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Roses by other names? Empathy, sympathy, and compassion in mental health nursing

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Abstract

Empathy and related concepts such as sympathy and compassion are considered fundamental to mental health nurses' work with consumers. However, there is often little consensus on the relationship between these interpersonal interaction factors and their similarities and differences. In this paper, these three concepts are discussed. Theoretical frameworks of empathy, sympathy, and compassion are presented with a social psychological model of empathy focused upon. From this, discussion is undertaken of how the mental health nursing process may be explained by such frameworks, as well as what unique aspects of the nursing relationship need to be considered. It is contended that precise definitions and understandings of empathy, sympathy, and compassion are vital, and the use of models allows researchers to consider where gaps are in current knowledge, and to identify what might be important to consider from a nurse education perspective.

Key words: compassion, empathy, mental health nursing, personal distress, perspective taking, sympathy.

Introduction

Relationships with consumers are indispensable to the work of mental health nurses. In Peplau's (1952/1991) classic examination of the nurse–consumer relationship, the importance of what we might consider *empathy* is reflected in her discussion of the phases of the developing nurse–consumer relationship and the role of the mental health nurse. Peplau described the process of empathising with a consumer in the following way: 'To be able to sit at the bedside of any patient, observe, and gather evidence on the way the patient views the situation confronting him, visualize what is happening inside the patient, as well as observe what is going on between them in the interpersonal relation' (p. 50). When the nurse can understand the consumer's perspective and the 'meaning of the [consumer's] experience', they are then able 'to function as an educative, therapeutic, maturing force' (p. 41). Similarly, Orlando's (1961/1990) early model of the nursing process stresses that nurses should see all consumer behaviour as reflecting an underlying need for help, with nursing involving 'attempts [by the nurse] to understand the meaning to the patient in a time and place context of what she observes and how she can exercise her professional function in relation to it' (p. 2). Furthermore, Travelbee (1963, 1964), another early theorist, believed that rapport, as a means of perceiving and relating to a consumer, involved the nurse experiencing and communicating empathy, compassion and, focused on in her work, sympathy.

Understanding a consumer's a consumer's situation from their perspective and experiencing congruent emotions to their situation are generally undisputed as determinants of consumer progress and recovery (Forchuk et al. 1998; Reynolds & Scott 1999, 2000). However, there is often little agreement as to what we are talking about when terms such as *empathy* and related concepts *sympathy* and *compassion* are evoked, and what they involve in the mental health nursing space. This is not a debate specific to nursing, but has existed in other fields, particularly for over half a century in psychology (Davis et al. 2004; Deutsch & Madle 1975; Duan & Hill 1996; Dymond 1949; Gerace et al. 2013).

Increasingly, such conversations are occurring in the nursing space. In the context of discussion of consumer-focused models of care, Sinclair et al. (2017) introduced empathy,

sympathy, and compassion, positing the following question, 'But what exactly do these three constructs mean within the context of healthcare delivery?' (p. 438). In a consideration of the terms a decade earlier, Schantz (2007) opined, 'Specifically, the meaning of the concept "compassion" (or "compassionate care") is neither clearly defined in nursing scholarship nor widely promoted in the context of contemporaneous everyday nursing practice' (pp. 48–49). Schantz further contends that 'nursing research that uses terms such as caring, empathy, sympathy, compassionate care, and compassion interchangeably, implying that these words are synonymous, not only promotes erroneous assumptions, but also compromises the validity of the research findings' (p. 49).

The aim of this paper is to engage with issues in defining these three nursing interaction components: empathy, sympathy, and compassion. To do so, work in mental health nursing, other nursing areas, and psychology will be examined. It is important to acknowledge the contentions of nursing scholars that nurses' use and experiences of empathy and related components are distinct from the work of psychotherapists and counsellors (Morse et al. 1992/2006; Schantz 2007) and, indeed, perhaps from how people in everyday life empathise with others. However, research in psychology is highlighted – given its breath – as a potential way to move towards a clearer understanding of these components, as well as research questions that are clearer. The focus will be on empathy although, as will be demonstrated, there is considerable overlap between concepts.

The importance of nurse–consumer connection is unfortunately evidenced when there seems to be a pervasive lack of an empathic, sympathetic, or compassionate approach towards mental health and other consumers by staff entrusted with their care. This has been demonstrated in enquiries into healthcare practices in Australia (Groves et al. 2017) and internationally (Francis 2013; Keogh 2013). I suggest here that greater clarity around these concepts at a theoretical and conceptual level can also translate into initiatives to ensure nurses are able to approach their work empathically or compassionately. In turn, nurses can build their awareness of what methods are available to them in their mental health nursing toolkit, with their strengths and weaknesses, to better understand and respond to their consumers' experiences.

Empathy, Sympathy, and Compassion: What are We Talking About?

Of the three concepts, empathy has perhaps been subjected to the most systematic investigation. However, Davis (1994/2018) contends that this research, which originated in psychology, has been largely fragmented. He suggested this relates to the term empathy reflecting 'two distinctly separate phenomena' (p. 9): cognitive empathy, or the process of taking another's perspective, and emotional empathy, which involves experiencing emotions such as care, concern or even distress as a result of being exposed to another's situation. Examining previous research, Davis suggested that an empathy episode could be usefully considered as consisting of four components: (i) antecedents to experiencing empathy in the specific situation; (ii) processes, including perspective taking; (iii) intrapersonal outcomes, which include both emotional and cognitive reactions to another's experience; and (iv) interpersonal outcomes, where the empathiser engages in some sort of behaviour. The model is a synthesis of previous literature, organising concepts investigated in different studies into a linear model.

Antecedents include factors about the person empathising and the specific situation. These factors tend to exist even before the empathiser has attempted to understand another person (whom we will call a 'target') or experienced any emotion. These include how empathically prone the person is, the similarity of the empathiser to the target, as well as the nature of the situation, such as the sorts of emotions that are involved.

Processes help the empathiser to apprehend the other's perspective, including those largely outside of cognitive awareness (e.g. motor mimicry) or based on conditioning principles, to the more cognitively advanced being perspective or role taking. Perspective taking is accomplished using a range of strategies, including imagining oneself in the other's place, thinking of similar past experiences to that of the other person, and using rules of thumb about likely reactions to a given situation (e.g. expecting sadness at a death; Gerace et al. 2015, 2017).

Like perspective taking, intrapersonal outcomes, which often result from perspective taking and other processes, reside within the empathiser. These may be more cognitively focused, including the empathiser understanding the other person's perspective and being able

to accurately infer what they believe they are thinking or feeling. Particularly relevant to the present discussion, intrapersonal outcomes also include emotions. Emotions are separated in Davis' (1994/2018) model into parallel outcomes, where the empathiser and the target share the same/very similar emotion (e.g. the empathiser is sad because the target is sad), and reactive outcomes, which are an emotion related to the target's experiences. An example is an empathiser being concerned because the target is sad. Such a reaction has often been called 'empathic concern' in the literature (Batson 2011).

Finally, according to the model, interpersonal outcomes occur, the most often studied being the empathiser helping the target. In this part of the model, other interpersonal behaviours might be enacted, however, such as the empathiser communicating understanding to the target, or the empathiser wanting to manage conflict if their attempts to understand the other person were driven by a misunderstanding or conflict (Davis 1994/2018).

For the purpose of the present discussion of definitional issues, it is important to further discuss emotional intrapersonal outcomes and how they relate to perspective taking and helping, which is central to the mental health nurse's role. As mentioned, reactive emotional outcomes are often termed empathic concern, which Davis (1983) defined in an earlier study as '"other-oriented" feelings of sympathy and concern for unfortunate others' (p. 114), and which Batson et al. (1997) describe as 'an other-oriented emotional response congruent with the perceived plight of the person in need; it taps feeling for the other' (p. 752). Interestingly, Batson, whose measure of empathic concern is arguably the most used measure of state empathy (i.e. empathy towards a specific other person), measures this component using the adjectives 'soft-hearted', 'tender', 'warm', and 'moved' and, importantly for the present discussion, 'sympathetic' and 'compassionate'. Also included under the banner of reactive outcomes in the model is the concept of personal distress, which involves 'more direct feelings of discomfort evoked by witnessing the plight of the other' (Batson et al. 1997, p. 752). While personal distress is a reaction to another's distress, thus explaining its inclusion, it tends to result in outcomes that are quite different to those of empathic concern. For example, while empathic concern is a predictor of motivation to help, personal distress can lead to a person wanting to escape a situation involving a needy other person (Batson et al. 1987; Eisenberg et al. 1989). Indeed, Mohr et al.

(2007) found that perspective taking predicted lesser participant anger in an interpersonal provocation situation, while personal distress involved increased anger reactions.

In Davis' (1994/2018) model, perspective taking leads to empathic concern or, to put it another way, empathic concern, sympathy, or compassion come about through taking the other person's perspective. This relationship has been particularly investigated in the empathy-altruism space. According to Batson's (2011) model of helping, which he first formulated in the 1970s (Coke et al. 1978), empathic concern is the result of taking the other person's perspective, with this emotional response – rather than other responses such as personal distress – leading to motivation to reduce the need of the other person by helping them.

The focus thus far has been on *empathy* and the presentation of a model; however, it is important to consider how sympathy and compassion have been defined in the literature. Some researchers include sympathy and compassion under the umbrella term of empathy (Batson 2011; Davis 1994/2018; Gerace et al. 2018), but this has not always been the case in the social psychological or the nursing literature. Sympathy, although less investigated today, has a longer history than the concept of empathy going back to moral philosophers such as Adam Smith (1790/2002). Based on his review of the psychology literature on empathy and sympathy (but including the work of Smith and others), Wispé (1986) defined sympathy as 'the heightened awareness of the suffering of another person as something to be alleviated' (p. 318). By contrast, he felt that empathy involves 'the attempt by one self-aware self to comprehend unjudgmentally the positive and negative experiences of another self' (p. 318). In this case, Wispé is reserving the term sympathy for emotional responses, with empathy ultimately involving what I have referred to as perspective taking.

Interestingly, while the word 'sympathy' was gradually replaced by empathy in the psychology literature, sympathy's definition, as defined by Wispé (1986), Travelbee (1963, 1964), and others, has even more recently been labelled with the term 'compassion'. For example, drawing on Buddhist teaching, Gilbert (2014) described compassion as 'a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it' (p. 19). Despite a move away from sympathy and increased attention to compassion, conceptualisations of compassion

involve many of the elements covered within earlier sympathy definitions and the Davis model (1994/2018) of empathy. Strauss et al.'s (2016) review of the concept found that compassion is seen to include recognising that another is suffering (akin to cognitive empathy), experiences of emotional empathy, sympathy, and concern while not being overwhelmed by exposure to a target's distress, and motivation to help (see also Kirby et al. 2017).

How do These Concepts Play Out in Nursing?

While many of the concepts discussed above originated in psychology or psychotherapy (Schantz 2007), they do mirror many conceptions in the mental health nursing and health professional space. For example Travelbee's (1964) definition of sympathy stressed a process very similar to definitions from psychology, where 'another human being enters into and shares our distress and thus relieves us of the burden of carrying it alone at a time when it is most difficult to do so. It means that our distress *concerns* this other person and that he will institute actions to relieve our distress' (p. 70). Much later, Jeffrey (2016) outlined different meanings of the terms empathy, sympathy, and compassion, suggesting that empathy involves taking the consumer's perspective, while sympathy and compassion can be thought of as 'reactive responses' (p. 449). Empathy, according to Jeffrey, is effortful and requires the person seeing differentiation between the self and the other person's perspective. As in Davis' (1994/2018) model, studies in nursing have supported the importance of considering cognitive, emotional, and behavioural aspects of a response. For example, in a study by Bramley and Matiti (2014), consumers described 'compassion' as involving the nurse taking their perspective, caring, and engaging and spending time with them.

In a study with mental health nurses utilising the Davis (1994/2018) model (Gerace et al. 2018), many of the factors in the model did emerge, albeit with a uniquely nursing focus. For example, nurses did refer to imagining themselves in their consumer's place and thinking about similar past experiences that helped them to understand the consumer's situation; strategies reflected in the social psychology literature (Gerace et al. 2017). However, they reflected on doing so at a distance, as they did not want to equate largely different life experiences with the

unique perspectives of the other person (e.g. hearing voices). Much more important were nursing techniques such as questioning and acknowledging the consumer's feelings and perspective. On the emotion side, nurses considered empathic emotions that involved feeling *for* the consumer as reasonable and important, with a blurring of the self-other distinction seen to be more problematic. In this way, nurses were largely discussing empathic concern type emotions as acceptable but were careful to ensure more parallel emotions or personal distress did not creep into their responses. This suggests that while many core social psychological processes are the same, they play out differently in nursing, such as the extent to which nurses feel they can be close emotionally with consumers.

A major theme in this study was the idea that nurses empathised while being mindful of their roles and responsibilities to manage consumer safety and avoid risk. While Davis (1994/2008) deals with the nature of a situation under the first part of the model involving antecedents to the empathy experience, there is a need to consider the contexts in a nursing setting that may not exist in other interactions, such as issues of the nurse's role, power, and status (Walker & Alligood 2001).

While many working in nursing make use of psychological models, concerns over reliance on psychology frameworks led Morse et al. (1992/2006) to posit a model of empathic communication. In the model, empathic communication starts with the nurse's *emotional* response, rather than a cognitive (perspective-taking) one. Specifically, being exposed to a consumer's distress results in the nurse experiencing a vicarious emotional response or 'empathetic insight', where 'the nurse is engaged with the patient's experience of suffering, and the patient's suffering is embodied by the nurse, and suffering becomes a shared experience' (p. 77). This in turn leads to several potential responses that might invoke the use of sympathy, compassion or other responses (e.g. pity), or more distancing responses to avoid over-involvement in potentially draining emotions. For Morse et al., therapeutic empathy, defined as a learned cognitive (perspective taking) and behavioural (e.g. communication) response, rather than a sharing of emotion, is a method of controlling engagement with the consumer's experiences.

Morse et al.'s (1992/2006) model is not specific to mental health nursing, However, many of the concepts are reflected in research in this space. For example, nurse distress reactions and difficulty with emotions involved in mental health care have been found to result in distance between nurses and consumers (Hem & Heggen 2003; Jackson & Stevenson 2000). Importantly, Morse et al. provide explicit definitions of sympathy and compassion. Sympathy is seen as 'an expression of the caregiver's own sorrow at another's plight' (p. 78), and compassion occurs when 'the compassionate caregiver echoes the sufferer's sentiment and shares in the suffering' (p. 80).

One area where nursing conceptions of empathy differ in their focus from psychological treatments is the need to consider how nurses communicate understanding to consumers (Reynolds & Scott 1999) and how a consumer interprets the perspective-taking efforts and emotional displays of the nurse. While Davis (1994/2018) does address the ways in which an empathiser engages with a target as a result of perspective taking and empathic concern, a large part of the model focuses on how the empathiser experiences internal cognitive and emotional processes. That is, in this social psychological model, the perspective of the empathiser is focused upon (e.g. 'Did I understand the person?') rather than that of the target ('Did I feel understood?').

Treatments of empathy in the nursing space do consider the communication of empathy to the consumer, as well as what consumers consider empathy (Reynolds & Scott 1999). In this way, a difference between nursing investigations and a model such as that of Davis (1994/2018) is that the success of an empathic approach is assessed through examining whether the consumer perceives that they have been empathised with and understood. In Gerace et al. (2018), for example, empathy defined by consumers involved nurses 'being there', spending time with and allowing the consumer to take time to discuss personal issues, and seeing the person as not solely their illness, but a person experiencing a difficult time in their life. Empathy could also involve speaking about movies and books with the consumer, rather than just risk assessments or questions about symptoms.

In a study of compassion, Sinclair et al. (2017) asked consumers who had a terminal diagnosis of cancer 'what does compassion mean to you?' (p. 439) as well as whether they

thought compassion and sympathy, and compassion and empathy, were related. For these participants, empathy was another person taking their perspective, which involved a connection and engagement with the consumer's feelings. In contrast, these participants focused on sympathy as a pitying and 'unhelpful' emotion with the person sympathising focusing more on their own emotional responses to the other person's plight. Compassion was seen to involve perspective taking, but then to invoke an altruistic motivation to help the other person.

Within nursing and other healthcare spaces, there has been increasing consideration given to compassion, although as researchers in the area have identified (e.g. Dev et al. 2019), the focus has often been on lack of compassion due to compassion fatigue and related concepts such as burnout, rather than consideration of how it can be enacted and strengthened. In a model initially formulated regarding physician compassion, but one which the theorists have used to examine nurse and other health professionals' compassion, Fernando and Consedine (2014) focused on factors that facilitate and constrain compassionate responses, at the physician (e.g. dispositional ability, fatigue), consumer and family (e.g. grateful vs ungrateful), clinical (e.g. type of illness, including perceptions of consumer blame), and environmental (e.g. busy environment, other demands) levels. These theorists stressed the interplay of factors, whereby 'compassion is not only a function of physician characteristics but reflects the physician in a transactional relationship with the patient, the clinical picture, and the institutional setting' (p. 291).

In a study of compassion in the hospice setting, Way and Tracy (2012) drew on theoretical models of compassion (Kanov et al. 2004; Miller et al. 2007) to understand the perspectives of hospice workers, the largest group of study participants being nurses. As Way and Tracy outline, the models of compassion drew upon an earlier model of sympathy (Clark 1997) and, indeed, the stages of sympathetic or compassionate response are quite similar, although the later models involve attempts by one person to alleviate the others' pain. Interestingly, these models, which were not formulated in the clinical space, share much in common with the components of the Davis (1994/2018) model. What emerges in examining these modes is while the processes of a response are often agreed upon, the terms used are not.

What's in a Name?

The reason that terms are important is because they determine what we choose to investigate in research, as well as how nurses approach their work. Also needed is awareness of what researchers consider when using these terms compared with the views of research participants. In the Gerace et al. (2018) study, consumers were asked what they considered empathy to be, before being given potential definitions. For nurses, definitions were presented first as it was presumed that they would be familiar with definitions from literature. While our definitions largely accorded with the nurses' own perspectives of empathy, there were unanticipated differences in related terms such as sympathy. For example, one nurse defined sympathy and empathy in this way: 'Sympathy is actually poor you, it's quite a pitying emotion, where empathy can be about building a bit of rapport and actually seeing it from their perspective but not seeing it as your problem'. This reveals a disconnect between what researchers might consider sympathy (e.g. Gerace et al. 2018; Morse et al. 1992/2006), and how research participants experience these phenomena.

If a lack of clarity abounds in theory and research, this restricts the type of questions that are asked and limits investigations into the strengths and weaknesses of approaches to understanding and connecting with consumers. This poses a problem for nurse education being evidence-based. It may also lead to, as Williams and Stickley (2010) argue, a focus on learning specific skills (e.g. listening), rather than 'the essence of an empathic way of being' (p. 754; see also Kunyk & Olson 2001; Morse et al. 1992/2006). Teaching and assessment of such skills also becomes problematic (Ançel 2006). At the individual level, nurses are left with a lack of understanding of how they should interact with a consumer.

Clarity of definitions and concepts allows researchers and practitioners to define what *is* and what *isn't* empathy, sympathy, or compassion. An example can be seen when considering sympathy. In a 1964 article titled 'What's Wrong with Sympathy?' Travelbee (1964) contended, 'to establish empathy with patients, most nurses will agree, is a desirable and proper goal – but we're not so sure about sympathy. As a matter of fact, nurses are usually encouraged to empathize, but cautioned *not* to sympathize' (p. 68). For Travelbee, empathy was what I have

defined in this paper as perspective taking and allowed the nurse to achieve empathic accuracy, but it is 'an essentially neutral process' (p. 68) as it might not involve motivation to help the consumer. This is how sympathy facilitates that motivation, where it 'implies a desire, almost an urge, to help or aid an individual in order to relieve his distress' (pp. 68–69). This definition is very akin to later definitions of empathic concern and speaks to Batson and colleagues' model of helping (see Batson 2011). This definition in turn shares considerable overlap with later understandings of compassion (Gilbert 2014).

Travelbee (1964) defined sympathy by discussing what is was not. Specifically, she outlined concerns that sympathy leads to overidentification with a consumer, an inability to meet the consumer's needs 'because she [the nurse] is too busy meeting her own' (p. 69), and parallel emotional reactions resulting in the nurse crying or becoming depressed when the consumer cries or is depressed. These reactions were not, for Travelbee, sympathy at all, nor was sympathy what she described as dehumanising actions such as pity.

Interestingly, Rich (2003) examined Travelbee's (1964) contentions some 50 years later, concluding: 'In answering Travelbee's question "What's wrong with sympathy?" the nursing profession should reply, "Nothing"' (p. 203). Rich did, however, suggest that perhaps the word compassion 'may be more acceptable to the nursing profession' (p. 203).

Conclusion

In this paper, I have presented some of the issues when defining empathy, sympathy, and compassion. In doing so, I have highlighted the importance of precise definitions so that, from a research point of view, researchers investigating in the area are aligned with the nurses or consumers with whom they research. Indeed, I would suggest that it may not matter so much what we call the nurse's responses (e.g. sympathy or compassion) so long as we are clear as to what the term encompasses and does not include.

There remains much work to do. In this paper, Davis' (1994/2018) model was presented as one possible model to understand an empathic interaction. While such a model has been

utilised by mental health nursing researchers (Gerace et al. 2018), there are other approaches (e.g., Morse et al. 1992/2006). What is needed are investigations into the parts of an empathic approach. Models such as Davis' (1994/2018), which was not formulated in nursing, or that of Morse et al. (1992/2006), which was not specific to mental health work, remain useful as they allow us to consider where there might be gaps in our understanding, as well as where future work should be directed. Such models can inform a mental health nursing specific treatment or theory of empathy, sympathy, or compassion. The concept analysis approach (see Rodgers et al. 2018; Walker & Avant 2019), which has been used in (non-mental health) nursing to examine empathy and compassion (Campbell-Yeo et al. 2008; Kunyk & Olson 2001; Schantz 2007; White 1997; Wiseman 1996) would be particularly useful to understanding empathy, sympathy, and compassion in mental health nursing work. Such an approach allows the researcher to consider antecedents, consequences, and illustrative (and contrary) cases of the phenomena.

In bringing clarity to these terms using such an analysis, an important consideration is to what extent we consider nursing empathy, sympathy, or compassion to be unique in mental health nursing, or whether we think wider psychological conceptions can help explain nurse–consumer interactions. In a qualitative study by Jackson and Stevenson (2000) for example, while not specific to empathy, mental health nurses described moving between three types of interacting with their consumers: 'ordinary me', akin to a personal relationship in terms of disclosure; 'pseudo-ordinary' me, where disclosure is of a more general nature (the favoured position of participants); and 'professional me', where nurse–consumer distance is more maintained. This suggests that nurses make use of specific modes of interaction when dealing with a consumer, and general models or measures may not be able to fully tap into these modes of interaction. At the heart of all this, however, is the need for precise definitions.

Recommendations for Clinical Practice

Besides highlighting gaps to direct future research, a clearer focus on what fundamental terms mean will allow nurses to have more clarity about the types of skills they bring to their work. As Yu and Kirk (2009) contend in regard to measuring nurse empathy responses, better

measures 'will assist the development of interventions to improve the quality of nursing care and training programmes aimed at promoting empathy' (p. 1804). Indeed, more recently, there have been calls for nurse educational approaches to focus on empathy (Dean & McAllister 2018) and reviews have found the efficacy of empathy training for nurses (Brunero et al. 2010; Levett-Jones et al. 2019). It is now, however, time to consider what we mean by these terms, so that we are clearer on what we are training and the outcomes we want to achieve by building empathy, sympathy, and compassion.

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