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Chapter 1:
Introduction

"Empathy is commonly one of the most neglected areas in nursing. This creates a barrier to effective nursing outcomes."

(Burnard and Morrison, 1991, [cited in: Duxbury, 2000, p156])

The Nursing and Midwifery Council (NMC, 2008) clearly states you must treat people as individuals and respect their dignity. The ability to empathise is to get inside another’s skin and to gain a perfect understanding of their feelings (Watkins, 2008), and historically, this is deemed a desirable trait of the nurse (Morse, Bottorff and Anderson, 1992). The purpose of this paper is to explore the current definition of empathy and its defining attributes. Its focus is on empathy within healthcare settings, nursing practice and patient care.
Rationale

Reynolds and Scott (2000) have found cumulative evidence showing nurses to have low levels of empathy, as do other health care professionals as a whole. Revisiting, developing and understanding the concept of empathy will encourage nurses and nurse educators to develop their empathetic skills in ways that will positively influence nurse-patient relationships, nursing interventions and patient goals (Chambers, 1994 [cited in: Reynolds and Scott, 2000]). Making empathy a more prominent feature in nursing practice has been found to be beneficial to patient outcomes (Hojat, Vergare, Maxwell et al, 2009).

Kunyk and Olson (2001) conducted the last concept analysis of empathy based on Walker and Avant’s (1988) model. Conducting another in a different time period would not only allow the concept to mature alongside the advances in health care, technology, consumerism and management (Carver and Hughes, 1990), but also allows room for further analysis and synthesis of new literature (Kunyk and Olson, 2001). A concept analysis will be conducted to help clarify and unravel the complexity of empathy. Using a this method of analysis will help examine the defining attributes of empathy and reviewing the current literature will allow the concept to be re-defined, allowing the reader to gain a deeper understanding of its current meaning in the healthcare profession. The analysis will also encourage reflection of the reader’s own practice and therefore become more critically aware of it.
A Concept Analysis of Empathy

The advantage of using a concept analysis over a literature review is that all the materials available are considered. If a normal systematic literature review was carried out then there is a possibility that the true meaning of empathy in the healthcare profession will be missed. Also, if the study was to be re-produced, the researcher may not gain the same results. A concept analysis uses 3 ‘Cases’ that show the concept being used in practice. The first case study demonstrates a situation where all the defining attributes of the concept are shown. The second includes some of defining attributes and the last shows none of the defining attributes of the concept. A normal literature review does not do this.

Empathy has been closely linked to sympathy and compassion and because of this close relationship the understanding of the concept can sometimes be misinterpreted or lost. Therefore a concept analysis will distinguish the defining attributes of empathy and link them into modern nursing practice, eliminating any confusion as to its current meaning and usage.
A Concept Analysis of Empathy

**Aim and Objectives**

The concept of empathy has previously been developed by a number of authors, the most recent being Kunyk and Olson (2001), Wiseman (2007), Reynolds and Scott (2000), White (1997) and Wiseman (1996). The purpose of this paper will be to review current research and literature and highlight the evolution of empathy and to question what has remained static and what aspects have developed through our changing society and nursing practice. The paper will explore the meaning of empathy in the healthcare context. Using a concept analysis as the methodology allows the author to explore different types of empathy and its perception, purpose and power in healthcare. Baldwin and Rose (2009) describe concepts as the building blocks of theory, and therefore creating a concept analysis will build on foundational nursing theory and, in turn, be influential in practice.

The objective is to determine the characteristics of empathy so it cannot be confused with similar concepts such as compassion, fellow feeling and sympathy. Another objective of this paper is to develop a new interpretation of empathy, to critically review the literature and to justify the new defining attributes of the concept using evidence based research. Williams (2001) recognises that the emotional work nurses undertake is not always valued, even though it is an inherent part of the profession. The paper will emphasise the importance of empathy and how it can be used to ensure patients feel understood and cared for. The findings will be used to recommend and implement changes to future practice.
Chapter 2:
The Background

In the early nineteen hundreds Lipps, a German philosopher, created the word 'Einfühlung' which was later translated to the English phrase 'feeling into', this term later developed into 'empathy' (Montag, Gallinat and Heinz, 2008). This was described by Rogers (1957) as:

“The ability to sense the client's private world as if it were your own without ever losing the 'as if' quality.”

(Rogers, 1957, pp185)

Empathy has been described and confused with many different terms, such as: 'emotional knowing' (Noy, 1984, cited in: Holden, 1990), 'empathetic understanding' (Barrett-Lennard, 1993), 'reflective responding' (Nelson-Jones, 1993) 'putting yourself in another's shoes' (French, 1994), 'feeling into' (Barnes and Thagard, 1997) and 'emotional contagion' (Mans and Brown, 2006). In understanding these terminologies, the reader can gain an insight into the defining attributes of empathy and how to distinguish it from similar concepts.
A Concept Analysis of Empathy

Barnes and Thagard (1997) state empathy symbolises the ability to comprehend another’s state without actually experiencing it. The term refers to the attempt to comprehend another’s state of mind whether it is positive or negative. Egan (1998) states "empathy is more than a communication skill it is a way of being" (p48). This 'way of being' must take time to develop through experience and in-depth knowledge on the subject. The empathiser will to be able to enter the private, perceptual world of a patient and to become thoroughly at home within in it (Rogers, 1980.)

Buber (1958) describes two types of relationships, the 'I-it' and the 'I-thou' relationship. These relationships can be related to nursing, for example the ‘I-it’ relationship is when the nurse regards the patient as an object and the 'I-thou' relationship is where the nurse is sensitive to the patient's autonomy and experience. Being able to develop an 'I-thou' relationship is an admirable trait of the nurse, and being able to understand their patient's point of view and show understanding is essential (Holden, 1990).

The prime purpose of empathy in the health and social care profession is to act on the basis of helping others or to affect therapeutic change. Empathy within healthcare has been described by Kalisch (1973) as a relief from loneliness and is important in valuing the patient’s viewpoints. Empathy can be viewed as a cycle a person goes through to gain an empathetic understanding of another.
Barret-Lennard (1993) describes five phases of the empathy cycle as: pre-empathy, empathic resonation, expressed empathy, received empathy and finally feedback and fresh expression. The author notes that when empathy is expressed, it is essential the receiver is open to the empathy being communicated for the cycle to be complete.

Some academics, such as Carkhuff and Traux (1965) [cited in: Cassidy and Cutcliffe, 1998] have tried to measure empathy using scales. The level of empathy was measured using observers to judge statements given by participants on videos and audio tapes. However this method has been highly criticised due to observer bias. Kalisch (1973) also attempted to measure empathy using the 'Nurse-Patient Empathetic Functioning Scale'. This is based on Carkhuff and Traux’s earlier work. It is a five point scale where 0 denotes the absence of empathy and 4 is where the nurse communicates empathy without uncertainty and has accurate awareness of the patient’s deepest feelings. These methods of measurement have been inconclusive. Walker and Avant (1988) support the use of measuring scales and believe completing a concept analysis is an excellent way to develop new empathy tools or to evaluate old ones.
Many academics refer to two types of empathy; basic and learnt (White 1997, Kalisch 1971 and Cassedy and Cutcliffe, 1999.) White (1997) describes basic empathy as empathy developed from childhood to adulthood, its an innate capacity, whereas learnt empathy is when empathy is developed through practice. Learnt empathy is built on one’s basic empathetic ability and is more commonly used in clinical practice (Pike, 1990). The author feels both basic and learnt empathy are important attributes in the ability to be sincerely empathetic. This paper will confirm or clarify whether or not this is the case.

Olson and Hanchett (1997) consider the notion of nurse expressed empathy, patient perceived empathy and the utilisation of empathy when a patient is distressed. The first is defined as understanding what the patient is saying and feeling and the nurse having the ability to communicate this understanding back to the patient. Patient perceived empathy is characterised by the individual having feelings of being understood and accepted by the nurse. The last idea is described as the nurse’s ability to draw upon her/his empathetic skills and be proactive in relieving the patient’s distress and anxiety.

In recent literature Kunyk and Olson (2004) seek to advance Olson and Hanchett’s (1997) work and describe a further five conceptualisations of empathy, these are empathy as a; human trait, professional state, communication process, caring and a special relationship.
A Concept Analysis of Empathy

The first of these conceptualisations (empathy as a human trait), involves an individual’s innate ability. This form can be identified, reinforced and refined but not taught. In contrast, empathy as a professional state implies it can be learnt using cognitive and behavioural components in teaching to transmit an understanding of a patient’s reality back to the nurse. Empathy as a communication process is also determined by applying a learnt skill. When the nurse empathises in each situation the nurse brings away a unique understanding which can be used to accurately transfer the learnt skill into another setting. For example, the nurse has relieved a patient’s anxiety by listening to their concerns, clarifying these concerns back to the patient and reassuring them by taking action. Then she can take this positive outcome and follow a similar process with any other anxious patient she comes across. Empathy in caring is described as a nurse being compelled to act because they understand its importance to the client through experience. Finally, Kunyk and Olson (2004) describe empathy as a special relationship where empathy is communicated through a long term reciprocal relationship and resembles a special friendship which some nurses may experience with patients who have a long term illness and are admitted to hospital on regular occasions, for example patients on chemotherapy or dialysis.
Olson and Hanchett’s (1997) ‘Middle Range Theory’ of empathy was largely based on Orlando’s (1961) model of nursing; the theory is specific to nursing and nursing practice. The theory uses patient distress as a baseline measurement and emotional relief as a measurement of the quality of the nurse’s interactions and patient care received. However Olson and Kunyk (2004) later state this theory is too general and abstract to test. Hence developing a concept analysis of empathy will allow a tangible, in depth definition to be constructed, which can then be utilised in future nursing practice.

Orlando (1972) and Olson and Kunyk (2004) believe nurse expressed empathy can greatly improve patient behaviour and will bring about more effective nursing care. Nurses will have the ability to professionally respond to patient distress rather than relying on an automatic (and perhaps irrational) personal response. Only some nurses may possess this personal skill or trait (Kunyk and Olson, 2001). Assuming an accurate representation of empathy is expressed by the nurse, the patients will feel comforted and more self-reliant or more understood.
The power of empathy was first recognised by psychologists and psychotherapists in the 1950's, and these professions dominated the concept (White, 1997). Reynolds and Scott (2000) believe empathy is an essential prerequisite for effective nursing practice. Empathy has been found to significantly enhance patient satisfaction (Stepien and Baernstein, 2006) and patient outcomes (Reynolds and Scott, 2000). For example, Squier (1990) found having an empathetic nurse-patient relationship may be the difference between misery, suffering and pain, and patients leading an active and productive lifestyle.

Rogers (1957) conducted a study that showed patients experienced relief from pain, improved pulse and respiration rate and a reduction in anxiety when they received care in interpersonal conditions (a nurse-patient interaction that enhances the patient’s experience). Chambers (1994) [cited in: Reynolds and Scott, 2000] developed this idea of empathy relieving pain by suggesting nurse-patient relationships have the potential to positively influence health outcomes. La Monica, Madea and Oberst’s (1987) work support these findings. They found patients who perceived the nurse looking after them as highly empathetic, were less anxious, depressed and/or hostile. This accumulation of evidence suggests perceived empathy is a strong factor influencing the nurse-patient relationship and the emotional wellbeing of the patients.
French (1994) describes 'care' as an emotional word. This suggests the nursing profession is an emotional and objective pursuit and that nurses need to understand patient distress and provide support through interpersonal communication (Reynolds, Phil and Scott, 2001). In doing so, nurses can sense and communicate the patient's meaning that perhaps they are scarcely aware of themselves (Rogers, 1980). Kalisch (1973), states that when empathy is communicated correctly it forms the basis for a helping relationship between nurse and patient; the nurse must understand the patient's current feelings for this to be achieved and be capable of communicating that understanding to the patient.

Many academics such as Hodges (1991), Reynolds and Presley (1987) and Layton (1979) [cited in Cutcliffe and Cassedy, 1999] have tried to incorporate empathy training into nursing practice. However, all of these results either lacked statistical significance or the evidence was inconclusive. From this, it could be suggested that communicating the defining attributes of empathy in teaching sessions could clarify what it means to nursing students and using ‘Cases’ to describe what is and what is not empathy will be useful to distinguish grey areas surrounding the concept. This in turn, could positively influence their practice. Walker and Avant (1988) state that a concept analysis encourages communication, which makes it easier to promote the understanding of empathy amongst healthcare professionals.
Reid-Ponte (1992) and Daniels, Denny and Andrews (1988) [cited in: Yu and Kirk, 2009] reported that nurses have low levels of empathy and Reynolds, Phil and Scott (2001) believe that the role of empathy needs to be revisited in the context of healthcare delivery. Gould (1990) described empathy as being part of individualised nursing care and nurses should take it upon themselves to correctly implement it into their practice. In doing so, it can help the patient become less dependent on the opinions of others and will have a high value of their own self concept (Kalisch, 1973).
A Concept Analysis of Empathy

The theory Behind a Concept Analysis

Meleis (1997) reiterates Wilson’s (1969) eleven step method for constructing a concept analysis. These steps to analysis involve techniques such as defining, identifying and describing the differences in dimensions and components of the concept by using antecedents, consequences and cases (the model, borderline and contrary cases). Walker and Avant (1995), Schwartz-Barcott and Kim (1993), Davis (1992) and Chinn and Kramer (1991) are scholars who have all incorporated Wilson’s work into their own theory and model development.

Meleis (1997) describes another method of concept analysis called simultaneous concept analysis. This method compares and contrasts similar concepts such as empathy and compassion and the hybrid strategy which was developed in 1986 by Schwartz-Barcott and Kim (Schwartz-Barcott and Kim, 1993). Their method synthesises empirical and theoretical approaches and identifies three phases: the theoretical phase, field work and analytical phase. The rationale behind using Walker and Avant’s (1995) model over the Hybrid and Simultaneous model is because it is the most current model and can easily relate to nursing practice by using Cases. Walker and Avant’s model is based on Wilson’s (1969) original model that appears to be the most cited source in relation to concept analysis. The model is well structured and allows a clear definition to be determined, the model, borderline and contrary cases are perfect for deciphering what is empathy and what is not and allows a clear explanation of its importance in nursing practice.
**Advantages and Limitations**

An advantage of using a concept analysis is that it renders a precise theoretical and operational definition that can then be used in future theories and research (Walker and Avant, 1988). It can clarify terms that have become catch-phrases or misinterpreted to the point of being meaningless. It also provides a firm foundation for investigation and action within practice.

Wilson (1969) stated some pitfalls in carrying out a concept analysis: the first being, a bias is already created when the concept under scrutiny is selected, however a counter argument is that most projects are based on the researchers initial interest. It could be suggested a concept analysis is too easy and not academic enough. However, Wilson (1969) reassures the author a concept analysis is perfect for exploring a concept in detail by methodically analysing the literature. Completing a concept analysis will help stop the concept of empathy being confused with similar ones, such as sympathy. A Final limitation to this method of analysis is that is easy to include all critical attributes/components read about empathy, rather than the few necessary defining ones. This can confuse and over interpret the concept. To avoid this pitfall, the defining attributes must be consistently mentioned throughout the identified literature.
Ethical and Resource Implications

As the study is a review and analysis of current research and literature there is no need for ethical approval from a committee as no person is being interviewed, surveyed or analysed. No consent or confidential medical or nursing material is needed to carry out this concept analysis. The resources that will be used are; books, journals, articles and websites. No funding will be required. The Cases used in this analysis use fictional characters which meets the Nursing and Midwifery Councils (NMC) (2008) confidentiality requirements.
Chapter 3: Methodology

A concept analysis will be carried out based on Walker and Avant Model (1995). This model is an adaptation of Wilson’s (1971) previous model. The rationale for using Walker and Avant’s is because it is adapted to be more relevant to nursing practice. This method of analysis has been described by Walker and Avant (1988) as a formal and linguistic exercise that determines the defining attributes of the concept, and in this case is empathy. A concept analysis is both an accurate (at the time of publish) and a tentative methodology; two people can often generate different ideas of the concept they are studying, because of the different resources available at the time of study. Many concepts are not static and change with time. What attributes defined empathy in 2001 (when the last concept analysis of empathy was carried out) may not be true today.

To begin, a data collection will be carried out. This involves using electronic search engines related to nursing practice (i.e.: CINAHL, MEDLINE, Psycho Info, PsycNet, EMBASE, Joanna Briggs Institute, Wiley Inter Science, Pub Med, Cochrane Library and Bandolier) to reveal articles about empathy. All the primary literature found by the search engines will be constructed into a table. On the next page is Table 1, showing the initial search criteria. All of the search results are available to read in Appendix 1.
Table 1

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<td></td>
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<td></td>
<td>Age: 19 years +</td>
<td></td>
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</table>
As the first search produced a large number of hits, an inclusion criterion was added. This means the articles to be analysed must include: Empathy being a *keyword* or *subject heading* in the search engine and they will be related to westernise nursing practice. The articles will be written between 2000 and 2010 and in the English language and finally it must be the full article, not just the abstract.

After the inclusion criteria was added, there was still an unmanageable number of results (i.e. in their hundreds), therefore an exclusion criteria was added. The exclusion criteria was as follows; the papers must not be related to counselling or psychotherapy and papers defining similar concepts such as 'emotional knowing' and reflective responding' were abandoned. This criterion has been set so only papers relevant to empathy in nursing practice will be analysed. Please see *Appendix 1* for Tables 2, 3, 4, 5 showing further inclusion/exclusion criteria and the produced results. All the remaining articles were read to gain in-depth, descriptive material that either clarifies or represents empathy (LoBiondo-Wood and Haber, 2006.)

In the initial search some search engines included an age range as an inclusion criteria (for example, ‘Aged 19+’), however as this criteria was not available in all the search engines used and therefore would not be a fair analysis. To avoid bias ‘age range’ was not considered in the final search criteria (see Table 5 on page 21).
Authors whose work dates back to the 20th century and are cited by many other academic sources may be included in the analysis. This is because their work is perceived to be seminal amongst other theorists who attempt to define empathy. These articles are called 'standard text'. Some examples of these authors are: Reynolds (2000), Rogers (1958), Wilson (1971) and Noy (1984). A shelf search will also be carried out, looking through books related to psychology, sociology and to some extent philosophy and nursing practice.

Across the page in Table 5 (in Appendix 1) are the results from the final search. All the papers found within each search engine were read and from this it was decided which papers were appropriate for further review. For example, Wiley Inter Science found 10 sources within the articulated criteria, some sources were too old, inaccessible or duplicates, therefore only 3 sources were appropriate for review.
# Table 5

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**Expanders**: Full text  
**Narrow by**: Subject  
Headings: ‘Empathy’ and ‘Nursing care’.  
**Limits**: Full Text. English Language. Human. | 11                       | 8                                      |
| EMBASE             | Empathy       | **Published**: 2000-2010  
**Expanders**: Full text  
**Narrow by**: Subject  
Headings: ‘Empathy’ and ‘Nursing care’.  
**Limits**: Full Text. English Language. Human. | 22                       | 3                                      |
| MEDLINE (ovid)     | Empathy       | **Published**: 2000-2010  
**Expanders**: Full text  
**Narrow by**: Subject  
Headings: ‘Empathy’  
**Limits**: English Language. Human. | 25                       | 15                                     |
| Psych Info         | Empathy       | **Published**: 2000-2010  
**Expanders**: Full text  
**Narrow by**: Key concept: ‘Empathy’ Any field: ‘Nursing’  
**Limits**: English Language. Human. | 19                       | 8                                      |
| PsycNet            | Empathy       | **Published**: 2000-2010  
**Expanders**: Full text  
**Narrow by**: ‘Empathy’  
Search within: care  
**Limits**: English Language. Human. | 7                        | 2                                      |
| Wiley InterScience | Empathy       | **Published**: 2000-2010  
**Expanders**: Full text  
**Narrow by**: Key concept: ‘Empathy’ and ‘Nursing’  
**Limits**: English Language. Human. | 10                       | 3                                      |
| **TOTAL**          |               |                                                                                     | **94**                  | **39**                                  |
As each journal is read a note of the defining attributes/themes that appear over and over again will be documented. A decision regarding the most cited, useful and definitive attributes will be made based on the themes and patterns that emerge from the literatures. There were 5 defining attributes of empathy found from the literature. These attributes are classed as the 'critical criteria' for empathy and differentiate empathy from any other related concept such as sympathy or fellow-feeling. The defining attributes are then transferred into three fictional cases which relate the empathy to nursing practice. The first case includes all of the defining attributes and is called the 'model case'. The second case, the 'borderline case', includes some, but not all of the defining attributes. Lastly is the 'contrary case' which contains no defining attributes of empathy.

The antecedents and consequences are then discussed. Antecedents are events that occur prior to being empathetic and Consequences are described as the result of the occurrence of empathy. These are useful as they help theorists identify underlying assumptions about empathy and can shed light on the social context that surrounds empathy (Walker and Avant, 1988.)
The findings from the Review of resources, Defining Attributes, Cases and Antecedents and Consequences are all linked to the Empirical Referents. These include papers from the Department of Health (DH) Mandates and Legislation and Nursing and Midwifery Council (NMC) to improve nursing and patient centred care throughout the UK. The purpose of this is to demonstrate the occurrence of the empathy in present healthcare systems and policies. Once identified, they can be used in the development of nursing practice and because they are clearly linked to the theoretical basis of the concept, it improves construct and content validity of the empirical referents (Walker and Avant, 1988). All of the findings will then be discussed and from the evidence presented a conclusion will made on what it means to be empathetic and how it should be used in nursing care. Recommendations are then suggested on how best to implement these findings into practice.
Chapter 4: The Review of Resources

Out of the 94 papers read, only 39 were deemed appropriate for further review. There were 55 papers excluded from the analysis because of the following reasons; the paper was irrelevant to empathy within a nursing or medical setting or because the paper was focused on a similar concept, such as compassion. Cash (2007) is an example of one of these papers. Other papers were excluded because they were too old, duplicated or inaccessible.

There were a number of themes found within the 39 papers read. Examples of these themes were as follows; components and dimensions of empathy, common assumptions, how the nurse should present himself/herself in an empathetic manner, the communicative process, responding to the patient’s needs, the effects of empathy on the patient’s emotional stability and outcomes, and the Nurse-Patient relationship. Other examples include; barriers to the empathetic process, variables and mediators. Each of these themes will be discussed in detail below.
A Concept Analysis of Empathy

Assumptions

There are a number of authors who make assumptions about what empathy is, however these authors have no hard evidence to prove their theories to be true. This is mainly because empathy is very difficult to measure and because there are numerous measuring tools it is hard to standardise or decipher which one works best. For example Salvage (2006) states empathy is a basic instinct, but there is no way of measuring this. However, his assumption is supported by other well known scholars who are experts in this field, such as Spiro (2009), Wiseman (2007) and Olsen (2001). Other authors like and Koslander and Arvidsson (2005) assume that the nurse-patient relationship has to be like a friendship for empathetic communication to be successful. Norfolk, Birdi and Walsh (2007), Benbassat and Baumal (2004) and Hojat, Gonnella, Nasca et al (2002a) all disagree and argue there is a greater need for a professional approach when communicating empathy. It is difficult to distinguish what empathy is assumed to be and what evidence based research tells us it is. Should the concept of empathy be solely based on evidence based research or can we trust the assumptions of well known authors like Rogers, Reynolds and Olsen? As these assumptions are based on their years of experience, knowledge and research, their work will still be considered in the concept analysis. However more weight will be given to papers that have been published in the last decade that include evidence based research.
Components of Empathy

Many of the papers analysed recited the work of Morse’s (1997) who believed empathy had four key components: moral, emotive, behavioural and cognitive (Yu and Kirk, 2009, Yu and Kirk, 2008, Stepieen and Baernstein, 2006 and Huggard, 2003). The moral component describes one’s innate ability to be empathetic and the emotive aspect is the ability to subjectively perceive another’s feelings. The behavioural component describes one’s ability to communicate empathetic understanding and concern and the cognitive component describes one’s intellectual ability to be empathetic (Morse, Bottorff, Anderson et al, 1992). Previously conceptualisations of empathy were found within the literature, these were empathy as; a personality trait, an ability, an attitude, a feeling, an interpersonal process, a sensitivity, and a perceptiveness (Reynolds and Scott, 2000 and Sunderland 1993 [cited in: Wiseman, 2007]).
For years there has been great ambiguity over the defining attribute of empathy; is it a cognitive or an affective ability, or is it both? Empathy as a cognitive skill is based on the nurse’s intellectual ability and what they have learnt through education and experience. Empathy as an affective skill is based on one’s innate ability. For example, if a person feels distressed, the empathiser will also feel distressed. This ability cannot be taught. When reviewing the resources, more authors suggest that empathy is predominately a cognitive ability within clinical settings (Crandall and Marion, 2009, Di Lillo, Cicchetti, Lo Scalzo et al, 2009, Kataoka, Koide, Ochi et al, 2009, Hojat, Vergare, Maxwell et al, 2009, Spiro, 2009, Benbassat and Baumal, 2004, DasGupta and Charon, 2004 and Olsen, 2001).

Other authors like Hojat, Vergare, Maxwell et al (2009), Wiseman (2007), Bellini and Shea (2005) Hojat, Fields and Gonnella (2003) and Hojat, Gonnella, Nasca (2002b) believe empathy has both a cognitive and affective component. Wiseman (2007) states empathy is an inherent human quality, and although many agree with this statement, empathy within nursing care needs to have more of a cognitive approach. This is because nurses need to have the mental capacity to understand the patient’s experience and be able to communicate this understanding back to the patient. This advanced level of communicative skill is not always inherent, however it can be learnt and improved with the correct education and experience (Crandall and Marion, 2009, Garden, 2009 and Olsen, 2001.)
The Review

For the complete reference list of the reviewed resources please see Appendix 2. In order for the review to flow, a ‘Note’ system has been put in place. This means if 4 or more authors have been referred to in the review of resources then a ‘see Note’ will be put in the reference’s place. The full list of authors will be found in the ‘Note Index’ in Appendix 3 under the indicated ‘Note’ number.

Empathy as a Feeling

Stepien and Baernstein (2006) believe that for empathy to be authentic there must be an affective impulse, this means the nurse must want to act on what they have heard or seen. Attunement is another innate quality (see Note 1) that is required for the communication of empathy. Both affective abilities cannot be learnt, they are inherent (Morse, Anderson, Bottorff et al, 1992 [cited in: Wiseman, 2007]).

The fundamental theme that was consistent throughout the literature was the importance of how expressed empathy is perceived by the patient and how it makes them feel once their anxiety and pain are alleviated and their emotions justified (see Note 2). For this to occur, Garden (2009) explains the patient must be their own expert by taking control of their own care and treatment. Mercer, Maxwell, Heaney et al (2004) support this idea and believe that if the patient has autonomy then there is more likely to be a positive and beneficial outcome.
Faugier (2006), Nortvedt (2005) and Eslinger, Parkinson and Shamay (2002) explain that the patient must first feel vulnerable or distressed for them to feel the need to open up to the nurse. The patient is more likely to share their feelings with the nurse if they believe themselves to be similar or feel they can relate to the nurse, in other words, if their nurse-patient relationship is like a ‘friendship’ (Wiseman, 2007 and Salvage, 2006). This way, the patient believes the nurse will have a greater understanding of what they are going through or why they are adopting certain behaviours.

The need for mutuality or mutual understanding has been expressed by many authors (see Note 3). The patient is more likely to welcome the nurse into their world if mutuality is present. Likewise, the nurse will have a stronger urge to care (see Note 4) and will be more willing to enter the patient’s world if they can relate to the patient (Myhrvold, 2003). Once the nurse has entered the patient’s world, they can only then imagine what it is like to be that person, experiencing the patient’s situation as she or he does (Burnard, 1988, [cited in: Wiseman, 2007]).
Empathy as a Nursing Skill

In a previous concept analysis of empathy, Reynolds (2000) and La Monica (1981) empathy was described as a skill. Empathy as a skill has many elements to it such as: common attributes, characteristics and personal and situational variables. These skills all lead to a positive nurse-patient relationship and an empathetic understanding. These will now be discussed in length.

The Characteristics and Attributes

When reviewing the sources, there were many ideal empathetic characteristics of a nurse were described, the most common ones being; the nurse being a good communicator (see Note 5), and listener (see Note 6), who is genuine, honest (see Note 7) and open (see Note 8). They have a full understanding of the patient’s situation (see Note 9) have an urge to care (see Note 4) and attend to the whole person (Norfolk, Birdi and Walsh, 2007, Määttä, 2006 and Salvage, 2006). For the patient to perceive empathy the nurse has to be sensitive to their emotions by using verbal and non verbal skills to engage with and understand the patient’s distress (see Note 10). These characteristics describe the ability of a competent nurse, which in itself is a desirable attribute (see Note 11).
As discussed in the ‘Components of Empathy’, there have been lengthy debates on whether empathy is an affective or cognitive skill. Spiro (2009) argues empathy is a natural, human emotional state, whereas as DasGupta and Charon (2004) and Olsen (2001) believe empathy is an intellectual ability. Crandall and Marion (2009) further this notion by stating that empathetic skills based on one’s cognitive ability can be advanced through teaching. Wiseman (2007) cites the work of Morse, Anderson, Bottorff et al (1992), who believe, empathy is an inherent quality that we are all born with and that the levels of empathetic understanding vary from person to person, and whether we draw on this ability is the individual’s choice. The development and maturity of empathy relies heavily on exposure, teaching and experience (Yu and Kirk, 2009). This research leans closer towards empathy being a cognitive ability as it can be taught through nurse training and years of experience.

To come to a conclusion about this dispute, the author agrees with the authors in Note 12, who all suggest empathy is both an affective and cognitive skill. For example, the nurse must possess innate abilities such as; having an urge to care and emotional awareness. They must also have the cognitive skills to communicate their awareness to the patient and be able to appropriately respond. The nurse may have begun with an innate empathetic capacity that they can then develop and enhance through training and experience.
Self Awareness

Wiseman (2007) explains how empathy can develop within a person and nurse-patient relationship along a continuum. At one end of the spectrum there is empathy as an ‘incident’; discrete episodes such as admitting patients into hospital or breaking bad news would come under this theme. The nurse can become more aware of how well she/he is being empathetic by the positive feedback she/he receives from the patient. Their relationship becomes stronger as the nurse’s knowledge of the patient increases with the number of incidents.

As the number of empathetic episodes increase, the nurse will find it easier to slip into an empathetic mode, which brings us to Wiseman’s (2007) ‘empathy as a way of knowing’. Knowledge and socialisation encircles Wiseman’s continuum because the nurse must be able to have both to successfully communicate and transpose themself into the patient’s world.

Wiseman (2007) believes once nurses have been exposed to many empathetic incidences, showing empathy becomes second nature and they start to see ‘empathy as a process’ as the nurse gains the ability to transfer and adapt their skills to suit each individual or situation.
Through recurrent episodes and years of experience, the nurse will eventually become self aware and they will fully understand how their actions affects each patient and within time their expression of empathy becomes effortless. This leads us to the end of Wiseman’s (2007) continuum; ‘empathy as a way of being’.
Variables of Empathy

As all patients are individuals, everyone has different values and perceptions of empathy. There are many variables which may affect how a nurse communicates empathy, how they interpret it and how a patient perceives it. A number of authors (see Note 13) comment on the different factors and variables that can affect the empathetic communication process. These factors are based on the nurse’s age, gender, level of experience and empathetic understanding and education (see Note 13). How a patient perceives empathy is reliant on their ethnicity, culture, physical ability, sexuality and class (DasGupta and Charon, 2004), and how easily they can relate to the nurse (Wiseman, 2007 and Faugier, 2006). The latter is dependent on what Colliver, Conlee, Verhulst, et al (2010) describe as the nurse having the ability to stand in their patient’s shoes. In other words, the nurse has to take on their patient’s perspective, be sensitive to their situation and build up a positive relationship by sharing experiences and gaining a mutual understanding of their distress or pain. Garden (2009) believes communicating empathetic understanding relies heavily on the nurse’s emotional and intellectual ability, which can be developed by repeat exposure to situations that require the nurse to be empathetic.

Socialisation is an important contributor to the development of empathetic skills. Exposure to different cultures, religions and personalities all help with adapting the nurse’s empathetic skills to meet each individual’s needs.
Communicating Empathy

Verbal and Non verbal Communication

Reynolds and Scott (2000) [cited in: McCabe, 2004] believe empathy is when a person can correctly perceive, reason and communicate their understanding of another person’s feelings and their attached meanings. The importance of communication is also noted by many other authors (see Note 14), these authors state communication is a fundamental part of empathy and empathy can not be perceived by the patient if not communicated correctly. Ways of communicating empathy are described by Shapiro (2002), who states that the empathiser must use verbal and non verbal methods to enhance communication. A number of authors have suggested using appropriate touch as a desirable non verbal communication method to show support or concern (see Note 15).

Other methods of non verbal communication have been described by Shapiro (2002) as use of posture and facial expression. Tone of voice is another important factor to consider when communicating your emotions and understanding (Wiseman, 2007). From the patient’s tone of voice you can decipher whether they are angry or sad, and from the nurse’s tone you can hear whether they are truly showing empathetic concern and apprehension or if they are showing no sensitivity to the patient’s situation.
The Communication Process

The authors in Note 16 have developed cycles/processes/dimensions of empathy, they use similar structures but with slight variations. From this, a newly proposed seven step empathetic communication process has been synthesised, by incorporating the most commonly cited steps from all processes and cycles found in the literature. The new process would progress as follows:

1. Using their innate ability the nurse detects the patients concern and using their cognitive ability, they identify what the concern is;

2. The nurse creates a calm atmosphere that encourages patients to share their feelings. Selph, Shiang and Engelberg et al (2008) describe the optimal environment for this as; having appropriate resources available and the nurse having time to listen. For example, the nurse having a small number of patients to care for.

3. The patient expresses their feelings to the nurse.

4. The nurse subjectively perceives the patient’s feelings by transposing themselves into the patient’s world. They reflect on what they have heard and seen, and reiterate their understanding back to them to elicit familiar feelings from their own experience; or to check their interpretation matches that of the patients.
5. The patient’s feelings are recognised and then validated.

6. The nurse enquires into any further concerns and communicates awareness and understanding of these back to the patient. She/he then appropriately responds to the patient’s needs, based on what they have heard and seen.

7. The nurse detaches his/herself from the process/situation (this is also referred to as self recovery).

After the nurse has understood the patient’s dilemma, they must be able to respond appropriately to a patient’s concerns, worries, or fears (see Note 17). This helpful and productive behaviour signifies high quality care (Crandall and Marion, 2009 and Wiseman, 2007). If the nurse establishes the patient’s needs as seen by them, (Ashworth, 1980 [cited in: Reynolds and Scott, 2000]). This proves to the patient that the nurse is caring and has a full understanding of their concerns. Another sign that shows good empathetic communication is if the patient is able to play an active role in making their own decisions about their care, through the help and support of the nurse (Selph, Shiang, Engelberg et al, 2008, McCabe, 2004 and Reynolds and Scott, 2000).
If the empathetic nurse-patient communication process is not carried out then the patient will not trust the nurse and they will not feel appreciated. If the nurse fails to understand the patient’s response and needs, then the nurse will not be seen as an expert by the patient, (Reynolds and Scott, 2000). Pushing the patient to reveal what they are not ready to discuss can also be harmful as it can intensify their anxiety (Reynolds and Scott, 2000).

**The Nurse-Patient Relationship**

Developing an interpersonal climate enables the patient to talk about their perceptions of needs (Reynolds and Scott, 2000). For communication to be effective and beneficial for both the nurse and patient, the nurse-patient relationship must be centred round the patient (*see Note 18*), reciprocal (*see Note 19*), respondent (*see Note 17*) and the patient must feel secure (Reynolds and Scott, 2000). In other words the relationship needs to be focused on the patient’s feelings, not the nurse’s. The nurse and patient have to have a shared and mutual understanding of the situation. For the patient to open up and share their fears, they must be able to trust the nurse (*see Note 20*). For the nurse to be trusted they need to engage with the patient on an emotional and intellectual level to gain a greater understanding of what the patient is communicating to them (Norfolk, Birdi and Walsh (2007). To achieve this bond the nurse and patient must be similar or be able to relate to one another (*see Note 21*). Being similar is described by Wiseman (2007) as the patient having a similar background or culture.
The Environment

Norfolk, Birdi and Walsh (2007) stress the importance of a stable environment to aid the empathetic communication process. They believe the environment should be welcoming and only a small number of patients present. There should be appropriate resources available within reach, and communication must be face to face and on a one to one basis for optimal efficacy (Selph, Shiang, Engelberg et al, 2008, Faugier, 2006 and Myhrvold, 2003). This can be achieved if the environment is quiet and private, with supportive props such as; tissues, hot and cold beverages and information leaflets readily available. The nurse should concentrate solely on the individual’s situation. They should set aside time for the patient to tell their story in their own time and without feeling rushed.
Conclusion of Identified Themes

Empathy needs to be shown most when the patient is distressed or feeling vulnerable (Faugier, 2006, Nortvedt, 2005 and Eslinger, Parkinson and Shamay, 2002). The nurse needs to have the cognitive ability to detect their distress and act on it (DasGupta and Charon, 2004 and Olsen, 2001). Norfolk, Birdi and Walsh (2007) believe the patient is more likely to open up to the nurse if they are in a calm, sharing and private environment. The authors in Notes 4 to 9 believe it is important the nurse is perceived as a genuine, open and honest character who wants to help. They must be good at listening and communicating, this in turn allows the patient time to express their feelings and gives the nurse time to fully understand and respond to the patient’s concerns.

The nurse and patient must have similar characteristic, ethnicity or background for a bond to occur. In other words the patient must be able to relate to the nurse (see Note 21). Their relationship must be reciprocal (see Note 19) and the nurse must be respondent (see not 17). The nurse must show she/he has a full understanding (see Note 9) by subjectively perceiving the patient’s feelings by entering their world and recognising and reflecting on their feelings. The nurse must communicate their understanding back to the patient to confirm it is correct and to ensure they have not misinterpreted their concerns (see Note 16).
The nurse must respond to the patient’s emotions and needs (*see Note 17*), this could be simply supporting them to make a decision or trying to alleviate their physical pain with the administration of analgesia or referring them to others who may be able to help the patient with their specific needs. This validates the patient’s feelings and proves to the patient that the nurse was empathetic and wanted to help them.

If all of the above is adhered to the positive outcomes for the patient are; relief from anxiety and distress (*see Note 2*), a sense of validation (Hojat, Gonnella, Nasca et al (2002a), more control in decision making and has more of an active role in treatment (Garden, 2009 and Mercer, Maxwell, Heaney et al (2004). They have a positive nurse-patient relationship because they feel understood and supported therefore nursing care is seen to be of high quality, this in turn increases patient satisfaction and wellbeing (*see Note 22*). After this, the nurse must then detach herself from the situation to prevent burnout and to allow them time to care for others (Huggard, 2003). However the nurse should not detach themselves from the relationship as they may be called on again.
Limitations to the Review

The main limitation to the review is that some authors make assumptions to what empathy is. For example empathy is an innate skill (Olsen, 2001), or that you have to possess certain characteristics to be a good empathiser (see Note 4 to Note 11). It is understandable that it is hard to collect data to scientifically prove this, therefore commonly held assumptions/opinions of authors who are commonly cited throughout the literature, is the most reliable source of information available at present.

Another criticism to the review is that a number of papers included were related to medical students. Some may argue these should have been excluded from the analysis, however, they proved to provide useful information on teaching skills and previously thought of components. Many of the reviewed papers cite old texts such as Stein (1989) and Rogers (1957). Some scholars may criticise including these citations in the review because they were not published between 2000 and 2010, therefore they do not meet the main inclusion criteria. However these texts are well known authors who are experts in this field, mentioning sections of their work shows the reader how the concept of empathy has developed through time, and therefore the author does not consider them to be a limitation to the analysis.
Chapter 5: Defining Attributes

In order to analyse the concept of empathy, the defining attributes need to be established. The defining attributes are described as the most commonly cited characteristics, phrases or words related to empathy found within the review of resources. From this review, the author’s current defining attributes of empathy are:

- Empathy as a feeling
- Empathy as a skill
- Empathy as a communicative process
- Empathy in a relationship
- Empathy as a response
Discussion of the Defining Attributes

Empathy as a feeling describes how the nurse should feel when they see a patient in distress and how empathy makes the patient feel. Stepien and Baernstein (2006) state the nurse must feel an affective impulse or attunement towards the patient and has an urge to care for them (see Note 4). For the empathetic process to begin, the patient must first present with signs of anxiety or distress (Faugier, 2006), Nortvedt, 2005) and Eslinger, Parkinson and Shamay, 2002). To alleviate these feelings their emotions need to be justified by the nurse. Patients are more likely to take control of decision making when they feel empathised with (Selph, Shiang, Engelberg et al, 2008 and McCabe, 2004). This will give the nurse and patient a sense of satisfaction that is beneficial to both parties (Garden, 2009, Stepien and Baernstein, 2006 and Mercer, Maxwell, Heaney et al, 2004).

Empathy as a skill describes empathy in a cognitive domain. This defining attribute include skills such as; the nurse being a good communicator (see Note 5) and listener (see Note 6). They are competent at their job (see Note 11) and are excellent at verbal and non verbal communication (Wiseman, 2007). For example, they know when and where it is appropriate to use touch to show support or concern. The nurse should be non judgemental, have a high degree of self awareness (Reynolds and Scott, 2000) and be able to transfer and adapt their skills to suit each individual or situation.
How a nurse communicates empathy is imperative. The following steps are an amalgamation of the author’s work referred to in (Note 16). First of all the nurse must detect the patient’s distress, this is a cognitive ability. They must then create a calm atmosphere that will encourage the patient to share their inner most feelings. Only then will the patient open up and express their thoughts. After the patient has let the nurse in, the nurse must then enter the patient’s world and subjectively perceive the patient’s feelings by listening and reflecting on what they have heard and felt. The nurse must reiterate their understanding back to the patient to ensure their interpretation is correct. When there is a mutual understanding the patient will feel their emotions have been validated. The nurse must then enquire further into their patient’s concerns, making sure they have not missed anything. Once the nurse has communicated their awareness and understanding of the patient’s situation and responded to it, only then can they detach themselves from the situation or process.
The nurse-patient relationship must be patient centred (see Note 18), reciprocal (see Note 19) and beneficial for both parties. For example the nurse must focus on the patient’s feelings and not her own feelings or judgements. The positive outcomes of empathy are that the patient feels well supported and less anxious (see Note 2), and because the nurse has helped, she will have a positive experience of the situation and increased job satisfaction (Garden, 2009, Norfolk, Birdi and Walsh, 2007 and Stepień and Baernstein, 2006). The relationship is likely to be stronger if the two individuals are similar (see Note 21). The patient must trust the nurse before they are willing to open up to them and share their inner most feelings (see Note 20).

The final defining attribute of empathy is ‘empathy as a response’, this can simply be described as listening and making the patient feel valued and supported. Selph, Shiang, Engelberg et al (2008) and McCabe (2004) believe the nurse must facilitate the patient in decision making and they must not make the decisions for them. They must make the patient believe that they are the expert in their own care (Garden, 2009). An example of an empathetic response is if the patient is distress because they are in pain, the nurse detects this distress and tries to understand what the patient is going through by ‘putting themselves in their shoes’. They reflect on this and express their understanding and their need for pain relief. A mutual understanding is gained and the nurse administers some analgesia.
If the nurse did not respond to their patient’s needs by taking action, then the patient would still be in pain and there would be no positive or beneficial outcome. A response can be through verbal communication, telling the patient you are here for them, and physical; actually being physically present and face to face with the patient. Verbal and physical responses will help support the patient to make their own decisions and hopefully take more control of their care.
Chapter 6:  
The Cases

The following three cases will help to contextualise empathy in nursing practice. The first case is the 'Model Case', and includes all the defining attributes of empathy. This has been described by Walker and Avant (1988) as the “pure case” (p40.) The ‘Model Case’ presents the newly defined concept of empathy in a clinical context. The second case, the 'Borderline Case', includes some, but not all of the defining attributes of empathy. This case study uses a nurse-patient scenario in a clinical setting. For example, the nurse may say she empathises with the patient but does not communicate this well or the patient feels the nurse does not understand them. The 'Contrary Case' is the last story written; again it will differ from the previous two, and will have no defining attributes of empathy. The ‘Contrary Case” is often very helpful, as it is easier to say what something is not rather than what it is (Walker and Avant, 1988.) Discovering what empathy is not helps to see how empathy is different from similar concepts such as sympathy and compassion. Appendix 4 contains definitions of sympathy to help the reader decipher between the two concepts. From these cases the reader can see what characteristics are and are not present to be able to be empathetic and how to communicate this successfully. The following cases are fictitious however the characters and scenarios are loosely based on previously observed situations.
The Model Case

Mrs Jones was a 59 year old woman who was admitted to hospital to have a right sided below knee amputation due to vascular disease. The day before her operation Mrs Jones was found crouched down in the bathroom by Nurse Duggins. Using her cognitive ability the nurse could detect Mrs Jones’s concern by the way she was holding her head in her hands and crying. The nurse felt concerned about the state Mrs Jones was in and had an urge to help her. Nurse Duggins asked Mrs Jones why she was crying, as she did not want to automatically assume it was because she was worried about the operation. Mrs Jones still did not answer and was trying to hold back the tears. Other patients started to look round to see what was happening. Nurse Duggins knelt down and put a comforting hand on her shoulder, she asked Mrs Jones if she would like to come and have a chat in a more private room. Mrs Jones nodded. The nurse then told another member of staff to watch over her other patients as she wanted to give Mrs Jones her full attention.

Inside the Quiet Room there was a calmer atmosphere, and because the room was private, it allowed Mrs Jones’s to openly share her feelings without worrying about the prying eyes of others. Nurse Duggins handed Mrs Jones a box of tissues and asked if she would like a cup of tea. Mrs Jones nodded.
Whilst the nurse was making the tea Mrs Jones had time to collect her thoughts and by the time the tea came she felt like she could talk. Mrs Jones thanked the nurse for the tea and apologised for crying. Nurse Duggins looked shocked and assured Mrs Jones there was no need to apologise for such a thing. The nurse then asked her why she was so distressed. Mrs Jones expressed her feelings and explained how she was scared about the outcomes of the operation, “What will I look like?” Nurse Duggins maintained eye contact and nodded to express her urge to hear more of Mrs Jones plight. Nurse Duggins tried to put herself in her patient’s shoes and thought to herself, “How would I feel in that situation?” She reflected on this question and listened intently to the rest of Mrs Jones’s concerns.

Once Mrs Jones had finished talking Nurse Duggins agreed, “It must be very difficult for you to go through such a big change in your life. From what you have told me, and from what I can understand, is that you are scared about your operation and have concerns about the overall cosmetic effect. Are you worried about how other people will see you when you are back at home? Is that right?”
Mrs Jones’ eyes widened and seemed to feel a sense of validation, “Yes that’s exactly right!” Nurse Duggins thought for a moment and asked if her surgeon had explained everything to her and answered all of her questions. Mrs Jones stated the surgeon had spoken to her about the operation but at the time she was in too much shock to take any information in or to formulate any questions. Mrs Jones added, “I’m just scarred about the operation going wrong, or not waking up. I don’t think I can go through with it nurse.”

Nurse Duggins replied, “This is a really big decision for you to make and it sounds like you don’t feel you know enough about what’s going to happen during and after the operation, is that right?” Mrs Jones agreed she is anxious because of this. Nurse Duggins then asked if she would like to have another talk with the surgeon or anaesthetist before going down to theatre. Mrs Jones nodded, “Is that too much trouble?” Nurse Duggins assured her it was no trouble at all and would be happy to arrange a meeting for her. The nurse also asked Mrs Jones if she would like her to come down to theatres with her for some moral support. Mrs Jones’ eyes lit up, “Oh would you? That would be so nice of you, that is, if it’s not too much trouble.” The nurse smiled and said it was no trouble at all and wants to support her. Mrs Jones was so gratefully and thanked the nurse for listening and for being so kind and understanding.
Nurse Duggins asked if Mrs Jones had any further concerns she would like to get off her chest and if she could help in any other way. Mrs Jones replied, “Oh no dear, you have been wonderful, just listening has made me feel much better, of course I still have fears, but knowing you are there to support me has made me feel a lot calmer.”

When Mrs Jones and Nurse Duggins finished their tea they started talking about Mrs Jones life and family which soon put a smile back on her face. When leaving the room Mrs Jones thanked the nurse again and said she felt relieved she had another chance to discuss her operation with the surgeon. After the nurse had arranged another meeting with the surgeon, she went on her daily ward routine, Nurse Duggins still felt she had a positive relationship with Mrs Jones but once she had done everything she could to help her, she felt she could now move on and detach herself from the situation, allowing her to continue her job without feeling burnt out or stressed. Nurse Duggins had plenty of job satisfaction when she had helped and supported others in making decisions about their care.
Summary of the Model Case

The Model case includes all of the defining attributes of empathy. The case shows the nurse to be completely empathetic. She follows the empathetic process (described on pages 36-37) perfectly and intently listens to her patient. She puts herself in Mrs Jones’ shoes and reflects on her feelings. Mrs Jones’ feelings are validated and her anxiety is relieved. The nurse responds to the patients concerns and gives her options which helps the patient to make her own decision (for example, having another meeting with the surgeon). The nurse appropriately responds to the patient’s fears by offering to chaperone Mrs Jones to theatre. The nurse enquires further into her patient’s feelings to ensure nothing has been missed. The nurse then detaches herself from the situation but not the relationship.
Borderline Case

Mr Smith was admitted to hospital due to a fall and Acopia (unable to cope). Mr Smith is an elderly man who lives alone in a bungalow with his cat, Monty. Mr Smith was admitted with a fractured neck of femur secondary to a fall. His predicted length of stay was 2 weeks. He had no family nearby and could not find his address book to call any of his neighbours or friends to tell them he was in hospital. Mr Smith was panicking about his cat being left by himself. Mr Smith had no means of telling a friend or neighbour to feed and look after the cat whilst he was in hospital. Nurse Hallett noticed that Mr Jones was distressed and went over to his bedside to see what the matter was. She closed the bedside curtains to allow more privacy and dignity for her patient. She hoped it would encourage Mr Smith to open up and share his concerns with her.

Nurse Hallett expressed her concern to Mr Smith’s anxious expression and asked him why he was distressed. He openly replied he was worried about his cat not being fed and let in/out whilst he was in hospital. Nurse Hallett exclaimed, “Oh no that’s awful!” Mr Smith continued telling her stories about his cat and how he had looked in all his bags for his address book but could not find it. Nurse Hallett had a quick look around his bedside for the address book. Another patient started asking her for more pain relief so she stopped looking and said she will look for it later, “I’m sure it’ll be around. Don’t worry your cat will be fine for a day or so.”
After this short conversation Mr Smith was still feeling distressed, which the nurse could see. On the evening drug round she came to Mr Smith’s bed, “still no luck with finding your book?” Mr Smith shook his head. She smiled and said, “Don’t worry these things have a way of working themselves out. If you tell the night staff I’m sure they will get in contact with someone for you. In the mean time are you okay taking your tablets?” Mr Smith nodded and then the nurse swiftly detached herself from the situation by moving onto the next patient. Mr Smith was left sunk in his chair, still anxious and becoming more withdrawn.
Summary of the Borderline Case

The borderline case presents a nurse-patient conversation in a clinical setting where only half of the defining attributes of empathy can be seen. Some of the crucial components of the empathetic communication process were missed out. The nurse has the cognitive ability to recognise the need for empathy and expresses some concern. She allows the patient to express his concerns however his feelings are not validated or appreciated. The communicative process is loosely followed. The nurse detects concern and tries to create a private and calm atmosphere by closing the curtains. The nurse allows the patient to express his feelings but the nurse does not subjectively perceive Mr Smith’s feelings, nor does she transport herself into her patient’s world. Mr Smith’s feelings are recognised, but not truly understood.

Nurse Hallett does not enquire further into Mr Smith’s concerns and she is unable to communicate the correct awareness of the situation and its importance to the patient. As a result, Mr Smith does not respect the nurse and no bond or relationship is formed. Nurse Hallett does not correctly respond to the needs of her patient and as a result Mr Smith is left feeling vulnerable and helpless.
In an ideal situation the nurse should have responded by helping him look further or asked for his neighbours name and address to see if it is in the phone book, or phoned his next of kin, to see if they could help. That way, it would show Mr Smith that his feelings were appreciated and the nurse had tried her best to help him. The nurse was able to easily detach herself from the situation because she did not put herself in his shoes and did not understand what Mr Smith was going through.
Contrary Case

Mrs Edwards was an elderly lady admitted to hospital for the removal of her gallstones. She hated hospitals because it reminded her of when her husband suddenly died in hospital the previous year and was scared she would have the same fate. After her operation she was closely monitor by staff on the ward, the doctor had written up regular and PRN (pro re nata, which translates to ‘as and when required’) Paracetomol, Buprofen and Morphine. Mrs Edwards had her 6 o’clock pain relief and after an hour was still experiencing pain. She scored the severity of her pain as 8 out of 10 on the last vital observational round. Mrs Edwards was described by some members of staff as an ‘over anxious’ and ‘demanding’ patient.

Mrs Edwards pressed her call bell for help. Nurse O’Donnell attended to her and asked why she had called. Whilst the nurse was talking to the patient she was filling in some paper work at the same time, not really listening to what Mrs Edwards was saying. Mrs Edwards explained she was experiencing pain around her operation site. At this point the nurse looked up from her paper work and asked when she last had pain killers. Mrs Edwards answered, “6’o’clock”.
Nurse O’Donnell sighed and said it was probably because she was getting herself worked up about it and that is all psychological. She advised Mrs Edwards to have a drink of water and try to relax. Nurse O’Donnell said she will get the night staff to give her some analgesia at 8 o’clock as there was no other nurse free to second check any Morphine at the time (as protocol states to). Mrs Edwards, not wanting to argue, nodded in silence. The nurse then avoided answering Mrs Edwards’s call bell for the rest of her shift.

Summary of the Contrary Case

None of the defining attributes of empathy are found within this case study. The nurse did not possess any cognitive or affective ability to empathise nor did she attempt to understand what the patient was going through. The communication of empathy was non existent and the patient was left in pain, anxious and vulnerable. The nurse did not have an urge to care or any intention to help. The severity of the patient’s pain was ignored, even though a high pain score was documented earlier. Mrs Edward’s feelings were not recognised or validated, which left the patient more anxious and distressed. The patient was left in pain for over an hour because the nurse did not respond to the patient’s needs by finding another nurse to check the Morphine, or by checking her drug card to see if she was able to have any other form of analgesia that had been prescribed. No form of empathy can be seen in this case study.
Chapter 7:  
Antecedents and Consequences

Antecedents are events that occur before the concept can be shown (Walker and Avant, 1988). For patients to feel like they are being empathised with, these events and feelings must occur before the empathy can be communicated. Consequences are the events that occur after the concept has been identified and communicated. In this section the author will discuss what follows on from the expression and communication of empathy. These consequences will affect patient outcomes, responses and the nurse’s experience. The antecedents and consequences are presented along a timeline. In other words, the first antecedent (patient distress) needs to come first before the second (identification) can occur and so on.
Antecedents

Patient distress

For the empathetic process to occur, the patient must have pre-existing physical or emotional ill health. For example, they are distressed, anxious and experiencing trauma or shock (Eslinger, Parkinson and Shamay, 2002). This is how one can distinguish who is the patient and who is not and whether or not they are in need of help. The patient must communicate their need for empathy through verbal or non-verbal communication. This is normally shown through aggression, tears, hysteria or becoming withdrawn (for example, exhibiting behaviours that are unusual for that individual). Any distress shown by a patient should be investigated and time should be set aside for the patient to tell their story in their own time.

Identification

Once the patient has shown the nurse they are distressed, the nurse will understand the need for identification. For the patient to be able to identify with the nurse, the nurse has to be open, friendly and approachable. Faugier (2006) believes identification is more easily achieved if the patient can relate to the nurse. For, example, if the patient and nurse have similar personality traits or values. This is helpful in the nurse-patient relationship because the patient is more likely to feel they have a mutual understanding and that the nurse would have reacted in the same way if he/she was in their shoes (see Note 3).
Not only does the patient have to identify with the nurse, the nurse has to correctly identify the patient’s feelings for the empathetic communication process to work. For this to be accurate the nurse has to ‘check back’ with the patient to ensure their feelings are correctly understood. The nurse must think like the patient and be non-judgemental before she/he can begin to empathise (Huggard, 2003 and Shapiro, 2002).

**Intention of knowing**

Once identification has been achieved, the nurse must then show the patient they have an intention of knowing. For patients to express their feelings openly, the nurse must be approachable, motivated (Osaka, Tanioka, Ueno et al, 2008 and Wiseman, 2007) and have an urge to care (*see Note 4*). The nurse must be prepared to help the patient in any way, whether it is in decision making, supporting them to remain hopefully or acting as an advocate (Selph, Shiang, Engelberg et al, 2008). In doing this, the nurse will create an empathetic opportunity. If these antecedents are shown in the first instance communication is likely to be reciprocal and the patient will be more willing to share. Showing these antecedents proves to the patient that the nurse cares and will be respondent to their needs.
Emotional stability

For the empathetic process to continue the nurse has to be emotionally stable and not let her/his own personal problems side track them from the patient’s situation. The emotional stability of the nurse is just as important as the patient’s. They must be attuned to the patient’s needs (see Note 1) and express this in a professional manner (Norfolk, Birdi and Walsh, 2007, Benbassat and Baumal, 2005 and Hojat, Gonnella, Nasca et al, 2002a). Stressed out and over worked nurses rarely make good empathisers because they are more likely to lose perspective or not feel like they have time to care. The authors in Note 11 and Note 20 believe that if the patient is to trust the nurse with their feelings then the nurse must show they are competent by having an empathetic attitude and the ability to engage with the patient on an emotional and intellectual level.

Intellectual ability

The nurse’s and patient’s intellectual ability is just as important as their emotional stability. To begin with, the nurse must know when their empathetic skills are required. Norfolk, Birdi and Walsh (2007) and Wiseman (2007) believed nurses must be self aware and responsive to the patient’s needs. An ideal empathetic trait is having the ability to predict another’s behaviour (Selph, Shiang, Engelberg et al, 2008, Wiseman, 2007 and Myhrvold, 2003).
The nurse must know what is considered to be a caring behaviour to each individual as cultural and religious influences may alter one’s perception of another’s. The nurse must know what is appropriate and what is not. For example the use of touch; some patients do not like to be touched and others find someone holding their hand comforting. The nurse should have the intellectual ability to evaluate whether the use of touch is appropriate behaviour or not. The authors in Note 5 and Note 6 all agree the nurse must be good at communicating and listening before engaging in any empathetic communication. If the nurse cannot do this then misinterpretation of the cause of distress is likely.

Time to Care

For the above antecedents to occur the nurse must make time for them to happen without distraction. Before the empathetic process can begin the nurse must first set aside time in her schedule to listen so the patient feels valued and understood, and for empathy to be genuine the patient must believe the nurse has an intention of knowing (Osaka, Tanioka, Ueno et al, 2008, Norfolk, Birdi and Walsh, 2007 and Wiseman, 2007). Inadequate staffing levels (Wiseman, 2007), depleted energy (Garden, 2009 and Wiseman, 2007) and stress or burnout prevent this antecedent from occurring (Stepien and Baernstein, 2006 and Huggard, 2003). The patient must believe the nurse cares and wants to help them, otherwise they will not feel valued or understood.
A Concept Analysis of Empathy

Consequences

The Patient’s Feelings and Concerns are Validated

The first consequence to be discussed is the validation of the patient’s feelings. When high quality care is provided and an advanced empathetic skill is demonstrated, the patient feels their behaviour and problems have been validated and appreciated, and as a result their anxieties will be alleviated (see Note 2). This can be achieved by the nurse making appropriate responses (see Note 17). This is beneficial to the patient as it takes the weight off their shoulders (Garden, 2009 and Hojat, Vergare, Maxwell et al, 2009), the patient’s responsibility and concern is decreased by sharing them with the nurse. Patients experience an increase in satisfaction and wellbeing if their emotions are justified and understood (see Note 22).
An Action Plan

Once the patient’s feelings are validated, and the nurse has responded to the patient’s needs in an appropriate manner, an action plan can be put in place to stop the patient ending up in the same situation. Selph, Shiang, Engelberg et al (2008) and McCabe (2004) believe the nurse must support the patient to make their own decisions and not make the decisions for them, as this undermines their capability and takes away their independence.

Patients will no longer feel lost or isolated and are likely to feel more in control and of their care. Decision making can be done either by supporting the patient to express their feelings to the right people or through advocacy. For example, an elderly patient told the nurse he was not coping very well at home by himself but did not want to go into a care home as he did not want to lose his independence. The nurse could then act on this by arranging a multi disciplinary team meeting with the patient and his relatives to see what they could do to help facilitate independent living. In the meeting the nurse acted as the patient’s advocate and was also there for moral support. This way his feelings have been understood and taken into consideration, decisions surrounding his discharge are centred round him and with his best interest in mind. Information is provided by and supported by the healthcare professionals. The nurse must make the patient believe that they are the expert in their own care (Garden, 2009), and that they have the capacity to make their own decisions and change them if they are not happy.
A Concept Analysis of Empathy

Patient Outcomes

Positive patient outcomes can only be achieved once the patient’s feelings have been validated and a plan has been decided upon. Yu and Kirk (2009) mention a number of authors that have found nurses and student nurses with higher empathy levels have often been associated with more positive patient outcomes. For example, patients felt less distressed and anxious because their needs have been identified (Olson, and Hanchett, 1997, Olson, 1995, Murphy, Forrester, Price et al, 1992 and Reid-Ponte, 1992).

Hojat, Vergare, Maxwell, et al (2009) believe cognitively defined empathy leads to optimal clinical outcomes. The authors also assume that the relationship between empathy and positive outcomes is linear. In other words patient outcomes become progressively better as a function if there is an increase in empathy. Larson and Yao (2005) and Halpern (2001) [cited in: Selph, Shiang, Engelberg et al, 2008] agree with this notion as their evidence suggests expressed empathy improves patient outcomes.
Detachment from the Situation

Detachment is the final consequence of empathy. Once the empathetic process is complete and the outcomes have been beneficial to the patient, the nurse must detach themselves from the situation, but not necessarily the relationship. Shapiro (2002) similarly describes this concept as ‘compartmentalise’. Meaning the nurse must have the ability to set aside her feelings from one patient as she/her moves to the next.

The nurse must stay attuned to each patient and still be part of their nurse-patient relationship, however they must be able to leave the empathetic situation behind them, otherwise they will build up and act as a burden. For example, once the empathetic process has been complete during a nurse led consultation, the nurse is required to set aside her/his feelings, ready for the next patient. However the nurse has the ability to pick up from where they left off during the first patient’s next consultation. In other words, the nurse should detach themselves from the situation, not the relationship. If she/he does not learn how to do this, it will decrease their ability to be empathetic with others. Huggard (2003) states detachment allows the nurse protection from burnout. It improves their concentration and rationing of time and they are more likely to remain impartial and objective. Not only this, a work – home life balance will be more easily maintained.
Benbassat and Baumal (2004) argue that detachment is detrimental to the expression of empathy. If the patient believes the nurse to be detaching themselves from the situation too early, it gives the impression the nurse is not listening to what they are saying, thereby producing an atmosphere of detachment and formality, and consequently losing the patient’s respect. From this debate the author concludes, detachment should not be seen as a negative element. For appropriate detachment to occur, the nurse must be sure the patient has finished telling their story by checking back with them. This is to prevent early detachment and the loss of patient respect.
Chapter 8: Empirical Referents

Empirical Referents are classes of actual phenomenon that by their presence demonstrates the existence of the concept itself (Walker and Avant, 1988).

Reynolds, Scott and Austin (2000) relate empathy to nursing practice by advising that care should be focused on the whole person. Nurses must recognise the person is a human being, not an illness or disease. The Department of Health (DH) (2010) believes people should feel that care is delivered in a compassionate and empathetic manner, which is respectful and non-judgemental to the patient at all times. This indication for best practice was cited in the following benchmarks: Bladder, Bowel and Continence Care, the Care Environment, Communication, Food and Drink, Prevention and Management of Pain, Personal Hygiene, Prevention and Management of Pressure Ulcers, Promoting Health and Well-Being, Record Keeping, Respect and Dignity, Safety and finally Self-Care.

The DH (2006) believes nurses have a responsibility to ensure patients have a good experience when in hospital. They should possess the skills and competencies to organise care around the patient’s needs. The DH (2007) aims to make the NHS more aware of the importance of improving patient’s emotional experience. Other drivers of promoting positive emotional experiences are ‘Essence of Care’ (DH, 2010) and ‘Creating a Patient-Led NHS’ (DH, 2005).
The DH (2005) believes in the following values; to give respect to patients for their knowledge and understanding of their own experience, to provide them with information and choice so they feel in control of their own care. To treat people as human beings and not an item on a conveyor belt and also to ensure people feel valued and treat them with respect, dignity and compassion.

The Nursing and Midwifery Council (NMC) (2009) published a leaflet for patients telling them what to expect from their nurse. This leaflet highlights some of the defining attributes of empathy but does not define nor include empathy as a main factor in patient care. For example the NMC (2009) asserts that nurses must have the knowledge, skills, and desire to provide a high standard of care. Nurses should also be trustworthy, dependable, and show empathy, compassion and kindness. Time should be taken to communicate with the patient to make them feel valued and listened to. Finally, the patient must believe their individual needs are being met in a fair, non-judgmental and respectful manner.
The DH and NMC have brought forward documents on improving patient’s experiences and emotional care, however no document or mandate was found on the existence of the concept of empathy within healthcare or how the empathetic process works. Therefore Haugh and Merry’s (2001) book based in Roger’s earlier work on empathy will be used as an empirical referent, as will the work of Reynolds, both of which are well established authors who have written many of the earlier papers on empathy (Rogers, 1980, 1958 and 1957 and Reynolds, Phil and Scott, 2001, Reynolds, Scott and Austin, 2000, Reynolds and Scott, 2000, Reynolds, 2000 and Reynolds and Presly, 1988). Evidence based literature will also be incorporated into the empirical referents.

The Department of Health and Nursing and Midwifery Council do not include any definitions of empathy in any of their publications, therefore the work of Yu and Kirk (2009), Reynolds (2000) and Rogers (1957) will be examined to show how the concept of empathy exists throughout society. For a list of all the definitions of empathy found throughout the review of resources please see Appendix 5. Rogers (1957) believes empathy is one of the six necessary and sufficient conditions for psychotherapy. He sees empathy as the ability to sense the client’s private world as if it were your own. In his later work Rogers (1958) goes on to say “the state of empathy is to perceive the internal frame of reference of another’s with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without losing the “as if” quality” (pp210-211).
Reynolds (2000) believes empathy is crucial to all helpful relationships, and the purpose of this helpful relationship is to develop a safe interpersonal environment that enables the patient to cope more effectively with threats to their health. Empathy allows healthcare professionals to appreciate the patient’s perspective and to respond in ways that result in positive outcomes for those who are seeking help. Reynolds (2000) goes on to say empathy is an interpersonal skill that is dependent upon the attitudes and behaviours of the helping person. To empathise is the ability to communicate the nurse’s attitudes and understanding of their patient’s world. It involves the patient’s awareness of the nurse’s communication, in order for the patient to feel understood. Reynolds (2000) cites the work of Gerrard (1978) and Rogers’s (1957), who previously reported patients having relief from pain, improved pulse and respiratory rates and reduced worry and anxiety when empathy was shown. Dawson’s (1985) [cited in: Reynolds, 2000] study found patients needed to discuss their responses to health care to order to feel in control and less anxious. For this outcome to occur, nurses have to demonstrate commitment to listening in order for their patients to feel in control and have an active role in problem solving.
Yu and Kirk (2009) found 12 empathy measuring tools or scales. Papers were only included if they described the original development of empathy measures, reported of some psychometric properties (reliability, validity or responsiveness) and were published in English. Yu and Kirk (2009) found the following measuring scales:

1. Barrett-Lennard Relationship Inventory – Empathy Understanding,
   (Barrett-Lennard, 1962, [cited in: Yu and Kirk, 2009])
2. Carkhuff Indices of Discrimination & Communication
   (Carkhuff, 1969, cited in: [Yu and Kirk, 2009])
3. Emotional Empathy Tendency Scale
   (Mehrabian & Epstein, 1972, [cited in: Yu and Kirk, 2009])
4. Emotional Intelligence Scale
5. Empathy Construct Rating Scale
   (La Monica, 1981)
6. Hogan Empathy Scale
   (Hogan, 1969, [cited in: Yu and Kirk, 2009])
7. Interpersonal Reactivity Index
   (Davis 1980, [cited in: Yu and Kirk, 2009])
8. Jefferson Scale of Physician Empathy
   (Hojat, Mangione, Nasca et al, 2001)
9. Layton Empathy Test
   (Layton 1979, [cited in: Yu and Kirk, 2009 and Cassedy and Cutcliffe, 1999])
10. Perception of Empathy Inventory


11. Reynolds Empathy Scale

(Reynolds, 2000)

12. Visual Analogue Scale


Yu and Kirk (2009) raised questions on the method of measure as half of the tools use self assessments and 3 measured empathetic behaviour. Both of these methods allow room for bias. Only 3 tools used measured patient ratings. Only this type of assessment can evaluate patients’ appreciation of nurses’ empathic behaviour. From Yu and Kirk’s (2009) findings they concluded empathy measuring tools should be developed in the nursing context. More tools should give insight into user’s views by involving them in the development of initial items and during the validation process. Yu and Kirk’s (2009) final recommendation was that more evidence is needed so that the tool can be used to measure empathy in practical situations, either through self assessment or by patient-rating scales within clinical settings.
Chapter 9: Discussion

This concept analysis brings to light the importance of empathy in nursing, what skills and attributes are needed to empathise, how it should be communicated and what are the variables to consider. The concept of empathy has long been under discussion and scholars have argued the components of empathy for decades. For example, Spiro (2009) believed empathy was a cognitive attribute and Wiseman (2007) found empathy to be an affective quality.

Empathy is a complex skill and feeling to define. It is difficult to determine which author is correct as many make assumptions based on their past experiences. A person can feel empathy for another but if they have poor communication skills (a cognitive skill) then the empathetic process cannot be complete. In other words, you need both attributes to be perceived as empathetic. Earlier research by Rogers (1957) was mainly focused on using empathy in counselling, whereas more recent authors are starting to realise the importance of empathy within nursing practice (see Note 24).
Previous concept analysis of empathy has defined empathy as the following;
empathy as a human trait, a communication process, as a caring and a special
relationship (Kunyk and Olson, 2001), a personality trait, an ability, an attitude, a
feeling, an interpersonal process, a sensitivity, and a perceptiveness (Reynolds

Wiseman (2007) created the most recent analysis, however did not use Walker
and Avant’s (1995) model, he conceptualised empathy as: an incident, as a way of
knowing, as a process and a way of being.

The author of this concept analysis has found empathy to be: a skill, a feeling, a
communicative process, a relationship and a response. The rationale for choosing
these were so the cognitive and affective components were both included, as from
the research the author feels both are equally as important. How to communicate
empathy is fundamental to the empathetic process, (see Note 14). If the patient
does not feel they are being understood then the empathiser has failed. In order
for reciprocal communication and sharing of feelings to occur the patient must have
a positive relationship with their nurse. They must be able to trust them
(see Note 20) and believe they are similar in character or can in some way relate to
them in order for them to open up (see Note 21).
The last defining attribute, empathy as a response, has not been mentioned before in previous concept analysis. However the author believes it is vital to completing the empathetic process. If the patient does not feel the nurse has shown an interest or have tried to helped them, then the patient will not trust the nurse and will not consider her/him an expert. If the nurse has not responded to the patient’s needs by encouraging them to take control in decision making or providing them with the necessary information, then the patient will still feel lost and vulnerable and may adopt negative coping styles such as: denial, hostility, avoidance and alcoholism, (Reynolds and Scott, 2000).

This paper has brought the concept of empathy up to date and strengthens and supports other researcher’s work and theories of empathy. However the paper does have some limitations which should be addressed if further work was to be carried out. Having ‘full text available’ as part as the inclusion criteria meant some papers which may have had relevance to this concept analysis were not included. Therefore if another concept analysis was done, more efforts would be made to find these papers, to make the analysis more detailed.
There were a large amount of papers related to medical students or doctors, even though ‘nursing’ was included in the search. Some of these papers include; Hojat, Vergare, Maxwell et al (2009), Hojat, Gonnella, Nasca et al (2002a) and Hojat, Gonnella, Nasca et al (2002b). Some may criticise these papers being incorporated in this concept analysis because they are not focused on empathy within nursing practice. The authors rationale for using such papers was because they provided evidence based knowledge on empathy within healthcare professionals, and this knowledge can be easily transferred to the context of nursing.

Garden (2009) believes if the communication of empathy is successful the patient will have a positive outcome. Numerous authors found patient anxiety and pain to be alleviated and emotions justified once they experience empathy expressed by their nurse (see Note 2). Communicating empathy gives the patient a sense of validation (Hojat, Gonnella, Nasca et al, 2002b), it has been found to increase their satisfaction and wellbeing if their integrity is intact (see Note 22) as they know their concerns have been appreciated and valued. All 7 stages of the empathetic communication process have to occur for the nurse to be perceived as genuinely empathetic. For example if the nurse fails to engage with the patient on an emotional and intellectual level or fails to feedback to the patient their understanding, the nurse may make assumptions or misinterpret the patient and they will no longer feel understood, valued and in control of their care and illness (see Note 23).
The last element of the empathetic communication process is detachment. This component was not considered in Barrett-Lennard’s (1981) earlier work on empathy, however Huggard (2003) and Tyner (1985) [cited in: Wiseman, 2007] believe if detachment from the situation is not gained there is an increased risk of burnout. Detachment has always been a problematic concept in relation to empathy, especially in the caring profession. Detachment is required in the empathetic process because it improves the nurse’s concentration levels when seeking a plan to alleviate the patients suffering. Their time is more equally rationed amongst their other patients and it allows the nurse to remain impartial. The nurse has to tackle obstacles such as: time restraints, poor concentration and lack of patience if the nurse is wants to avoid burnout (Klitzman, 2006, Stepien and Baerstein, 2006 and Huggard, 2003).
Teaching


Crandall and Marion (2009) believes this intellect can be developed through teaching. Spiro (2009) believe the best way to teach someone how to be empathic is to teach by example, but Osaka, Tanioka, Ueno et al (2008) believe any kind of empathy teaching is not sustained. Määttä (2006) supports this statement by stating the ability to ‘feel’ empathy cannot be taught. In light of this evidence some may suggest teaching empathetic skills in nurse training is pointless or ineffective. However, Katoka, Koide, Ochi et al (2009) dispute this and argue that empathetic skills improve with training.
To settle this argument I looked at the quality of evidence each author brings. Määttä (2006) based his/her work on the Edith Stein’s model of empathy and there is no qualitative or quantitative data to support their statement. Osaka, Tanioka, Ueno et al’s (2008) qualitative study was only based on 5 participants, which did not specify whether they were nursing students or not so it is difficult to generalise to nursing. Their method was precise but as they used Electroencephalogram (EEG) readings in their research, there were limitations, for example blinking and tears. The study measured how emotional the participants got when looking at emotional and unemotionally charged videos. The study concludes that the participants share the actors/actresses emotions but what the study cannot prove is that the communication of empathy cannot be taught.

Katoka, Koide and Ochi et al (2009) used a large number of participants and a well tested empathy measuring tool. The evidence supports the validity and reliability of the Jefferson Scale of Physician Empathy (JSPE). The study is limited because it is based on Japanese students, whereas this concept analysis of empathy is related to Westernised nursing, and the study uses medical, not nursing students. In light of this it is difficult to determine who is correct, therefore more evidence needs to be gained to settle this debate.
Evidence needs to be collected over a number of years to see how empathetic understanding and communication changes through the years, with and without annual training. Using a randomised control trail would be most appropriate as there can be no participant bias. A recommended measuring tool should be used, using nursing participants only.

Although teaching in itself not an empathetic component, it is still an important factor in a nurse’s development of the skill. If empathy is largely a cognitive component then teaching can help refresh empathetic skills and emphasise its importance in clinical settings. There is no evidence to suggest teaching can change a nurse’s inbuilt characteristics, however Salvage (2006) believes caring behaviour can be taught, which allows the nurse to approach the situation in a professional manner (Norfolk, Birdi and Walsh, 2007, Benbassat and Baumal, 2005 and Hojat, Gonnella, Nasca et al, 2002a).
January 2011 Search

To ensure this concept analysis was up to date as possible another search was completed in January 2011. The same search engine with used and with the same inclusion/exclusion criterion as before, except the published date was extended to 2011. From this search 44 new papers were found, but once read only 17 papers were relevant and transferrable to the concept of empathy. The other 27 papers were excluded from further review because of the following reasons; the paper was inaccessible or the paper was focused on a similar concept (such as compassion), or because the paper was not relevant to the concept of empathy within a healthcare setting.

No new research was found to alter the defining attributes of empathy. For full references of the included and excluded papers please see Appendix 6. What was concerning about this review was that some search engines brought up papers from previous years that were not brought up in the original search (for example Lee-Hsieh, Fang, Kuo, and Turton, 2004). The author expected these papers to be found into the initial search back in July 2010 as the exact same step by step search criteria was used. The author can only conclude that these papers were not available online at the time of the initial search last year.
Chapter 10:
Implications and Recommendations

Carrying out this analysis has made me more aware of how I and others communicate with patients and how our attitudes affect their emotional wellbeing and perception of care. Now the new defining attributes of empathy have been determined I now know what I need to work on in my own practice, such as finding time to listen and being patient. When incorporating this new found knowledge into practice I have found ‘checking back with the patient’ really helps me to understand their situation and what to say next.

I am currently on placement in an Emergency Department. Nurses in the department are working hard to empathise with patients in an environment which is loud, busy and stressful. I feel these barriers need to be addressed to help the empathetic process along. I propose to talk to the training and education team within the Emergency Department to see how we can address these issues. For example producing a leaflet on the defining attributes of empathy and the seven step communication process so nurses can try and follow this in the little time they have. Patients admitted to the Emergency Department have just entered an unfamiliar environment and they are likely to be anxious, in pain and distressed so it may be beneficial to students if I wrote a small section about the concept of empathy in the students introduction pack.
My dissertation will also be available to read in the medical library for any one interested in the subject to read. Dr Helena Priest, a lecture at Keele University has asked for some of my research and references on the concept of empathy as she is currently writing a new book called, ‘Learning to care; a psychological approach to nursing and healthcare practice’, published by Routledge. Dr Priest has also written numerous articles and a book on psychological care in nursing, such as Priest (2006), Priest, Sawyer, Roberts and Rhodes (2005), Priest and Gibbs (2004), Priest (2002), Priest (1999a) and Priest (1999b). This is a great honour and another step forward in bringing empathy into the forefront of nursing.

To make future nursing students more aware of the empathetic communication process I will offer to carry out a teaching session on the subject next year and will create a poster describing the Seven Steps To Empathy‘ (described on page 36-37) and place it in the clinical setting I will be working in when qualified.
Further Research

More evidence based research needs to be done to show how empathy is beneficial to patients. This can be done by using randomised control trials and patient centred questionnaires to detect how they feel empathy is communicated best, what it takes to be a good empathiser and how it affects their care. Evidence that suggests empathy having health benefits is old and out dated, therefore it could be suggested these trials should be carried out on today’s society. Evidence needs to be collected to prove how empathy makes patients more independent with decision making and to what level do their blood pressure or heart rate decrease by when their anxiety is alleviated, after empathy has been shown.
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A Concept Analysis of Empathy


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A Concept Analysis of Empathy


Smith, RG (1958) I and Thou. (2nd Ed) New York. Charles Scribner’s Sons


## Appendix 1
### Search Tables

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No other database could provide substantial or justifiable results for the entailed search criteria

### Table 4

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| EMBASE        | Empathy       | **Published:** 2000-2010  
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| Psyc Net      | Empathy       | **Published:** 2000-2010  
**Expanders:** Full text  
**Narrow by:** ‘Empathy’ Search within: care  
**Limits:** English Language. | 7 | 2 |
| Psych Info    | Empathy       | **Published:** 2000-2010  
**Expanders:** Full text  
**Narrow by:** Key concept: ‘Empathy’ Any field: ‘Nursing’  
**Limits:** English Language. Human. | 19 | 8 |
| Wiley Inter Science | Empathy     | **Published:** 2000-2010  
**Expanders:** Full text  
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**Limits:** English Language. | 10 | 3 |
| **TOTAL**     |               |                      | **94**                   | **39**                                  |
Appendix 2

Review of Sources References

Medline


Bellini, LM and Shea, JA (2005) *Mood change and empathy decline persist during three years of internal medicine training.* *Academic Medicine.* 80(2):164-167
**A Concept Analysis of Empathy**

**Wiley Inter Science**


**CINAHL**


**EMBASE**


**Psyc Net**


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Psycho Info


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**Appendix 3**

**Notes Index**

**Note 1 – The nurse is attuned to the patient’s feelings**

Crandall and Marion (2009), Garden (2009), Harrison and Westwood (2009), Selph, Shiang Engelberg, Curtis and White (2008), Norfolk, Birdi and Walsh (2007), and Wiseman (2007), Klitzman (2006) and Benbassat and Bauml (2004),

**Note 2 – Patient’s anxiety and pain is alleviated and their emotions justified**


**Note 3 – There is a mutual understanding**

Note 4 – The nurse has an urge to care

Note 5 – The nurse is a good communicator

Note 6 – The nurse is a good listener

Note 7 – The nurse is genuine and honest
Note 8 – The nurse is open

Note 9 – The nurse has a full understanding

Note 10 – The use of verbal and non verbal communication
Note 11 – The nurse is competent

Note 12 – Empathy is a cognitive and affective ability

Note 13 – Variables of empathy

Note 14 – Importance of communication
**Note 15 – Use of touch**


**Note 16 – Previous empathetic processes/cycles**


**Note 17 – The nurse is responsive**


**Note 18 – The nurse-patient relationship is patient centred**

Note 19 – The nurse-patient relationship is reciprocal

Note 20 – The patient must trust the nurse

Note 21 – The patient must be able to relate to/be similar to the nurse

Note 22 – Patients have increased satisfaction and wellbeing

Note 23 – Common assumptions
Note 24 – Papers that related empathy specifically to nursing practice

Appendix 4

What Empathy is not

Throughout the literature there has been a clearly stated that empathy and sympathy are two very different approaches. To decipher between the two, here are some explanations of sympathy:

- To be like someone else or agree with them (Määttä, 2006).
- Sympathy is a first level empathetic response and is a verbal and non-verbal expression of the nurse’s own sorrow or dismay at the patient’s situation (Morse, Bottorff, Anderson et al, 1992 [cited in: McCabe, 2003]).
- Sympathy is a predominately affective attribute (Hojat, Vergare, Maxwell et al, 2009, Hojat, Gonnella, Nasca et al, 2002a).
- A pro-social behaviour that is prompted by sympathetic feelings is more likely to be triggered by egocentric motivation to reduce personal distress (Hojat, 2007, [cited in: Hojat, Vergare, Maxwell et al, 2009]).
- Sympathy is an emotional attribute (Crandall and Marion, 2009).
- Sympathy is when the nurse can imagine how they would feel if they were to experience what is happening to their patient (Wiseman, 2007).
Appendix 5
Definitions of Empathy

Below are definitions of empathy found within the review of resources:

“To sense the client’s private world as if it were your own, but without ever losing the ‘as if’ quality.”


“The ability to share the patients experience wherein one is able to predict the behaviour of the patients.”


Empathetic understanding: “Caring skill of temporally laying aside our views and values for entering into another’s world without prejudice.”


“To perceive the internal frame of reference of another with accuracy and with emotional components and meanings which pertain thereto as if one were the person, but without ever losing ‘as if’ condition.”

(Rogers, 1959, [cited in: Määttä, 2006, p.7]}
“An extraordinary ability”

(Kohut, 1977, Olden, 1953 and Sullivan, 1953 [cited in: Määttä, 2006, p.5])

“The ability to perceive and reason as well as the ability to communicate understanding of the other persons feelings and their attached meanings.”


“The ability to understand or become involved in the other’s immediate psychological situation.

(Travelbee, 1999 [cited in: Myhrvold, 2003, p.35)

“Humanity’s basic emotional faculty”


“Empathy is a prerequisite for the development of an awareness and understanding of the emotions and feelings of another.”


“Exquisite empathy: a discerning, highly present, sensitively attuned, well boundaried, heartfelt form of empathetic engagement.”

(Harrison and Westwood, 2009, p.213)
“Empathy refers to the reactions of one individual to the observed experiences of another.”


“Putting yourself in someone else’s shoes, or as the moccasins for three days to get to know them.”

(Salvage, 2006, p.22)

“The ability to identify with the patients emotional state.”

(Morse, 2000, p.35)

“Empathy refers to a caregiver’s cognitive and vicarious understanding of the patient as a person – an understanding that is thought to generate confidence and trust in the doctor-patient relationship and to promote effective treatment and healing.”

(Colliver, Conlee, Verhulst et al, 2010, p.558)

“Empathy - like beauty- would seem to be in the eye of the beholder – the patient’s, not the caregiver.”

(Colliver, Conlee, Verhulst et al, 2010, p.591)
“Putting oneself into others shoes.”
(Colliver, Conlee, Verhulst et al., 2010, p.592)

“Standing in the patient’s shoes.”
(Colliver, Conlee, Verhulst et al., 2010, p.592)

“The ability of physicians to imagine that they are the patients who has come to them for help.”
(Baron-Cohen, 2003 [cited in: Di Lillo, Cicchetti, Lo Scalzo et al., 2009])

“Letting apart of you becoming the patient and going through her experience as if you were the patient.”
(Gianakos, 1996 [cited in: Di Lillo, Cicchetti, Lo Scalzo et al., 2009])

“Understanding of others feelings and concerns are the key ingredients of empathetic engagement.”
(Greenson, 1967 [cited in: Di Lillo, Cicchetti, Lo Scalzo et al., 2009])
“Empathy is predominately cognitive (rather than emotional) attribute that involves and understanding (rather than feelings) of experiences, concerns and perspectives of the patient, combined with a capacity to communicate this understanding.”

(Hojat, 2007 [cited in: Kataoka, Koide, Ochi et al, 2009])

“Empathy as ‘I and you’ becomes ‘I am you’ or ‘I could be you.’”

(Spiro, 2009)

“Empathy is neither deviation from intelligence nor the single route to it. Sometimes we need detachment (objectivity): many other times we need attunement (receptivity). And those who can toggle between the two.”

(Wiseman, 2007, p.1174)

“The ability to perceive the meanings and feelings to the other.”


“Imagining what it is like to be that person, experiencing the situation as she or he does.”

(Burnard, 1988 [cited in: Wiseman, 2007, p.61])
“Providing an ethical and philosophical basis for nursing, where the individuality of the patients and patients own experience of illness is paramount.”

(Reynolds, Scott and Austin, 2000 [cited in: Wiseman, 2007, p.66])

“Empathy is a multidimensional construct that encompasses both cognitive and affective components.”


“The ability to perceive another’s point of view and be aware of one’s effect on others.”

(Hohan, 1969 [cited in Bellini and Shea, 2005, p.164])

“Empathy is a multiphase process rather than a single event.”


“Empathy has three distinctive components: a cognitive component in which the clinician enters the perspective of the patient, an emotional component in which the clinician puts himself in the place of the patients and finally the action component in which the clinician communicates understanding by checking back with the patient.”

“Empathy in health care delivery is defined as a cognitive component (as opposed to affective) attribute that involves understanding the experiences and perspectives of the patient combined with the ability to communicate this understanding to the patient.”


“Empathy involves cognitive as well as affective or emotional domains”


“Putting myself in the patient’s shoes.”

(Shapiro, 2002, p.324)

“Climbing into the same boat as the patient”

(Shapiro, 2002, p.324)

“Empathy is more than an intellectual understanding or a cognitive analysis.”

(Shapiro, 2002, p.324)

“Empathy involves a personal relatedness.”

(Shapiro, 2002, p.324)
“The ability to step outside our own perspective and consider the needs and goals of others in a high level way of ‘knowing others’ and helps us navigate the social landscape often with more positive adjustment, productivity and smoother interpersonal relations. Self-centredness, alienation of others, resentment and conflict may otherwise occur.”

(Eslinger, Parkinson and Shamay, 2002, p.95)

“These studies describe empathy as involving emotion, reason, and a desire to help a person in distress.”


“Recognising and explicitly acknowledging the patient’s emotions”

(Cohen-Cole and Bird, 1995 [cited in: Garden, 2009, p.123])

“Empathy is a collaboration with the patient that involves an action component: physicians must “check back” with patients to confirm or to correct their shared understanding.”

“Clinical empathy is incomplete when it doesn’t lead on to an attempt to help and ethically empathic physicians move beyond psychological engagement to material aid.”

(Benbassat and Baumal, 2004 [cited in: Garden, 2009, p.123])

“An emotional attunement with patients which involves mindfully eliciting patient’s perspectives and feedback to avoid confusing empathy with the physician’s projection of his/her needs onto the patient.”


“Clinical empathy is a form of emotional labour which requires both deep acting or intentional modification of one’s true motions and surface acting, the deliberate display of emotions such as enthusiasm or concern that one doesn’t actually feel.”

(Larson and Yao, 2005, [cited in: Stepien and Baernstein, 2006, p.524])

“Empathy as a ‘way of being’, where the helper, without judgement enters the private world of the client. The helper gains insight, beyond that of the client, into the client’s own story.”

Reynolds extends Rogers definition by including “communication of this understanding of ‘the story behind the story’ to the client as a means of validating the client’s world.”

(Reynolds, 2000 [cited in: Huggard, 2003, p.163])

“Empathy as a sense that the other is in some way like oneself, it forms a basis for an expectation of mutual understanding of meaning, therefore it’s the sine qua non for knowledge of mental phenomena in others and thus of human relations.”


“Empathy arises from the perception of mutuality with another person.”

A Concept Analysis of Empathy

Reference List for Appendix 5


A Concept Analysis of Empathy


Huggard, P (2003) **Compassion fatigue: How much can I give?** Medical Education. 37(2):163-164.


A Concept Analysis of Empathy


Salvage J. (2006) **It's the action that counts.** Nursing Standard. Royal College of Nursing. 20(49): 20-23


A Concept Analysis of Empathy


A Concept Analysis of Empathy


Appendix 6

Updated Search Criteria for 2011

An additional search was created in 2011 to make the concept analysis as up to date as possible. The same inclusion/exclusion criteria was used, apart from the date published, which has now changed to ‘Published: 2000-2011’ All papers were accessed on 15\textsuperscript{th} January 2011. Below are lists of papers found in the 2011 search. No new papers were found in the following search engines: Cochrane Library, EMBASE, Psyc Net, Psych Info, Bandolier and Wiley Inter Science.

CINAHL

The following papers were found using CINAHL and were relevant to the concept analysis of empathy.

Chism, LA and Magnan, MA (2009) \textit{The relationship of nursing students’ spiritual care perspectives to their expressions of spiritual empathy}. Journal of Nursing Education. 48(11): 597-605

Franks, J (2009) \textit{The caring character}. Nursing Standard. 23(26):61


The following papers were also found in CINAHL, however they were not included into the analysis for the following reasons, they were either: not relevant to the concept of empathy within nursing practice, were related to a similar concept or were inaccessible:


Moore, ML (2006) Conversations with colleagues. Cultural immersion: how an intensive language program can help you provide better care. AWHONN Lifelines. 10(5):370-4


MEDLINE:

The following papers were found using MEDLINE and were relevant to the concept analysis of empathy.


**Pub Med**

The following papers were found using **Pub Med** and were relevant to the concept analysis of empathy.


The following papers were also found in Pub Med, however they were not included into the analysis for the following reasons, they were either: not relevant to the concept of empathy within nursing practice, were related to a similar concept or were inaccessible:


A Concept Analysis of Empathy


**Joanna Briggs Institution (JBI)**

The following papers were found using JBI and were relevant to the concept analysis of empathy.


The following papers were also found in JBI, however they were not included into the analysis for the following reasons, they were either: not relevant to the concept of empathy within nursing practice, were related to a similar concept or were inaccessible:


Rees, S and Williams, A (2009) **Promoting and supporting self-care management for adults living in the community with physical chronic illness: A systematic review of the effectiveness and meaningfulness of the patient-practitioner encounter.** JBI Library of Systematic Reviews. 7(13):492-582