Methodological notes on empathy

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FOR THE PAST 30 years, nursing literature has been addressing the concept of empathy. In 1958 the *American Journal of Nursing*[1] published a sociological analysis of the nurse role that described the specialized function of the nursing profession as an expressive role involving a willingness to listen and understand. From the writings of Florence Nightingale[2] to contemporary theorists,[3,4] the common denominator presents the nurse as the one who creates a caring and helping atmosphere in which healing can be facilitated.

Early discussions of empathy treated the concept as integral to therapeutic nursing and presented implications for application.[5-10] More sophisticated delineations over the past decade[11-14] have contributed to the refinement of the meaning of the concept of empathy as it occurs in the nurse-patient relationship.

Numerous studies have been conducted to assess the level of empathic ability in nursing subjects. The conclusion that nurses are low in empathic ability has been

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supported by the research of Duff and Hollingshead,[15] Kalisch,[16] LaMonica et al,[17] Peitchinis,[18] and Truax et al.[19] On the other hand, Forsyth,[20] Kirk,[21] and Johnson[22] reported empathic levels in nurse subjects that were considered high or comparable to empathic levels of counselor therapists. The varying methodologies utilized in empathic studies warrant scrutiny and contribute to a rationale calling for reassessment of empathic measurement in the nursing arena.

Attempts by nurse researchers to develop empathic instruments have been limited[23-25] and have not resulted in application by other researchers, nor has reliability and validity been demonstrated for these tools. Nursing studies have predominantly relied on empathic instruments borrowed from related disciplines. These involve self-rating, rating by judges, and client rating of empathy. Most popular have been the Hogan Empathy Scale,[20,26] the Carkhuff indexes,[17,27] the Truax Accurate Empathy Scale,[16,28,29] and the Barrett-Lennard Relationship Inventory (BLRI)—Empathy subscale.[16,20-23,30,31]

DEFINITION OF EMPATHY

Any helping relationship involves the complexities of empathy, regardless of the depth of the relationship.[32] Nursing definitions of empathy have their origins in the theoretical works of Katz,[33] Carkhuff and Truax,[32] Reik,[34] Rogers,[35] and many others who have explored the psychotherapeutic significance of this concept. Empathy in the interactive sense is defined in these works as the ability to perceive the meanings and feelings of another person and to communicate that understanding to the other. This is the definition most often referred to in nursing research.[13,14,16,23,27,31]

OPERATIONALIZATION OF EMPATHY

Difficulty arises for nurse researchers in operationalizing empathy. The varied approaches and tools used in the measurement of empathy present differing and partially contradictory results. Although Layton[23] demonstrated a correlation between three empathic tools, other nursing studies utilizing more than one type of tool did not necessarily find agreement between tools.[16,20] Of particular relevance is Forsyth's[20] study in which the Hogan Empathy Scale and the BLRI were both utilized. Only 50% of the nurses perceived themselves as highly empathic, whereas 98% of the subjects were rated as highly empathic by patients.

The manner in which empathy is assessed is a question of central importance. The application of self-rated tools carries a potential for inherent bias, since these tools rely on cognitive understanding of empathy and do not attempt to measure the subject's empathic ability in operation. The Hogan Empathy Scale[36] is such a measure and is composed of 64 true-false items based on the intellectual apprehension of another's state. Similar to this is the

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Carkhuff "Helpee Stimulus Expression: An Index of Discrimination,"[37] consisting of 16 excerpts from counseling situations. The respondent is asked to check one of four possible responses. The index measures the subject's cognitive appreciation for the concept of empathy rather than demonstrated empathic ability.

Rating of empathic ability by a panel of judges presents other problems. The Truax Accurate Empathy Scale[38] involves ratings of recorded helper-client interactions by judges who assess the degree of empathic communication being demonstrated. This depends on accurate interrater reliability and precludes direct experiencing of the helper-helpee communication. Since the empathic process is subjective in nature, involving both verbal and nonverbal modes of communication, it seems that an external assessment regarding its occurrence would merit cautious assumption.

It has been suggested that the most conceptually valid measure of empathic ability assesses the perceptions of the client through the use of a client-rating tool.[31] The BLRI is a client-rating tool that was originated for the rating of counselor empathic ability by clients in a counseling situation.[39] The BLRI consists of five scales with 92 items measuring level of regard, empathic understanding, congruence, unconditionality of regard, and willingness to be known. The Empathic Understanding subscale, consisting of 16 items, has been utilized in nursing studies. Kurtz and Grummon[40] demonstrated that client-perceived empathy is the best predictor of client outcome, with taped-judged empathy being less related to client outcome and self-rated empathy as being particularly suspect. Barrett-Lennard[39] has shown a positive correlation between patient improvement and high scores on four of the subscales (including the Empathy subscale) of the BLRI. This offers evidence for the validity of the BLRI and supports client rating of empathic ability as conceptually sound.

APPLICATION OF THE BLRI, EMPATHY SUBSCALE

The most widely used tool in empathic nursing studies has been the client-rating Empathy subscale of the BLRI (see boxed material). Several studies have used this tool to assess results of empathic training programs. Kalisch[16] utilized actual clients in the rating of 49 student nurses pre-empathic and postempathic training, with no indication of increase in empathic ability. Kirk,[21] however, showed an increase of empathic ability after a training program in which clients rated psychiatric nursing personnel. Simulated clients in interaction with 56 nursing students were utilized by Layton.[23] The subscale ratings in this exercise indicated an increase of empathic level after empathy training for junior students, but not for senior students. Law[41] reported an increase in empathic ability of 17 nurses rated by clients after an empathic communications program. Studies using alternate means of measurement also offer evidence of the positive effect of education on the empathic process.[17,42,43]

Other studies have used the BLRI Empathy subscale to expand knowledge about the empathic process in nurse-patient interaction. Stetler[31] employed simulated clients to rate 32 nurses to study the relationship between empathy and communication behaviors. The study by For-

Empathy Subscale of the Barrett-Lennard Relationship Inventory*

1. She/he tries to see things through my eyes.
2. She/he understands my words but not the way I feel.
3. She/he is interested in knowing what my experiences mean to me.
4. She/he nearly always knows exactly what I mean.
5. At times she/he jumps to the conclusion that I feel more strongly or more concerned about something than I actually do.
6. Sometimes she/he thinks that I feel a certain way because she/he feels that way.
7. She/he understands me.
8. Her/his own attitudes toward some of the things I say, or do, stop her/him from really understanding me.
9. She/he understands what I say, from a detached, objective point of view.
10. She/he appreciates what my experiences feel like to me.
11. She/he does not realize how strongly I feel about some of the things we discuss.
12. She/he responds to me mechanically.
13. She/he usually understands all of what I say to him/her.
14. When I do not say what I mean at all clearly, she/he still understands me.
15. She/he tries to understand me from her/his own point of view.
16. She/he can be deeply and fully aware of my most painful feelings without being distressed or burdened by them herself/himself.

The respondent is asked to mark each of the above statements according to how strongly the statement was felt to be true or untrue:

+3 I strongly feel that it is true.
+2 I feel it is true.
+1 I feel that it is probably true, or more true than untrue.
−1 I feel that it is probably untrue, or more untrue than true.
−2 I feel that it is not true.
−3 I strongly feel that it is not true.

*Barrett-Lennard GT: Dimensions of therapist response as causal factors in therapeutic change. *Psychological Monographs* 76(43, Whole No. 562), 1962. Derived from the original client form of the Relationship Inventory, copyright 1962 by the American Psychological Association. Reprinted/adapted by permission.

syth[20] involved 70 nurses rated by 70 clients. Forsyth commented on the discrepancy between the low Hogan self-rating scores and the highly positive results of the Empathy subscale by suggesting "that clients perceive all nurses as empathic, whether they are or not."[20(p59)] Johnson[22] utilized 24 clients to rate four nurse practitioners. The clients found that patient satisfaction and adherence correlated with empathic ability of nurse subjects.

Conceptual problems

Based on the premise that client rating is the best indicator of empathic ability, Gagan used the BLRI in a study that explored the relationship between fear of death and empathic ability in nurse subjects.[30] Thirty nurse-patient dyads were established in two hospitals, and after providing 3 consecutive days of nursing care to terminally ill patients, nurses completed the Dickstein Death Concern Scale,[44] and patients rated the nurses by means of the Empathy subscale of the BLRI. Because empathy is said to occur when there is no intervening self-consciousness on the part of the one who has the counselor role,[10,12] fear of death, it seemed, would preclude the self-abandonment necessary for the perception of another's affective state. Consequently, an inverse relationship between death anxiety and empathy was hypothesized. This was not substantiated by data analysis, however. The nurse subjects were found to have a level of death anxiety consistent with the general population and with other nurse populations. Empathic levels of the nurse subjects approximated those found in studies of counselor/therapists[39,40,45] and of nurse subjects in two other nursing studies.[21,22]

The BLRI operationally defines Rogers' view of the empathic process: sensing the client's world as if your own and being able to communicate that understanding to the client. This definition is consistent with that most frequently applied in nursing research, but the application of this tool in the nursing arena may not be consistent with the nurse-patient relationship. Except for the Kalisch study in 1971,[16] use of the BLRI in nursing studies has predominantly occurred within the last 2 years. The suitability of its adoption for nursing has not been fully addressed. Considering that 69% of the nurses in the sample of Kalisch's study reported no communication or empathic education in their background and that the majority reported an educational level of associate degree or diploma, it seems questionable that nurses with a limited exposure to the empathic concept in their training would score as high or higher in empathic ability than therapists specifically trained to incorporate the empathic component into the counseling relationship.

Suitability of the BLRI

Originally developed for use in the client-therapist arena, the BLRI is devised for the evaluation of the therapeutic process in which the client presents a specific psychological problem. The client is encouraged to look at behavior and life styles within the context of an established one-to-one relationship between the therapist and client committed to exploration and clarification of a psychological problem. Psychological problems within the hospital context are often not specifically defined and are interrelated with physical vulnerability. The nurse takes his/her place within the health team to facilitate the correction of a physical complaint by utilizing components of nurturance and support. If specific psychological factors arise within this context, the nurse's approach might well be one of support and acceptance. Hospital nursing generally does not entail the commitment of one nurse to one patient in an ongoing relationship, although widespread adoption of primary nursing may change this. Such a relationship has as its purpose the exploration and clarification of psychological problems.

Specific comments by the patients in the author's study suggested the need for an instrument more adapted to the nurse-patient setting. "What does this question mean?" "These questions are hard to answer." "I don't think I know the nurse that well." These are typical examples of statements made by the clients. They illustrate two problems in the application of this tool. First is the consideration that patients may need to get to know the nurse better in order to respond to such questions as, "She/he appreciates what my experiences feel like to me." Second is the assumption that all the respondents could operate at a level of mental abstraction sufficient to respond to such items as, "Her/his own attitudes toward some of the things I say or do, stop her/him from really understanding me." Johnson,[22] in her study of the empathic level of four nurse practitioners as rated by 24 clients, presented the same two problematic factors in her appraisal of the Empathy subscale. Johnson's observations offer further support to the need for reconsideration of application of the Empathy subscale of the BLRI to the nurse-patient relationship.

It is suggested that patients, in desiring to rate the nurturant and supportive qualities of the nurse subjects in the studies

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employing the Empathy subscale of the BLRI, responded to the inventory in a manner that did not include assessment of the exploratory and clarification functions of the therapist-client interaction that were incorporated into the original design of the tool. Because hospital populations may be more cross-sectional than populations seeking psychological counseling, a sophistication may be presupposed and reflected in the construction of the BLRI that does not take into account the heterogeneous nature of hospital populations. Consequently, the construct validity of the BLRI is brought into question regarding the evaluation of empathy in the nurse-hospitalized patient relationship.

SITUATION OF THE CLIENTS

Of equal importance when considering client rating of empathic ability of nurse subjects is patients doing the rating. The question must be posed as to whether or not clients who are in a dependent and passive position in the hospital feel free to express themselves in as candid a manner as clients in mental health clinics being seen as outpatients and not dependent on therapists for physical care. Freidson[46] has described the situation of the hospitalized person as being restricted to performing only the role of a patient. He postulates that the knowledge and ethicality of the medical profession have been created independently of the client's perspective, have resulted in a monopoly over the specific work of the profession and of the setting in which the work is carried out, and have resulted in illness as shaped by the profession's definition and organization of how it is expressed.

> In ambulatory care the social behavior and experience of the sick person can never be wholly or even mostly controlled by the professional notions of illness and treatment. In contrast, when the sick person is institutionalized, the experience of being ill becomes far more amenable to organization by staff demands, for the person tends to lose his social and physical mobility, to be isolated from his lay associates, to be cut off from the information he would need in order to assume an active role in the management of his illness, and to be fitted into administrative routines organized to permit the staff to work in ways they consider effective and convenient. In fact, only when he is institutionalized can the sick person be restricted to performing only one role—that of the patient.[46(p326)]

When Forsyth[20] suggests that patients perceive nurses as empathic whether they are or not, the dependent and passive nature of the client's role could well account for such a perception. The possibility of a bias against hospitalized patients being able to evaluate their caregivers objectively should not be ignored in the consideration of client rating of empathic ability of nurse subjects.

RECOMMENDATIONS

Provocative questions regarding the nature and assessment of empathy within the nursing arena are raised by the factors

considered in this article. Prior to any further assessment of empathic ability in nurse subjects, it is appropriate to call for an in-depth study to determine the precise nature and characteristics of the empathic process within the confines of the nurse-patient relationship. The empathic process is brought to bear on diverse and multiple relationships. It stands to reason that each of these relationships is characterized by specifics that shape the unfolding of the process within that context. The psychologist-client relationship carries elements of exploration and confrontation usually not found in the nurse-patient relationship within the general hospital. This latter relationship primarily focuses on elements of support and nurturance. Exactly how these elements (as well as other elements of the nursing empathic process) are actualized is unknown. This points to the need for methodological observation and identification. An observatory, exploratory study is suggested to investigate and delineate the precise nature of the empathic process in the nurse-patient relationship. Such a study would need to consider the emerging role of the nurse into areas of increased responsibility and accountability in regard to client outcome.

Subsequent to this there is need for the development of a tool to measure the empathic process in the nurse-patient relationship. While assuming that a client-rated tool would be the most valid measure, the factor of patient response set bias must be taken into account and in some manner controlled. Consideration of another approach to the assessment of empathic ability may be warranted.

This challenge involving the operationalization of empathy offers nursing research the opportunity for scientific discovery and advancement specific to its discipline.

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