THE NATURE AND MORALITY OF EMPATHY

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This dissertation explores the nature of empathy and its role in moral thinking and in medical practice. First, I focus on articulating an adequate philosophical account of affective empathy. One standard account of affective empathy involves imaginatively taking the perspective of a target, experiencing an affective match with the target’s affective state, and maintaining a distinction between the self and the target. I argue that empathy requires perspective-taking and an affective match between the subject and the target, but that this match should be broadly construed. Such an account better captures several plausible cases of empathy, and it also better explains why we care about empathy.

Second, I explore the purported role of empathy in ordinary moral thinking and motivation. Empathy is often associated with morally desirable characteristics or action. However, skeptics argue that empathy is overly provincial and often distorts our moral thinking. For this reason, they argue that we are better off ignoring or eliminating empathy from our moral thinking. I argue that moral thinking and motivation informed by a particular account of empathy (involving both cognitive understanding and affective responsiveness) produces better moral results than available alternatives, and I develop an account that explains why this occurs.

Finally, I address the growing discussion of empathy in clinical settings, specifically the role of empathy in the physician-patient interaction. First, I develop a defense of cognitive empathy in clinical settings against critics who argue that it is either conceptually incoherent or overly liable to produce error. Second, I argue that recent proposals to employ affective accounts of empathy in physician-patient interactions are not justified epistemically, nor are they clearly supported by the relevant empirical literature. I argue that the ideal account of empathy in
medicine remains cognitive, though there is a central role for expressing empathic concern towards patients.
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INTRODUCTION

The term ‘empathy’ was first introduced into the English language by Edward Titchener in 1909, as a translation of the German word ‘Einfühlung’ (literally ‘feeling into’). The modern study of empathy grew from research in aesthetics, phenomenology, and psychology during the 20th century. This research has developed rapidly in a number of disciplines, with important contributions from psychology, neuroscience, and philosophy. More widely, the role of empathy has been discussed in relation to medical and therapeutic care, human rights and humanitarianism, peace and conflict studies, jurisprudence and jury selection, and moral

1 Titchener used this term to describe the process of imaginatively projecting ourselves into aesthetic works, with the focus of the projection being the emotional nature of the target or situation. See Edward Titchener, Experimental Psychology of the Thought Processes (New York: Macmillan, 1909).
This dissertation aims to present and defend an account of empathy, and then examine the role of empathy in moral thinking and clinical practice.

In chapter one, I explore whether affective empathy requires perspective-taking or affective matching. There is some disagreement about how to best characterize affective empathy. Psychologists have generally characterized affective empathy broadly. On such accounts, empathy involves experiencing an affective state that is triggered or caused by the affective state in another individual. Philosophers and neuroscientists often characterize affective empathy more narrowly, as involving three features: (i) perspective-taking, (ii) some form of affective match between subject and target, and (iii) a clear self-other distinction.

First, I argue that we have reasons to prefer a narrower account of affective empathy, which requires perspective-taking. I argue that while wider accounts of affective empathy may explain the development of our empathetic capacities, such accounts are often too broad and they fail to explain why we typically care about empathy.

Second, I discuss the form of perspective-taking required for affective empathy. Some have argued that the process of perspective-taking is incoherent, or involves a distortion of the inner lives of others. I argue that there are coherent forms of perspective-taking, and that such processes need not distort the inner lives of others. Instead, they function as part of a limited, but important form of interpersonal engagement.

Third, I challenge the standard account of affective matching thought to be required for affective empathy. On one widely held view, affective empathy requires an actual affective

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"Thinking Like Non-Lawyers: Why Empathy Is a Core Lawyering Skill and Why Legal Education Should Change to Reflect Its Importance" (New York: Social Science Research Network, 2010).

match between the subject and the target of empathy. I argue that while empathy often involves an actual match, we also count as empathizing with the target if we share the fitting state in their situation. This account better captures a number of plausible cases of empathy, and it also better explains why we care about empathy.

In chapter two, I explore whether empathy leads us morally astray. Many people believe that being an empathetic person is morally desirable. If Jones is generally empathetic, he is (in the absence of other information) probably a decent fellow. Following this, we might think that if Jones could expand his empathy for others, this would be even better, morally speaking. However, skeptics have raised a number of concerns about reliance on the role of empathy in the moral life. Skeptics argue that the nature of empathy is overly partial and that to improve our moral thinking and motivation, we would be better off extirpating or ignoring empathy.

I outline and respond to these arguments. I distinguish between two forms of the skeptical claim. The first is that empathy is partial and can lead us morally astray. The second claim is stronger, asserting that we would be better off ignoring or eliminating empathy from our moral thinking. I argue that while there are reasons to accept the former claim, those reasons do not support the latter claim. I argue that moral thinking and motivation informed by a particular account of empathy (involving deliberate perspective-taking and affective responsiveness) produce better moral results than the alternatives proposed by skeptics.

In chapter three, I explore whether physicians should be empathetic. The role and importance of empathy in medicine has been widely discussed. Definitions of empathy in these discussions vary, ranging from a cognitive form of understanding, to a combination of cognitive and affective capacities, and even to behavioral responses. While definitions of empathy in
medicine differ, the goal of employing such capacities in clinical settings is to produce better health outcomes for patients.

I focus on the ideal of clinical empathy, as involving both cognitive and affective capacities. I argue that an increasingly discussed account of clinical empathy is subject to several objections. My main concern is that a central feature of the account (emotional resonance with patients) is typically a liability in clinical settings, and is not clearly supported by the relevant empirical research. Instead, I argue that the ideal account of empathy in medicine remains cognitive, though there is a central role for expressing empathic concern towards patients. Then, after detailing my account, I defend it from a number of recent criticisms of employing empathy in medicine.
CHAPTER I: DOES EMPATHY REQUIRE PERSPECTIVE-TAKING OR AFFECTIVE MATCHING?

Introduction: Empathy in Common Usage

The term ‘empathy’ is often used to describe a cognitive capacity to understand what other people think or feel in particular situations. Those who are empathetic are able to imaginatively ‘step into the shoes’ of others and take their perspective on a situation. While this process will typically involve imaginatively adopting mental states like beliefs (in addition to affective states), historically the term ‘empathy’ has, in addition, a core emotional or affective focus. This emotional sense of empathy is what continues to be the central focus in moral philosophy and moral psychology. For example, imagine Jones responding to a fearful colleague: “I definitely can empathize with what you’re feeling right now. I was also really frightened when I had my first surgery, but the process is painless.” While this form of empathy might produce matching affective states (Jones actually feels a shared fear), this is not required or typical. Jones might continue: “Look, I’m not personally afraid right now, but I certainly empathize with your fear.” Here Jones might imagine what his colleague is experiencing, but in a relatively detached manner.

While empathy is typically directed at actual persons, it can also apply when the target is fictional. Imagine Smith, a literary critic, addressing a writer: “I like this character, I can really empathize with his responses in this chapter.” Alternately, he might argue, “I totally fail to

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11 Hoffman (2000), 29. Perspective-taking requires a subject S (the perspective-taker), T (the target) and C, the circumstances of T. In self-oriented cases, the subject S imagines herself in T’s situation C. In other-oriented perspective-taking, the subject S imagines being T in situation C.
12 See Heidi Maibom, Empathy and Morality (Oxford: Oxford University Press, 2014) for a recent review of the literature.
13 For example, the term ‘empathy’ was first introduced in English by Edward Titchener in 1909, as a translation of Einfühlung (literally “feeling into”). Titchener used this term to describe the process of imaginatively projecting ourselves into aesthetic works, with the focus of the projection being the emotional nature of the target or situation.
empathize with the protagonist. He is flat, and his behavior is unmotivated. Either give him some heart, or get rid of him.” This example also raises the ordinary notion that even attempted empathy with a target may succeed or fail. Pete might say, “I really empathize with you right now, I totally see why you’re so angry.” Alternatively, it is no less plausible for Pete to respond, “I am trying to ‘get into your shoes,’ but I can’t empathize, and I just don’t understand why you’re so angry right now.” For clarity, let’s call this group of ordinary intuitions about empathy the understanding intuitions. We achieve a cognitive understanding when we imaginatively step into the position of others and come to identify with their emotional response, though we need not actually experience that affective state.

While ‘empathy’ is often used to describe a form of understanding, it is also used in ordinary speech to describe a form of emotional responsiveness to other people in particular situations. We might call a person empathetic when they are affectively sensitive to the state and situations of others and respond to this in a particular manner. This form of empathy is often praised as being a positive feature of our character, or perhaps something to be cultivated. Imagine that your partner has been humiliated by his boss. As he recounts the humiliating event, we might step in his shoes imaginatively and come to share his anger.

In many cases, this form of empathic responsiveness involves responding with a similar affective state as the target, but it need not. I may have felt distress on behalf of an animal (though it was pleasantly paralyzed), joy when my friend received an award (though he was duly unimpressed), and anger at a spouse’s rude boss (though my partner was merely sad). However, what seems to unify these cases is that they all involve an actual affective experience that involves a responsiveness to the target’s state and situation. Let’s classify this group of ordinary intuitions about empathy the responsiveness intuitions. We experience an empathetic
responsiveness when we come to actually feel some measure of what it might be like to be another individual in a particular situation, though our affective state need not directly match the target state.

Characterizing Affective Empathy

There is some disagreement about how to best characterize affective empathy. Psychologists have generally characterized affective empathy broadly. For example, Martin Hoffman (2011) defines empathy as an “emotional state triggered by another’s emotional state or situation” which involves feeling what they feel (or may feel).\(^{14}\) Philosophers and neuroscientists often characterize affective empathy more narrowly, as involving three features: (i) perspective-taking, (ii) some form of affective match between subject and target, and (iii) a clear self-other distinction made between subject and target.\(^{15}\)

First, I will argue that we have reasons to prefer a narrower account of affective empathy, which requires the cognitive mechanisms of perspective-taking. I will develop my initial arguments in response to Frans de Waal (2008), who argues that narrow accounts exclude plausible cases of empathy in infants and non-human animals. I argue that de Waal’s account is a reasonable explanation of the development of our empathetic mechanisms, but the account is too

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\(^{14}\) Hoffman (2011), 231.

broad and often fails to explain why we typically care about affective empathy (and empathetic individuals).

Second, I will discuss the form of perspective-taking required for affective empathy. Some, like Peter Goldie (2011), have argued that the process of perspective-taking is incoherent, or involves a distortion of the inner lives of others. I argue that we can avoid the conclusion that perspective-taking is incoherent by adopting a more modest form of perspective-taking. However, I think that Goldie’s more pressing concern is that perspective-taking (as a form of simulation) involves a distortion of the inner lives of others. I argue that we can assuage these concerns by viewing perspective-taking as part of a limited feedback process for engaging with the lives of others, that is often better than alternative routes of epistemic engagement alone.

Third, I mount a challenge to the standard account of affective matching thought to be required for affective empathy. On one widely held view, affective empathy requires an actual affective match between the subject and the target of empathy. I reject this view. I argue that while empathy often involves an actual match, we also count as empathizing with the target if we share the fitting state in their situation. This wider account better captures a number of plausible cases of empathy, and it also better explains why we care about empathy (and having empathetic friends and family). Finally, I will address how to best understand the causal relationship between perspective-taking and the relevant affective match.

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16 To be more clear, if I feel what it would be fitting for Jones to feel in his situation, then I affectively empathize with him.
Section I: Empathy and Perspective-Taking

Frans de Waal’s Mentalistic Challenge

Some have argued that it is a mistake to conceptualize ‘affective empathy’ narrowly, as requiring higher-level capacities like perspective-taking. For example, Frans de Waal (2008) argues that affective empathy only requires the capacity to “be affected by and share the emotional state of another.”17 De Waal argues that it is a mistake to “[drive] wedges between emotional contagion, compassion…and deliberate empathy” since “all of these capacities are connected.”18 He proposes a ‘Russian Doll Model’ of empathy where capacities like perspective-taking are ‘built onto’ capacities like empathic concern (sympathy/compassion) and emotional contagion.19

De Waal argues that the Russian Doll account accurately captures the likely evolutionary development of our empathic capacities and better explains a number of plausible cases of empathy that overly mentalistic accounts rule out. For instance, young infants contagiously mirror the affective states of other infants, and young children engage in forms of vicarious distress (looking sad and crying when perceiving distress).20 In addition, many mammals appear to engage in empathic behaviors, mirroring the affective states of those around them, as well as engaging in targeted helping and consolation behavior.21 Since de Waal argues that these more

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21 Targeted helping involves responding in a very specific way to the needs of a target. For example, a young chimp might perceive a need in another elderly chimp (trying to climb a tree). There are many ways to respond to perceived needs (like throwing food, or giving them a hug), but such responses would fail to satisfy that specific
fundamental capacities appear to be necessary for the standard development of affective empathy, they deserve to be included in a broader account of affective empathy. As such, any account that requires higher-level cognitive capacities for affective empathy is mistaken.

Response to de Waal’s Mentalistic Challenge

De Waal’s model of our empathic capacities is an interesting evolutionary model of the development of empathy. It seems quite plausible that higher-level cognitive modules emerge to function in conjunction with low-level, more proximate mechanisms. Further, in standard human development, we seem to observe lower-level processes like emotional contagion and mimicry functioning before more advanced cognitive capacities like perspective-taking.

However, while de Waal’s model is a plausible account of the development of empathy, his central claim that empathy involves merely the general capacity to be affected by and share target affective states seems too broad. If we accept such an account, it allows for a number of rather counter-intuitive instances of affective empathy. Consider the following cases:

Chain o’ Wailin’: Three newborn infants lay quietly awake in a nursery. Infant One begins to cry due to stomach pain. Infant Two and Three ‘catch’ these affective cues via emotional contagion and begin to cry in unison with Infant One. However, only Infant One is crying in response to her pain. Infant Two and Three cry as a result of their emotional contagion with Infant One.

Sensitive Sally: Sally is a very affectively resonant individual, but she is unaware that other individuals experience affective states. She ‘catches’ nearly all non-conscious affective expressive cues and resonates with them, experiencing whatever affective states are present (or expressed) in others around her. However, she pays no attention to this affective ‘buzz’ and thinks (and cares) only about painting sunsets.

Anger Detector: Terrence is unable to perceive or understand anger in other individuals. However, he is equipped with a chip (connected to his visual center) that neurally stimulates anger when he perceives angry individuals who express behavioral anger cues.

need. In this case, if the younger chimp climbs down and helps push the elderly chimp into the tree, this would count as an instance of targeted helping. The young chimp appears to have perceived a specific need in another and responded with the relevant range of behavior to satisfy that particular need.
On de Waal’s account, each of these cases count as an instance of affective empathy. However, they each fail to explain several ordinary intuitions that we have about empathy. None of the cases involve any features of empathetic understanding since each stipulates that the ‘empathizer’ is ignorant of the target situation. Further, each case seems to lack central features of empathic responsiveness. In *Chain o’ Wailin’,* Infants Two and Three are not aware of the situation of Infant One, or that Infant One is a distinct entity in the world. While they do experience the same type of affective state as Infant One, their experience (and attention) is also not directed at the situated state of Infant One. In *Sensitive Sally* and *Anger Detector,* Sally and Terrence are both unaware of the source of their affective states. Sally might even explicitly deny that other individuals experience such states.

However, it seems like a conceptual mistake for the parents of the triplets in *Chain o’ Wailin’* to proudly claim that their children are *so very* empathetic in virtue of their late-night contagious crying chain. We might also find it implausible to think that Sally is one of the most empathetic people we know, even though she does not believe that other people experience emotions. Finally, it seems quite odd to think that Terrence empathizes with my frustration (say, at doing my taxes) even though he has no understanding that I am angry, and his shared anger is triggered by my wrinkled brow (via his implanted chip).

I think part of what is missing here is that the triplets, Sally, and Terrence all seem to lack a certain sensitivity to the *situated* affective states and experiences of the target. While these individuals have a triggered response to features of the world, their feelings are not experienced

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22 One concern here might be that this is merely a verbal dispute. In the following section, I argue that there are good reasons that we care about empathy and being empathetic, and that a view that requires more cognitive sophistication better captures those features of empathy. Since our central interest in empathy involves it being an other-oriented form of emotional response, I suggest that only those accounts which include this feature ‘count’ as forms of affective empathy.
as responsive to (or with) others as individuals. Sally doesn’t as much empathize with me and my anxiety at my upcoming test results as become involuntarily invaded by an affective ‘buzz,’ which she systematically ignores.

While I think that the low-level affective processes involved in *Chain o’ Wailin’* are not clear instances of affective empathy, we see the responsiveness intuitions more clearly satisfied as a child develops cognitively. For example, between the ages of one and two, a child who perceives distress in a target and becomes distressed herself will respond by attempting to comfort herself. By age two, the child has typically developed a clearer distinction between self and other, which results in other-oriented, targeted consolation behavior in response to distress in the other. Consider the following observational case:

2-year-old David…brought his own teddy bear to comfort a crying friend, who was accidentally hurt when the two were struggling over a toy. When it didn’t work, David paused, then ran to the next room and returned with the friend’s teddy bear; the friend hugged it and stopped crying.23 When David’s more egocentric attempt to comfort fails, he attempts a more targeted form of consolation. David’s distress is responsive to the situation of the crying friend, and he operates with the understanding that the best form of consolation for his friend is not the same as for himself. This seems to require that David distinguish between himself (and his needs) and his friend. My intuition is that such cases better capture general intuitions about empathy as a certain form of emotional responsiveness which takes the situation of the other into account.

Another clue that de Waal’s account of empathy may be overly broad is that he more readily attributes empathy to those animals that researchers argue have the most advanced cognitive capacities. For example, he argues that empathy is the “most conspicuous in the

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23 Ibid., 72.
bonobo ape” but also notes that such apes also appear to “show a degree of perspective-taking.”

He outlines one interesting case which supports this claim, involving a female bonobo:

Kuni…found a wounded bird in her enclosure…[She] picked up the bird…climbed to the highest point of the highest tree, carefully unfolded the bird’s wings and spread them wide open, one wing in each hand, before throwing it as hard as she could toward the barrier of the enclosure. When the bird fell short, Kuni climbed down and guarded it until the end of the day, when it flew to safety.

De Waal argues that what Kuni did “would have been inappropriate toward a member of her own species. Having seen birds in flight many times, she seemed to have a notion of what would be good for a bird, thus giving us an anthropoid illustration of [Adam] Smith’s ‘changing places in fancy.’”

There are additional reasons to hold that affective empathy requires higher-order capacities to ‘count’ as empathy. First, the central reason we seem to be concerned about empathy is that it is a capacity for directly relating to the lives and situations of others. When people desire to have empathetic friends, they want more than an individual who will unconsciously catch their present affective states without any consideration of how (or why) they feel that way. If I am angry at a personal injustice, I would prefer that you share my anger at the injustice rather than just catching my angry cues and stomping about. If I grin and laugh as I deliver a (very clever) joke, I would be disappointed to learn that you only smiled because you caught my joyful facial cues.

Notice here another important feature of many ordinary instances of interpersonal empathy. We often appear to engage in affective empathy with others without ever catching perceptual or affective cues from an external source. For example, my brother might describe to

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25 Ibid.
26 Ibid.
me (over the phone) a mean-spirited insult he received from a client. Upon hearing this narrative account, I may come to feel (on behalf of my brother) upset at the client. While I engage with my brother’s perspective imaginatively, I do not appear to engage my lower-level capacities like emotional contagion in order to feel irritated or upset on his behalf. Instead, the process appears to occur from the ‘top down.’ This suggests that contagion is not required to experience affective empathy with others.

Second, there is a fairly widespread intuition that people ought to be more empathetic in some situations, or that a lack of empathy in some situations is blameworthy. But, this intuition is more difficult to explain if empathy is merely a hard-wired, low-level capacity. While processes like emotional contagion can be consciously down-regulated, there is no clear evidence that it can be cultivated where it did not previously exist. This suggests that empathy requires some higher-level cognitive capacity that we can deliberately choose to engage (and possibly improve upon), or fail to engage (and perhaps open ourselves to blame).

Because we find emotional contagion early in human development and outside of our species, it is fair to hypothesize that empathetic engagement involving perspective-taking might be underwritten by these lower-level capacities. But, as I have stressed, these lower-level capacities alone are insufficient to capture what is central and important about affective empathy in ordinary human life and experience. Analogously, while some form of social mirroring might function as a central part of the developmental process for understanding social rules, it seems a mistake to argue that we cannot understand or respond to particular social rules without engaging in a related act of social mirroring. So, while affective empathy might begin with low-level mirroring or emotional contagion, I think that we draw closer to the core of our ordinary
intuitions about empathetic responsiveness when we adopt an account of empathy that includes cognitive capacities like perspective-taking and the ability to maintain a self-other distinction.\(^{27}\)

*Peter Goldie’s Conceptual Challenge*

I have argued that the most intuitive account of empathy requires perspective-taking. However, in recent years, Peter Goldie has developed a number of arguments against the conceptual coherence and accuracy of certain forms of perspective-taking. If Goldie is correct, then any account of empathy involving such perspective-taking will seemingly inherit such problems and shortcomings. Goldie argues that in very basic instances of perspective-taking (what he calls a *base case*), subjects imagine themselves in the target’s shoes (engages in self-oriented perspective-taking), and due to their accidental psychological similarities, this results in an empathetic match. For example, Seema fears a visit to the dentist. John imagines being in Seema’s position and (given their shared psychological disposition) comes to have an empathetic match with her fear.\(^{28}\) However, Goldie argues that it is a serious mistake to think that this process will suffice for standard cases of empathetic engagement which involve targets that are necessarily psychologically complex (influenced by non-conscious dispositions, or dealing with confusion, conflict, or decision). Accordingly, Goldie argues that empathy fails in principle when we instead attempt to imagine *being* the other person (other-oriented perspective-taking). This failure of empathy is not a contingent feature of our imagination, but results from our inability to

\(^{27}\) A further issue here is that while we might accept that empathy proper involves more cognitive sophistication than mere emotional contagion, it perhaps need not involve perspective-taking. I attempt to address this concern more carefully in the section ‘Is Sympathy a Basic Form of Affective Empathy?’ The basic argument is that the earliest features of empathic concern emerge (targeted helping and consolation) once an infant is able to distinguish between the self and the other and attribute distress to the other. I outline some of the growing evidence that at this stage in development, infants are likely engaging in implicit perspective-taking with others in such situations. We can further distinguish this low-level perspective-taking from more developed forms of imaginative perspective-taking characteristic of more developed empathy.

operate with a “full-blooded” characterization of first-personal agency. Imagining being the another person “usurps the agent’s own first-personal stance toward what he is thinking; only the agent himself can take his stance towards his own thoughts, decisions, and intentions.” In other words, the other-oriented perspective-taking that is often thought to be involved in empathy is an attempt to take a perspective on an agent’s life that is only accessible from that agent’s first-personal point of view.

To see the problem clearly, consider a case involving John and Seema. Imagine that John attends a party with numerous attractive men. John is unaware that he is unconsciously attracted to several of these men and is behaving in a flirtatious manner with them. However, John is morally opposed to any same-sex desire, believing it to be sinful and deviant. He would loathe himself if he actually understood what his behavior was revealing. If Seema attempts to imagine what it is like to be John in this situation, she must attempt to consciously simulate his unconscious same-sex attraction. However, Goldie argues that this empathetic attempt “produces a fundamentally distorted model of...thinking,” since Seema is attempting to consciously simulate (in deliberation) John’s unconscious states.

John and Seema’s case is not atypical. Adult human beings are psychologically complex individuals, and they will always be under the influence of non-conscious mental influences and often face internal conflict or decisions about how to behave. As such, often the only way to engage in other-oriented perspective-taking with others in such situations will involve injecting our first personal account of agency into our characterization of their inner lives, which Goldie

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29 Ibid., 303.
30 Ibid., 308.
31 Ibid., 309.
describes as “a particularly virulent form of contamination.” Since this process necessarily involves a distortion of the inner lives of others, it risks resulting in mistaken assumptions and ungrounded inferences about the extent to which we understand what it is like to be other people.

Response to Goldie’s Conceptual Challenge

There are at least two responses to this argument against other-oriented perspective-taking. The first is to accept that other-oriented perspective-taking is incoherent (and will readily produce distortion) and instead engage in self-oriented perspective-taking with others. This self-oriented account of empathy appears to be the default process when we attempt to adopt the perspective of others. I will argue that such an approach is overly prone to egocentric bias and misses something fundamental about empathetic understanding, namely that the focus of our experience is other-oriented. Another approach is to grant that full or complete other-oriented perspective-taking is not possible, but that the process (and development) of such limited empathetic engagement reveals better information over time and is more likely to give rise to concern for the inner life of others. For this reason, it is better to adopt such an approach in practice, even if it fails to ever be fully successful.

Consider the first approach. Goldie argues that self-oriented perspective-taking is possible, and is useful for achieving empathetic matches when applied to the broad base case of empathetic engagement. However, by engaging in merely self-oriented perspective-taking, we

32 Ibid., 316.
also increase our likelihood of being influenced by egocentric biases and errors.\textsuperscript{34} Consider an example to clarify this claim:

\textit{Two Sisters:} Loud Amanda is a gregarious and obnoxious socialite who is largely unaware of the feelings of others. Amanda’s sister, Quiet Susan, is a friendly but extremely shy woman. They meet for dinner and Quiet Susan explains to Loud Amanda that she (Quiet Susan) has been invited to a raucous party with her new co-workers. In addition, she overheard several of her colleagues whispering about a possible hazing ritual. Internally, Quiet Susan is terrified of the prospect, but she hides any evidence of her fear from her sister.

Imagine that while Susan is talking, Amanda imagines \textit{herself} in her sister’s place. Amanda becomes giddy at the thought of being the center of attention, and she admits she is jealous of Susan. However, she is puzzled by Susan’s reluctant and fearful demeanor. By merely imagining \textit{herself} in the place of Susan, Amanda appears to have fundamentally failed to appreciate Susan’s predicament, from Susan’s perspective. By merely shifting her perspective into the place of Susan, Amanda seems to lack a deeper empathetic understanding of how things seem to Susan.

To see this more clearly, imagine that Susan and Amanda were actual persons. The conversation might continue as follows:

Susan: “Why would you ever think I’d be excited about this? I hate social events!”
Amanda: “Oh, you don’t mean that! Meeting new people is fun!”
Susan: “Perhaps for you! I just don’t think you’re really seeing it from \textit{my} perspective here.”

As is common in practice, we often encourage others to ‘step into our shoes’ or ‘see things from our perspective.’ In some cases, we may even demand that they do this, and hold them to account when they fail to engage with us in this way. This is particularly true if we perceive that another person has treated us unfairly, or has perhaps acted in a harmful or careless manner toward us. When we encourage (or exhort) others to ‘step into our shoes’ this often means expecting something more substantial than asking them to merely imaginatively shift their full perspectives into a new set of extended circumstances. Instead, we often want others to see it

from *our* perspective, given something more substantial about our psychological point of view or the situation we find ourselves in. If empathy serves an important role in understanding others, then it must involve something more substantial than self-oriented perspective-taking.

However, as Goldie has rightly noted, imagining *being* another individual (via other-oriented perspective-taking) is not conceptually coherent in many instances. And in some cases, for the reasons he notes, it will produce quite distorted results. The remaining issue is whether it is still plausible to *attempt* to engage in other-oriented perspective-taking, or to work to extend our perspective-taking beyond the merely self-oriented. In both cases, I think we have good reasons to maintain and develop this approach, particularly if we are working to better understand the lives of others. To illustrate my arguments here, consider the following case:

*Unexpected Surprise*: Christi is an outgoing and driven woman. She balances the pressures of her demanding job in the financial industry with being a mother of two. Recently, she learns that her sister has passed away, leaving a child behind. There are no other relatives nearby, and Christi and Mark (her husband) hastily decide to take the child into their care. However, Christi is very worried that she will not be able to cope with the stress of an additional child, especially given her pressures at work. As she sits alone in the bathroom trying to think through the future, she begins to panic.

If I engage in self-oriented perspective-taking with Christi, I might imaginatively project my perspective into her situation. But, this is a strained process. I have never been a woman, I do not work in finance, and I have not recently learned that a relative has passed away, leaving me with a child. So, trying to imagine just *myself* in this position involves something of a problem. In this case, engaging in self-oriented perspective-taking might be as difficult as engaging in other-oriented perspective-taking.

However, it is possible to shift my attention from self-oriented perspective-taking so that I am not merely imagining myself occupying a new location in the world. We might think of this
process as a way of feeling into a new perspective. Initially, taking the perspective of Christi involves bringing my perspective to bear on the details of Christi’s situation. Since this process is imaginative, it will not be possible to insulate the simulation entirely from my first-personal perspective. So, this process appears to begin with a self-oriented form of perspective-taking. But, what makes the process other-oriented is that I focus my attention on the unique features of Christi’s psychology and her circumstances, working to integrate them into my simulation, rather than focus on the particulars of my own perspective in that situation.

Such an extension of self-oriented perspective-taking seems quite conceptually manageable in ordinary life, and there is some empirical evidence that such an imaginative shift is possible and produces results that differ from merely self-oriented forms. For instance, Batson et al. (1997) found that asking subjects to imagine how a target feels in a distressing situation (other-oriented) more frequently produces empathic concern (sympathy/compassion) for the target, but asking the subjects to imagine how they themselves would feel in the distressing situation (self-oriented) produces both empathic concern for the real target, but also personal distress in themselves. Feeling empathic concern is empirically correlated with pro-social, helping behavior, but personal distress (personally felt anxiety, fear, etc.) typically induces people to leave/escape the source of distress.

The conclusions produced by Batson et al. have been supported by subsequent studies. Jackson et al. (2005) asked subjects undergoing an fMRI to view photographs of human hands in typically painful/neutral circumstances. The subjects were asked to imagine and rate the level of imagined pain from different perspectives (either self- or other-oriented). Taking a self-oriented

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35 Adam Smith calls this way of approaching others a sort of feeling into their situation. We imaginatively ‘work our way into’ their perspective on the situation, with a focus on their affective states in the situation.

perspective on a painful looking situation produced higher pain ratings among subjects than other-oriented perspective-taking. The former also involved more extensive activity in the (hypothesized) neural ‘pain matrix.’

Because the imaginative (and phenomenal) differences between both forms of perspective-taking produce different patterns of motivation, it appears that self-oriented and other-oriented forms of perspective-taking are distinct. This supports the claim that there is a form of other-oriented perspective-taking that is distinct from mere self-oriented perspective-taking, but also coherently employed by ordinary individuals to better understand the perspectives of others.

It seems unlikely that Goldie would deny that we might be able to re-orient the focus of our perspective-taking, but his concern seems to be that the very attempt at imagining being others is going to necessarily produce distorted and erroneous outputs. And this seems like a problem for a process that purportedly delivers a greater understanding of others. Consider imagining a shift in gender (which would be required to imagine being Christi). Imagining what it is like to be a woman (when you are not one) involves much more than imagining having a different job or being more outgoing. It requires background knowledge about what it means to be a woman in a particular place and time, and will likely trade on limited information and stereotyping. By compounding this with a first-personal simulation of someone dealing with

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37 Similar results were found when using video footage of patients undergoing painful procedures. See Lamm et al. (2007). One hypothesis for this motivational shift (in self vs. other perspective-taking) is that other-oriented perspective-taking involves additional regulatory mechanisms which help suppress the beliefs/emotions of the self. Jean Decety and Sara Hodges, “The Social Neuroscience of Empathy,” in Bridging Social Psychology: Benefits of Transdisciplinary Approaches, edited P. van Lange (Erlbaum, 2006), 103-109.

38 Notice that in many situations, other people do not typically complain when you try to engage with their lives in this way. What people often object to is when you draw overly determinate conclusions about the nature of these experiences, or claim too direct an understanding of the totality of the situation.
confusion, or engaged in deliberation, it seems very likely that the results of such perspective-taking will produce a distortion of what it is like to be Christi, and a likely empathetic mismatch.

I think that these are significant problems, and it is clear that in an attempt to better understand others via perspective-taking, we often risk disrespecting them by reducing their experiences to a caricature, or in more complex situations simply distorting central features of their inner life. In saying this, attempting to engage in other-oriented perspective-taking with Christi is likely to overcome the shortcomings of self-oriented approaches, and it may stand to deliver more information about her situation than I would otherwise have access to. In my view, the typical process of other-oriented empathy functions as a ‘rough and ready’ interpersonal process which draws on available (and limited) information about a target and their situation. In this case, I am more readily re-oriented to the form of life that Christi inhabits, and my attention is directed to the features of her situation more directly than I had previously experienced. In this case, I don’t merely see that something matters to Christi, I come to have a greater understanding of how and why it matters.

Goldie is correct to note that perspective-taking will not always deliver clear matching output states in ‘one shot’ simulations, nor will it always produce matching as the simulation updates with more information. This is a serious problem if we expect empathy to function in this manner, or if the essential value of empathy is as a relatively detached mechanism to successfully output ‘one shot’ matching simulations. This is an apparently widespread assumption in many discussions of the use of perspective-taking and simulation as an epistemic tool, so it seems fair to target such accounts. However, I do not think that this is how empathy is typically utilized in ordinary interaction, nor do I think this is why it has importance in interpersonal engagement and the understanding of others. For example, the frequent empathetic
failures that we encounter (due to the complex and inaccessible internal lives of others) can often motivate a better understanding of them in ongoing interaction. Imagine that I meet Christi for coffee and she shares the basic details of her case mentioned above. She seems genuinely upset and quite anxious. I try to take her perspective and work my way into understanding her position, but even with my limited access, I just cannot see the grounds for her anxiety (from her perspective).

In response, she informs me that Mark has been recently diagnosed with a serious and expensive illness. I can see that even talking about it causes her to shift around anxiously. These new details help me re-frame my perspective, since I had made assumptions about Mark due to a lack of information. Now, I begin to see (or perhaps even feel) the basis for her fear in this case. The manner that empathy functions in this scenario does not require that I adopt a robust characterization of Christi’s initial state in order to feel into her situation. I make adjustments with the information available, and I can often check my understanding in the interaction. However, this process also plausibly involves something more substantial than just shifting my entire perspective into her position. This empathetic ‘back and forth’ is a common feature of interpersonal interaction and suggests that it is also a mistake to divorce empathy (as a means of interpersonal understanding) from the wider context of human interaction within which it functions.

Gaining an empathetic understanding of Christi’s life involves trying (in part) to perceive the situation from her perspective by feeling into her situation. The purpose of empathy in typical human interactions is often to better understand or be responsive to the experience of another person, not to produce a ‘one-shot’ match of particular mental states. In actual cases, we empathize with the situated, messy lives of individuals, not psychological states or processes. In
this way, we can grant Goldie’s claim that the most robust forms of perspective-taking are incoherent, and such attempts are liable to distortion without jettisoning the process of other-oriented perspective-taking as a means to empathetically engage with others. While such forms of imaginative engagement with others are fallible, they often function to deliver more information than was previously accessible.

Further, while I have argued that self-oriented perspective-taking is limited, engaging in both self- and other-oriented perspective-taking often reveals morally important features of a situation and typically motivates concern for others. For example, Linda is the object of a demeaning comment at work. When Joe imagines how he would feel being the object of such a comment, he can infer how Linda likely feels. It is rather remarkable how often even this basic form of perspective-taking is neglected in our ordinary lives. Extending this approach, the idea of more carefully considering what it is like to be others in various situations seems to be closely related to feeling concern for them. For example, the most widely used experimental means for motivating empathic concern (sympathy/compassion) toward others is to ask people to take the perspectives of the targets. This suggests that if we want to improve our understanding of others (and potentially our other-regarding motivation), we might have reasons to attempt to engage in other-oriented perspective-taking, even with its associated shortcomings.

Section II: Empathy and Affective Matching

*The Standard Account: Actual Affective Matching*

Many formulations of affective empathy require an actual affective match between the subject and the target. Call this the *Actual Matching Account*. A recent proponent of this account is Amy Coplan (2011). She argues that “affective matching occurs only if an observer’s affective

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39 See Batson (2011) for a review of the current literature.
states are qualitatively identical to a target’s, though they may vary in degree.”⁴⁰ A qualitatively identical match requires that the empathizer “must experience the same type of emotion (or affect) as the target.”⁴¹ She further notes that to accurately represent the target’s emotional experience, this strictly requires “replicating those emotions.”⁴²

Frequently, there is no doubt that affective empathy involves the subject sharing the actual affective states of the target. Consider the following case:

**Brewing Anger**: Tracey manages a popular coffee shop. One morning she is rudely berated by a customer for not knowing how to make a cappuccino. In fact, Tracey had made a perfect cappuccino, but the customer was misinformed about the nature of the drink (expecting it to be sweet). Tracey is polite to the customer, but is very angry. That evening, she returns home and informs her partner Nancy of the incident. Nancy takes Tracey’s perspective in the situation and shares Tracey’s anger at the ignorant customer.

The *Actual Matching Account* seems plausible because a number of typical cases of affective empathy are like *Brewing Anger*.

**Resisting the Actual Matching Account: Empathy with Fiction**

However, there are multiple problems with the *Actual Matching Account*. The first is that it has trouble accounting for our apparent affective empathy with fictional characters in film and literature. When we read a good novel or watch a moving film, we often find ourselves getting ‘pulled in’ to the drama and emotionally attached to the characters. If the narrative is sufficiently captivating and the characters are well developed, we can often find ourselves sharing the fear of the protagonist, or their anguish at loss. These are often attenuated emotional responses compared to how we might respond to the fearful or tragic events in our own lives, but our emotional engagement with fiction seems powerful and real nonetheless. Also, consider that

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⁴¹ Ibid. This (she argues) will rule out cases of reactive affect counting as empathy (like feeling angry at a target’s oppressor even when the target fails to be angry).
⁴² Ibid., footnote 22. Coplan wants to rule out congruent and reactive emotions since they are “not sufficiently accurate representations of a target’s situated psychological states.”
researchers regularly employ fictional characters and constructs in experimental settings to elicit and measure the emotional responses of test subjects. This is particularly true in the psychological and neuroscientific study of empathy.

Given the apparent ubiquity of our emotional responses with the fictional lives of characters, consider the following argument: (1) If empathy necessarily involves an actual affective match, then we cannot empathize with fictional targets (2) We can empathize with fictional targets (3) Thus, empathy does not necessarily involve an actual affective match.

The first premise raises a number of issues related to the nature of fiction. Consider two accounts of fictional entities.43 On the possibilist account, fictional entities exist in other possible worlds (though not in the actual world). On one reading of such an account, if empathy requires an actual qualitative affective match with the target, such a match would be possible if a fictional target were represented as experiencing the relevant affective state. So, on this account, a critic might argue that empathy with fictions (involving actual affective matching) is possible, so long as we grant certain claims about modal realism. The difficulty here is that many are resistant to such accounts of possible worlds.

On an alternate account, fictional entities are best understood as abstract artifacts or creations. While fictional entities are represented as having certain properties (within or indexed to a narrative or aesthetic context), they fail to actually have those properties. For example, as a child I used to imagine that the street lamp outside my house was lonely. I had constructed a narrative account wherein the lamp was represented as being the sort of character that could have emotional states, and I took his (her?) slumped form and separation from his friends to be evidence for his loneliness. In this way, it was true that (per my narrative) the lamp was lonely,

43 See Kroon & Voltolini (2011) for an overview.
but it is unclear that I could achieve an actual match with the lamp’s lonely (sad) state, since that state existed only indexed to my narrative, and was (in that sense) an artifact or creation.\footnote{Perhaps we might think of it as if it were a real emotion or individual.}

Second, a critic might reject the second premise of the argument that we can actually empathize with fictions. If the second premise is false, then those who hold this view in ordinary situations are confused. Further, those who rely on this distinction in experimental settings are similarly confused. Empathy is simply not possible with fictional entities in novels or films, since the targets in the former always lack actual affective states and typically lack them in experimental settings.

However, I think we have good reason not to reject the second premise, at least without a careful argument. A central reason is that our ordinary emotional experiences with fiction make it fairly hard to deny. For instance, in Sophie’s Choice, I seem to actually feel a deep grief with Sophie when she must choose to send one of her children to the gas chambers. Such moving affective experiences with (and for) fiction are not exceptions, they are central to what makes fictional narratives captivating and entertaining. We often even criticize fictional accounts for being difficult to emotionally identify with in this way, for having ‘flat’ characters that are lifeless (‘inhuman’), or being psychologically unbelievable or unmotivated. This sort of aesthetic discourse seems to rely on the capacity that we have for affective empathy with fictional characters in their depicted states and situations.

Rejecting the second premise of the argument also has implications beyond the discussion of fictions in aesthetics. It would also entail that the experimental literature on affective empathy is potentially flawed. Researchers and their numerous test subjects in psychology and neuroscience would be conceptually confused when referring to the relevant
experimental constructs as ‘empathy,’ since any felt affective experiences on the part of the test subjects could not match (in principle) the represented affective states of the fictional constructs. So, if we can provide an account of empathy which does not entail that ordinary users of the concept are committing widespread error, then this is theoretically desirable.

*The Wide Matching Account of Affective Empathy*

One possible solution to the problem of fictional empathy is to reject the actual matching requirement of affective empathy. Consider a case to motivate this kind of account:

*Bad Health*: Bill is visiting Ted, a friend in poor health who has been hospitalized. During Bill’s visit, a doctor shares some important news about Ted’s health. The doctor informs Ted that he only has about six weeks to live. Bill takes Ted’s perspective and responds with the fear and sadness that would be fitting for Ted to feel, offering to help in any way that he can. In fact, Ted is in such shock that he does not feel anything.

On the *Actual Matching Account*, Bill fails to empathize with Ted, since he (Bill) fails to share Ted’s actual affective state in the situation. Instead, given his information about Ted, Bill feels what would be fitting for Ted to feel in a situation, where he has learned that his medical condition is terminal. Bill attempts to engage with Ted’s state and is sensitive to the situation the way he (Bill) believes it would be appropriate for Ted to respond.

Although Bill’s response fails to match Ted’s affective state (we stipulate here a neutral absence of affect), it is directly responsive to features of Ted’s situation which are important or should be important to someone like Ted, even if Ted fails to ever recognize them. Further, it is precisely this kind of emotional engagement that we hope to be given by our friends, loved ones, and care-givers. If I were Ted, I would (after the fact) appreciate Bill’s acute responsiveness to my news. For these reasons, I propose that we may be said to successfully affectively empathize with the target if we have an affective response that matches the actual, or fitting state of the

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45 Since Ted feels nothing here, it seems like it would not be possible to engage in affective empathy with him at all (if we accept the *Actual Matching Account*).
target in the target’s situation. Let us call such an account a *Wide Matching* account. We find a precursor to this account first suggested by Adam Smith, who noted in his discussion of ‘sympathy’ that it “does not arise so much from the view of the passion, as from that of the situation which excites it.” One virtue of this account is that it captures interesting cases of affective empathy that *Actual Matching* views rule out. It also explains the social and normative importance of empathy in a way that the *Actual Matching* account cannot.

Next, consider an alternate case involving a wider, fitting affective match:

*Proxy Embarrassment*: Ben invites Charlie to a party. Charlie is having a difficult time making conversation, and tells several jokes that ‘fall flat’ to awkward smiles. Getting the sense that people are *really* warming up to him, he tosses out a particularly awkward racist joke which elicits several surprised, but disgusted laughs. Seeing the laughter, Charlie glows with pride. However, taking his perspective, Ben feels extremely embarrassed on his behalf, and pulls him aside to ‘help’ him with something, sparing him from further social damage.

In *Proxy Embarrassment* Charlie feels no negative affective states (like embarrassment or shame), and he fails to detect that the disgusted laughter is directed at him, as an object of scorn or disdain. In fact, he is pleased to be the ‘life of the party.’ Unlike *Bad Health*, Charlie is actually experiencing an affective state (the warm glow of pride) in the situation.

While Charlie fails to detect important features of this situation, Ben acutely experiences how Charlie’s embarrassing behavior is perceived by the group, and as a result how Charlie perhaps ought to feel if he were more socially acute, or had more information. Ben might be said to be embarrassed *on behalf of* Charlie, and Ben shares a measure of the embarrassment that

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46 Hoffman (2000) argues that empathy may involve feeling what someone may be expected to feel (232). D’Arms (2000) allows for empathy involving an expected response, but calls it *misfiring* empathy. See Justin D’Arms, “Empathy and Evaluative Inquiry,” *Chi.-Kent L. Rev.* 74 (2000), 1481. Darwall (2002) allows for an empathy with what the target “should feel” (51). Gallagher (2012) suggests that empathy is an “other-directed feeling” which need not match the target’s affective state. See Shaun Gallagher, “Empathy, Simulation, and Narrative,” *Science in Context*, vol. 25, no. 3 (2012), 376. I think that several of these claims are plausible, and my aim is to more carefully develop the rationale for that account here.

would be fitting for him to feel in the situation. This is true, even when Charlie utterly fails to recognize this fact. He might even fail to see the problem when it is carefully explained to him.

It is fairly clear that Ben fails to empathize with Charlie with regard to Charlie’s actual response. This might lead us to think that Ben fails to fully understand Charlie’s perception of the situation. However, Ben is not unaware that Charlie is proud and could certainly give an account for why this would be the case. We are all familiar with the feeling of amusing others with a quick-witted remark or joke. Instead, Ben seems to have a greater understanding of Charlie’s situation than Charlie does. After all, Charlie desires to amuse people with his clever joke, not be the object of derisive laughter (which Ben understands).

In this way, Ben’s affective response (of embarrassment) is directly and experientially responsive to features of Charlie’s situation (and his perspective) of which he is unaware. Were Charlie to more clearly see these facts, he would likely fittingly feel embarrassed. If I were to ever to be in a state where I began to behave like Charlie, I would want friends who were similarly empathically engaged to ‘rescue’ me in some manner.48 As noted previously, this kind of emotional responsiveness seems central to what matters to us about having empathetic friends, family, and colleagues. As such, it seems to be a plausible form of empathic responsiveness, or affective empathy.49

Finally, consider an example of a wider, morally fitting affective match:

*Abuse and Loathing:* Tim and Eric have been in a relationship for a number of years. Tim is violent and abusive toward Eric. Over time, Eric has come to loath himself and believes that his abuse is merited. One afternoon during coffee with his sister (Janet), Eric finally opens up about his abusive relationship with Tim. Janet takes Eric’s perspective, and comes to feel a firm resentment toward Tim.

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48 I think that a form of this case often occurs when an individual is highly intoxicated and begins to ‘make a fool’ of themselves.  
49 It should be noted that while the affective response itself is largely outside of our control, we can direct our attention (more or less) to the perspective and situation of others. In this way, this form of empathy meets the requirement that empathy be something over which we can exert some measure of control, and possibly be blamed for failing to engage in when it is merited.
In *Abuse and Loathing*, Janet feels the resentment that she thinks Eric *should* feel. She might grant that having suffered abuse, it might seem reasonable for Eric to come to loath oneself. In this sense, she might empathetically understand Eric’s loathing of himself, without emotionally responding to it in the way that Eric does. However, Janet sees more clearly that Tim *merits or deserves* Eric’s resentment. In addition, she *feels* that Tim merits Eric’s resentment. We might even imagine that she is also a bit upset at Eric, since he has somehow arrived at the erroneous conclusion that he is worthless, which is patently false. Janet (like most of us) would urge Eric to see his false beliefs about his self-worth and his attendant self-loathing. Instead, she might argue that Eric should be deeply resentful of his unjustified treatment at the hands of a bully.\(^5\) It is from her engagement with the perspective and situation of Eric that she feels this emotional responsiveness. Here again, Janet’s direct, emotional responsiveness to Eric’s situation (with reference to his perspective) seems to be a strong candidate for a form of affective empathy with Eric.

Some have suggested that we may be properly said to empathize with a target if we come to experience a state that would match their *expected* state in their circumstances. In some cases, this seems intuitive. Consider the following case:

*Proxy Job Jitters*: Rupesh knows that Mike is interviewing for a job. Mike is disorganized and scatterbrained, resulting in a generally panicked approach to life. However, for this interview Mike has been studiously and seriously preparing. As a result, he feels confident and self-assured. Rupesh knows that Mike greatly needs this job, but given his general disorganization if life, Rupesh feels great anxiety on Mike’s behalf for the upcoming interview. Rupesh does seem to be emotionally engaged in Mike’s situation, considering Mike’s history. However, if we accept an account of empathetic matching that allows for expected matching, it will be difficult to explain how empathy fails in many circumstances. If I am terribly confused

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\(^{5}\) Janet’s response here might be unjustified. Perhaps it is always better not to encourage powerful negative emotions if possible. However, as a matter of fact, people often encourage each other to respond in these ways.
about your state and situation, and I feel how I expect you will feel, it is unclear why I have successfully empathized with you. An individual might even maintain a willful ignorance about the lives of others (perhaps blindly holding that everyone around me enjoys being hurt and abused). As a result, they empathize with the joy of those they injure, since they expect such a response. However, this result seems counterintuitive. While allowing for an expected match might seem intuitive in some cases, I propose that these features can be better captured by the ‘fitting match’ criteria, which appropriately indexes our empathetic match with actual features of your situated state, even if you feel an emotion that diverges from what is fitting.

The kinds of cases captured by the Wide Matching Account are ubiquitous in our interpersonal and moral relationships. If affective empathy requires that we come to actually share the affective states of those around us (via perspective taking), then this form of emotional engagement will be a fairly rare occurrence. The result is that even those who make a fairly diligent effort to engage with the lives (and perspectives) of others will often not achieve the requirements of a proper empathetic responsiveness.

In addition, it seems like such an account is much more limited in practice. While I can share your sadness when you are sad, or your pride (when you are proud), much of our empathetic engagement with others does not appear to involve merely matching the affective states of those around us. If you fail to feel what is fitting it your situation (but I do), I may use my response to advise or encourage you to think about how you are construing the situation, or challenge your concerns. It seems intuitive that my emotional responsiveness in this way counts as empathetic, even if I fail to share your actual responses. Since many people have the strong intuition that our empathetic engagement with others is widespread and ordinary, our account of empathy should capture this feature of our ordinary intuitions.
Further, another widespread intuition about empathy is that it involves something much more engaged than ‘state-matching’ of a certain sort. Some psychological and neuroscientific accounts of empathy seem to make the object of our empathetic engagement a matter of mental state-matching. However, what we desire in empathetic friends and family members are individuals who either understand us as individuals in particular ways, or are responsive to *us* in our situated contexts. We want (and attempt) empathetic engagement with people, not states. This is especially true when our responses fail to be fitting in particular situations (and we need help, guidance, or correction). Since the *Actual Matching Account* rules out a number of these otherwise intuitive and important instances of empathy (or renders such engagement rare), this gives us further reasons to think that the *Actual Matching Account* is inadequate.

*Is Sympathy a Basic Form of Affective Empathy?*

In ordinary discourse, the terms ‘empathy,’ ‘compassion,’ and ‘sympathy’ are sometimes used synonymously. While, I think that there are several good reasons to maintain the conceptual distinctions between these terms, one result of the *Wide Matching Account* is that it explains why an emotional response like sympathy is often categorized as a specifically empathic emotion. Consider a widely cited account of the emotion known as empathic concern (sympathy or compassion) which is “an other-oriented emotion elicited by and congruent with the perceived welfare of someone in need.”

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In standard childhood development, the basic form of sympathy or compassion appears to emerge from our ability to directly share the distress of those around us. On Batson’s account, empathic concern seems specifically related to the perceived needs of others, and typically involves a feeling of concern, or sorrow directed at this perceived need. This ability appears to be modulated as we further develop our cognitive and imaginative abilities. In the more extended versions of sympathy, we typically feel bad for (a sorrowful, sad form of distress) the target who is either directly experiencing some negative affective state, or is in some negative situation. In some cases, we can feel sympathy for a target that is not experiencing any negative affect, but whose situation is negative. Consider the following pair of cases of sympathy:

*Sympathy for Abuse:* Tina is raped by a stranger after an evening out with friends. She feels deep shame for having dressed too provocatively and also a misguided guilt for being out too late. Sam learns of Tina’s situation and this causes Sam to feel bad for Tina.

*Joyful Dementia:* Ted is an elderly man suffering from severe dementia, and he spends most of his afternoons playing happily and singing songs from his childhood. While Ted is not in pain, his son (Dan) knows that his father was a dignified man, and would be saddened at losing his rational faculties in this way. As a result, Dan feels concern for his father.

Both cases here bear structural similarities to previous cases of *Wide Matching* affective empathy. In both cases, Sam and Dan feel a form of distress which is directed at their respective targets who are in a negative situation. In typical cases, this distress is experienced by the subject as a form of sadness, itself an emotional response that typically tracks absence or loss of something valuable. In this way, sympathy with a target involves an emotional response which directly represents their state as involving the form of loss or absence of something important or valuable. According to Batson, our sympathy is felt in congruence with the perceived welfare

53 This is a variant of Adam Smith’s example about a man who has lost his ability to reason.
54 There is a sort of inverse emotional state here that is primarily discussed in the Buddhist tradition called *sympathetic joy* or mudita. When I feel sympathetic joy, I am joyful or pleased that you are well or have experienced something that improves your well-being.
of an individual in need, so that the relevant loss (or absence) is related to whatever features of
the world are ‘well-being’ makers for the target.\textsuperscript{55}

In many cases of sympathy, this form of emotional responsiveness need not match the
actual responses of the target in the situation. In \textit{Sympathy for Abuse}, Tina feels only shame and
guilt. In \textit{Joyful Dementia}, Ted feels contentment and ease. But, in both cases, it seems plausible
to think that some form of sorrow in their respective positions is merited. In Tina’s case because
she has been unjustifiably harmed and deeply violated. In Ted’s case, sorrow seems merited
because his independence and autonomy is now absent. So, in both cases, the sadness of the
empathizing subject seems fitting in the situated state of the target individual because it
accurately represents the person having suffered an important loss. In this way, sympathy may be
an ideal candidate for a special form of empathic engagement with the state and situation of other
individuals, and involves sharing the actual or fitting distress or sadness of the target in their
situation.

One of the foremost researchers on altruism (C.D. Batson) has argued that empathic
concern requires (i) perception of the target in need, and (ii) perspective-taking.\textsuperscript{56} However,
some have suggested that the key difference between affective empathy and empathic concern
(sympathy) might be that the latter lacks a perspective-taking requirement. Indeed, Batson
himself has recently altered this account, now arguing that the necessary antecedents of empathic

\textsuperscript{55} However, it may well be that sympathy more accurately is felt for an individual \textit{for} their sake, not merely in
response to changes in their well-being. For example, Coons (2012) suggests the case of foster parents who are
motivated to promote the well-being of their child (to receive a welfare check), but \textit{not for the sake} of the child in
question. Similarly, he proposes a case of a civil servant who is fully devoted to maximizing human well-being
without caring for anyone (or himself). When I feel sympathy for Tina, it is not so much that I feel this because her
well-being has been reduced, it is because I have come to care about what happens to her. See Christian Coons, “The

\textsuperscript{56} See Batson (2011) for review.
concern are (i) “perceiving the other as in need,” and (ii) valuing the other’s welfare.” He gives several reasons for this shift. The first is that we can take the perspective of an individual without feeling empathic concern. This seems plausible, but it only shows that perspective-taking is not a sufficient condition for empathic concern.

Batson’s second reason involves a more direct denial of any necessary connection between perspective-taking and empathic concern. He argues that we can feel empathic concern for a target “without being instructed to adopt the other’s perspective.” His reasoning is that:

[m]ost people naturally place at least a moderate value on the welfare of other people—even total strangers…As a result of this moderate valuing, when research participants provided with no perspective-taking instructions learn about a stranger in clear, legitimate need, they typically report levels of empathic concern only slightly below the levels reported by those instructed to adopt the other’s perspective (Batson, Eklund et al., 2007). In such situations, it seems more accurate to say that adopting an objective perspective reduces empathic concern than to say that adopting the other’s perspective increases it. A moderately sympathetic orientation, not a dispassionate orientation, seems to be the default.

Batson, Eklund et al. have shown that valuing a target’s welfare leads subjects to more readily engage in perspective-taking with that target. However, they have not shown that perspective-taking is not required for (i) perceiving the other as in need, and (ii) valuing the other’s welfare.

What this research demonstrates is that in the absence of explicit instructions to engage in perspective-taking, test subjects often still come to report some level of empathic concern for the fictional subjects. However, the first-personal narrative case used in Batson et al. (2007) makes it unlikely that test subjects are not taking the perspective of the target. Consider his initial vignette about Ben, a student who is late for his class:

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57 Ibid.
58 Ibid., 44.
59 In this kind research, taking an ‘objective stance’ involves instructing participants to try not to get emotionally involved (or caught up) in how the target feels. Instead, the test subjects are encouraged to remain detached.
60 Ibid.
61 Though we might again distinguish here between valuing or promoting welfare in a detached or general manner, and caring for or promoting the welfare of an individual for their sake.
On the way up the hill, there was this old woman in the middle of the sidewalk. The weather was really bad that morning, and she was just standing there, holding a bag of groceries. She stopped me, and sort of wild-eyed and confused, she said she couldn’t find her house. She seemed really upset.  

In the first-person, Ben describes either rudely dismissing the woman or kindly helping her on her way. As he rushes to his class, he is hit by a car, and then discusses his injuries, recovery, and concerns about completing his degree on time. Even before perspective-taking is explicitly mentioned in the experiment (and manipulated by researchers), the narrative prompt could plausibly have engaged them in this manner.

It is an open question whether some form of perspective-taking is required for empathic concern. A subject who feels sympathy (in standard cases) must perceive another individual with a “discrepancy [real or apparent] between the other’s state and what is desirable for the other on one or more dimensions of well-being” and “attention must be focused on the person in need, not on the self.” This all requires that the sympathizing subject can recognize that the target as qualitatively distinct from inanimate objects, and recognize that the target has goals, feelings, and values.

To recognize a target as a distinct individual with goals, desires, and feelings, and to perceive them as embedded in a situation that falls short of a real or perceived ideal for them seems to require that they engage in at least some minimal (or implicit) form of perspective-

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63 After either helping or denying help to an elderly, confused woman, Ben rushes to class: “I was really late for class now, so I started running. That’s when it happened, just as I was cutting between two parked cars to cross the street. I hit. I never saw the car, and the driver didn’t see me. It all happened really fast. Anyway, it was pretty bad. It broke both my legs and my left arm, and I got a fairly severe concussion. As you can guess, I didn’t make it to class that day. In fact, I haven’t been to class since. It’s impossible because I can’t really walk—or even use a wheelchair. The doctors say I won’t be able to get back up on campus for at least another three weeks, maybe more. I’m trying to keep up with my classes and assignments the best I can, but it’s really hard not being able to go to class or get up on campus. I’m really getting behind. If things don’t get better, I think I’m going to have to drop out for this semester, which will really cause me problems in trying to get my degree on time…” (Batson et al. 2007, 67).
64 Batson (2011), 33-34.
taking, framing their response to the situation with reference to their situated perspective. Such a process need not be causally antecedent for empathic concern, but we may need to situate their perspective within a context or situation before we might be said to have empathic concern (e.g. sympathy) for them. While we can grant that individuals often engage in theorizing about the states of others, or catching affective cues via perception, such activities are often performed alongside the contextual features of perspective-taking, not in opposition to it.\footnote{Shaun Nichols (2004) argues that perspective-taking is not required for empathic concern, since there is evidence of empathic concern is infants that emerges several years before infants are able to pass the false-belief test (typically around the age of four). Instead, he argues that we only need to be able to attribute positive or negative states to the target to be able to feel empathic concern for them. See Shaun Nichols, *Sentimental Rules: On the Natural Foundations of Moral Judgment* (Oxford, Oxford University Press, 2004). However, there is growing evidence that infants may engage in implicit perspective-taking much earlier than the age of four. For example, infants as young as 9-12 months are sensitive to the goals, intentions, and desires of others (Woodward, 2003). When researchers use experiments involving 'look-time,' there is also evidence that infants are engaging in implicit perspective-taking several years before they are able to pass false-belief tests. See Southgate et al. (2007) and Southgate (2013) for review. Perhaps what primarily distinguishes empathic concern from empathy proper is that empathy proper involves more advanced forms of perspective-taking, and involves emotional responses which expand past the basic sorrowful forms of concern that characterize empathic concern. See Victoria Southgate at al., “Action Anticipation Through Attribution of False Belief by 2-Year-Olds,” *Psychological Science*, 18 (2007) 587–92; Victoria Southgate, “Early Manifestations of Mindreading,” in *Understanding other Minds*, edited by Simon Baron-Cohen, Helen Tager-Flusberg, and Michael V. Lombardo, 3-19 (Oxford University Press, 2013); A.L.Woodward, “Infants’ Developing Understanding of the Link between Looker and Object,” *Developmental Science* 6 (2003) 297-311.}

In this section, I have given some reasons to reject the *Actual Matching Account* of affective empathy and given a number of reasons and cases to support (and clarify) a *Wide Matching Account* of affective empathy. I have argued that the latter account better captures a number of plausible (and important) cases of affective empathy and explains the relationship between affective empathy and what is often known as empathic concern (sympathy).

*The Causal Requirement for Affective Matching*

In the final section of the paper, I will discuss the causal relationship between perspective-taking and the relevant affective match involved in affective empathy. For some, the cognitive state of perspective-taking must be the causal antecedent of the affective state. For
example, Coplan (2011) argues that “the matching must come about in a particular way, namely through other-oriented perspective-taking.” She proposes this view in part to avoid spurious and accidental affective matches and to best capture an accurate representation of the target state. Call this the PT Antecedent View of Empathy, which requires that perspective-taking cause the affective match with the target.

The PT Antecedent view captures several ordinary cases and should avoid spurious and accidental matches. Consider a case: Jones is afraid of flying since he hates the restricted spaces and sharing all those hideous germs with unknown strangers. Smith is afraid of anything that involves leaving his house. When Smith learns of Jones’ flight, he becomes afraid at the thought (since it involves him leaving the house). Here it is less clear that Smith empathizes with Jones’ fear of flying (on this account) even though his emotion matches that of Jones. Were Smith to first more accurately take Jones’ perspective in the situation (framing the situation in terms of a fear of flying and germs), this would rule out the otherwise accidental nature of the affective match (and ‘successful’ empathy).

However, I have two concerns with the PT Antecedent view. The first is that it rules out plausible cases of affective empathy. The second is that it may fail to rule out the kinds of spurious and accidental affective matching that Coplan is keen to avoid. Let’s begin with the cases of affective empathy that the PT Antecedent view rules out. Since the view requires perspective-taking as the causal antecedent, any ordinary interaction where an affective state is

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initially caused or triggered by psychological processes besides perspective-taking will fail to count as a case of affective empathy.\(^6^9\) Consider this case:

*Contagious Job Jitters:* Smith feels anxious about an upcoming job interview and exhibits jittery behavior. I contagiously mirror this anxiety via perceptual cues (and begin to feel uneasy), but I realize that my situation is not the source of my anxiety. Smith then explains that he has a big job interview coming up. My experience of anxiety is then focused on his upcoming interview as we continue to talk. Only at this stage in the process do I come to adopt his perspective on the situation and cognitively situate my anxiety in relation to his situation.

On the PT Antecedent account, *Contagious Job Jitters* fails to count as a case of empathy since the affective state occurred before I took Smith’s perspective. However, while the affective state was not produced by perspective-taking, it seems implausible to deny that I am empathically responsive to his anxious situation once I have re-framed my self-directed anxious experience with regard to his situation.

Next, consider that the motivation of the PT Antecedent view is to rule out causally coincidental and spurious affective states. However, even if we have the account, this result is not guaranteed. To see why, consider this case:

*Existential Eric:* Thomas has cancer and is waiting to hear back on some tests which will determine how fast it is progressing. He is very afraid. To ease his mind, he begins talking with his friend Eric. Eric is not a particularly thoughtful fellow, but he does his best to take Thomas’ perspective. However, the process of taking the perspective of another individual is itself jarring for Eric, who experiences a deep existential anxiety at the world of existence outside himself. So, as a result of talking with Thomas (and taking his perspective), Eric feels deeply upset and very afraid.

In this rather odd case, it is unclear that Eric is responsive to Thomas’ situated state. Thomas is afraid since he values his life and likely desires not to suffer the pain and financial harm of undergoing medical treatment. Eric experiences a deep existential fear as he comes to first realize the fundamental otherness of others. It is this existential shift which causes Eric’s fear rather than some feature of Thomas or his situation. In *Existential Eric*, Eric achieves an

\(^6^9\) One feature of Coplan’s account is that it will effectively rule out cases of emotional contagion from counting as instances of empathy. So, on Coplan’s account, *Chain o’ Waitin’,* *Sensitive Sally,* and *Anger Detector* will each fail to count as cases of empathy proper. Such an account would also be inconsistent with De Waal’s broad account of affective empathy.
affective match directly produced by perspective-taking (meeting Coplan’s requirements), but the match seems to be highly spurious.

One way to avoid even this form of spurious or accidental causal result would be to further stipulate that empathy involves taking the perspective of the target (other-oriented), which produces an actual affective response to the target which matches their affective state, for the same reasons that they experience their affective state. While there might be a theoretical merit to this narrower account since it is perhaps more precise, we might be concerned that it simply rules out too many cases which otherwise satisfy our intuitions about affective empathy. If this account were correct, we also might worry that empathy with others is a fairly rare occurrence. This seems too great a price to pay for theoretical precision.

Instead, I think we have good reason to allow that a plurality of mechanisms may causally trigger the affective match that may eventually constitute my affective empathy with another individual. In some cases, this may be low-level emotion contagion, or it may involve making various inferences about the world, or even taking the perspective of an individual. However, we might argue that until that affective state is framed by perspective-taking with reference to the situation of the target, then we are not properly said to be empathizing with their actual, or fitting state in that situation.

So, consider the case of Existential Eric. While it is in virtue of him taking the perspective of Thomas that he becomes afraid, his fear is focused on himself and his existential

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70 The trouble here is that we often do not have a clear account of the reasons that motivate others. You might believe that double-parking is one of the worst moral offenses that an individual can commit, and upon seeing a car double-parked, you express your seething anger. Upon taking your perspective, but lacking all of your idiosyncratic beliefs, I might share a measure of anger at the rude behavior of the offending driver. But, if my anger must be a response to the situation based on the reason that this is the worse sort of moral offense, then my response appears not to constitute affective empathy according to the same reasons account of matching. This seems somewhat implausible.
situation. It would be strained to suggest that he feels fear on behalf of Thomas, since his experience no longer seems to be properly focused on Thomas. Were Eric to refocus his attention on Thomas, to attempt to see what it is like to nervously await cancer results, and to direct his existing fear in this manner, then we have a much more plausible case for the claim that Eric empathizes with Thomas. On the account that I have defended, this would be the case even if (for some reason) Thomas was too stunned to feel anything. In other words, to empathize with a target requires that I take account of the target and their situation via perspective-taking, though what constitutes my affective match with the actual, or fitting affective state of the target may be causally triggered in other ways.

Conclusion

I have presented an argument in favor of an account of empathy that (i) requires perspective-taking, (ii) requires an affective match between the subject and the target (though this affective match is broadly construed as involving either a match with the actual, or fitting state of the target), and (iii) does not require that perspective-taking causally trigger the relevant affective match. I have argued that there are several virtues of such an account. If empathy does not involve perspective-taking and sensitivity to the situation of others, then we can be empathetic without knowing it, against our will, or even while maintaining a complete lack of concern for others. These results are implausible. If empathy requires an actual match with a target, there is a concern that we cannot empathize with fictional characters and more importantly, that we will fail to empathize with others even when (upon considering their situation) we feel emotions that it would be appropriate for them to feel (but they are unable to feel). The actual matching account of empathy would relegate affective empathy to a less
common feature of ordinary life, and would rule out the kind of engagement we have with others that forms the basis for advice, moral instruction, or care.
CHAPTER II: DOES EMPATHY LEAD US MORALLY ASTRAY?

Introduction

Many people believe that being an empathetic person is morally desirable. If Jones is generally empathetic, he is (in the absence of other information) probably a decent fellow. Following this, we might think that if Jones could expand his empathy for others, this would be even better, morally speaking. However, skeptics have raised concerns about any reliance on the role of empathy in the moral life. Skeptics argue that the nature of empathy is overly restrictive and partial. Empathy targets particular individuals, drawing our attention away from more global moral problems, and we more readily empathize with individuals who are near, or share familiar characteristics. Such skeptics argue that to improve our moral thinking and motivation, we would be better off extirpating or ignoring empathy.

In the first section of my argument, I briefly clarify a number of central terms before outlining the skeptical case against empathy. Here I distinguish between two forms of the skeptical claim. The first is that empathy is partial and limited and can lead us morally astray. This claim will be referred to as Empathetic Partiality (or EP). The second claim is stronger, asserting that we would be better off (morally speaking) ignoring or eliminating empathy from our moral thinking and motivation. This claim will be referred to as Empathetic Elimination (EE). Next, I argue that while there are reasons to accept EP, those reasons do not support EE. In response, I argue that moral thinking and motivation informed by a particular account of empathy (involving both cognitive understanding and affective responsiveness) produces better moral results than the alternatives proposed by skeptics. In the course of my discussion, I also attempt to address why engaging in empathy with others produces these results.
Clarification of Terms: Empathy and Empathic Emotions

Before I address the skeptical case, I want to clarify my use of the term ‘empathy,’ as well as several related emotional processes. It is important to clarify these terms in this discussion, since some objections to the moral worth of empathy may only have force under a particular definition. Broadly, we can distinguish between two senses of empathy: (i) empathy as a form of cognitive understanding, and (ii) empathy as a form of affective responsiveness. For John to cognitively empathize with Mary, he imaginatively reconstructs Mary’s perspective in her particular situation. John’s empathy is *successful* when he is able to imagine sharing her situated response, though he need not actually experience the relevant affective state.\(^{71}\) On my account, for John to affectively empathize with Mary requires an affective match between John and Mary (either a match with the actual, or fitting emotional state) and perspective-taking, though affective empathy does not require that perspective-taking causally trigger the relevant affective match.\(^{72}\)

There are several related emotional processes that might also be distinguished here. The first is often referred to by psychologists as *empathic concern*. Psychologist Daniel Batson defines empathic concern as the “other-oriented emotion elicited by and congruent with the perceived welfare of someone in need.”\(^{73}\) Consider a paradigm case of empathic concern. Mary has fallen ill, and trembles with a high fever. John perceives Mary’s situation, and feels sympathy, a sorrowful emotion felt for Mary in her negative state. We might think of sympathy or compassion as paradigmatically *empathic* emotions, since they take as their object the

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\(^{71}\) This cognitive form of empathy is other-oriented, and involves more than merely imagining *yourself* in a different spatial location. It might also involve a wider set of mental states. I am only concerned with affective states here.

\(^{72}\) The match can be triggered by low-level psychological processes (like emotional contagion) or high-level processes like perspective-taking, belief or inference.

\(^{73}\) Batson (2011), 11. For Batson, ‘empathic concern’ can refer to several emotional responses including compassion, sympathy, pity, and tenderness.
experiences and situations of others and they are responsive in valence to those states (sympathetic sorrow involves a negative affective response to a negative situation or perceived need).

Empathic concern is typically distinguished from an emotional response known as ‘personal distress.’ John experiences personal distress when he perceives Mary in a distressed state (or experiencing distressing emotions), and this causes him to experience distress. However, during an experience of personal distress, John’s focus turns to his own experience (and alleviating his distress), rather than the initial target and situation that produced the distress.

The Case against Empathy: Prinz and Bloom

While there is a widespread intuition that being empathetic is morally desirable, there have been several notable arguments against the general worth of empathy in our moral thinking and motivation. I will focus on recent arguments proposed by Jesse Prinz (2011a/b, 2014), since they are the most developed and influential versions of the criticisms.74 I will also discuss a related set of objections proposed by psychologist Paul Bloom (2013, 2014, 2016).

Prinz defines empathy as a “matter of feeling an emotion that we take another person to have” which may be produced by “associative inference from observed or imagined expressions of emotion or external conditions that are known from experience to bring emotions about.”75 As such, Prinz’s account is best understood as an account of affective empathy, though he allows that imagination and perspective-taking may be involved in this process. Given this understanding of empathy, Prinz presents several arguments for the claim that utilizing empathy in moral practice leads us astray.

First, Prinz notes that empathically experiencing personal distress (self-focused distress at the distressed state of another individual) can motivate to avoid the source of distress instead of helping.\textsuperscript{76} If your distressed state causes me to be distressed (and I have an accessible means to avoid you), then an effective means to alleviating my discomfort is not always to help you in some way, but to leave or avert my attention to something else. This phenomenon is sometimes observed when people shift away from accounts of suffering or tragedy by shifting their attention. For example, one might skip to another news article, or switch the TV channel.

Second, according to Prinz, empathy can be readily manipulated to violate norms of fairness. Call this the \textit{Wrong Response Objection}. For instance, mock juries may deliver different sentences when they feel empathic concern for the victim or defendant. In one study, the perception of visibly sad victims tended to produce harsher sentencing for the defendants, while the perception of sad defendants produced lighter sentences for the latter.\textsuperscript{77} In another experiment, Batson et al. (1995) featured a vignette about Sheri, a terminal patient waiting for an experimental drug. Test participants were asked if Sheri should be moved higher in the list (above needier individuals). Compared to the control group, participants who were encouraged to feel empathic concern for Sheri were more likely to move her above needier individuals.

Third, Prinz outlines a number of examples which illustrate that empathy is biased toward the ‘near and dear.’ Call this the \textit{Provincial Objection}. For example, we may be “more likely to focus on the gripping resentment of our neighbor…than cases involving international genocide.”\textsuperscript{78} We are also prone to ‘cuteness effects.’ Batson et al. (2005) showed that

\textsuperscript{78} Prinz (2011a), 224.
undergraduate studies felt more empathic concern for cute creatures in distress (puppies, babies) than for a peer in a similarly distressed situation. Prinz leans heavily on this concern, concluding that we are “grotesquely partial to the near and dear.” We also tend to feel more empathy for those who are like ourselves, and less for those who are unlike us. Xu et al. (2009) showed that Caucasians showed less empathy for the pain of Chinese participants (than fellow Caucasians), and vice versa. These results have been replicated for other racial groups.

The narrowness of empathy is often noticed when international tragedies occur. Consider that while there was great concern for the victims of Hurricane Katrina, the earthquake in Java one year later (with a larger death toll) produced far less news coverage or concern. Prinz argues that the “best explanation is that empathy increases for those who are nearby, culturally and geographically.” Further, since wars and natural disasters are more newsworthy events, they occupy more attention than diffuse problems like persistent disease or famine. Since some tragedies are less salient than others, “they induce little empathy.”

One might reply that the concerns just noted are not sufficient to indict empathy. Perhaps they suggest that we simply need more empathy in certain situations. However, Prinz presses the

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79 The ‘cuteness effect’ works to produce more sympathy for cute targets, but subjects still showed empathic concern for their peer (in distress). Further, there are reasons to think that the emotion that is responsive to ‘cute-making’ features in the world is likely something distinct from sympathy. For the distinction between tenderness and sympathy, see David Lishner et al., “Tenderness and Sympathy: Distinct Empathic Emotions Elicited by Different Forms of Need,” *Personality & Social Psychology Bulletin* 37 (5) (2011): 614–25.

80 Prinz (2011a), 224.


83 Ibid.

84 Ibid.
argument, claiming that the ‘dark side’ of empathy may be “intrinsic to it,” that empathy is “not a suitable tool for morality,” and that “we can no more overcome its limits than we can ride a bicycle across the ocean.” A morality “based on empathy would lead to preferential treatment and grotesque crimes of omission.”

Prinz rejects the suggestion that we might utilize more specific instances of empathetic engagement to reflectively generalize to a more general moral perspective:

> As attractive as this idea is to a liberal readership, it is bad psychology. The fact is, we rarely adopt such a point of view, and empathy is probably the greatest impediment...[T]here is no way to cultivate empathy for every person in need, and the focus on affected individuals distracts us from systemic problems that can be addressed only by interventions at an entirely different scale. Empathy is ineluctably local, and the great efforts that are made to cast its net wider have some positive impact but too often land in the wrong place...With empathy, we ignore the forest fire, while watering a smoldering tree.

While “[t]he general point of view is not a bad idea” Prinz concludes that “its greatest hope may lie in the extirpation of empathy.” This is particularly true when making policy, where we would “be better off ignoring empathy.”

Finally, even though cognitive and affective empathy do seem to be motivate some pro-social behavior, Prinz argues that this connection is not particularly strong compared to other potential motivators. Call this the Motivational Objection. Instead, Prinz argues that it is preferable to cultivate more powerful negative emotions like anger directed at the wrong-making action types of the aggressor. While affective states like anger, pleasure, or guilt are subject to bias, they are motivationally stronger, and are not hampered by being bound to individuals.

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85 Prinz (2011a), 229.
86 Prinz (2011b), 227.
87 Prinz (2011a), 228. Prinz’s concluding claim here is stronger. He notes: “The general point of view is not a bad idea, but its greatest hope may lie in the extirpation of empathy” (2011a, 228).
88 Ibid.
90 Prinz (2011b), 219-220.
91 “The biases that burden our other moral emotions may be easier to circumvent. Anger at injustice, pleasure in charity, and guilt about environmental devastation can carry us across seas because their proper objects are action-
Most recently, Prinz has argued that a sense of justice, driven by righteous anger (even rage), is a better motivator for correcting injustice since righteous rage is “highly motivating, difficult to manipulate, applicable wherever injustice is found, and easier to insulate against bias.”

Another skeptic, Paul Bloom, argues that empathy involves “experiencing the world as others do, or at least as you think they do. To empathize with someone is to put yourself in her shoes, to feel her pain.” While Bloom’s account of empathy is also affective in nature, it necessarily involves imaginative perspective-taking. Bloom shares most of Prinz’s concerns, arguing that empathy is “parochial, narrow-minded, and innumerate” and that we are “often at our best when we’re smart enough not to rely on it.” While he does not deny the value of a detached compassion, kindness, or love, he argues that “if you want to be good and do good, empathy is a poor guide” since it “leads us astray.”

Bloom specifically focuses on the deleterious effects of an empathetic morality on social policy:

[O]ur public decisions will be fairer and more moral once we put empathy aside. Our policies are improved when we appreciate that a hundred deaths are worse than one, even if we know the name of the one, and when we acknowledge that the life of someone in a faraway country is worth as much as the life a neighbor, even if our emotions pull us in a different direction. Without empathy, we are better able to grasp the importance of vaccinating children and responding to climate change. These acts impose costs on real people in the here and now for the sake of abstract future benefits, so tackling them may require overriding empathetic responses that favor the comfort and well being of individuals today. We can rethink humanitarian aid and the criminal justice system, choosing to draw on a reasoned, even counter-empathetic, analysis of moral obligation and likely consequences.”

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92 Prinz (2014).
93 Bloom (2014).
95 Bloom (2014).
97 Bloom (2014).
Like Prinz, Bloom is also concerned about the weaker motivational effects of emotions like empathic concern, though he is somewhat skeptical that more anger is the best solution to promoting wider social good. Instead, he argues that being “a [morally] good person likely is more related to distanced feelings of compassion and kindness, along with intelligence, self-control, and a sense of justice.”

Answering the Case against Empathy

First, it is important to be clear about Prinz and Bloom’s targets. Both focus their discussions on an account of affective empathy which often involves a broad affective match. While Prinz allows that imaginative mechanisms and perspective-taking might be involved in empathy, Bloom requires this as a condition of empathy. Second, we should clarify the relevant moral concerns at stake. Prinz’s concern seems to be that a moral stance or perspective *based on* empathy is a moral liability, while Bloom discusses the problems of reliance on empathy as a *moral guide*. One understanding of both of these claims is that empathy would (or should) function as our *sole* moral guide or as a sufficient means to appropriate moral actions, drawing our attention to and motivating us to perform morally appropriate actions.

Perhaps some proponents of empathy in the moral life hold such views, though it is difficult to find defenses of such positions. If this is the case, I think such a position is implausible, and I am inclined to agree with the critics that empathy is not sufficient for appropriate moral thinking and motivation. In my view, the evidence presented in the previous

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98 Bloom (2014).
99 For Bloom, we might feel what we think the target feels. For Prinz, we may feel an emotion we take the target to feel.
100 Michael Slote seems to endorse the limited normative nature of empathy, but it is unclear that he holds that empathy is a sufficient guide for appropriate moral thinking and action. See Michael Slote, *The Ethics of Care and Empathy* (Routledge, 2007).
arguments is sufficient to establish that reliance on empathy can sometimes lead us morally astray (EP).

Given a number of the comments previously outlined, both Prinz and Bloom seem to mean that regular reliance upon empathy in our moral thinking (or as part of our standard motivational set) produces worse results than moral thinking and motivation without such a guide or basis. For Prinz, it would be better to rely on a sentimentalist approach which privileges other emotional states (particularly anger), joined with our cognitive understanding of justice. For Bloom, it would be better to be guided by a rational sense of justice, and perhaps a detached form of kindness or compassion. In the following section, I will argue the evidence presented for EP does not clearly support EE. I will argue that empathy serves a central role as an epistemic guide and springboard to moral reflection and motivation, and that such approach produces better moral results than available alternatives.

*Extending Empathy: Integrated Empathy*

Both Prinz and Bloom argue that empathy and empathic emotions have certain limitations. However, they both also argue that empathy is (by its nature) subject to these limitations, which in part explains why it so often leads us morally astray. However, EP is contingent, based on the particular account of empathy employed. For example, I will argue that a number of partialities that appear to be intrinsic to affective empathy can be overcome when affective empathy is framed by (or combined with) more engaged forms of perspective-taking.\(^{101}\)

Let us call this an *integrated account* of empathy.

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\(^{101}\) Here I am employing my previous account of affective empathy involving a wider affective match, alongside a developed form of other-oriented perspective-taking.
Consider one example to illustrate this point. Prinz notes that sharing the distress of a target can motivate us to leave a situation where someone needs help to alleviate our own distress. In this way, affectively empathizing with a target often leads us morally astray. However, it should also be noted that this form of personal distress can be substantially mitigated by taking the perspective of the target. For example, in one study, subjects were given a vignette about Katie, a college student whose parents had recently been killed in a car accident. She was left to care for her brother, and desperately worked to complete college, with the goal of making enough money to keep him from being adopted. Test subjects were instructed to adopt one of three perspectives: objective (consider the case objectively and in a detached manner), self-oriented perspective-taking (imagine how you would feel in such a situation), and other-oriented perspective-taking (imagine how they feel in that situation).

By re-framing Katie’s distress and imagining what she was experiencing (other-oriented perspective-taking) rather than what they would experience in that situation, test subjects reported substantially less personal distress, closer to the amount experienced by those in the objective/detached condition.\(^{102}\) Further, subjects reported feeling greater empathic concern, itself motivationally related to helping behavior. This suggests that an integrated account of empathy (which utilizes perspective-taking), helps mitigate the concern that vicarious distress motivates us to avoid helping others.

While one might argue that this form of engagement requires a special or unusual effort or attention, this kind of cognitive re-framing (i.e. focusing more on the perspective of the target) is an ordinary feature of engaging with other individuals, and the accounts of their lives. This is

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not to deny that in some cases, such re-framing is more demanding. This is particularly true when faced with higher levels of more immediate suffering or distress, like in a traumatic or highly distressing clinical situation. In such cases, succumbing to personal distress is more difficult to avoid. Even so, in such situations, actively engaging in perspective-taking is one tool employed by clinical staff to help regulate their personal distress.\textsuperscript{103}

\textit{Empathy as Guide to Moral Understanding}

In the next several sections, I will argue that the integrated account of empathy has the resources to respond to the objections posed by critics. First, I will argue that integrated empathy functions as a unique guide to moral understanding. It is a direct, experiential means of understanding the concerns and problems of other individuals, and reveals important patterns of value in the lives of the others that are typically unavailable otherwise. Additionally, while integrated empathy typically remains dyadic (targeting individuals), it still serves a vital role as an initial epistemic and motivational ‘springboard’ for moral thinking. Critics err when they argue that moral thinking and motivation would be improved by eliminating or ignoring the deliverances of empathy in the moral life.

Consider first the central epistemic role of more developed, imaginative perspective-taking. When I engage in perspective-taking with another individual, this often has the effect of making features of their situation salient to me in a manner that was otherwise not apparent. I may come to realize fundamental patterns of information that I had previously overlooked. For example, upon taking the perspective of someone who has recently been stricken with a

debilitating disease, I come to see how difficult even ordinary tasks would be to perform. Without such a shift, we ordinarily fail to fully attend to these details. I also see that without the ability to perform the standard tasks of employment (and the associated health benefits that come with work), illness can rapidly affect the financial stability of an otherwise well-off individual. These concerns become more salient and inform expectations about a wider patterns of beliefs, emotional states, and desires. Such perspective-taking presents a salient representation of an alternate picture of the world, and much more readily engages our sentiments.

This pattern of information which is integrated in a particular perspective might (theoretically) be accessible to me in other ways. Perhaps I could learn about these concerns by interviewing the target, or if I knew the individual well, could infer some of them with careful reasoning. However, shifting our focus to the perspective of the other provides a unique epistemic stance from which to perceive the unity or coherence of this pattern of information. Coming to identify with or understanding your perspective (even if only in degree) involves an engagement with you as an individual and the objects of your attention. For the perspective-taker, it involves a partial inhibition or suspension of their own present concerns in favor of that of the other.

Further, I think critics overestimate the strictly individually-directed nature of perspective-taking. In many cases, our simulations (even of single individuals) serve to draw us into the simulation of a wider context or situation in which an individual is embedded. To take the perspective of an individual fleeing a civil war, I also need to broadly simulate background conditions of war. In this way, we are also empathetically engaging with an environmental
context, and in many cases, this provides us with a rich alternative stream of information to consider.\textsuperscript{104}

Given the salience of the information presented in perspective-taking, we often come to feel a measure of the emotional states of the target. In some cases, these are experiences we had not considered, or they highlight features of the world (from a particular perspective) with which we were not previously aware.\textsuperscript{105} To adopt the perspective of a target and come to share a measure of their grief or distress involves a practical (though not necessarily theoretical) recognition of the facts which ground their loss. These responses are often simply unavailable without attending to their circumstances. Our empathetically shared aversion to harm, anger at injustice, grief at loss and gratitude toward perceived benefits experientially reveal a shared source of value, grounded in the relevant state of affairs. This practical, affective recognition of these shared sources of value provides a plausible explanation for why perspective-taking often produces shifting attitudes towards others and their situated state. When I begin to affectively empathize with you, I come (in a limited manner) to see features of your situation as they would likely matter to you.

While affective states can be elicited in numerous ways, emotions typically track features of the world. For example, imagine Dan’s beloved dog has recently passed away. Also, imagine Xena has never really thought much about Dan’s dog (she’s not much of a dog person). When Dan first informs Xena that his dog has passed, it doesn’t really phase her. She is not a cruel or

\textsuperscript{104}I appreciate Peter Railton’s comments on these issues.

\textsuperscript{105}This also explains why accurate perspective-taking weakens stereotypes about the target class. When I rely on a stereotype to explain or predict some behavior of a target class, I am applying a simplified schema of that class to a particular case. For example, a racist might rely on the stereotype that a minority group is violent, ignorant, and callous, inferring that a given individual member of that group (that they see on the bus) is violent, callous, etc. However, perspective-taking with an individual often reveals shared responses (and similarities) with the target. This individualized information and perspective make it more challenging to maintain a more abstracted and generalized stereotype about the individual.
unfeeling person and she likes Dan, but the loss of his dog does not really concern her much. However, Dan briefly recounts how he is going to miss those evenings where he came home alone after a hard day at work and was warmly greeted by Mr. Ruffles. Upon considering this from Dan’s perspective, Xena feels a real pang of sadness on his behalf. She was aware Dan had lost his dog, and that presumably the loss meant something to him. But, now she appears to see something more clearly by feeling a degree of that loss from his perspective.106

Taken together, an integrated account of empathy, involving perspective-taking and broad affective responsiveness functions as a unique and powerful guide to the moral understanding of other individuals. By empathizing with others, we can reveal shared sources of value, and access distinct patterns of concerns that may have been previously obscured. In some cases, these responses maybe reveal facts that are in tension with our beliefs and behavior, forcing us into inconsistency or further reflection. This also supports the idea that empathetic engagement (via an integrated account of empathy) involves more than just the illicit manipulation of sentiments. Instead, empathetic engagement draws us to a rich contextual source of information about the lives of others.

*Pre-Existing Value Objection*

One concern about this argument is that engaging in perspective-taking with a target may presume that the subject of empathy already values the state of the target, or that such a form of engagement presumes access to the requisite information that I have suggested it delivers.107 In

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106 One powerful feature of affections is that they may track (and reveal to us) sources of value that we do not initially explicitly realize. The eliciting stimuli for many emotional experiences often occur outside of our immediate rational and cognitive deliberation about our circumstances (or the features of the situation that might elicit the emotion). In some cases, we receive cues and information via the experience of affection that we are then able to consider in deliberation.

107 For a version of the initial claim, see de Vignemont & Jacob (2012), who argue that care is required for affective empathy.
order to address this concern, we should distinguish between taking an interest in \( x \), or noticing a feature of \( x \) in an environment, and taking \( x \) to matter in some more central sense. To take a basic interest in \( x \), or to notice \( x \), involves a very low sense of commitment. I might notice a leaf flutter by and take enough interest to watch it without placing any significant value on the leaf itself or concern about where it is going. It simply engages my attention as I perceive it. We can engage with other individuals with this same low level of interest. Neil might (with the barest level of curiosity) stare at another man in an airport lounge without any further commitments of concern for the stranger. We might say that he cares enough to stare, without really caring for (or being concerned for) the object of his attention. Or, Terri might view a deli baker as just a means to getting a bagel. She is interested in this individual only insofar as they stand to promote her bagel-related interests.

I mention this lower-level sense of interest, since it will often be required to engage with much of anything in the world, including other people. We can distinguish this low-level of interest from higher-levels of concern. I might greatly care that your health improves, or that you are able to work through your recent psychological problems. I might place great value on your achievements, and great disvalue on your losses. In such cases, I will be motivated to help you to avoid negative circumstances and pursue positive ones. I will likely share excitement in your success and sadness at your losses.

We need not hold that a particular target of our attention is valuable in any important sense (or that their state or situation necessarily matters) before we engage in empathy with them. In fact, we might place nearly no value on the target and their state of affairs (perhaps we merely find them a curiosity, like a lone fluttering leaf). Worse, we might initially engage with them in a contemptuous, disdainful manner. Perhaps Terri has made a cruel comment to Landon,
and is beginning to imagine how he would feel, hoping he is appropriately wounded.\textsuperscript{108} Even in such circumstances, imagination and perspective-taking can still function in an indirect manner, drawing in the subject with available information about the target and their situation. To see this, consider Pete, a moderately racist U.S. citizen living in the late 19\textsuperscript{th} century. He decides to purchase a copy of \textit{Uncle Tom’s Cabin} to ‘see what all the damn fuss is about.’ One powerful feature of written narratives is that they reveal introspective thoughts and emotions in a way that is less accessible than our interactions in ordinary life, making it much easier to come to share the perspective of a given character.\textsuperscript{109} Imagine Pete reading about Tom’s life and beginning (via cognitive empathy) to share in his hardships, perhaps even in spite of his ordinary resistance to paying people like Tom concern. Perhaps the prejudicial stereotypes typically block this sort of imaginative engagement or provide quick explanations that make further consideration of people like Tom unnecessary or undesirable.

In fact, continuing to read about Tom (and beginning to share or imagine sharing his responses) might even be rather agitating for Pete. One solution to this tension would be to shut the book and divert his attention. However, the force and intrigue of a narrative (and natural curiosity) may well motivate Pete to continue reading. In a case like this, Pete might work his way into empathizing with the character of Tom, even though he is initially resistant to caring (in any moral sense) for people like Tom. In this way, cognitive empathy need not be motivated by initially valuing the target, though it often can motivate further concern for other individuals.

\textsuperscript{108} On the account of empathy that I have outlined, a sadist may be able to cognitively empathize (and even identify with the pain of their victim in an intellectual sense), but they will likely fail to affectively empathize with their victim. This is because the sadist’s affective states are inverse to those of their victim. If I am sympathetic to your suffering, I will experience a negative affective state when you are in a negative situation. If I am a sadist (or ‘antipathetic’), I experience a positive state (perhaps pleasure) when you are in a negative state (like physical or mental pain).

\textsuperscript{109} One potential result here is that for those interested in developing empathy, the novel (with its attendant, introspective details) will likely provide a better tool for such a purpose than the narratives found in film.
Empathy and the Merging Hypothesis

I have argued that an integrated empathy serves a central role in improving our understanding of (and responses to) other individuals. As a result of such improved understanding, we would expect to see better treatment of individuals unlike ourselves, and less reliance on stereotypes when we consider their situation. However, there are other explanations for why perspective-taking is thought to contribute to improved attitudes and treatment of the wider group. Dovidio et al. (2004) summarize a number of existing explanations in the literature:

(a) generalizing positive feelings toward a specific group member to the larger group, (b) enhancing interest in the welfare of others, (c) arousing feelings and perceptions of injustice concerning the treatment of members of particular groups, (d) altering cognitive representations of target group members, and (e) inhibiting stereotyping.¹¹⁰

While it has been demonstrated that perspective-taking produces cases where (a)-(e) obtain, it is not clear why perspective-taking produces any one of these states. This is because most of these explanations involve additional states (connected to perspective-taking) that require a further explanation for their relation to perspective-taking. For example, why does perspective-taking contribute to positive feelings for the target and to greater interest in the welfare of the target, or arouse feelings of injustice?

One frequently cited hypothesis for a more fundamental mechanism involves “merging the self with the other person” that occurs when we take their perspective.¹¹¹ For example, Galinsky et al. (2005) argue that when “we take the perspective of others we come to include their traits, even stereotypic ones, as being part of the self.”¹¹² Seeing ‘the self in other’ refers to

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“perceiving the other as possessing characteristics of the self” while seeing ‘the other in self’ involves the converse relation. For example, when test subjects were given a picture of an attractive cheerleader and were asked to write a narrative ‘day in the life’ from her perspective, they were later more likely to rate themselves as more attractive than the control group. Or, in cases where subjects were asked to take the perspective of a professor, they were more likely to rate themselves as intelligent. In addition (and in accordance with common stereotypes), those who adopted the perspective of the cheerleader performed more poorly on a later cognitive task, while those who took the perspective of a professor performed better (both compared to controls).

These claims suggest that it is not necessarily an improved understanding of the other that produces a favorable shift in attitude (or greater interest in their situation), but a form of projecting ourselves into the situation of the other, and then perceiving our own traits as theirs, or importing their known traits into our conception of ourselves. So, what might appear to be a paradigmatically other-oriented engagement in the lives of others more properly involves a psychological extension of the ego. This has led some researchers to conclude that much of the purportedly ‘altruistic’ behavior produced by perspective-taking is ultimately egocentrically motivated.

Perhaps engaging in cognitive empathy with a target involves the subject implicitly merging their conception of themselves with the other, with the result that they ‘read off’ attributes from one to the other. However, it seems somewhat implausible to think that in

114 Ibid.
ordinary instances of perspective-taking, we mistake our self-conception with that of others.\textsuperscript{116} If I am asked to take the perspective of an attractive cheerleader, I do not infer that (in fact) her traits are part of myself, or that she is an extension of myself. Instead, it seems more likely that by imaginatively adopting the perspective of an individual who is explicitly described as attractive, I am more likely to notice those features in myself.\textsuperscript{117}

\textit{The Wrong Response Objection}

Both Prinz and Bloom argue that empathy has a distorting effect on our judgments about what is just. Prinz argues that a sense of justice (utilizing anger) produces a better pattern of moral thinking and motivation, while Bloom argues that the latter is better achieved by appealing to justice, combined with a detached kindness or compassion. What both critics overlook is that utilizing empathy in moral thinking and motivation is not inconsistent with rational reflection or with appeals to normative constraints like justice.

Consider the previously cited study, where participants who were primed to feel empathic concern for Sheri were more likely to move her higher in the list for an experimental drug treatment which would improve her quality of life, but not lengthen it, violating a basic standard of justice. Such a result is troubling, but it is also plausibly evidence of faulty moral reflection and behavior on the part of the test participants that acted in this manner.\textsuperscript{118} It is important that


\textsuperscript{117} In the cheerleader case, “participants rated themselves on how well the traits attractive, gorgeous, and sexy described them. These were the only traits presented to participants” (Galinsky et al., 406).

\textsuperscript{118} In this study, participants are given a short narrative about Sheri (a young girl with a terminal disease) and some are primed to imagine how she feels about her sickness. They are then informed that an experimental drug is available, but it is available in limited quantities (and allocated based on need). Finally, they are given a form that allows them to move Sheri up the list (into a higher group), and are asked to agree with the following statement: “I understand that this will mean that children currently higher on the Waiting List than this child will have to wait longer to receive help” (C.D. Batson et al., “Immorality from Empathy-Induced Altruism: When Compassion and Justice Conflict,” \textit{Journal of Personality and Social Psychology} 68 (6) (1995): 1049). One issue here is that the language on the final form might suggest (to some) that while the other children that are displaced in the list will
we feel for the plight of the terminal child, but the fact that many other children share a similar state give us good reason to design and maintain a waiting list. In this case, test participants have failed to extend their empathetic engagement with Sheri in a rationally justifiable manner to the other claimants in this case. In more mature moral thinking, empathy keeps us attuned to various sources of need, but operates alongside reflective thought and deliberation.

We see similar limitations in the sole reliance on other emotional responses, like anger. While anger is certainly a potent emotional response, it is (like any emotional response) also subject to bias and liable to distort our patterns of thought. Anger has the effect of narrowing our focus, and can readily lead us to make rash and ill-proportioned decisions. For example, when people are angry, they are more likely to punish others indiscriminately,119 often seeking to satisfy a retributive urge even when such responses are ill-directed. Individuals under the influence of anger are also more likely to act quickly,120 and are more prone to making cognitive errors.121 Even a detached form of compassion or kindness is prone to producing the wrong responses when considered alone and without more careful reflection.

However, none of these facts about the limitations of certain emotional capacities or responses demonstrate that moral thinking that utilizes empathy produces less desirable results than alternatives. What matters is whether we can utilize and regulate particular emotional

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capacities (alongside reflection and normative considerations) to produce the best outcomes (morally speaking) given our psychological constitution.

*The Motivational Objection*

Both Prinz and Bloom argue that empathy and empathic emotions (like empathic concern) lack motivational force, and we would be better served (morally speaking) by cultivating alternate patterns of moral motivation. Prinz argues that we are better served by cultivating emotions like anger directed at action-types, like unjust actions. Such a response would be more motivationally potent than affective empathy, and since it targets action-types instead of individuals, it would not be prone to the criticism of being overly narrow and provincial. However, for this alternative to be plausible, we need to have good reason to think that we can shift the target of our anger (which is also typically directed at individuals), to more abstract action-types.

First, such a shift seems somewhat unlikely. While certain rule violations often elicit anger, our anger is not directed at violations of rules or particular action-types (breaking rule X), but at individuals who violate rules. When I am angry that Chuck stole a car from Mike, my anger is directed at Chuck given that he stole Mike’s property. I am not angry at his actions, I am angry at him. Further, it is rather hard to imagine how we could shift such responses to general types of wrong-making actions. The object of my anger is not a particular action-type, but that *Chuck* did something that (in this case) harmed Mike. This is true even when the perpetrator is anonymous. If emotional responses that target specific individuals are problematic for motivational reasons, they pose the same issues for Prinz’s account as those defending empathy in moral motivation.
Second, even if we grant a role for anger in our best account of moral motivation (given our psychological constitution), Prinz may overlook the scope of our capacities for affective empathy when we experience certain forms of anger. While the most widely discussed empathic emotions are empathic concern, empathic anger is also an important feature of our moral lives. Consider a variant of an earlier case:

**Empathic Anger and Concern:** Tina is raped by an aggressor. She feels deep shame and also misguided guilt for being out too late, and for dressing too proactively. Sam learns of Tina’s rape (and how she is now punishing herself) and this causes him to feel a deep anger on behalf of Tina, directed at her aggressor, as well as empathic concern (sympathy) for her, in her situation. Sam’s anger fuels his search for justice, even though Tina has internalized guilt about her state.

In *Empathic Anger and Concern*, Sam’s response upon considering Tina’s perspective is to experience two empathic emotions. He feels empathic concern for her in her difficult circumstances. He might offer his careful consolations, or offer to help Tina as she works through this difficult situation. Additionally, he feels a righteous empathic anger on Tina’s behalf, which drives his search for justice. He may even carefully encourage her to share his anger (which is fitting, but which she is unable to feel).

In our ordinary moral lives, this pair of empathic emotions is commonly involved when we learn about various forms of tragedy, abuse, and injustice. Perspective-taking and affective empathy sensitize us to the plight of victims of wrongdoing and tragedy, frequently giving rise to empathic concern, in the form of sympathy for the victims (itself evidence that we care for their state). While empathic concern alone is certainly not as motivationally potent as anger, is it closely associated with pro-social motivation and helping behavior. This combined with the

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123 See Batson (2011) for an in-depth review.
force of empathic anger which we also feel in tandem with more tender emotions provides a powerful set of moral motivators for defenders of an empathetic morality. It is also not an emotional response directed at a general feature of the world, but is grounded in the situation of individuals and felt on behalf of them.

I do not dispute Bloom’s claim that a rational sense of justice, and even a detached sense of compassion, are important virtues in the moral life. However, such virtues are not inconsistent with utilizing cognitive and affective empathy as moral guides, and such an approach may overlook the central causal role that empathy plays in understanding and responding to instances of injustice and need.

First, consider some indirect evidence about the relationship between empathy and interest in justice. Recent research suggests that having an empathetic perspective may incline us to take justice (and matters of injustice) more seriously as a general matter. Decety & Yoder (2016) found that dispositional measures of perspective-taking and empathic concern predicted an individual’s sensitivity to justice. Individuals who have high justice sensitivity are more likely to act in ways that avoid injustice, and work toward correcting or restore justice. This study only suggests an indirect relationship between empathy and justice, but it supports the intuitive idea that more empathetic individuals are more motivated to act justly, and to work to correct injustice. Given the importance that Prinz and Bloom place on matters of justice, such results might give us further reason not to abandon (or set aside) our empathetic engagement with the world, even in matters of moral thinking or motivation. Even granting the partiality of empathy

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in some cases, cultivating such an approach in moral thinking might better promote the desired ends than the available alternatives.

The Provincial Objection

One of the central criticisms of empathy as a moral guide is that it is partial and provincial, and according to critics, hopelessly and inherently so. I will argue that while affective empathy is reported to be felt more strongly for kin and those with greater similarities, such responses can be modulated in deliberation. This fact would also support the claim that it is a mistake to indict affective empathy per se as inherently parochial or provincial since these results may depend on the account of empathy being utilized. For example, an account of affective empathy that is more deliberately framed by perspective-taking can be an important tool in overcoming bias and prejudice. In one study by Stephen and Finlay (1999), test subjects were asked to read a narrative account of discrimination faced by an individual from a racial out-group while imagining what the target was experiencing. Subjects reported experiencing increased shared reactive emotions toward the in-group (i.e. test subjects experienced more emotions like anger on behalf of the victim) and reported improved attitudes toward the out-group members. Here, it appears that engaging in perspective-taking resulted in similar affective responses on behalf of the victims, and inclined the study participants to improve their attitudes toward the target class. In a related study, Batson et al. (2002) showed that reduction in prejudice (after empathy inductions) also increased the likelihood that test subjects would actually help a

127 While perspective-taking is important, the shift in attitudes and subsequent affective responses is central for the subsequent moral thinking and behavior of the relevant parties.
stigmatized individual. Further, even brief instances of induced empathy can produce reductions in racial prejudice that persist for months.128

Additionally, rather than merely reinforcing in-group biases as Prinz and Bloom suggest, an integrated empathy can serve an important role in conflict resolution to promote inter-group understanding.129 Bruneau & Saxe (2012) found evidence to support the claim that personal interactions involving mutual perspective-taking between members of groups in current social conflict produced a positive change in attitudes toward members of the opposing group.130 This suggests that an integrated form of empathy might serve as an initial and important engine for reconciliation. Paluck (2009) conducted a yearlong field study in Rwanda, based on a radio drama that involved positive character interactions between Hutus and Tutsis. Interviews found that listeners experienced greater empathic concern for living survivors, prisoners, and political leaders as a result of the drama.131

We find similar results produced by Malhotra & Liyanage (2005), who studied opposing groups in Sri Lanka who had participated in a peace workshop involving discussion and role-playing. Even a year after the interactions, the workshop groups showed greater understanding of (and empathic concern for) members of the opposing group, including an increased willingness to donate money to vulnerable members of the out-group (compared to two control groups).

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130 While perspective-taking helps shift our attention to the circumstances of the other, affective empathy is motivationally effective when it reliably engages our relevant affective responses.
131 There were also a number of positive changes in their attitudes toward prejudicial social norms (though the actual beliefs of the participants remained largely unaltered).
Similar methods and techniques employed in a number of these studies have also been adapted in schools and programs designed to increase emotional intelligence and reduce aggression in school children.\textsuperscript{132}

Perhaps by empathetically engaging with particular individuals, we can reflectively generalize to a wider group, broadening our moral perspective or motivating appropriate moral action. Several philosophers have suggested this form of ‘springboard’ for moral thinking. For example, Nancy Sherman (1998) concludes a discussion on humanitarian aid and giving, noting that “we would not mobilize that respect for persons if we did not transport ourselves to others and their circumstances through empathy.”\textsuperscript{133} Similarly, Peter Railton (2010) suggests that “empathy and the pressure of consistency have led to widespread recognition that our fellow animals should receive humane treatment.”\textsuperscript{134}

Prinz rejects the suggestion that we might cultivate particular instances of empathetic engagement to generalize to a wider or general moral perspective. Instead, he argues that the local nature of empathy might be one of the largest impediments to this process. I think that this response is overly pessimistic, especially when we consider the advantages of an integrated account of empathy, which arguably has helped us attain a more general moral perspective. To briefly illustrate this possibility, briefly consider the development of abolitionism, which emerged in 18\textsuperscript{th} century England.


Abolitionists found that personal narratives and visual aids were the most effective means of communicating the harsh realities of slavery to popular audiences who had never seen or experienced this practice. In many cases, such audiences had never met (or seen) a slave in person. To engage the public against the practice of slavery, the founding member of the largest abolitionist group\(^{135}\) (Thomas Clarkson) travelled throughout the country collecting thousands of eyewitness testimonies (and physical artifacts of the slave trade) from slaves, sailors, and merchants. In the following years, abolitionists utilized “relentless propaganda based on graphic evidence of suffering,” which finally culminated in a national sugar boycott in England, the largest ever for any single cause.\(^{136}\) Within two decades of the initial formation of his society, Clarkson helped found 1200 different chapters across England\(^{137}\) and helped eventually usher in the legal prohibition of slavery.

While abolitionists appealed to a variety of arguments against slavery, the “[g]raphic portrayals of slaves’ subjective experience[s] of physical pain emerged as common antislavery fare.”\(^{138}\) Many slave narratives were harrowing, involving individuals being beaten and tortured to death,\(^{139}\) raped,\(^{140}\) or subjected to extremely cruel work practices.\(^{141}\) In addition, the disregard for and subsequent separation of enslaved families was often utilized in abolitionist speeches and

\(^{135}\) Society for Effecting the Abolition of the Slave Trade.


\(^{137}\) The Abolition Project, http://abolition.e2bn.org/box_58.html

\(^{138}\) Elizabeth Clark quoted in Sajó (2011, 171).

\(^{139}\) James Curry recounts his mistress beating a nine-year old girl (with a willow bunch) from before sunrise to ten in the morning (Blassingame, 1977, 131). John Homrn recounts a fellow worker who became ill and (as a result) was beaten so badly for several days that he committed suicide. The owner’s explanation for the event was laziness (Blassingame, 1977, 257). See John Blassingame, Slave Testimony: Two Centuries of Letters, Speeches, Interviews, and Autobiographies (Louisiana: LSU Press, 1977).

\(^{140}\) Madison Jefferson recounts how women were frequently raped by their masters, and were required to continue working until they gave birth (often in the fields (Blassingame, 1977, 221).

\(^{141}\) Some field masters arranged their slaves by work efficiency and those who worked more slowly were under constant threat of severe beating (Blassingame, 1977, 134).
tracts. Such first-personal accounts were a vital element of the abolitionist strategy to shift public thinking on the topic. As the abolitionist Elizabeth Margaret Chandler notes:

> It is clear that the purpose of at least some of these articles was to force the reader to put himself imaginatively in the place of the slave. This would be the first step toward his learning that the Black man felt the degradation of slavery as he himself would.  

In the abolition case, we see an integrated form of empathy functioning to mobilize the public against slavery. Engaging in perspective-taking with the narrative accounts of individuals caught up in the slave trade gave audiences a direct first-personal perspective on the experiences of the slaves, expanding their understanding of the human reality of the situation. This expansion of the empathetic understanding of viewers more directly and saliently prompted the empathetic responsiveness of the public (particularly empathic concern and empathic anger), providing the motivation which led to the eventual abolition of the institution of slavery in England.

One might argue here that while empathetic engagement appears to be driving this moral ‘springboard,’ it is primarily the information about the circumstances of certain individuals (i.e. of need, poor conditions, injustice) that drives our affective responses and motivates social change. In one respect, this concern is merited. Empathy is a capacity that requires requisite conditions and information to function. Without some basic information about the world (or a particular individual), one cannot hope to cognitively or affectively empathize with them. Further, cognitive empathy is not clearly required to understand many events and actions in the world, and affective empathy is not always required to respond to particular circumstances with a wide range of emotions.

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142 “The continual dread of this separation of husband and wife, parents and children, by sale...is one of the greatest miseries hanging over the head of the slave. His life is spent in fear of it” (Blassingame, 1977, 346).
143 Sajó (2011), 172.
144 Ibid., 66.
Having said this, information that is assimilated via perspective-taking (and imaginatively reconstructed) has a direct salience that third-personal accounts lack. Without engaging the public with an integrated empathy, it is likely that they would have readily failed to experience the directness and intimacy of the experiences of those who were subject to such practices, and the powerful resultant empathic concern. Even in the absence of explicit instructions to take the perspective of others, it is often difficult to avoid shifting into a form of imaginative perspective-taking when presented with a narrative account of another individual, particularly first-personal accounts. So, while information is required for empathy, the unifying features of empathetic engagement (and our shift in perspective) serve to present this information in a unique and salient manner that is not readily available otherwise.

However, even if we grant that empathy can help improve our understanding of individuals and perhaps expand our moral perspective in some situations, critics still argue that the dyadic nature of this capacity (and related emotions) reliably blinds us to many diffuse moral problems and tragedies. In response, I will argue that given our human ‘blindness’ to certain features of the world (involving abstraction, large numbers and complex future events), we are best served by first mobilizing our available psychological capacities, like affective empathy, to promote more engaged reflection with moral problems. While critics like Bloom argue that we are better served putting empathy aside when developing and enacting social policy, I will argue that alternative approaches risk leaving us unaffected and unmotivated in the face of certain more widespread moral problems.

Many of the moral and social problems that Prinz and Bloom identify involve large numbers of individuals (genocide), or have distant and diffuse effects (global warming or famine). Human beings have a notoriously difficult time grasping (and being concerned about)
statistical presentations of problems or likely distant effects, given the cluster of cognitive biases that operate when we attempt to think in these terms. For example, while the likely results of uncontrolled climate change are more threatening to our livelihood, terrorism is a higher national priority in the U.S. because instances of terrorism are more visible to the public (while climate change is diffuse and less visible). But, rather than thinking that we should ignore or leave behind empathy in the face of such problems, there are good reasons to think that most effective solutions to many such problems will directly employ our empathetic capacities and emotions to improve our understanding of distant issues, and will help direct and motivate us to action.

To see this, consider issues related to global poverty or humanitarian relief. Typically, in order for aid organizations and charities to mobilize donations and action, it is necessary for them to raise public awareness for specific problems (and needs) and receive donations in the form of time or money. Charities and aid organizations have found that the most effective means of raising awareness of a particular problem is to expose viewers (or listeners) to a particular need, typically the need of a particular group of individuals, combined with information about how to meet that need.

146 Humanitarian aid is just one example of a class of direct human needs. Consider that many unjust systems and processes have real and salient human victims. Consider: victims of faulty healthcare policies, children subject to mistreatment, citizens subject to unsafe environmental conditions. While the solutions to such problems are complex, the reasons to be concerned with solutions are seen clearly when attending to the plight of individuals caught up in the process.
The most widely discussed emotional response associated with charitable and humanitarian giving is empathic concern.\textsuperscript{148} Empathic concern for a target can be elicited in a number of ways, and increases when the target is perceived as similar, proximate, and identifiable.\textsuperscript{149} As Deborah Small notes, most “human-need charities feature images of victims in their appeals.”\textsuperscript{150} One reason that films and photographs are so effective is that they more readily engage our immediate empathetic capacities, and more readily engage our empathic concern.\textsuperscript{151} To encourage empathic concern for others, the most widely employed method in empirical research is to ask research participants to explicitly take the perspective of the target.\textsuperscript{152}

We see this approach employed in many effective charity campaigns for humanitarian intervention. For example, a recent \textit{Charity: Water} campaign ad follows the daily life of a family and their struggle to access safe drinking water.\textsuperscript{153} The characters are abstracted animations, but the narrative draws the viewer into imagining what it is like for the family trying to access water on a daily basis (what opportunities they give up to find water, the dangers associated with travelling to water sources, and the quality of the water itself).

While this presentation could be understood in a detached manner, it seems designed to engage the empathetic capacities of the viewer. For example, the ad begins by informing us that “when they’re thirsty, they can’t just turn on the faucet for a nice cold glass of water…” In the animation, the small girl runs to the faucet with a glass, only to see it disappear. This has the

\textsuperscript{150} Ibid., 156.
\textsuperscript{151} Ibid., 157.
\textsuperscript{152} Ibid., 152.
\textsuperscript{153} Charity: Water (2011) <http://www.youtube.com/watch?v=BCHhwxvQqxs>
effect of drawing the viewer into the situation of the girl, since we are being reminded in this sequence that we do have such access, and we think about what it means for those who do not.

In a widely influential ad for *Save the Children UK*, viewers are presented a sequence of one second segments (per day) in the life of a young girl living in London as the city falls into a devastating civil war. The short film begins with the girl celebrating her birthday (surrounded by family), and engaging in school activities or playfully relaxing (even trying to avoid a pinch from Grandma). As the film progresses, viewers see evidence of an emerging war and social upheaval in the background. After bombs begin falling, the family escapes to the country. In one upsetting segment, her father is trapped as they flee from violence. Eventually we find her being treated for wounds in what is likely a refugee camp, and the film closes with her grimly celebrating her birthday with her mother. The film ends with the following text: “Just because it isn’t happening here, doesn’t mean it’s not happening: Save Syria’s Children.”154

In order to understand this presentation, the viewer must rapidly reconstruct the narrative which is presented in brief intervals into a meaningful account. It is very difficult not to be drawn into the perspective of the young girl, and share some of her distress in certain circumstances. The nature of the content presented is designed to overwhelm the viewer with empathic concern when the film concludes with the second birthday scene. Being so forcefully presented with a familiar situation (for UK viewers) and reminded that others are in this situation seems like a direct and deliberate attempt to prompt greater empathetic understanding (and empathic concern).

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154 [https://www.youtube.com/watch?v=RBQ-IoHfimQ](https://www.youtube.com/watch?v=RBQ-IoHfimQ)
Further, this way of engaging with a specific instance of a problem in a personal case helps humanize a problem that can be difficult to understand for many people otherwise. The war in Syria is distant, and the immediate concerns of ordinary individuals caught up in the conflict are not easily accessible at a distance. By emphasizing the situation of one individual who is a representative of the vulnerable in the conflict, viewers are given a personal and salient presentation of a problem and then use this information to gain a clearer understanding of the distant problem. As I noted earlier, this engagement is not merely with an individual and their internal psychology, but also involves a broad simulation of their situation and embedded context.

Notice a possible concern for more detached approaches like Bloom’s here. Advocating a detached form of compassion seems to more readily avoid the criticisms previously outlined against relatively unregulated affective empathy, but it also risks failing to reliably motivate people in the presence of diffuse or distant concerns. The issue is that more directly attending to or engaging with the problem will more readily engage people’s empathetic capacities (subjecting them to objectionable biases and distortions). So, Bloom’s approach may require us to engage our empathic capacities to help engage, inform, or motivate us (by presenting an issue via an affectively and epistemically salient manner) without crediting this engagement as central in the process of our moral thinking.

One criticism of this line of argument is that focusing on specific, identifiable victims to engage the understanding and motivation distorts how we engage with widespread moral problems. Such distortion in our apparent value of the lives of others is often referred to as the

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155 Peter Singer still begins his general presentations on poverty relief with a case involving an individual. His current organization *The Life You Can Save* uses the example of the ‘drowning child’ to motivate the wider argument. See [http://www.youtube.com/watch?v=onsIdBanyY](http://www.youtube.com/watch?v=onsIdBanyY)
‘identifiable victim effect,’ where people are more likely to help “one identified individual than to help numerous unidentified or statistical victims” facing the same circumstances. In one study, the amount of donations that participants are willing to give decreases when a single further needy individual is presented (and drops further when eight are presented). Surely relying on (or cultivating) such an irrational approach to moral motivation should be discouraged in favor of a more detached approach to systemic moral issues like famine or global humanitarian crises.

I think there are a number of ways to respond to this line of criticism. To begin with, a particular need is affectively communicated to the public (or more generally, any kind of appeal for help) is distinct from how particular goods are distributed or allocated in response to that need. Presenting an identifiable victim could result in large donations directed solely to the victim, but nearly no organizations function in this manner, nor do potential donors expect this. In fact, there are some rather significant tools that may be used to mitigate these effects while still employing a powerful affective and imaginative means of engaging with others. In another study by Västfjäll, Slovic et al. (2014), participants treated a group of individuals the same as a single identifiable victim (were willing to donate as much) when the other individuals were presented as the victim’s family. This study replicated research by Smith, Faro, and Burson (2013) who found that participants increased donations to a group if individual victims were presented as part of a unified or singular group.

These findings suggest that we can engage in particular instances of empathetic engagement with various particular needs in ways that promote goods beyond the individual

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157 Ibid.
specified in the appeal. Even simply more carefully ordering an individual appeal for help can produce more positive results. Hsee et al. (2013) found that asking donors to indicate an initial donation for a single individual, then asking how much they would be willing to donate to the same group in need increased donations for the larger group. More recent research also suggests that empathic concern felt for an individual in a group reliably generalizes to other individuals in that group (and our willingness to help them). These kinds of results suggest that we can generalize from our engagement and concern for a smaller group of individuals to take action on issues that involve larger groups and social problems.

The fact that it seems to be possible to harness our responses to individuals to ‘springboard’ our attention and action to wider groups (or issues) is encouraging since, as Small notes such personal appeals generate “more aid than any other pitch.” So, while an alternate motivational set might always allocate help and resources according to need, it does not follow that we should extirpate empathy from our moral thinking and motivation. One concern is that such an alternate motivational set really might not be psychologically possible, and will plausibly lead to less engagement with widespread and distant moral problems.

Global moral concerns like the recurrent problems of distant genocide or the growing threat of climate change are complex issues, and it is likely that the most effective solutions will involve a complex set of features. However, in neither case is continuing to engage our empathetic capacities unimportant. In fact, it is often the abstracted, numerical, and distant

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features of these problems which help to ‘blind’ us from seeing the gravity of the problem clearly and taking action.

Consider the tragedy of genocide. Something that is troubling about recurrent instances of genocide is that it can be difficult to mobilize public support (and action) against such violations of human dignity. As Paul Slovic, a prominent researcher on the psychology of dehumanization has noted, the explanation cannot be that people simply do not care about the suffering of others, even those quite unlike themselves. Instead, Slovic (2007) argue that the statistics, or descriptions of genocide often “fail to convey the true meaning of such atrocities” and further fail to “spark emotion or feeling and thus fail to motivate action.”161 One concern here is that Bloom’s proposal of employing a detached form of compassion, alongside a firm sense of justice might be prone to such problems. A distanced approach risks failing to motivate individuals, but engaging too closely with the problem of human need, harm, or injustice risks engaging our faculties and sentiments in a manner that he argues often produces illicit patterns of motivation.

One reason that we often fail to see the significance of mass atrocity is related to our general sensitivity to environmental changes. Human beings seem to be adapted to detect smaller changes in their environment, but this quickly decreases as the “magnitude of the stimulus increases.”162 Slovic et al. argue that this feature of human cognition and perception functions in the same manner when considering the value of the lives of others, which they term *psychophysical numbing*. In such cases, the “importance of saving one life is great when it is the

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first…but diminishes marginally as the total number of lives saved increases.”

This is troubling, since it often means we are somewhat numb to the loss of life past a certain point, resulting in an apparently calloused response to large amounts of suffering.

One response would be to set aside our affective responses to such problems (given that most reasonable people judge that all lives are equally meriting of our concern), and rely on purely rational deliberation when we consider and enact responses to such problems. There is great merit to approaches that work to protect decision-making (and decision-makers) from effects like psychic numbing. For example, Slovic et al. advise designing default response measures (policies that are triggered by human rights violations that pass a threshold), creating better early warning networks, and pre-authorizing local actors (who are less vulnerable to psychic numbing) to act with force in relevant circumstances. Each of these recommendations could provide more timely and effective impediments to conflict descending into genocide.

However, there several reasons to think that the role of empathetic engagement has often not been properly utilized when attempting to confront widespread human rights violations. As Slovic et al. note:

> Efforts by international organizations to document mass human rights violations typically focus on the widespread nature of violations rather than on narratives or other information about the individuals who have been harmed. Statistics prevail over stories. A good example of this is the Darfur Atrocities Documentation Project…which compiled a database of over 10,000 eye-witnessed incidents but reported mostly the percentages of different types of abuses.\(^{164}\)

The problem with this approach is that given our relatively detached response to statistics (particularly larger numbers), such approaches often fail to fully engage both the public and policy makers. As such, Slovic et al. recommend a mixed-approach to human rights reporting,

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163 Ibid., 4.
164 Ibid., 11.
blending factual and statistical information with “in-depth narratives and visual personal stories describing the predicament of individual victims.”

Conclusion

I have addressed a number of skeptical concerns regarding the moral worth of empathy in moral thinking and motivation. While there are good reasons to think that Empathetic Partiality (EP) is true, this same evidence does not support ignoring or eliminating empathy from our moral thinking and motivation (Empathetic Elimination (EE)). Further, I have attempted to argue that the alternative motivational schemes proposed by Prinz and Bloom will not reliably produce the ideal pattern of moral engagement and motivation given our psychological constitution. Rather than putting empathy and empathic emotions aside, I have argued that more carefully guiding and prompting empathy enables us to improve our manner of approaching widespread moral problems.

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165 Ibid., 12.
CHAPTER III: SHOULD PHYSICIANS BE EMPATHETIC? THE IDEAL ROLE OF EMPATHY IN MEDICINE

Introduction

The role and importance of empathy in clinical practice has been widely discussed. Definitions of ‘empathy’ in these discussions vary, and range from the cognitive ability to understand the emotional states (and perspective) of the patient, to a combination of cognitive and affective capacities (like emotional resonance or response) and even behavioral responses. It is also an important feature of empathy in medicine that a physician be able to communicate their understanding of the patient state back to the patient. Ultimately, the goal of employing empathy in clinical settings is to produce better health outcomes for patients.

Proponents of empathy in medical practice argue that empathy plays a crucial role in the physician-patient relationship, fostering better communication, treatment, and patient satisfaction. Ideally, a physician employing empathy in communication and patient engagement will learn more about patient concerns and symptoms, since they are more attentive to the emotional state and perspective of their patient, and because the patient is more willing to communicate. Such engagement is thought to produce a better diagnosis and treatment plan. Patients will feel that they have been listened to and understood, and that their physician is concerned about their well-being. Given these purported benefits, some proponents argue that

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empathy is one of the “essential attitudes and skills” of a medical practitioner.\textsuperscript{171} For example, the Association of American Medical Colleges (in the learning objectives for medical school) that “physicians must be compassionate and empathetic in caring for patients,”\textsuperscript{172} and several prominent hospitals and medical schools have begun to adopt empathy training programs.\textsuperscript{173}

Critics of empathy in medicine have developed a number of objections to utilizing empathy in clinical situations. Some argue that attempting to empathize with patients involves a fundamental confusion, since cognitive empathy with others (involving other-oriented perspective-taking) is not fundamentally possible.\textsuperscript{174} Further, even if such subjective engagement were possible, it lacks the psychological distance required for properly objective medicine.\textsuperscript{175} Others argue that engagement with the affective lives of patients impedes effective medical treatment, since it exposes physicians to increased susceptibility to error.\textsuperscript{176} For example, reliance on empathy may increase the likelihood of physicians making unwarranted assumptions about the perspectives of their patients. Still others argue that empathy in medicine is incomplete, since as a concept it lacks behavioral or moral motivations.\textsuperscript{177}

\begin{footnotesize}
\textsuperscript{172} https://www.aamc.org/members/orr/84566/orr_responsibilities.html
\textsuperscript{175} Macnaughton (2009).
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This paper will focus on the ideal of clinical empathy, as involving both cognitive and affective capacities. I will argue that an increasingly popular account of clinical empathy is subject to a number of objections. My main concern is that a central feature of the account (emotional resonance with patients) is typically a liability in clinical settings, and is not clearly supported by the relevant empirical work. Instead, I will argue that the ideal account of empathy in medicine remains cognitive, though there is a central role for expressing empathic concern (sympathy/compassion) towards patients. After having detailed my proposed refined account, I will defend the refined account from a number of recent criticisms of employing empathy in medicine.

I have divided the following discussion into several sections. First, I will frame the scope of the discussion by outlining the relevant target class of physicians, and by explaining how I understand ‘effective’ medical treatment. Second, I will outline Jodi Halpern’s widely discussed account of clinical empathy and develop a number of criticisms of this account. Third, I will then present a more refined account of empathy in medicine and detail several arguments in favor of this view. Finally, I will argue that such an account avoids various objections to clinical empathy in the literature.

Who are Physicians and What is Effective Medical Treatment?

Before we address the issue of empathy in clinical settings, we need to delineate the relevant class of individuals for whom empathy is therapeutically relevant, as well as the medically desired outcomes of this process. Since empathy has been proposed as an important (or to some, necessary) feature of the physician-patient relationship, I will limit the scope of the

discussion of empathy in medicine to the subset of physicians who have regular, medically related personal interactions with patients as part of the patient diagnosis and treatment process. This would include both primary care physicians (PCPs) (e.g. general practice, family physicians) as well as the host of specialist practitioners (surgeons, radiologists, oncologists).

Next, we should carefully define effective medical treatment. I propose that if a medical treatment is deemed to be efficacious, then it reliably provides a benefit to a patient that if followed is at least as good as any available alternative. One issue with this statement of effective treatment is that a physician could effectively treat a patient’s immediate ailment (at least as good as any available alternative), but in a manner which eroded the future trust of the patient. Perhaps the physician was callous in their approach, making the patient less likely to ask questions or even return for future medical problems. The often ambiguous nature of ‘effective treatment’ in discussions of empathy in medicine is problematic since it does not follow that because a particular intervention is successful (say in terms of treating or eliminating a particular ailment), this particular structure of the physician-patient relationship is the most effective means of treatment across time. I think we have good reason to prefer a practice of medicine that provides the most efficacious medical treatment for patients over time.178

From Detached Concern to Clinical Empathy

According to Jodi Halpern (2001), the emotional ideal for the physician in modern medicine has been one of emotionally detached concern.179 The ideal of detached concern involves observation and projection into the inner life of the patient “without feeling…difficult

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178 It is also often unclear how hospitals should measure effective treatment. A satisfied patient may not leave a treatment regime having received the most effective (or even relevant) long-term care. This is a growing problem where physician income may be partially determined by patient satisfaction surveys.

This is not to deny that physicians can and will experience negative emotions, but that they should make efforts to avoid such experiences. For example, Hojat et al. (2009) define empathy in medicine as a “cognitive (as opposed to affective or emotional) attribute that involves an understanding…of patients’ experiences, concerns, and perspectives combined with a capacity to communicate this understanding” to the patient. Such cognitive empathy is measured by focusing on the perspective-taking abilities of the subjects.

There are a number of reasons that proponents of detached concern have favored this ideal. First, sharing the negative affective states of patients is believed to impede effective medical care, since such exposure can produce emotional fatigue, leading to less careful treatment. Second, such intellectual engagement provides an additional source of information about a patient’s history and present state, and promotes further diagnostic communication. Finally, since detached concern is an intellectual capacity, it can be developed with educational programs and techniques in a way that seems less obvious for affective and emotional responses.

Clinical Empathy

While detached concern has plausible advantages over less engaged modes of information gathering and communication with patients, it has been challenged in recent years. For example, Jodi Halpern (2001, 2003) has argued that we should replace the detached concern model with Clinical Empathy. Clinical empathy is presented as a response to the merely cognitive approach of detached concern and is “an experiential way of grasping another’s

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181 Hojat (2009), 1183. Hojat employs the Jefferson Empathy Scale, which focuses on perspective-taking abilities.
183 Hojat (2009), 1183.
emotional states.”\textsuperscript{184} It is a skill that employs cognitive empathy but encourages and often relies on emotional resonance with patients, though sharing the emotional states of the target is not always required.\textsuperscript{185} Halpern gives several ordinary examples of emotional resonance. For example, when “listening to an anxious friend, one becomes anxious, while talking with a coworker, one feels heavy, depressed feelings.”\textsuperscript{186} While emotional resonance may occur throughout an encounter with a patient, the physician must imaginatively “unify the details and nuances of the patient’s life into an integrated affective experience.”\textsuperscript{187} In addition, clinical empathy involves being able to communicate this understanding back to a patient as part of the therapeutic relationship.

In more recent research, Decety, Halpern et al. (2014) argue that “the underlying rationale for implementing a ‘detached concern’ approach is no longer tenable” for a number of reasons.\textsuperscript{188} First, they argue that patients respond better to emotionally attuned physicians, and that empathetic physicians produce more efficacious treatment.\textsuperscript{189} Second, they argue that affective engagement helps improve empathic accuracy and understanding, since cognitive and affective processes typically work together in the experience of empathy. Finally, they argue that the view that emotional resonance (in clinical settings) necessarily produces emotional turmoil in physicians is empirically unsupported. I will examine each of these claims and outline a number of objections to each of them.

\textsuperscript{184} Halpern (2003).
\textsuperscript{185} Halpern (2003). She notes that emotional attunement serves as a “backdrop” to imagining what the patient is feeling. It is through the experience of certain emotions that the physician is guided through an associative form of emotional reasoning to better diagnose and treat the patient. See Halpern (2001), 92-93 for further discussion of emotional resonance.
\textsuperscript{186} Halpern (2003).
\textsuperscript{187} Halpern (2001), 88.
\textsuperscript{188} http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4219055/
\textsuperscript{189} One plausible explanation is that patients who feel that the physician is listening and concerned are more willing to share more details about their present concerns, emotions, and physical state.
Response: The Value of Emotional Resonance in Clinical Situations

Emotional resonance and patient trust

A central claim in the literature of empathy in medicine is that when physicians engage in affective attunement with patients, it increases patient trust. As a result, patients are willing to give fuller case histories and will adhere to their treatment schedules more closely. The study most widely cited to support this claim is Suchman et al. (1997). Suchman et al. present a model for more effective clinical communication, based on patient interviews with primary care physicians. The study found that physicians that acknowledged expressions of patient emotions (defined by Suchman et al. as ‘empathic response’), or probed for further information based on emotive clues, achieved more complete histories from patients.

I have two concerns with the general connection between emotional resonance and patient trust and treatment adherence. To take the Suchman et al. study as an example, researchers studied the extent to which physicians observed and drew attention to emotions and patient descriptions of emotional states. There is no clear evidence provided by this study that physicians who were more effective communicators in such interactions were utilizing emotional resonance as a means to this end. One could engage in cognitive empathy with the patient, while acknowledging the importance of the patient’s emotional states and various verbal clues that they suggest about their emotional states. In other studies on this topic, the account of empathy in physician-patient communication is a cognitive form of understanding. In other words, we can

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grant the importance of giving attention to the emotional state of the patient (and patient concerns) without encouraging emotional resonance in clinical situations.

Empathy and delivering bad news

Another claim is that patients cope better when their physicians deliver bad news to them empathetically.\textsuperscript{193} This is a plausible claim, but it is important to clarify how empathy is typically used in such recommendations. One widely cited schema for breaking bad news in clinical settings (known as SPIKES\textsuperscript{194}) defines ‘empathy’ as an exclusively cognitive attribute. It involves observing a patient’s emotion, identifying the emotion (and reason for the emotion), giving the patient time to express the emotion, and acknowledging the emotion by connecting it with the reason for the emotion. The study cited by Halpern (2003) as support for this claim (Girgis et al. (1998)), does not clearly define ‘empathy,’ but does suggest that physicians give patients time to express their feelings and remind them that it is normal to feel negative emotions in such situations.\textsuperscript{195} Here again, while there is support for recognizing and acknowledging patient emotional states, there is not clear support for emotional sharing or resonance with patients in clinical settings.

Physician empathy improves therapeutic efficacy

Halpern (2007) cites a number of studies in support of this claim. Roter et al. (1998) found that patient trust was vital to adherence to treatment regimes. However, the study showed that patient trust was dependent on whether the physician seemed to be concerned about the

\textsuperscript{195} Girgis et al. (1998), 57.
patient’s health, not whether some measure of emotional resonance was employed. The studies that explicitly mentioned empathy as part of the communication process employed cognitive accounts of empathy. For instance, Beck et al. (2002) defines empathy as a cognitive capacity and found that additional non-verbal behaviors like mutual gaze, nodding, and ‘leaning in’ predicted more favorable outcomes. Kim et al. (2004) defines affective empathy as the ability to be responsive to and improve the patient’s emotional state. Measures included items like whether the physician responded mechanically or showed interest in patients and their well-being. A study that was cited from Kerse et al. (2004) did not mention empathy, and instead measured how well patients felt understood/listened to during their appointment.

These studies give us good reason to think that establishing open communication with patients is therapeutically efficacious and increases patient satisfaction. Further, attending to the emotional state of the patient (and their perspective) as part of the clinical interaction is important. However, this research does not give us clear reasons to adopt Clinical Empathy as an emotional ideal in medical practice, or to think that sole reliance on cognitive empathy in medical contexts (alongside standard diagnostics) is no longer tenable or would not produce effective treatment.

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198 Kim et al. (2004), 209.
The epistemic value of emotional resonance

Emotional resonance may provide an additional source of information about the patient state. For instance, a physician who resonates with a patient’s emotional state throughout a conversation has a direct source of affective information that they may use to better understand the patient’s needs or perspective. Since emotional experiences guide and frame our ordinary ways of thinking and deliberation, having more direct access to such states could provide a better window into patient concerns. Such emotional ‘data’ may support the current understanding of the patient, or in cases where this information conflicts with the patient reports, provide grounds for investigation. For example, a patient might report feeling fine, but the physician might directly resonate with their expressed depressed/fearful/anxious/distressed state. Such a mismatch of information may provoke further questioning or examination.

I have two concerns with this line of argument in practical situations. The first is that in many clinical settings such information is also accessible via basic observation, or by perhaps using a process like cognitive empathy. Further, it is unclear why it is diagnostically useful for a physician to experience (even in subtle or attenuated ways) the state of the patient as a means of properly diagnosing or treating patient problems. Second, the exact emotional state of a patient in the diagnostic stage is less important than the relevant range of symptoms (or problems) they exhibit, their history, and the object of their emotional concerns. Each of these aspects of diagnosis can be more accurately determined without additional emotional resonance.

Consider the first issue. Many of the affective states experienced and expressed by patients in hospitals and clinics are negative. Patients are often anxious, irritable, angry, or depressed. In many cases, they are dealing with varying levels of pain, discomfort, and distress.

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201 Halpern discusses this kind of associative emotional reasoning at length. See Halpern (2001).
Further, such states are often the first to be directly reported by patients when they detail their concerns (e.g. “I’m in terrible pain with these migraines,” “My kid won’t stop screaming when I touch his belly”). In this way, an additional affective source of information throughout the diagnostic process is typically unnecessary and distracting.

There are cases where a patient may not be verbally explicit about their emotional state or concerns. Or, perhaps the patient’s expressive and behavioral cues conflict with their verbal reports about their symptoms or condition. For example, a patient might share only partial symptoms with a physician while blushing or averting their eyes. In such cases, a physician can imagine what would motivate such behavior (perhaps embarrassment), prompting further gentle questioning. Perhaps the patient is averse to a particular form of examination, so they avoid sharing the symptoms related to this area of their body. Here, further questioning might be required for the optimal diagnosis. But, in such cases, basic observation, cognitive empathy, and inference appear to be sufficient to guide the physician through this process.

My second concern is that epistemically the current state of the patient throughout the physician-patient encounter is less important than the range of symptoms or problems they exhibit, the details of their medical history, and the objects of their present concerns. Each of these elements can only be properly obtained through dialogue, imagination, and detailed inference/induction from available information. This is not to deny the importance of cognitive empathy, imagining the situation and problems from a patient’s perspective or giving attention to their emotional state. While emotional resonance will deliver some data about the present state of the individual, it arrives without clear context or object. Since most of the explicit emotional states exhibited by patients in clinical settings are negative (fear, frustration, and irritability;
pained distress), sharing these states amounts to an additional cognitive burden without any clear epistemic benefit for the patient.

One response to these concerns might be that the form of emotional engagement that I have just outlined (attention to emotion without sharing) is just what is meant by ‘clinical empathy.’ However, if this is the case, then it is difficult to see how this approach to the physician-patient relationship significantly differs from the detached concern model of empathy. If clinical empathy is a substantial development of the previous detached model, it seems to be because of the additional element of emotional resonance. But, as I have noted, the epistemic advantages in favor of the additional affective elements are not clearly more effective than a purely cognitive approach utilizing basic observation and cognitive empathy.\(^{202}\)

Does emotional resonance necessarily produce turmoil?

While emotional resonance does not necessarily produce emotional turmoil for physicians, personal distress (the negative emotions felt in response to the emotions or state of others) is a widespread and serious problem in clinical settings. Personal distress is strongly correlated with physician burnout and ‘compassion fatigue.’ Decety & Gléichgerrcht (2013) found that physicians with lower abilities to regulate their emotional responses suffered higher personal distress when dealing with distressed patients, and there is evidence of the deleterious effects of personal distress in multiple clinical fields, including the increased likelihood of medical errors.\(^{203}\)

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\(^{202}\) I should clarify that I think that the ideal approach to patients does involve emotional responsiveness, just not in the form of affective resonance or matching. Instead, I think that we have good reason to employ and encourage more empathic concern (compassion) in clinical settings.

Outside of the medical environment, the typical response of an individual to the perception of pain and distress in others is an aversive experience.\textsuperscript{204} However, it seems that as part of standard medical training and experience, physicians learn to down-regulate their negative emotional arousal when perceiving painful procedures.\textsuperscript{205} Further, the regulatory abilities of the physician serve an important role in decreasing personal distress. There are a number of regulatory strategies that can be employed in clinical settings. Gleichgerrcht & Decety (2012) note three: (i) exposure control, (ii) emotion suppression, and (iii) framing.\textsuperscript{206} An example of exposure control would involve scheduling shifts so that clinical staff are not required to experience constant patient distress or pain, or to balance emotionally demanding medical care with less intense patient interactions. Emotion suppression involves deliberately not thinking about the target of distress, while framing might involve reappraisal of the patient distress (it’s not \textit{that} bad) or deliberate objectification (they are not real, they cannot feel at all).\textsuperscript{207} Another important method for reframing involves more deliberately taking the perspective of the target, which has been shown to down-regulate personal distress in subjects.\textsuperscript{208}

While emotional regulation arguably helps to protect the physician from vicarious distress, Gleichgerrcht & Decety (2012) argue that total affective detachment is not clinically desirable for two reasons. First, “[e]xcessive regulation has been shown to lead to personal

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\textsuperscript{206} See Hodges & Biswas Diener (2007).


\textsuperscript{208} See, Batson et al. (1997).
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distress and increased anxiety with both physiological and sociopsychological consequences that included increased blood pressure, disrupted communication, and reduced rapport. Second, they argue that some measure of personal distress is necessary to be “attune to and empathetically understand patient’s emotions” as well as fully benefit from the positive aspects of patient care, or what is sometimes called ‘compassion satisfaction.’

It may be that total affective detachment in clinical settings is not desirable, but the evidence cited for this is not clear. In the study cited to support the claim, Butler et al. (2003) argue that “in some contexts…suppressing emotion disrupts communication, hinders the development of social bonds, and is physiologically taxing for both the suppressor and her social partner.” Emotional ‘suppression’ involves not showing or communicating emotional states that were being experienced. It is also worth noting that while this form of suppression has costs, the authors also noted that in some contexts the benefits of suppression will outweigh the associated costs. I think there are good reasons to think that in many clinical interactions, this is likely the case.

Many of the negative emotions experienced in clinical settings by physicians would be unsettling to many patients to see expressed by their physicians. In some cases, such emotions are irrelevant to the patient interaction (the physician is angry, or bored) and in others, they will

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211 Gleichgerrcht & Decety (2013): “This study also contributes to the idea that a minimum level of empathy is necessary to benefit from the positive aspects of professional quality of life. Participants experienced compassion satisfaction when they reported a certain level of personal distress in response to someone’s suffering. One likely explanation for this surprising finding is that enhanced empathic responses result in increased motivation to help those in distress, thus promoting a more satisfactory experience for the health professional.” See Ezequiel Gleichgerrcht, and Jean Decety, “Empathy in Clinical Practice: How Individual Dispositions, Gender, and Experience Moderate Empathic Concern, Burnout, and Emotional Distress in Physicians,” PLoS ONE 8 (4) (2013).
likely be distressing for the patient. Consider a physician who shares a bad prognosis with a patient (who is already clearly afraid), but does not hide their own shared anxiety at the results. Such a response would likely exacerbate the already difficult situation for the patient. Or consider how unpleasant it might be for a patient who suffers from an embarrassing ailment to see the empathic embarrassment in the faces of his care providers.

Even if we grant that some measure of emotional resonance is an inevitable feature of working with patients (particularly those in distress), it does not follow that the most effective context for the expression of the physician’s emotions is within the clinical interaction (which is the proposed function of clinical empathy), or that it has a useful diagnostic function. Instead, this line of response would only give us reason to think that physicians would be best served by having relevant outlets for much of their negative emotional expression.\textsuperscript{213} For example, this need could be met if physicians could more readily share their negative emotional states with other medical professionals, support groups, or support staff (like therapists).\textsuperscript{214} But then we might wonder in what manner this process involves empathizing with patients.

The second claim also needs to be qualified since I do not think that clinical empathy (often involving emotional resonance) is either motivationally or epistemically required for careful and effective medical treatment. In order to feel empathic concern (sympathy) for patients, this typically involves feeling some negative response (like sadness) directed at the negative state of the target. However, this emotional experience has a different emotional ‘shape’ than affectively resonating with a patient or experiencing personal distress. For example, merely

\textsuperscript{214} It also does not follow that because some measure of emotional resonance is inevitable that it is a \textit{positive} feature. It may be that the ideal strategy should be the regulation (or avoidance) of such experiences.
resonating with your anxiety, anger, or pain is not alone sufficient for a physician attempting to maintain a sympathetic response to your clinical woes. Neither is experiencing personal distress, which is typically defined in clinical settings as a self-directed form of emotional distress produced by external perceptions of distress.\textsuperscript{215}

While emotional resonance might serve an epistemic role in motivating a compassionate response, we often feel sympathy without sharing any of the actual affective states of the target or being focused on our own discomfort. Epistemically, what seems necessary for sympathy is that we understand that the target is in a negative state, in a particular situation. In addition, we feel an other-oriented emotional state that is congruent with this negative state (in cases of sympathy, a form of sadness). While affective engagement can help us track these cues, we can determine this information based on cognitive empathy.\textsuperscript{216} For the reasons just noted, it is not clear that physicians need to be able to directly share the affective state or experience self-directed personal distress in response to their patients to engage in sympathy for them.

Refining Clinical Empathy

The previous literature mentioned does give us reasons to think that many of the benefits of empathy in clinical communication and information gathering are the result of cognitive engagement with patients, in some cases employing cognitive empathy. More recent research also supports this latter claim. Ogle et al. (2013) argue that third-party institutional reviews of physician-patient interactions found a close relationship between the physician’s ability to place herself in the position of the patient (and see the world from the patient’s perspective) and the

\textsuperscript{215} Decety & Gleichgerrcht (2013) use the standard definition noted here.
\textsuperscript{216} For example, perspective-taking is the typical means by which researchers elicit empathic concern in psychological study.
general competence of the physician as a clinical communicator (as perceived by the
reviewer).217

As previous research suggests, there does seem to be a relationship between the
empathetic abilities of the physician, understood as their abilities to take the perspective of the
patient and more favorable health outcomes for patients,218 as well as increased satisfaction as
reported by patients.219 Finally, Lamothe et al. (2014) have found evidence that as the
perspective-taking abilities of physicians increase, their rate of burnout decreases. I think that
there are a number of plausible reasons for this relationship between perspective-taking and
physician communication, patient outcomes, and the lower rates of physician burnout.220

More deliberate perspective-taking functions to re-orient the attention of an individual
toward the life of the other. In a clinical interaction, when a physician more carefully attends to
the perspective of the patients, the focus of the conversation remains on the patient’s concerns.
Further, a skilled physician is utilizing empathy as part of a feedback process, so the questions
that the physician uses to probe for further information will typically open up the process of
conversation. Since many health issues have a deeply subjective nature, it seems plausible that
more engaged means of approaching patients in clinical interactions leave patients feeling as
though they have been listened to, and have had their problems understood. In any human

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217 J. Ogle et al., “Empathy is Related to Clinical Competence in Medical Care,” Medical Education 47 (8)

218 Hojat (2011).
219 B. Blatt et al., “Does Perspective-Taking Increase Patient Satisfaction in Medical Encounters?” Academic
220 Martin Lamothe et al., “To Be or Not to Be Empathic: The Combined Role of Empathic Concern and Perspective
interaction, such efforts at interpersonal understanding are the plausible basis for an increasing level of trust, something that also seems to be occurring in clinical settings.

Another interesting feature of perspective-taking that is often mentioned in the literature is the relationship between perspective-taking and emotional burnout. One explanation for this relationship is related to the other-oriented nature of perspective-taking. When you are in distress as a patient, and I (as a clinician) become flooded and alarmed with distress (on a regular basis) this is emotionally burdensome and will certainly contribute to emotional ‘burnout’ in such situations. Perspective-taking re-orient my focus onto the source of the distress (you are feeling this way) and the deliberate nature of this process functions to inhibit my experience of vicarious distress.

In addition, perspective-taking and engaging in the inner lives of others is an effective means of encouraging empathic concern (sympathy/compassion). While I have argued against the value of shared emotional resonance in clinical settings, this does not entail that emotional engagement with patients is unimportant or to be avoided. I propose that we refine the ideal account of empathy in clinical settings to include both cognitive forms of empathetic understanding and the emotional response of empathic concern, sometimes referred to as ‘empathic concern.’ Some measures focus on both the cognitive and affective features of empathy in medicine. For instance, the Consultation and Relational Empathy measure (CARE) captures patient perceptions of active listening, attention to the patient’s narrative, and the physician’s expression of compassion. Recent research has found a significant relationship
between these measures and compliance with treatment, improved health outcomes, and greater patient enablement. This should not be terribly surprising, since patient satisfaction surveys often suggest that patients crave healthcare providers who really seem to care about them.

Working to encourage medical practitioners to actively care also appears to be beneficial for healthcare providers themselves. For example, both Decety & Gleichgerrcht (2013) and Lamothe et al. (2014) have found that along with higher levels of perspective-taking, higher levels of empathic concern (sympathy) were associated with greater ‘compassion satisfaction’ (satisfaction derived from effective medical care) and lower rates of burnout among physicians. While this is likely not the case for all medical practitioners, many who practice medicine are motivated by concern for the health of others. To be (and feel) engaged in this process is clearly very satisfying for many individuals. Doctors are (after all) humans, and humans are often motivated by the desire to do some good in this world.

There remains an issue about whether such empathetic capacities can be taught or developed, particularly in the stressful environment of modern medicine. Research in this area is relatively recent, but there are some reasons to think that cognitive empathy can be improved with training, and that our abilities for empathic concern can be cultivated. For example, Riess et al. (2012) developed a training program in empathy to teach physicians how to more accurately interpret emotional cues in facial and bodily behaviors, regulate their own emotional states in

clinical situations with perspective-taking, and deliver bad news empathetically.\textsuperscript{224} Physicians who received empathy training were rated as significantly more empathetic by patients than those who did not receive such training. Some research also suggests that deliberately cultivating compassion toward a target in a state of suffering reduces the negative neurological response of the subject while producing positively valenced emotions, even while continuing to perceive the target in distress.\textsuperscript{225} Such results could have important implications for employing empathic concern in clinical settings, particularly in terms of strategies for mitigating negative arousal in the presence of suffering. However, more research is required in clinical settings to support this claim.

**Objections and Responses to Empathy in Clinical Practice**

A number of critics oppose employing empathy in clinical practice. Since I defend a version of empathy and empathic emotions in medicine, I will outline and respond to several objections to such an approach.

*Objection: Cognitive Empathy is Not Possible*

Jane Macnaughton (2009) presents two objections to attempting to employ empathy in medicine. Her central concern is that it is not in principle possible to cognitively empathize with the psychological experiences of *any* other subject, although we can imagine *ourselves* in their physical position.\textsuperscript{226} Since we are fundamentally closed off from the subjective world of other agents, it is a mistake for physicians to attempt to engage with patients in this manner. Further,

\textsuperscript{224} Riess et al. (2012).
\textsuperscript{226} Macnaughton (2009), 1941: “It seems, then, that it is possible for us as clinicians to have some empathic understanding of what it might be like to be in someone’s shoes physically, but not psychologically.”
given this fundamental separation, it is dangerous for physicians to infer that they understand how their patients feel or think via a process like cognitive empathy.\textsuperscript{227}

However, even if the process of empathy were possible, Macnaughton argues that such subjective inter-relations are “not appropriate for the clinical situation.”\textsuperscript{228} The practice of medicine requires that the physician maintain an objective stance with regard to their patients. Attempting to engage with the patient as a subjective source of experience (as a subject) and to share these experiences usurps the clinical stance (with the patient as the object of treatment). So, either empathy employed by physicians involves unjustified (and potentially dangerous) assumptions, or empathy employed by physicians involves a distortion of the appropriate medical stance.

\textit{Response: Cognitive Empathy is Psychologically Possible}

It is appropriate to be concerned about any purported approach to patients that would distort a healthy relationship between a physician and their patient. However, neither of the objections outlined by Macnaughton strongly support this concern. First, her central concern only follows if we accept a particular account of what constitutes other-oriented cognitive empathy. If empathy necessarily involves a first-personal self-other merging, then we can grant that such a psychological stretch is not possible. However, there are good reasons to think that a central form of other-oriented cognitive perspective-taking (which extends beyond mere imagining ourselves in another physical location) is possible, even if we grant that we cannot literally share the direct, first-personal experiences of another individual. Instead, it is possible to take the perspective of the target, adjusting our imaginative simulation based on the

\textsuperscript{227} Macnaughton (2009). For a more recent version of this particular argument, see Slaby (2014).

\textsuperscript{228} Macnaughton (2009), 1940.
characterization of the target (and updating as we learn more) which can allow us to share some measure of understanding what it is like to be in their situation, without mistakenly inferring that we are them (or are completely merged with them).

What makes the process other-oriented is that our focus is on the details of the target’s state, her imagined perspective and situation, rather than on the details of our own perspective in that physical situation. This process does not presume that we have direct first-personal access to the target’s psychological states. Instead, the typical process of other-oriented cognitive empathy functions as an interpersonal feedback mechanism that draws on available (and limited) information about a target and their situation. This will inevitably be incomplete, and the process of simulation ‘fills in’ some of the missing motivational and psychological details.

However, as we gather more information (via conversation, inference, and perception), it is possible to update and adjust the process of perspective-taking. This process is also distinct from merely imagining oneself in a different spatial location and produces empirically distinct results from self-oriented empathy. In addition, the literature on empathic accuracy supports the claim that people are able to attain such a better understanding of the experiences of others and more accurately predict their current states and behavior based on these experiences.

Macnaughton’s second claim relates to the appropriate psychological structure of the physician-patient relationship. It is true that in clinical settings the physician must take the patient as the object of their medical attention. Further, taking an individual as a patient will involve a particular professional stance. For example, it would be a professional error for a physician to love all of her patients. However, such examples do not entail that sound medicine

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229 Batson et al. (1997).
requires strict emotional detachment. Some emotions seem vital for good diagnosis (curiosity), while others seem fairly detrimental (e.g., disgust or persistent fear on the part of medical staff). What remains to be determined is whether as the object of medical scrutiny, it is inappropriate to engage with the subjective, emotional perspective of the patient.

Macnaughton’s concern seems to be that it is disrespectful for a physician to assume (or infer) that they “know what it is like” to experience what the patient is experiencing.\textsuperscript{231} I think that this concern can be assuaged when we remember that engaging with and understanding the subjective state of patients is often a requirement for diagnosis. Macnaughton does not deny that the patient is a seat of experience, but she argues that “[all] that is possible psychologically [for us to know] is an awareness of the other as an experiencing being” and that if we “take time to ask, they can tell us what that experience is like.”\textsuperscript{232}

Once we grant that cognitive empathy involves simulating the perspective of another (and not literal mind-melding), Macnaughton’s concern with empathy in medicine can be avoided. A physician employing empathy may use such a process to establish a coherent conception of the patient state, from which a continued dialogue and diagnosis can proceed. While this may seem rather cognitively demanding, it is arguably more manageable than the purely theoretical procedures employed by some physicians to explicitly avoid cognitive empathy. Consider the account detailed by Weiner & Auster (2007):

> By precisely observing his appearance and his context, his words (and this includes the particular words selected to express a thought, feeling, or action) and their actions, I construct from those observations a context in which it all makes logical sense and then ask whether my construct accurately reflects his experience. When it does not, I ask how it does not, and based on their reply, I make continuing adjustments to that construct until it is in line with the other’s reality.\textsuperscript{233}

\textsuperscript{231} Physicians and clinical staff are routinely warned not to use this phrase with patients.
\textsuperscript{232} Macnaughton (2009), 1941.
\textsuperscript{233} Weiner & Auster (2007), 127.
It may be possible to employ such a strictly theoretical (or theory theory) account of patient minds during diagnosis. However, even if it were possible to engage in detached patient ‘modelling’ without engaging with the perspective of patients, there is recent evidence that physicians who engage in cognitive empathy (with their patients) during the diagnostic process more accurately diagnose the nature of emotional distress in their patients than those who rely on standard diagnostic methods.

This would give us reason to at least employ a hybrid theory (employing perspective-taking and theory theory modelling) during the diagnostic process. Generally, if a better understanding of the patient can produce more effective treatment (without imposing undue burdens), then it is a desirable goal in medicine. If more directly engaging with the subjective perspective of a patient will entail a better diagnostic and communication process, then it should be pursued.

Objection: Cognitive Empathy Impedes Effective Medical Practice

However, this brings us to the central concern of a number of critics, which is that physicians who engage in cognitive empathy will impede effective medical treatment. One argument is that employing empathy in clinical encounters increases the likelihood of unjustified assumptions and mistakes in clinical diagnosis and communication. Such epistemic errors are reasonably thought to increase the likelihood of harm to patients. For that reason, critics argue that cognitive empathy is a capacity that should be avoided in clinical encounters.

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234 I am skeptical than anyone with a mature theory of mind can navigate complex social situations without relying on some measure of simulation and theorizing, and possibly even some further intersubjective processes.

For example, Richard Landau (1993) argues that while it is vital that the physician be able to understand the situation and ailment of the patient, physicians “who place themselves in the patient’s position, will not be able to reliably fulfill all of these requirements.” Cultivating empathy “will undermine their ability to function as wise, understanding doctors.” Perhaps Landau’s underlying concern is that by engaging in empathy, the physician is shifting her focus to her own emotional response, rather than maintaining a clear focus on the patient. In such cases, the additional emotional experiences (and subsequent introspection) seem only to cloud the diagnostic interaction. Instead, Landau argues that a process of deempathization is required and that “[s]ound therapeutic decisions necessitate the detached assessment of the diagnosis with consideration of all facets of the patient’s life situation.”

Weiner & Auster (2007) detail a number of further concerns with utilizing cognitive empathy in clinical situations. First, the empathetic process may lead physicians to misjudge the target’s state or situation, or may justify halting further inquiry or questioning. Cognitive empathy functions with available information, and a physician who assumes too much about the patient state may feel assured that they empathetically understand the patient state and situation, failing to correctly check their own understanding against various features of the patient’s experience.

Second, such empathy in a clinical encounter proceeds by assuming that “the physician has correctly arrived at the source of the patient’s distress,” which itself presumes access to what is important or valuable to the patient. However, Wiener & Auster argue that physicians rarely

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236 Landau (1993), 108. Landau defines empathy as “intellectual identification with or vicarious experiencing of the feelings, thoughts, or attitudes of another” (103).
237 Ibid.
239 Ibid.
have access to the relevant information about patient values, and it is risky to make such assumptions. Third, they argue that the small sample size involved in physician empathy makes any knowledge claims (on the part of the physician) highly prone to personal bias. Unlike empathy with fictional characters (or for some imagined aesthetic perspective), they argue that any reliance on cognitive empathy in clinical settings involves a great risk of harm to persons.

Finally, related to previous concerns, Garden (2007) has argued that clinical empathy places more emphasis on the narrative and imaginative experience of the physician, often obscuring the suffering and state of the patient. This has the unfortunate result of shifting an apparently ‘patient-centered’ approach back onto the experiences and imaginative capacities of the physician. Further, since empathy is often felt in proportion to similarities between the target and the subject (in this case, the physician), empathy becomes strained as the cultural and historical background of the patient differ in substantial ways from that of the physician.241

Response: Cognitive Empathy Need Not Impede

While critics are right to be concerned about employing methods that detract from good patient care, there are good reasons to think that a properly employed account of empathy in medicine can avoid such criticisms. To begin with, we should reiterate the function of empathy in medicine. A central desire in medicine is to understand the state and situation of patients. Cognitive empathy has been proposed to improve patient diagnosis, treatment, and physician-patient communication. Another goal in medicine is to care for (and express concern for) patient well-being. Empathic concern has been proposed as a means of more directly connecting with

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240 Ibid. They compare physician empathy to a “participant-observer case with an n of 1.”
patient emotional states, or as a particular emotional response to the situation or concerns of patients.

However, neither cognitive empathy nor empathic concern are sufficient for appropriate patient care. Employing empathy in medicine arguably supports a more patient-centered approach, and supplements the standard diagnostic relational process. It is important to clarify this feature of discussions about emotional ideals in medicine, since some criticisms of empathy only entail that empathy is not sufficient for proper medical care. However, this does not demonstrate that empathy in medicine is not important, or would not improve the satisfaction and outcomes for patients.

First, consider the claim that taking the perspective of the patient would lead to the emotional ‘swamping’ of the physician, or that expression of empathic emotions would disturb the patient. Landau might be correct that a physician who visibly mirrored patient anxiety or embarrassment, or wept at bad news, might be upsetting for patients, but such concerns would only rule out direct (and expressed) emotional resonance. Rather than think that perspective-taking is a liability, it seems to function as a regulatory mechanism to help individuals avoid becoming overwhelmed with shared negative emotions. Subjects who engage in perspective-taking with distressed targets experience less personal distress and feel higher empathic concern (sympathy) for the target.242

Further, as the perspective-taking abilities in physicians increase, their rate of burnout decreases.243 There is also evidence that when physicians are explicitly instructed to adopt the perspectives of their patients throughout a clinical encounter, patients report higher satisfaction

242 Batson et al. (1997).
243 Lamothe et al. (2014).
In such cases, nothing about employing a cognitive empathy in the diagnostic and communication process entails that a physician will be unable to perform their ordinary duties in an effective manner. In fact, there are some advantages to employing such an approach.

Next, consider the claim that (due to empathetic failure) physicians may misjudge the target situation, leading to premature suspension of questioning, or may make unjustified assumptions about patient concerns and values. We should first note that employing empathy in clinical settings is not a sufficient approach to patient care. Cognitive empathy in medicine is a skilled approach to physician-patient communication that is to be used in conjunction with the standard diagnostic tools (involving question/response, physical and mental examinations, and checklists). There is also nothing about reliance on cognitive empathy as part of the standard exploratory and diagnostic process that would entail a premature abandonment of the standard clinical investigative procedures involving a patient’s symptoms or health history.

Further, while sole reliance on cognitive empathy as a private epistemic tool in medicine could potentially produce more harm than otherwise, it functions quite unlike empathy in aesthetic interactions. In the latter cases, there is no feedback from the target about the accuracy of empathetic engagement. Since one feature of standard accounts of cognitive empathy in medicine involves physicians communicating their current understanding of the patient’s state and situation back to the patient in the course of the diagnostic process, it functions as part of a wider feedback loop with patients. This means that cognitive empathy is regulated by and

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244 Blatt et al. (2010).
245 It is also worth noting that doctors are subject to cognitive errors in their assessments, but this is not grounds for rejecting the role of cognition (per se) in medicine. See Groopman (2007) for a discussion of the cognitive biases that often shape physician diagnosis. Jerome Groopman, *How Doctors Think* (New York: Houghton Mifflin, 2008).
246 Even if empathy in medicine was not typically defined as involving any form of communication, the clinical encounter itself functions in this manner.
constrained to facts revealed in the standard diagnosis of the patient. This gives us good reason to resist the concern that the empathetic physician is merely relying on private (and illicit) empirical generalizations about their patients via their empathetic engagement.

There are also important epistemic advantages of employing empathy over a more detached, ‘check-list’ approach to information gathering. As noted earlier, physicians who engage in perspective-taking with their patients make more accurate assessments of the nature of the emotional distress experienced by their patients.\(^{247}\) Consider cases where the self-reports of the patient conflict with their perceptual and behavioral cues, or what a physician might imagine would be the fitting response of the patient given their situation. These opportunities where conflict and confusion arise can motivate further investigation of patient concerns. In other cases, learning more about the patient’s situation can allow a physician to better reconstruct the perspective and narrative of the patient, and to better understand the patient’s hesitancy about certain course of treatment. Or, the physician may be able to better frame options in a way that will be understood by the patient. In the latter cases, showing proper respect for the autonomy of the patient might require a more extensive reconstruction of the perspective of the patient.

Additionally, engaging in perspective-taking with patients may help mitigate implicit biases (and stereotypes) that negatively influence the behaviors of clinical staff.\(^{248}\) For example, in one study researchers found that implicit racial biases influenced nurses to recommend more pain medication for one racial group over another. With instructions to imagine how any given patient felt before making the recommendation, such biases were eliminated.\(^{249}\) Since one feature

\(^{247}\) Yagil et al. (2015).
of stereotypes is that they block proper epistemic access to a target (since we then fail to ‘see’ their actual qualities), reducing the effects of stereotypes is an indirect form of improving epistemic access to patients. Critics of empathy in medicine also often fail to recognize that any means of engaging with others opens us to generalization and emotional and cognitive bias. What I have argued in this section is that engaging in cognitive empathy in clinical settings is no more prone to error than standard alternatives (as part of the standard diagnostic and communication process), and in fact has a number of advantages over otherwise detached forms of engagement.

Objection: Cognitive Empathy is Too Limited: Better to Employ Etiquette

Smajdor et al. (2011) argue that due to limitations with cognitive empathy in medical settings, it would be better replaced with the concept of ‘physician etiquette,’ a basic practical requirement to maintain polite and courteous communication with patients:

Etiquette is formal and generalisable. It is not based in the intimate ‘I/thou’ relationship that Buber proposes nor in the response to the unique subjectivity of patients that Cowley advocates. Etiquette enables people who are not in intimate relationships to interact without having to enter into each others’ subjective experiences, desires or values. Being polite may seem a very minimal requirement but, in fact, it is specifically with basic courtesy that doctors frequently struggle.\textsuperscript{250}

It seems plausible that in medical interactions where basic etiquette (understood as polite engagement) is lacking, it would be beneficial to implement, or even require, such practices. However, it is not clear that this approach to patients is inconsistent with utilizing empathy in medicine, or is even a clear alternative to such an approach.

\textsuperscript{250} Smajdor et al. (2011), 383. Etiquette would involve “keeping consultations to time without offending patients; persuading patients to comply with medication; encouraging them to give up smoking or take exercise. Patients value clear and courteous communication; unsurprisingly, it makes them feel better. Teaching doctors these skills is thus a valuable enterprise, but is it really empathy that is required in order to achieve this?”
Response: Replacing Empathy with Etiquette Bypasses Benefits

Replacing the account of clinical empathy that I have proposed with a thin form of etiquette risks losing the benefits of cognitive empathy in medical practice. While it is important that patients are treated politely, much of the previous argument suggests that employing cognitive empathy in patient interactions and consultations provides more information about patient states and fosters greater communication between physicians and patients. Further, patients report greater satisfaction when physicians employ perspective-taking in physician-patient encounters.

If (as Smajdor et al. argue) this basic sense of etiquette is missing from ordinary clinical encounters, it would certainly be an improvement to include it in ordinary practice. However, the central argument in this paper involves the ideal cognitive and emotional approaches to patient understanding and well-being. As such, there is a plausible case for employing a refined account of empathy in medicine over an otherwise detached, but friendly approach to patient diagnosis and treatment.

Objection: Emotions in Medicine are Unnecessary: Replace with Acting

Let us grant that the positive results (in patient care and recovery) that have often been associated with empathy are due to the emotional connection patients feel with their physicians and medical staff, as well as the compassion and concern that physicians express in medical situations. What is important to note is that even if a physician genuinely experiences empathic concern (sympathy or compassion), none of these states need to be actually experienced by the physician for the patient to perceive that the physician experiences such an emotional response.

As such, there have been several proposals in the medical literature for clinical staff to employ emotional labor in their medical practice. The term ‘emotional labor’ was first
introduced by Arlie Hochschild (1983) and “requires one to induce or suppress feeling in order
to sustain the outward countenance that produces the proper state of mind in others - in this case,
the sense of being cared for in a convivial and safe place.”251 In other words, to employ
emotional labor is to pretend to experience (and express) an appropriate range of emotions, given
your social and institutional context. For example, consider the friendly greeting when you enter
a local store. The individual greeting you might be hung over, angry, or despairing. But, they are
expected to maintain a warm demeanor nonetheless.

Applying this approach to medicine, Finestone & Conter (1994) argue that doctors must
improve their acting abilities to convey the “expressive performance” of emotions which signal a
concerned attitude toward the patient.252 In a clinical setting, a physician might deeply furrow
their brow in a sympathetic manner as they listen to a patient in distress, or shift the tone of their
voice as they tenderly console a patient in a time of loss. Physicians can do these things without
feeling actual sympathy or being emotionally moved by the actual concerns of their patients.
Larson & Yao (2005) distinguish between deep and surface forms emotional labor in medicine.
The former involves generating “emotional and cognitive reactions before and during empathic
interactions with the patient,” while the latter involves “forging empathic behaviors toward the
patient, absent of consistent emotional and cognitive reactions.” They further note that while
“deep acting is preferred, physicians may rely on surface acting when immediate emotional and
cognitive understanding of patients is impossible.”253

253 Eric Larson and Xin Yao, “Clinical Empathy as Emotional Labor in the Patient-Physician Relationship,” JAMA
Response: Emotional Labor in Medicine is Unethical/Ineffective

There are a number of issues with encouraging the suggested forms of emotional labor in medicine. However, emotional labor, as a form of deception, is rather unlike other deceptive practices like invoking therapeutic privilege or the use of placebos. Therapeutic privilege involves a physician withholding information (e.g. about patient condition) to prevent likely harm to the patient. In emotional deception, the physician need not withhold any relevant information, they merely deceive the patient into thinking they are the proper object of concern. The use of placebos typically involves giving the patient an inert substance with the proviso (implicit or explicit) that it will be effective for a particular outcome. Emotional deception is similar to placebo treatments, but rather than being given an inert drug, the very context and structure of the physician-patient relationship is emotionally ‘inert,’ without attention being drawn to this fact (“By expressing my emotional concern for you, I increase the likelihood that you will feel cared for. Trust me and adhere to my treatment.”)

The practice of emotional deception in medicine seems at least prima facie ethically objectionable. The patient is not being deceived about treatment details, but rather about the very nature of the care relationship. While patients typically are not looking for a best friend in their doctor, they do often desire genuine concern and compassion of medical staff (as evidenced by the numerous responses on patient satisfaction surveys). To be intentionally manipulated into a more trusting role, or to believe that someone truly cares for your well-being when you are very ill (even for beneficent ends), seems to be particularly deep violation of autonomy, even if for the goal of promoting patient health and well-being.

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254 Tom Beauchamp and James Childress, Principles of Biomedical Ethics (Oxford University Press, 2013).
First, I am not convinced that patients would consent to such practices. They would likely consent to being treated politely (even if the physician were feeling anxious or angry), but I suspect most would find deceptive empathic concern to be objectionable. Imagine that a patient is treated by a physician expressing deceptive care and concern. The patient is quite unwell, but given his interaction and treatment plan in hand, he now firmly believes he is in ‘good hands.’ This is due, in part, to the warm care he received. Were the patient to overhear the physician outside of his room discussing the interaction mechanically and dismissively, I think this would likely erode future trust and communication.

Second, I think the issue of emotional deception in medicine is complicated by the fact that there is a fast-growing institutional interest in patient satisfaction in medical care. A growing portion of physician compensation is tied to patient satisfaction measures, which will almost certainly introduce perverse incentives for physicians to engage in such emotional deception. While the practice seems questionable even in cases where the goal is beneficent (I deceive to potentially produce better health), it seems particularly objectionable when the explicit goal is self-interested (I deceive to improve survey responses for an expected pay increase). If the practice is to be justified at all, it must be motivated by the interest of

Perhaps (for the sake of argument), we can grant that emotional deception in medicine is morally justified if the intention is to promote positive patient ends. Even so, it is an open question whether such practices would have the desired therapeutic effects. I think that there are two reasons to suspect that such practices (if they became widespread) would likely fail to promote the desired outcomes. One concern is related to a standard objection to placebos in medical treatment: namely, that widespread public use will undermine trust. Another issue with empathy training in hospitals is that it is receiving increasing media attention as hospitals clamor
to engage medical ‘customers’ with better care. Even merely the idea that physicians are taking acting classes to better pretend to be concerned for our health would certainly seem to undermine patient trust.

An additional concern with empathy in medicine as a form of emotional deception is twofold. First, it places an additional burden on medical staff to receive and hone their theatrical abilities. Since presumably what drew them to medicine was not stagecraft, it is rather unclear that we can expect them to be effective actors, particularly under stress. This is problematic when we consider that Larson & Yao advocate two forms of acting: surface and deep. Surface acting is the otherwise superficial expression of certain emotional cues. The issue with this form of interaction is that it is more likely to produce a hollow and awkward form of engagement in the hands of otherwise busy medical professional.

On the other hand, the ‘deep acting’ that they prefer (which is a form of method acting) will often involve looking inward to conjure previous emotional states or experiences as a means of producing more intense or expressive emotional states. The issue with this form of engagement is that it takes concentration (and cognitive effort) away from the medical interaction, and turns the perspective of the physician inward to performance, rather than outward to patient needs. Physicians engaged in deep acting will likely give more convincing emotional performances, but my concern is that the focus on theatre legitimately detracts from the details of the patient’s perspective and needs. Time spent ‘rehearsing’ before an interaction is better spent reviewing case details.

My final concern with emotional labor (deception) is related to physician satisfaction (and burnout). There are reasons to think that encouraging physicians to engage in acting deprives them of certain benefits of actually engaging emotionally with patients (i.e. being
emotionally responsive to the situation of the target). There is some evidence that empathic concern might be beneficial for physicians. As noted earlier, both Decety & Gleichgerrcht (2013) and Lamothe et al. (2014) have found that higher-levels of perspective-taking and empathic concern (compassion/sympathy) were associated with greater ‘compassion satisfaction’ (satisfaction derived from effective medical care) and lower rates of burnout among physicians. In this way, the placebo-account might block physicians from a number of the benefits that accompany genuinely motivated medical care.

*Objection: Empathy in Medicine is Incomplete without Behavior*

Some critics have argued that the concept of empathy in medicine is incomplete, or requires theoretical extension. Benbassat & Baumal (2004) and Garden (2008) argue that accounts like clinical empathy are insufficient since they do not involve an action or behavioral component.255 For Garden, this behavioral component involves acting in a way that will alleviate the suffering of the patient. Similarly, Weiner & Auster (2007) argue that clinical empathy is similarly incomplete and propose that it be replaced with ‘caring,’ which is “a sustained emotional investment in an individual’s wellbeing, characterized by a desire to take actions that will benefit that person.”256

*Response: Empathy in Medicine is Conceptually Adequate*

The concern of critics seems to be that mere reliance on clinical empathy might not alone promote effective treatment or proper interventions on behalf of the patient. The claim that clinical empathy is not sufficient for effective medical treatment is plausible. After all, an empathetic physician could carefully examine and diagnose a patient, only to leave them waiting

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255 For Benbassat & Baumal, empathetic engagement produces compassion which motivates alleviation of concern.

256 Weiner and Auster (2007), 126.
in the exam room, to go on vacation for two weeks. Rather obviously, a physician can be empathetic without translating that empathetic response into a meaningful intervention or treatment.

However, there are several reasons to think that the concept of empathy in medicine is adequate. First, it is important to draw a distinction between the experience of a particular affective state or capacity and the typical behavioral motivations and actions that result from such a state. I may understand or feel what you are going through without any motivation to do anything about your state. Perhaps if I could, I would ordinarily be motivated to try to do something. But, the typical actions that result from my shared state are importantly conceptually distinct from what constitutes the experience of that state. I think it is a mistake to argue that my concept of a particular state (for example sympathy) must include a typical, though not strictly necessary, consequent of that state. In the case of sympathy, it might be to help, console you, or perhaps even cry.\textsuperscript{257}

At the same time, there are good reasons to hold that emotional states typically motivate us to behave in a number of ways. Empathic concern (compassion/sympathy) is closely related to engaging in pro-social behaviors, and perspective-taking continues to be a typical experimental tool for producing empathic concern.\textsuperscript{258} In clinical settings, the expected behavioral response of the physician can be derived from the larger professional and moral commitments of the medical profession, which has always placed great importance on promoting beneficence, alleviating unnecessary suffering, and respecting the autonomy of the patient. In this way, the institutional

\textsuperscript{257} Similarly, it seems odd to think that the concept of ‘stethoscope’ is incomplete because it does not involve the conceptual requirement that it be used for physically benefiting the patient. While a physician might fail to use their stethoscope for effective treatment (perhaps they use it to whip their irritating patients), this is not an obvious inadequacy with the concept of ‘stethoscope.’

\textsuperscript{258} See Batson (2011) for review. Batson has previously argued that perspective-taking is required for empathic concern, but he more recently denies this claim.
requirements for medicine already fix the goal for effective medical practice. Ideally, a physician (via empathy) may better understand or emotionally connect to patient concerns, but we expect the institutional norms of medicine to promote effective care even in the absence of such emotional engagement on behalf of the clinical staff.

As I have argued, employing empathy in medicine is a more effective means to patient treatment, the latter of which is assumed to be the goal in medical settings. In this way, clinical empathy is proposed as one of the tools (albeit a psychological one) of the effective physician. But, I think that it is an error to require that (conceptually speaking) the goal of alleviating patient suffering should be built into the concept of empathy in medicine.

The Problem of Time Constraints

There is at least one further objection to employing more patient-centered approaches to medical care that is not typically discussed in the literature on empathy in medicine: the growing problem of time allocation. Due to budgetary and institutional constraints, physicians are increasingly under great pressure to provide rapid medical diagnosis and treatment. For example, the average primary care consultation in the U.S. is approximately 15 minutes long.259 While this is adequate for very basic issues, it becomes highly problematic when the health concern is more serious, or when the patient has important questions about their health. There is a growing concern that even this slim window may be decreasing due to financial and bureaucratic pressures. According to a recent review conducted by Johns Hopkins University and the University of Maryland (shadowing medical interns), only about 12% of intern time was spent directly with patients, which amounted to approximately 8 minutes per patient interaction.260

One response might be to argue that our ideal approach to patients ought not to yield to bureaucratic pressure, and that the deeper institutional cause of the ‘time crunch’ should be identified and reformed. However, it is unlikely that this complex institutional problem will be clearly identified and solved anytime soon. So, this places pressure on approaches which seem to require lengthy and detailed narrative interactions with patients.

I think that the problem of the ‘time crunch’ poses a serious concern for providing effective medical care regardless of the account of empathy in medicine which we hold. However, there are good reasons to hold that the cognitive account of empathy is practically feasible, even with restricted patient consultations. Cognitive empathy need not involve a full, rich reconstruction of the patient’s subjective states to be effective. Close attention to facial and bodily cues, as well as targeted applications of perspective-taking in a consultation are not overly cognitively demanding and can be effectively utilized even in brief interactions. Since cognitive empathy still functions in a communication feedback loop, these brief simulations can be checked against the current patient state in the basic diagnostic conversation.

It is also important to note that not every physician-patient interaction demands the utilization of empathy. In some cases, just briefly checking a wound for infection, or inquiring about whether a medication has produced the expected results, can be done with a few questions and a simple observation. The extent to which it is appropriate to utilize empathy in a given case (and the depth of the investigation) will depend on the relevant circumstances and time available. Like many tools, techniques, and approaches, part of being a skilled medical provider is making a judgment about which tools to employ in a given situation to produce the most effective treatment.
Conclusion

I have argued that a widely discussed account of clinical empathy (involving emotional resonance with patients) is not well supported by the relevant empirical literature. Further, it is typically a liability in clinical settings. In response, I have argued that the ideal account of empathy in medicine remains cognitive, though employing empathic concern should be cultivated and expressed towards patients. I have further argued that such an account has the resources to plausibly respond to several objections to employing empathy in medicine.
REFERENCES


Batson, C. D., Shannon Early, and Giovanni Salvarani. “Perspective Taking: Imagining How Another Feels Versus Imagining How You Would Feel.” Personality and Social


———. “Perspective-Takers Behave More Stereotypically.” *Journal of Personality and Social


Landau, R. L. “And the Least of These is Empathy.” In *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, edited by Spiro, H., Curnen, M. G., Peschel, E., St James, D. Yale University Press, 1996.


———. “Commentary on Bloom’s Against Empathy.” *Boston Review*, 2014


*The Abolition Project* <http://abolition.e2bn.org/box_58.html>


