993; Hojat et al., 2017; Morse et al., 1992; White, 1997; Wynn & Wynn, 2006). The process of empathy is considered to be successfully completed if empathees recognize the expression of empathic understanding as accurate or if they perceive the expression of empathic emotions as similar or in line with their feelings. For instance, in a qualitative study into received empathy, a participant states: "I really felt that she felt what was going on inside me. She was listening to me, she told me to let go, to get it off my chest… through her hoarse voice, her tears on the brim of her eyelids, she proved to me that she was experiencing what I experienced."

(Bachelor, 1988, p. 232). The empathic expression was positively evaluated as the empathee felt that the empathizer shared in her experiences.

Although communicative conceptualizations of empathy include the role of care receivers and potentially give them a more powerful position, their role is still restricted to being a passive recipient of empathy and confirming its accuracy. This paper has argued that empathees can be active participants and that it "takes two to empathize" (Betzler, 2019; Zaki et al., 2008). Based on empirical research, we further argue that empathy involves dynamic interaction in which people not only communicate or receive and recognize empathy, but also affect and influence each other's experiences.

Freedberg (2007) emphasizes the importance of reciprocal affective impact which she believes is just as important as empathic accuracy. She argues that it is essential for the well-being of care receivers and for the quality of the relationship that caregivers not only provide accurate understandings but also allow themselves to be affected by the other's experiences and show this. In turn, care receivers may be touched and feel recognized when they notice that they have affected the caregiver. A fragment from a qualitative study into empathy from a client's perspective illustrates her argument. A participant vividly recalls the affective impact she made on her therapist: "…I was talking about something really intense and I could tell she was teary-eyed and she started to cry and I started to cry and I think, that from that, that was really early on, and so I felt she was really empathetic the entire time, and maybe some people misconstrue that, but I feel like she is just human, really human, and she makes herself really human to her clients" (MacFarlane, Anderson, & McClintock, 2017, p. 6). It was meaningful for the client to experience that her therapist feels with her and shows her emotions as it makes her see her therapist as being human. Freedberg (2007) speaks of empathic responsiveness "in which both worker and client feel the impact each has made on the other." (p.251) This responsiveness contributes to the process and sustainability of empathy, as both parties feel encouraged to keep sharing experiences and to empathize.

Empathic accuracy and affective attunement are dynamic and interactive for another reason as well. Emotions and thoughts fluctuate, partly because both empathizer and empathee influence each other's experiences. Ratcliffe (2012) offers an example of a parent reading a bedtime story to a child. The storyteller himself finds the book boring. However, sharing in the child's experience transforms his own experience of the book: "Soon, the fact that the book is boring no longer features in your experience. The interaction reshapes your experience of the world" (p.488). When empathizing, people not only experience the other's situation or experiential world, but their own experiences may be affected, reshaped and transformed through the empathic experiences. Similarly, the experiences of the empathee may be reshaped by the empathizer. Kerem, Fishman, and Josselson (2001) provide an example based on their research into lived experiences of empathy. A participant explains how an empathic relative helps her to organize her experiences: "She is the only one who can… take all the emotions I have, all the confusion, take them and put them in the correct proportions… put things in order (…)" (p.719). Thus, empathy enables people not only to "feel with" or understand, but also to "work with" the other's experiences, to "put them in perspective" and thus change them. As a consequence, empathy can be a transformative experience for both participants.

6 | EMPATHY AS A QUALITY OF THE RELATIONSHIP

Lastly, we will explore the relational nature of empathy by arguing that it is embedded and developed in relationships, that it can be a quality of relationships and that these relationships may be affected by the institution or society that they are a part of.

First, empathy is embedded in relationships (Williams, 1990). Whether or not people experience or receive empathy not only depends on the abilities and activities of both participants but also on the quality of the connection or relationship between them (Freedberg, 2007; MacFarlane et al., 2017). For instance, mutual trust is a quality of relationships that may greatly impact the practice of empathy, since trust promotes sharing and self-expression (Reynolds & Scott, 2000). Without trust, patients may experience their caregivers' attempts to empathize with them as intrusive, which may result in anxiety and in a further decline of trust (Reynolds & Scott, 2000). Similarity or familiarity is another well-known factor that may enable empathy between people. It is also one of the reasons why empathy has been called biased (Oxley, 2011). People empathize more easily with those to whom they can relate, based on similarities such as a shared background, history, values or interests (Wiseman, 2007). The length and depth of the relationship may further influence the quality of the empathic experience. For instance, in a qualitative enquiry into everyday experiences of empathy, one of the participants answers to the question which people appear most empathetic to him: "[the people I chose are] people who can, because of their closeness to me, and the length of our relationship, they can kind of feel me. (…) Because they are close to me and know me well, they can see through my eyes" (Kerem et al., 2001, p.720).

Second, empathy may be a quality of the relationship itself. When patients feel encouraged to talk about their experiences in a trusting environment and when caregivers feel safe to disclose personal experiences, an empathic relationship between caregiver and patient may develop (Freedberg, 2007; Kunyk & Olson, 2001; Raudonis, 1995). In such a relationship of reciprocal sharing and concern, patients may experience and express empathy towards their caregivers. It is important to stress that care receivers cannot be required nor expected to fully empathize with their caregivers. Caring relationships are inherently asymmetrical and caring is fundamentally other-directed: the main focus is on the good and welfare of the care receiver (Nordhaug & Nortvedt, 2011; Van Nistelrooij & Leget, 2016). Reciprocal self-disclosure and empathy can, however, be meaningful for both caregiver and care receiver

and it may strengthen the caring relationship. For instance, in a qualitative research into hospice care, patients described the development of a deeply empathic relationship with their nurses (Raudonis, 1995). The nurses attempted to know their patients on a personal level and at times disclosed some of their own experiences as well. Although the well-being of the patients was and remained the main concern, it was meaningful for the patients to be empathic to their caregivers. It made them feel special and valued, which contributed to their sense of well-being. Some participants even compared the relationship to a friendship.

Third, care ethicists stress that caring relationships are part of an institutional, political and societal context (Pettersen, 2012). Empathy not only depends on the mutual abilities of both caregiver and care receiver or on the quality of their relationship, but also on the organizational and societal context. Empathy can flourish when the caring relationship is embedded in care practices and institutions that support and facilitate empathy, but it may be frustrated or even blocked when the organization does not value empathy or even discourages it (Wiseman, 2007). For instance, empirical research in the UK and in the United States indicated that clinical nurses in hospitals show low levels of empathy (Reynolds & Scott, 2000). The authors provide various reasons for this lack of empathy, some of which concern the role of the organization. For instance, a lack of humanity and of empathic support from colleagues may discourage the practice of empathy (Reynolds & Scott, 2000). A culture of detachment may further influence the emergence of empathy in healthcare practices (Halpern, 2003). In such a culture, the focus is on professional distance instead of closeness. Consequently, empathy may be blocked.

7 | CONCLUSION

Empathy has traditionally been defined as an individualistic, unidirectional and sometimes self-referential concept. In this paper, we proposed to conceptualize empathy as a multidimensional, dynamic and relational concept and identified four inter-related understandings of empathy: (a) A co-creative practice of both the empathizer and the empathee; (b) An experience that is fundamentally other-directed without losing the connection with oneself; (c) An interpersonal process that is bi-directional, interactive and dynamic and that requires continuous attunement and responsivity; (d) A quality of a relationship in which empathy can flourish based on qualities such as openness, relatability and trust. It is our hope that this enriched conceptualization helps to better understand and investigate the functions and limitations of empathy in everyday care.

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CONFLICT OF INTEREST

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REFERENCES

Annells, M. (2006). Nursing theory and concept development or analysis: Triangulation of qualitative approaches: Hermeneutical phenomenology and grounded theory. *Journal of Advanced Nursing*, *56*(1), 55–61. https://doi.org/10.1111/j.1365-2648.2006.03979.x

Bachelor, A. (1988). How clients perceive therapist empathy: A content analysis of "received" empathy. *Psychotherapy: Theory, Research, Practice, Training*, *25*(2), 227–240. https://doi.org/10.1037/h0085337

Barrett-Lennard, G. T. (1993). The phases and focus of empathy. *British Journal of Medical Psychology*, *66*(1), 3–14. https://doi.org/10.1111/j.2044-8341.1993.tb01722.x

Batson, D. C. (2011). *Altruism in humans*. Oxford, NY: Oxford University Press.

Betzler, M. (2019). The relational value of empathy. *International Journal of Philosophical Studies*, *27*(2), 136–161. https://doi.org/10.1080/09672559.2019.1598081

Brunero, S., Lamont, S., & Coates, M. (2010). A review of empathy education in nursing. *Nursing Inquiry*, *17*(1), 65–74. https://doi.org/10.1111/j.1440-1800.2009.00482.x

Coplan, A. (2011). Will the real empathy please stand up? A case for a narrow conceptualization. *The Southern Journal of Philosophy*, *49*, 40–65. https://doi.org/10.1111/j.2041-6962.2011.00056.x

Douglas, D. H. (2012). Empathy. In J. J. Fitzpatrick, & M. W. Kazer (Eds.), *Encyclopedia of nursing research*, 3rd ed. New York, NY: Springer Pub.

Duyndam, J. (2010). Empathy and the potential body of imagination. In G. Bottà, & M. Härmänmaa (Eds.), *Empathy and the Potential Body of Imagination*. Helsinki: University of Helsinki, Language Centre.

Freedberg, S. (2007). Re-examining empathy: A relational-feminist point of view. *Social Work*, *52*(3), 251–259. https://doi.org/10.1093/sw/52.3.251

Gippenreiter, I. B., Kariagina, T. D., & Kozlova, E. N. (1994). The phenomenon of congruent empathy. *Journal of Russian & East European Psychology*, *32*(6), 44–56. https://doi.org/10.2753/RPO1061-0405320644

Håkansson, J., & Montgomery, H. (2003). Empathy as an interpersonal phenomenon. *Journal of Social and Personal Relationships*, *20*(3), 267–284. https://doi.org/10.1177/0265407503020003001

Halpern, J. (2003). What is clinical empathy? *Journal of General Internal Medicine*, *18*(8), 670–674. https://doi.org/10.1046/j.1525-1497.2003.21017.x

Hamington, M. (2004). *Embodied care: Jane Addams, Maurice Merleau-Ponty, and feminist ethics*. Urbana, Chicago: University of Illinois Press.

Hodges, S., & Myers, M. (2007). Empathy. In R. F. Baumeister, & K. D. Vohs (Eds.), *Encyclopedia of Social Psychology*, Vol. *1* (pp. 297–298). Thousand Oaks, CA: SAGE Publications Inc.

Hoffman, M. L. (2001). *Empathy and moral development: Implications for caring and justice*. Cambridge, UK: Cambridge University Press.

Hojat, M., DeSantis, J., & Gonnella, J. S. (2017). Patient perceptions of clinician's empathy: Measurement and psychometrics. *Journal of Patient Experience*, *4*(2), 78–83. https://doi.org/10.1177/2374373517699273

Hojat, M., Louis, D. Z., Maio, V., & Gonnella, J. S. (2013). Editorial: Empathy and health care quality. *American Journal of Medical Quality*, *28*(1), 6–7. https://doi.org/10.1177/1062860612464731

Kerem, E., Fishman, N., & Josselson, R. (2001). The experience of empathy in everyday relationships: Cognitive and affective elements. *Journal of Social and Personal Relationships*, *18*(5), 709–729. https://doi.org/10.1177/0265407501185008

Kunyk, D., & Olson, J. K. (2001). Clarification of conceptualizations of empathy. *Journal of Advanced Nursing*, *35*(3), 317–325. https://doi.org/10.1046/j.1365-2648.2001.01848.x

Kupetz, M. (2014). Empathy displays as interactional achievements: Multimodal and sequential aspects. *Journal of Pragmatics*, *61*, 4–34. https://doi.org/10.1016/j.pragma.2013.11.006

Määttä, S. M. (2006). Closeness and distance in the nurse-patient relation. The relevance of Edith Stein's concept of empathy. *Nursing Philosophy*, *7*(1), 3–10. https://doi.org/10.1111/j.1466-769X.2006.00232.x

MacFarlane, P., Anderson, T., & McClintock, A. S. (2017). Empathy from the client's perspective: A grounded theory analysis. *Psychotherapy Research*, *27*(2), 227–238. https://doi.org/10.1080/10503307.2015.1090038

Maibom, H. L. (2014). (Almost) everything you ever wanted to know about empathy. In H. L. Maibom (Ed.), *Empathy and morality*. Oxford, UK: Oxford University Press.

Main, A., Walle, E. A., Kho, C., & Halpern, J. (2017). The interpersonal functions of empathy: A relational perspective. *Emotion Review*, *9*(4), 358–366. https://doi.org/10.1177/1754073916669440

Meneses, R. W. F. (2011). *Experiences of 'empathy'*. University of Birmingham, Birmingham. PhD Thesis.

Meneses, R. W. F., & Larkin, M. (2012). Edith Stein and the contemporary psychological study of empathy. *Journal of Phenomenological Psychology*, *43*(2), 151–184. https://doi.org/10.1163/15691624-12341234

Mercer, S. W., & Reynolds, W. J. (2002). Empathy and quality of care. *The British Journal of General Practice*, *52*(Suppl), S9–12. https://doi.org/10.1007/0-387-33608-7

Morgan, A. (2016). Against compassion: In defence of a "hybrid" concept of empathy. *Nursing Philosophy*, *18*(3), e12148. https://doi.org/10.1111/nup.12148

Morse, J. M., Anderson, G., Bottorff, J. L., Yonge, O., O'Brien, B., Solberg, S. M., & McIlveen, K. H. (1992). Exploring empathy: A conceptual fit for nursing practice? *The Journal of Nursing Scholarship*, *24*(4), 273–280. https://doi.org/10.1111/j.1547-5069.1992.tb00733.x

Noddings, N. (2010). *Complexity in caring and empathy*. Abstracta Special Issue V(5), 6-12.

Noddings, N. (2012). The Language of care ethics. *Knowledge Quest*, *40*(5), 52–56.

Noddings, N. (2013). *Caring: A relational approach to ethics and moral education*, 2nd ed. Berkeley, CA: University of California Press.

Nordhaug, M., & Nortvedt, P. (2011). Mature care in professional relationships and health care prioritizations. *Nursing Ethics*, *18*(2), 209–216. https://doi.org/10.1177/0969733010389257

Nussbaum, M. C. (2001). *Upheavals of thought: The intelligence of emotions*. Cambridge; NY: Cambridge University Press.

O'Hara, M. (1997). *Relational empathy: Beyond modernist egocentricism to postmodern holistic contextualism. Empathy reconsidered: New directions in psychotherapy*. (pp. 295–319). Washington, DC: American Psychological Association.

Oliveira-Silva, P., & Gonçalves, Ó. F. (2011). Responding empathically: A question of heart, not a question of skin. *Applied Psychophysiology and Biofeedback*, *36*(3), 201. https://doi.org/10.1007/s10484-011-9161-2

Oxley, J. C. (2011). *The moral dimensions of empathy: Limits and applications in ethical theory and practice*. Houndmills, Basingstoke, Hampshire, New York: Palgrave Macmillan.

Pettersen, T. (2012). Conceptions of Care: Altruism, feminism, and mature care. *Hypatia*, *27*(2), 366–389. https://doi.org/10.1111/j.1527-2001.2011.01197.x

Pettersen, T., & Hem, M. H. (2011). Mature care and reciprocity: Two cases from acute psychiatry. *Nursing Ethics*, *18*(2), 217–231. https://doi.org/10.1177/0969733010392301

Ratcliffe, M. (2012). Phenomenology as a form of empathy. *Inquiry: an Interdisciplinary Journal of Philosophy*, *55*(5), 473–495. https://doi.org/10.1080/0020174X.2012.716196

Raudonis, B. M. (1995). Empathic nurse-patient relationships in hospice nursing. *The Hospice Journal*, *10*(1), 59–74. https://doi.org/10.1080/0742-969X.1995.11882782

Reynolds, W. J., & Scott, B. (1999). Empathy: A crucial component of the helping relationship. *Journal of Psychiatric and Mental Health Nursing*, *6*(5), 363–370. https://doi.org/10.1046/j.1365-2850.1999.00228.x

Reynolds, W. J., & Scott, B. (2000). Do nurses and other professional helpers normally display much empathy? *Journal of Advanced Nursing*, *31*(1), 226–234. https://doi.org/10.1046/j.1365-2648.2000.01242.x

Richardson, K., MacLeod, R., & Kent, B. (2011). A Steinian approach to an empathic understanding of hope among patients and clinicians in the culture of palliative care. *Journal of Advanced Nursing*, *68*(3), 686–694. https://doi.org/10.1111/j.1365-2648.2011.05793.x

Rogers, C. R.. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science Formulations of the Person and the Social Context*, Vol. 3 (pp. 184–256). New York, NY: McGraw-Hill.

Sevenhuijsen, S. (2014). *Care and attention*. Paper presented at the A meaningful life in a just society: investigating wellbeing and democratic caring, Utrecht. http://www.selmasevenhuijsen.nl/index.php?p=weblog&xml:id=82

Slote, M. A. (2007). *The ethics of care and empathy*. London, New York: Routledge.

Smith, D. W.. (2018). *Phenomenology. The Stanford Encyclopedia of Philosophy*. Summer 2018. Retrieved 27 juni, 2019

Stein, E. (1964). *On the problem of empathy*. The Hague, the Netherlands: Martinus Nijhoff.

Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. New York, NY: Routledge.

Van Heijst, A. (2011). *Professional loving care: An ethical view of the healthcare sector*. Leuven: Peeters.

Van Nistelrooij, I. (2018). Affective coexistence: Pity as a connection between emotion and ethical knowledge. In S. Bourgault, & E. Pulcini (Eds.), *Emotions and Care: Interdisciplinary Perspectives*. Leuven: Peeters.

Van Nistelrooij, I., & Leget, C. (2016). Against dichotomies: On mature care and self-sacrifice in care ethics. *Nursing Ethics*, *24*(6), 694–703. https://doi.org/10.1177/0969733015624475

Van Nistelrooij, I., & Visse, M. (2018). Me? The invisible call of responsibility and its promise for care ethics: A phenomenological view. *Medicine, Health Care and Philosophy*, *22*(2), 275–285.

Vanlaere, L., Timmermann, M., Stevens, M., & Gastmans, C. (2012). An explorative study of experiences of healthcare providers posing as simulated care receivers in a 'care-ethical' lab. *Nursing Ethics*, *19*(1), 68–79. https://doi.org/10.1177/0969733011412103

Verducci, S. (2000). A conceptual history of empathy and a question it raises for moral education. *Educational Theory*, *50*(1), 63–80. https://doi.org/10.1111/j.1741-5446.2000.00063.x

White, S. J. (1997). Empathy: A literature review and concept analysis. *Journal of Clinical Nursing*, *6*(4), 253–257. https://doi.org/10.1111/j.1365-2702.1997.tb00313.x

Williams, C. A. (1990). Biopsychosocial elements of empathy: A multidimensional model. *Issues in Mental Health Nursing*, *11*(2), 155–174. https://doi.org/10.3109/01612849009014551

Wiseman, T. (2007). Toward a holistic conceptualization of empathy for nursing practice. *Advances in Nursing Science*, *30*(3), E61–E72. https://doi.org/10.1097/01.ANS.0000286630.00011.e3

Wynn, R., & Wynn, M. (2006). Empathy as an interactionally achieved phenomenon in psychotherapy: Characteristics of some conversational resources. *Journal of Pragmatics*, *38*(9), 1385–1397. https://doi.org/10.1016/j.pragma.2005.09.008

Zahavi, D. (2008). Simulation, projection and empathy. *Consciousness and Cognition*, *17*(2), 514–522. https://doi.org/10.1016/j.concog.2008.03.010

Zahavi, D. (2014a). Empathy and other-directed intentionality. *Topoi*, *33*(1), 129–142. https://doi.org/10.1007/s11245-013-9197-4

Zahavi, D. (2014b). *Self and other: Exploring subjectivity, empathy, and shame*. Oxford, UK: Oxford University Press.

Zaki, J., Bolger, N., & Ochsner, K. (2008). It takes two: The interpersonal nature of empathic accuracy. *Psychological Science*, *19*(4), 399–404. https://doi.org/10.1111/j.1467-9280.2008.02099.x

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