In Defense of Sympathy, in Consideration of Empathy, and in Praise of Compassion: A History of the Present

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History is the best medicine for a sick mind, for in history you have a record of the infinite variety of human experience plainly set out for all to see, and in that record you can find for yourself and your country both examples and warnings: fine things to take as models, base things rotten through and through to avoid.

Livy, Roman Historian.

The Historical Roots of Sympathy

Amid the shock of so many passions that oppress the weak or marginalize the unfortunate, from the bottom of its heart humanity secretly pleads the cause of sympathy and avenges it from the injustice of fate by arousing the sentiment of natural equality.

Sophie de Grouchy.

Introduction

Beyond Semantics

Sympathy, empathy, and compassion are frequently invoked concepts in contemporary health care, particularly in incidences when we find ourselves at a loss for words or curative interventions. Linguistic epistemologists remind us that words are powerful—they shape our thoughts, determine what is truth, influence our actions, and can instil healing or harm in the patients in our care.1 But are sympathy, empathy, and compassion words that everyone uses, but no one understands?—being treated dichotomously on the one hand and conflated on the other.1–4 Although the perspectives of current patients, practitioners, policy makers, researchers, and contemporary thinkers are an invaluable source of knowledge in helping to disentangle these terms,1,4–6 the humanities remind us that contemporary thoughts on the nature and differences of these concepts may not be as novel, revolutionary, and enduring as we might think. The purpose of this article was to provide an account of the evolution of these terms within history and health care to provide clarity and to understand the clinical implications associated with them in contemporary practice.

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in describing how symptoms in a distinct region of the body are affected by illness/pathology within a seemingly separate region of the body. As Holmes summarizes, “Sympathy” is overwhelmingly used by Galen to express what must have been an existing technical notion within the learned medical tradition, according to which, diseases, or more properly, ‘affections’ (pathé) are trafficked from one part of the body to another.\(^\text{19}\)

The term sympathy retained a largely biophysical meaning until the end of the 16th century when it began to be used to explain the ability of one individual to attune to the feelings of another. As a result of this expanded understanding of sympathy to the affective realm, sympathy enjoyed exemplary status within Western society so much so that the 18th century has been coined the “age of sympathy.”\(^\text{10}\) As Hume lauds, “No quality of human nature is more remarkable ... than the propensity we have to sympathise with others, to receive by communication their inclinations and sentiments, however different from or contrary to our own.”\(^\text{11}\) The realization of the ability to emotionally resonate with others was considered a mechanism for prosocial behavior and social reform by philosophers, educators, and ethicists and was readily incorporated into discourses on child rearing, morality, and human relations.\(^\text{11–14}\) As a result, by the end of the 18th century, sympathy was largely synonymous with our contemporary understanding of compassion. According to Adam Smith, the famous 18th-century philosopher and economist, sympathy involved putting ourselves through our imagination in the place of someone else and feeling what they feel, be it joy or sorrow; and thus enlivening joy and alleviating grief through shared feelings.\(^\text{14}\) The close affinity between this historical understanding of sympathy and contemporary understanding of compassion is further evident in the fact that the Greek word *sympatheia* was increasingly translated as *compassio* in Latin, Italian, French—eventually resulting in the original meaning of *sympatheia* being literally lost in translation.

### The Fall of Sympathy: Contemporary Insights

Sympathy’s demise was a slow and gradual one. While throughout the 20th century “sympathy” was still used to describe the ability to feel what others feel, its potential for societal reform was increasingly disdained and replaced with a growing sentiment of cynicism.\(^\text{1,15,16}\) Twentieth-century definitions of sympathy by social and developmental psychologists were increasingly denuded from its etymological roots of “fellow feeling,” taking on a more pejorative meaning of feeling sorrow or pity for the emotional state of an “other.”\(^\text{17–21}\)

The devolution of sympathy within health care to what was recently described as a pity-based response that was unwelcomed and in some incidences despised by patients\(^\text{5}\) is due in part to the emergence of the more objective, scientific, and apparently more complex construct of empathy within the 20th century.\(^\text{1,22}\)

#### The Historical Roots of Empathy

Don’t judge a man until you have walked a mile in his shoes.

*Cherokee Proverb*

The English word empathy has its etymological roots in the late-19th-century German term *Einfühlung*, which literally means “in feeling,” with its first known usage being attributed to the German psychologist Robert Vischer in 1873, to describe the ability to project the self into a viewed object such as a piece of art or into another person’s situation.\(^\text{23,24}\) Another German psychologist, Theodore Lipps, described empathy as “objectified self-enjoyment,”\(^\text{25–27}\) whereas his colleague E.B. Titchener defined empathy as the process of humanizing objects, of feeling ourselves or reading ourselves into them.\(^\text{28}\) The legacy and impact of empathy within psychoanalytic schools of the 20th century can be traced through the translation of Freud’s works into English, with empathy being used to translate Freud’s use of *Einfühlung*.\(^\text{28}\) In this way, empathy implied a psychological projection but not specifically esthetic,\(^\text{24}\) through object relations theorists and the self-psychology of Heinz Kohut who defined empathy as “vicarious introspection.”\(^\text{29}\)

Following his theory, “We see a person who is unusually tall. It is not to be disputed that this person’s unusual size is an important fact for our psychological assessment—without introspection and empathy, however, his size remains simply a physical attribute ... Only when we think ourselves into his place, only when we, by vicarious introspection, begin to feel his unusual size as if it were our own and thus revive inner experience in which we had been unusual or conspicuous, only then begins there for us an appreciation of the meaning that the unusual size may have for this person and only then have we observed a psychological fact.”\(^\text{20}\).

As a result, empathy, in its original usage, attempted to avoid the messiness and vulnerability of “feeling with” a fellow human being associated with sympathy, in favor of a more objective and emotionally detached stance that was dependent on the ability to literally “put oneself in the shoes of another.”
The Rise of Empathy: Contemporary Insights

Over the course of the late 20th century and early 21st century, empathy began to develop a softer side, affective empathy—the ability to not only understand what it would be like to be in a person’s situation but also resonate or attune to the person’s feelings—thereby returning and reinserting sympathetic resonance into the vernacular of 20th-century empathetic discourses. Based on this new understanding, contemporary researchers with the aid of scientific progress and technology began to identify “the empathy circuit,” a series of neural circuits within the cortex and limbic system that are activated when observing another person’s feelings. In addition to identifying a neurological basis for emotional resonance, researchers noted the activity of mirror neurons in regions of the brain associated with thought and language formation, suggesting that a more detailed understanding of the situation was also occurring. Thus, whereas cognitive empathy facilitates an understanding of the emotions of another person by discerning body language, perspective taking, and reflecting this objective understanding back to the person in need, affective empathy involves understanding the experiences of another person by sharing their emotions—directly attuning to the feelings of the other person.

Although the majority of researchers acknowledge the cognitive and affective domains of empathy, the prosocial aspect of empathy, such as having concern or its orientation toward action, is contested. Some researchers depict empathy as a series of evolving concentric circles, moving from cognitive perspective taking, emotional resonance, developing feelings of concern, and a motivation to address suffering. A second group of researchers postulate that although empathy allows us to know what the other person is feeling or thinking, it does not necessarily include any warm feelings of concern or the desire to help. In fact, some researchers have even suggested that there is a potential “dark side” to empathy involving attuning to the feelings of another person to take advantage of their vulnerability, to manipulate them, or even to exacerbate their suffering. Increasingly, however, researchers and patients themselves associate empathy with the ability to acknowledge, understand, and emotionally resonate with a person’s feelings and situation, reserving the prosocial desire to help and action aimed at the alleviation of suffering to compassion.

Although the Latin root for the term compassion (compassio) was often used interchangeably when translating sympatheia from ancient Greek in the 16th century, the concept originally held a deeper meaning and religious connotation that was rooted in love and the spiritual connection of living beings through a Higher Power, God, the Universe, Nature or a Life Force. The higher purpose and deeper meaning of compassion is evident in the words of the 16th-century Christian mystic Teresa of Ávila, “You are the eyes through which to look out Christ’s compassion to the world,” the Dalai Lama, “Whether one believes in a religion or not and whether one believes in rebirth or not, there isn’t anyone who doesn’t appreciate kindness or compassion... Our prime purpose in life is to help others,” and Albert Einstein, “A human being is a part of the whole, called by us ‘Universe,’ a part limited in time and space. He experiences himself, his thoughts, and feelings as something separate from the rest—a kind of optical delusion of his consciousness. The striving to free oneself from this delusion is the one issue of true religion. Not to nourish it but to try to overcome it is the way to reach the attainable measure of peace of mind.” Whereas the emotional resonance of sympathy and empathy was limited to the connection between human beings, compassion, both in terms of its motivation and source, added a transpersonal dimension to the interconnectedness between providers and recipients of compassion.

Compassion: Back to the Future

In the latter part of the 19th and much of the 20th century, the importance of compassion within health care was especially emphasized within the field of nursing, which was strongly influenced by the religious orders within which many schools of nursing found their origins. In fact, for early nurse leaders such as Nightingale, Dock, Goodrich, and Wald, compassion was esteemed as the essence of nursing occupying a prominent place in nursing textbooks and training programs for much of the 20th century. By the end of the 20th century, however, nursing researchers began to recognize that compassion was receding from the prominent position that it once occupied within the discipline, a phenomenon that has been attributed to a variety of factors including...
the professionalism, medicalization, consumerization, and secularization of nursing and health care in general.67–69 Ironically, recent high-profile reviews of health care failures in the U.K. not only identified a lack of compassion as a significant systemic cause but also unfairly implicated nurses in the process, calling for the renewal of compassion training for future and practicing nurses.61–66

Contemporary researchers on compassion recognize that a further distinctive feature and challenge of compassion is its deeply personal nature—invoking health care providers' personal qualities or character and not simply their professional qualities. As William Osler attests, "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised as much as your head."67 Thus, compassion requires a willingness on the part of health care providers to be vulnerable, to not only "feel with" their patient, but also "suffer with" them,68 being professionally and personally impacted in the process.69–71 Although this has raised many questions about the potential negative impact of providing compassion,72,73 other researchers argue that providing compassion actually has a sustaining effect that disentangles health care providers from emotional contagion to action.4,64,74 For example, Tania Singer, a neuroscientist, recently discovered that empathy activated regions of the brain in the observer associated with pain, while the loving kindness and pro-social aspects of compassion extend beyond this mirroring state, activating regions of the brain associated with love, warmth, reward, and affiliation.75 As a result, although researchers acknowledge that health care providers are susceptible to burnout, vicarious suffering, and occupational stress, attributing these conditions to compassion may be misguided and harmful for both health care providers and patients.48,74

**Clinical Reflections—The 3Rs for Assessing and Enhancing Compassion in Practice**

Based on this historical overview, patient research, and our clinical experience as a psychologist and spiritual care provider working with palliative patients and their families, we suggest that there are three essential questions that health care providers consider in assessing and enhancing compassion in their patient care: 1) Relate: How do I relate to the person in my care? 2) Respond: What is my response to suffering? 3) Role: What are my beliefs about my role in this process?

**Relate**

Compassion requires health care providers to reflect not only on how they see the patient but also on how they see themselves in relation to them. The language we use in referring to individuals in our care can be a powerful indicator and influence of these underlying attitudes. Whether we refer to them as a client, a resident, a health care consumer, the 65 year old with metastatic pancreatic cancer in Room 463, a patient, a person, or by their first name not only tells us how we see them but also tells us how they are seen by us. Compassion also implores us as health care providers to consider how we see ourselves in relation to the person in our care—is our relationship based on shared humanity, mutual suffering, interrelatedness on a spiritual level or a strict physician/patient relationship, deservedness, or based on a socioeconomic, cultural, or religious similarities. While on the surface these may seem like simplistic or esoteric questions, in our experience, they have a profound and tangible effect on patients' experiences of compassion and are often a distinguishing feature of colleagues we esteem as exemplary compassionate health care providers.

**Response**

How we as health care providers respond to suffering is the second demarcating feature of compassion. Although sympathetic resonance is an important starting point for compassion, as an end point, it is largely ineffective in alleviating suffering. Although sympathetic resonance may have a cathartic effect for patients knowing that their health care provider commiserates in their suffering, it may have the opposite effect on health care providers whose only option is to absorb their patients' suffering, making them susceptible to vicarious suffering. Similarly, while empathetic concern adds an element of cognitive and emotional understanding to health care providers' response to a patient's suffering, historically, it entails a more objective response that, while making patients feel understood, does not necessarily translate to them feeling cared for or having their suffering addressed through action. A compassionate response to suffering extends sympathetic resonance and empathetic concern by engaging the virtues of health care providers and the addition of action. Although compassion requires more from health care providers, both on a personal and professional level, contrary to popular opinion, this does not necessarily make them more susceptible to burnout.75 In fact, true compassion may have a sustaining effect on health care providers by allowing them to practice in a self-congruent manner and by providing an outlet for suffering—action that protects against emotional contagion on the one hand and helplessness on the other.

**Role**

Cultivating compassion as health care providers also requires us to reflect on our beliefs about our role in
addressing suffering. While compassion requires health care providers to engage and attempt to ameliorate the suffering of our patients, this does not mean that we are responsible for finding answers or annihilating suffering altogether. History and clinical practice teaches us that in regard to compassionate care, while health care providers play an instrumental role in the healing process, their role is not fundamental to this process. The latter leads to chronic caring that places the onus for alleviating suffering on the health care provider, whereas the former allows health care providers to fully engage suffering knowing that they are but one medium of healing within a broader team or a greater source of healing.

Conclusion

Compassion is a verb. Thich Nhat Hanh.

Understanding the history of the concepts of compassion, empathy, and sympathy can provide important insights that can optimize the care that we provide to patients and protect health care providers in the process. History teaches us that although these terms share a common lineage, they also evolved, devolved, and borrowed from each other over time. Thus, although history can teach us about the original meaning of these terms, patients can teach us about their contemporary meaning and how they distinguish between these interrelated terms. Sympathy has come to be understood by patients as an unhelpful, pity-based response that often exacerbates their suffering, whereas empathy involves acknowledgment, attunement, and understanding of a person's situation and feelings through emotional resonance. As for compassion, history and patients largely agree—compassion is a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action. This understanding has not only stood the test of time but also is a form of care that patients prefer and hope is a more prominent feature of their health care experience in the future.

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