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A Phenomenological Approach to Clinical Empathy: Rethinking Empathy Within its Intersubjective and Affective Contexts

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A Phenomenological Approach to Clinical Empathy: Rethinking Empathy Within its
Intersubjective and Affective Contexts

by

Carter Hardy

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
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Dedication

To Raechel, for always believing in me and keeping me smiling

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Abstract

This dissertation contributes to the philosophy of empathy and biomedical ethics by drawing on phenomenological approaches to empathy, intersubjectivity, and affectivity in order to contest the primacy of the intersubjective aspect of empathy at the cost of its affective aspect. Both aspects need to be explained in order for empathy to be accurately understood in philosophical works, as well as practically useful for patient care in biomedical ethics.

In the first chapter, I examine the current state of clinical empathy in medicine including professional opinions about empathy, the dominant definition being employed, and the problems that arise from this definition. By trying to define empathy in a way that is useful to the current presuppositions in medicine, clinical empathy aligns with simulation theory, which has three problems: the discrepancy between the way empathy is defined and the way it is explained, the lack of diversity that this theory of empathy allows in our understanding of others, and the lack of affective understanding and affective engagement involved in the patient-physician interaction. These three problems are used to derive three questions that are important for any theory of empathy: (1) What is the phenomenon being explained? (2) What is the intersubjective context of empathy? (3) What is the affective dimension of empathy? The best theory of clinical empathy can be formulated by answering these three questions as they relate to phenomenological theories, which are more attuned to overcoming presuppositions.

Chapters two and three each examine a different phenomenological approach to empathy from opposite extremes in their theories of intersubjectivity. Husserl and Stein begin from an isolated, transcendental subject that needs empathy to bridge the gap between itself and others,

while Scheler begins from a primary intersubjectivity in which self and other are undifferentiated, making empathy a largely unnecessary skill. Despite their strongly opposed positions, and the acknowledgement that their theories of intersubjectivity necessitate their theories of empathy, I argue that both fail to understand the affective dimension of empathy. Husserl and Stein leave no room in empathy for it to be an affect, while Scheler prioritizes affects that reunite subjects, but leaves empathy itself as a non-affective skill.

Chapter four explains Gallagher's interaction theory as a more moderate approach to the relation between empathy and intersubjectivity. He draws on the insights of the other two theories, but conceives of empathy as a multi-leveled phenomenon that allows for an understanding of others. While this theory does aid in addressing the intersubjective context of empathy in a way that best solves the first two problems with clinical empathy, interaction theory still fails to fully address the affectivity of empathy, maintaining empathy as a largely cognitive ability. Gallagher does acknowledge the affective core of empathy, but he does not explain the way in which it is affective. In response to this problem, I explain Anya Daly's application of Merleau-Ponty's theory of reversibility to affectivity as a possible solution to the problematic gap in Gallagher's theory.

Chapter five focuses on theories of clinical empathy in order to address the neglected affective aspects of empathy, and respond to the problem of detached concern. The problems caused by detached concern are explained, as well as why the theories discussed in the middle chapters are still unable to solve them. This is done in two parts. In the first part, I explain the basis of this issue in the cognitive/feeling divide, as explained in the philosophy of emotion. Then, I give a brief overview of the phenomenology of affectivity to be used as a guide to the affectivity of empathy. In the second part, I examine three theories of clinical empathy that

attempt to solve the problem of detached concern, noting their strengths and weaknesses based on their similarities to phenomenological approaches to empathy and affectivity.

Introduction¹

According to recent studies, the physician's ability to empathize with patients is weakened during medical training, and this weakened ability can lead to a serious deficiency in patient care (Eikeland et al. 2014; Hojat et al. 2004; Hojat et al. 2009; Suchman et al. 1997; Tavakol et al. 2012; Ward et al. 2012). The cause of this weakened ability is attributed the overall lack of interest that medical students and professionals have in empathy. According to these studies, there is some pivotal point during medical school when students begin to believe that empathy is not a worthwhile experience, and this lack of interest in empathy is maintained even after students become physicians (Eikeland et al. 2014; Hojat et al. 2009). This demonstration of the devaluation of empathy in medicine is problematic and has been connected to a deficiency in patient care. Therefore, in the interest of improving patient care, these studies also argue that empathy is a skill that should be fostered in a student's initial medical training. While they are not alone in this push (Derksen et al. 2013; Di Blasi and Kleijnen 2003; Halpern 2001; Hooker 2015; Pedersen 2008; Roter et al. 2006), it is no coincidence that affective experiences like empathy have been devalued in medicine, and therefore it needs to be explained why empathy is valuable to medicine.

To begin with, empathy was devalued largely because it is an affective experience. Among other affective experiences—such as emotions, mood, and feelings—empathy was understood as being opposed to good medical practice because it detracts from the objectivity of

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the field, which has become one of the foundations of contemporary medicine. Medicine is a science, and medical problems are understood as scientific problems—they are physical, observable problems with definitive, identifiable solutions. Even for illnesses without cures, there is both the expectation that cures will be found and the understanding that some form of treatment or care is available to help patients live with their illnesses. This scientific foundation for medicine—often called evidence based medicine (EBM)—has serious benefits. These benefits include, but are not limited to, the objective identification of diseases and their causes, the rapid advancement of medical technology and pharmaceuticals, and the greater confidence in the healing abilities of medical professionals. Overall, EBM has led to the view that there is objectivity in medical practice and that the best patient care is achieved by maintaining this. As such, subjective experiences, such as emotions and feelings, should be avoided because they may serve to derail the objectivity of medicine. Like computers, physicians are expected to be unbiased and devoid of emotions; they are expected to be capable of taking in information and giving out results quickly and accurately. This expectation is held by patients and physicians alike.

For physicians, there is a fear that emotions and feelings will unnecessarily complicate the physician-patient relationship. They will not only detract from objective judgment; they will lead to dangerous attachment and the possibility of professional burnout (Ekman and Halpern 2015; Eikeland et al. 2014, 5; Halpern 2011; Hooker 2015, 542; Testerman et al. 1996). Physicians risk becoming overly invested in their patients' lives and health, to the point that it will affect their judgment and emotionally exhaust them with further emotional responses. Whether treatments are successful or unsuccessful, physicians will experience emotional highs

and lows that can be dangerous for the physicians' mental health. For this reason, many believe it would be easier to abstain from emotional responses and attachments.

For patients, there is an expectation that physicians will be able to hear everything that the patient says about his or her condition, identify the problem, and offer a definite solution. We see this mentality within the practice self-diagnosis through programs like WebMD. Patients now have the ability to check all their information against a database and quickly match it to possible illnesses and treatments. Even if this is only the first step prior to a visit to the doctor's office, these searches are seen as genuine ways to determine the patient's condition. Many patients expect physicians to be no more than sophisticated versions of these online databases. They are expected to be efficient and unbiased such that they will help patients with their illnesses in exactly the way that the patients want. However, as becomes evident in such examples, there are costs to this view of medicine and medical professionals as being affectively neutral.

These costs include an increased demand on what physicians need to know, a decrease in the importance of the patient's perspective, and a greater disconnect between patients and physicians. In clinical interactions, patients often feel alienated, misunderstood, and as if their points of view on their own illnesses are unimportant (Derksen et al. 2013; Halpern 2014a, 303). Physicians seem to be studying them rather than listening to them. On the other hand, physicians tend to feel a significant amount of stress, a disconnection from their work, and a lack of fulfillment (Eikeland et al. 2014, 1; Halpern 2014a, 304; Larson and Yao 2005, Shanafelt et al. 2005). There is a discrepancy between what is expected of physicians and what is desired of them. When patients inevitably meet with physicians, they want and need more than a computer in a clinic.

Physicians are not merely machines. In fact, they are not even merely scientists. Unlike many other sciences, the relationship between physicians and patients is not one between a subject and an object, but rather an intersubjective relationship—a very ethically delicate intersubjective relationship in which the physician carries a very heavy burden. Unlike with machines, physicians have the opportunity to genuinely understand us and our health problems. In clinical interactions, understanding is essential to good medicine and providing the best patient care. Patients do not just go to physicians because they need information; they go to physicians because they need help. We turn to physicians because clinical expertise is more than simply taking in data about the patient and providing an answer. They not only hear the symptoms that we report but know how to draw other important information out of us. They do not just offer all possible diagnoses and treatments, but offer what they believe to be the more likely answers. Therefore, to do their jobs well—to best care for their patients’ needs—physicians need to be able to understand their patients. This understanding, however, is not easy to achieve.

To begin with, the ideal interaction, in which patients calmly tell their physicians all of their relevant symptoms in such a way that the physicians can (more or less) easily determine the problem and best solution, is a myth. In reality, patients are often afraid and confused. They know very little about their conditions, nor what other problems their conditions may indicate. They hold ideologies that hinder what they will share, what they believe about their conditions, and the treatments they are willing to even attempt. In many cases, the patient may not be able to talk to the physician at all, either due to a physical problem, such as being unconscious, or because they are afflicted with a psychological disorder that prevents them from talking. More difficult still are situations when the patient left no written or verbal indication of what they

would want done. Despite all of this, physicians need to understand their patients' conditions, symptoms, medical and family histories, religious beliefs, and so on. Physicians need a way to move through all of the confusion so that they can best understand their diverse patients in a variety of situations. In short, understanding patients can often be a difficult task.

Additional problems for understanding arise from the physician's perspective. Physicians are emotional beings dealing with other emotional beings, and therefore will not usually be able to approach their patients neutrally. They do not have the luxury of examining and assessing objects like in many other sciences. They have to deal with subjects. Patients can be difficult, disagreeable, and unlikable. Physicians can have good days and bad days. They can suffer from anxiety, depression, and other mental disorders that alter their perceptions of the world. All of these features of the intersubjective, clinical interaction make the possibility of an affectively neutral interaction incredibly unlikely, which can in turn make understanding the patient more difficult.

This difficulty understanding the other in a field where understanding is not only helpful, but also essential to care, is a serious problem that needs to be solved. However, despite the traditional popularity of abstaining from all affective experiences, this solution has been shown to be flawed. Neither physicians nor patients can actually get rid of their emotions and feelings, and pretending they can is more of a flight from reality than a genuine solution. Affects need to be acknowledged and accommodated. Some may serve to derail reason and objectivity, but some guide and enhance our reasoning and understanding. It is for this reason that some are now revisiting the topic of empathy as something that is essential to good medical practice—something that is believed to provide physicians with better understandings of their patients.

However, while any opportunity to improve patient care and physician mental health should be supported, and the human ability to empathize does have its merits in regard to our care for one another, proponents of empathy need to be careful. Empathy is a term that has many meanings and is often used in different ways to solve many problems. If empathy is going to be accepted as a genuinely useful experience for physicians, then we need to understand exactly what we mean by empathy and the ways in which it is useful for medical practice. However, even when we do isolate a specific definition for clinical empathy, it leads to new problems that need to be addressed before empathy can be accepted as useful for medical practice.

The discussion of empathy has a very rich tradition. This is true of both the discussion of empathy in philosophy and the discussion of clinical empathy in medicine. From these discussions, as well as others in aesthetics, psychology, and the cognitive sciences, we now possess a variety of different theories for what empathy is and how it works. While these areas discuss empathy differently, theories of empathy have predominantly fallen under one of two approaches. There is empathy as it has been addressed within the analytic tradition of philosophy in which it is a method that we apply, and empathy in the phenomenological tradition in which it is something that we experience. Each of these have led to very different insights regarding the nature of empathy. While analytic theories have been the most prominent in medicine, it may be very beneficial for both approaches be examined and understood, and possibly intertwined into new, hybrid theories of empathy. However, in the history of attempts to revalue clinical empathy, it is only the former that has gained any significant attention.

Again, for much of the history of clinical empathy, it was viewed as an emotional experience directed at the other. It is for this reason that it was understood as a dangerous experience for physicians. As an emotional experience, was a subjective way of understanding

the world. It was not something that could be controlled and therefore could derail their objective understanding against that better judgement. However, in order to revalue empathy in medicine, it has been argued that empathy is actually is something that we do—a cognitive process or method that we implement in order to gain some detached, objective understanding of the other (Halpern 2001). Despite how promising this may seem, as a process there are a number of problems that can arise if the wrong theory of empathy is accepted. Solving these problems will require us to examine empathy holistically, as both an intersubjective understanding of other and as an affective experience.

In chapter one, I examine the practical problems that can arise for purely understanding-based theories of empathy by examining the role empathy plays in medicine. I further examine the transition from the traditional views of empathy in medicine to the current state of empathy in medicine, as revalued in line with simulation theory (henceforth ST)—that empathy is a simulation of the patient’s mental states, as well as the proposed benefits of empathy. Next, I identify three problems that arise for the simulation theory of clinical empathy: the discrepancy between the way empathy is defined and the way it is explained, the lack of diversity that this theory of empathy allows in our understanding of others, and the lack of affective understanding and affective engagement involved in the patient-physician interaction (or the problem of detached concern. This maintains many of the same problems of traditional medicine in which empathy was rejected. In the final section, these three problems are used to derive three questions that are important for any theory of empathy: (1) What is the phenomenon being explained? (2) What is the intersubjective context of empathy? (3) What is the affective dimension of empathy?

In this sense, chapter one provides the current, problematic definition of empathy that needs to be redefined by better addressing the three questions of empathy. In short, empathy is a non-affective simulation of the other that is required for a subject to have any understanding of the other's hidden thoughts and feelings. In the following chapters, I examine three phenomenological theories of empathy in order to consider how well alternative theories of empathy address the three questions presented above where ST failed. The first two reject empathy as being a process of understanding, while the third theory interprets empathy as both an experience and a process.

In chapter two, I explain and critique the theory of empathy presented by Edmund Husserl and Edith Stein, which is one of the most prominent phenomenological approaches to empathy. Despite the benefits of their approach, their attempts to describe empathy itself from the standpoint of the transcendental ego creates problems for both the intersubjectivity and affectivity of empathy. Transcendental intersubjectivity neither guarantees the existence of *actual* other subjects, nor does it give us access to them if they do exist. This makes empathy necessary for intersubjectivity. Both argue that empathy is an irreducible form of intentionality that allows a subject to experience a foreign consciousness. As such, empathy is a special kind of perception, but one that cannot be affective, at least not in terms of Stein's theory of affectivity. Therefore, I critique this theory for focusing too strongly on how empathy serves the problem of intersubjective understanding at the cost of the affectivity of empathy.

In chapter three, I explain and critique Scheler's discussion of empathy, which approaches the topic from the opposite extreme of Husserl and Stein. That is, Scheler begins from the position of primary intersubjectivity—an undifferentiated, intersubjective stream of experiences that belong to both subject and other, and from which both subject and other are

extracted. This leads him to reject empathy and instead focus on the intersubjective affects that reunite us with others. While there are advantages to his theory of intersubjectivity and his revaluing of other affects like sympathy, I argue that his explanation and rejection of empathy is unwarranted, and it causes him to neglect the affectivity of empathy itself.

In chapter four, I explain Gallagher's interaction theory of empathy (henceforth IT), which responds to problems in the theory of mind debate by appealing to phenomenological approaches. In this way, he serves as a promising example of how both analytic and continental theories can be merged into better theories. IT defines empathy as an understanding of the other, which can be achieved at different levels. Rather than being based on theories or simulations, this understanding is accomplished in our interactions with others. His theory maintains many of the positive aspects of the phenomenological theories from the previous two chapters, while presenting a more moderate theory of the intersubjectivity of empathy. As such, only the affectivity of empathy is left in need of elaboration. However, it is possible to interpret some of the levels of intersubjectivity/empathy as being affective in Gallagher's theory. To demonstrate, I appeal to Anya Daly's argument that empathy is affective reversibility, which corresponds to the levels of primary and secondary intersubjectivity. She intentionally uses the work of Merleau-Ponty to build on Gallagher's theory and offers an interpretation of empathy as an affect in interaction theory.

In chapter five, I turn to theories of clinical empathy in order to further address the neglected affective aspects of empathy in an applied way. I do so by showing the way that they build on the insights of the same narrative-based approach as IT in order to respond to the problem of detached concern. The focus of the previous chapters was primarily on the close connection between the explanation for empathy and the intersubjective context of this

explanation, while revealing how the affective dimension of empathy is either left unaddressed, poorly addressed, or addressed as an entirely separate topic. The negative effects of neglecting the affectivity of empathy are highlighted by the problem of detached concern that arises in medicine, in which this neglect has led to serious problems in patient care. I explain phenomenological insights in the philosophy of affectivity and how these relate to the problems that arise in the affectivity of empathy. Then, I examine three different contemporary approaches to defining clinical empathy that build on the insights of IT.

Examining the theories throughout these chapters will allow for a better, hybrid theory of empathy to be presented. Rather than settling for ST and the problems that arise for it within its tradition, theories of clinical empathy need to be opened up to the theories in other traditions, such that empathy can be addressed holistically. This is meant in two ways. The first is that empathy is not isolated to merely its intersubjective context—as has been the directive in traditional approaches—but rather also assessed within its affective context. The second is that, by applying the three questions to both analytic and continental theories of empathy—which have, until recently, been largely-isolated approaches to empathy—a theory can be created that will actually lead to a better understanding and better patient care. While both traditions have failed to address all the important aspects of empathy, I primarily focus on the phenomenological theories of empathy, since the dominant theory of clinical empathy (ST) is already an analytic theory. Phenomenological theories of empathy have been neglected in medicine, thus making the examination of their strengths and weaknesses helpful in improving contemporary theories of clinical empathy.

Chapter One: The Problem of Clinical Empathy²

While the topic of empathy is gaining more attention in medicine, the exact nature, purpose, and benefits of empathy are not clear. In contemporary medicine, empathy is still largely seen as unimportant to most medical practice, at best being delegated as a skill that is uniquely required for nurses (Cadge and Hammonds 2012, 270; Henderson 2001; Määttä 2006; Svenaeus 2014a, 247; 2016, 242). This is likely because nurses have traditionally been charged with the care of patients on a personal level, at which they must interact with patients as well as connect with them on an affective level. Other medical professionals, on the other hand, are expected to be more detached in their approach to patients, searching for empirical facts in order to solve objective medical problems. This view is now changing and empathy is being seen as a necessary skill for clinical interactions. The problem is that the newfound desire for empathetic physicians does not help with the actual prescription of empathy, since empathy itself is not a well-understood phenomenon.

To begin with the discussion of empathy is not limited to the medical field. Clinical empathy, though a very important kind of empathy, is only one context-specific theory of empathy. Many different fields discuss empathy in many different ways. This means that it is not uncommon for different people in a discussion about empathy to talk past each other. Even when isolated to specifically the medical field, a single definition of empathy is difficult to identify (Garden 2008; Pedersen 2008; 2009; 2010; Svenaeus 2014a; 2014b; 2015). However, the

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vagueness of empathy does not mean that the topic itself is vacuous, nor should it discourage discovering the prominent theory of empathy in medicine. What this vagueness indicates is a need for an examination of the background assumptions for theories of empathy, as well as what specific problems empathy is meant to solve. Doing so will allow us to have a better understanding of the role empathy is expected to play in medicine (if any), how clinical empathy is being defined, and whether or not the explanation meets the desired results. In order to accomplish these goals, this chapter proceeds in three parts.

First, I explain the current state of empathy in medicine. In doing so, I explain the traditional view of empathy as a negative experience that ought to be avoided, as well the more recent view that empathy needs to be revalued in medicine. This section concludes with an outline of simulation theory, which is the most prominent theory of empathy currently being applied in clinical interactions. Second, I address three serious problems that arise for the current conception of clinical empathy. These include the discrepancy between the definition and the explanation of empathy, the diversity problem, and the problem of detached concern. In the final section, I use these three problems to outline three questions that any theory of empathy needs to be able to answer in order for us to have a complete understanding of the experience. The current conception of clinical empathy has serious problems associated with each question, indicating the need for a new theory of empathy. I recommend a phenomenological approach to empathy as the best way to answer these questions.

1.1 The Current State of Clinical Empathy

In order to best assess the current theory of clinical empathy, we need to have a good understanding of both traditional and contemporary views of empathy in medicine. In this section, I begin by explaining the negative view of empathy in medicine, including the reasons

why both medical students and professionals are reluctant to implement empathy in their field. Next, I give an overview of the ways in which this view of empathy is also being resisted in current philosophy of medicine and biomedical ethics. Empathy is now being seen as a positive skill for physicians—one that that has benefits for both patients and physicians—and thus as a skill that needs to be cultivated. However, this need for empathy in clinical interactions, which are not currently structured for the inclusion of empathy, necessitates a specific conception of empathy to be cultivated in medical professionals. Therefore, I conclude this section by isolating the simulation theory of empathy as being the theory that is most commonly associated with clinical empathy. While this theory has a rich history and several benefits for clinical interactions, it can be shown in the next section that it does not actually solve the problems clinical empathy is meant to solve.

1.1.1 The Negative View of Empathy in Medicine

Many have noted and discussed the difficulty of current medical students and professionals to empathize with patients (Eikeland et al. 2014; Hojat et al. 2004; Hojat et al. 2009; Suchman et al. 1997; Tavakol et al. 2012; Ward et al. 2012). Studies have made use of multiple tools to measure this decline in empathy, including the Jefferson Scale of Physician Empathy (henceforth JSPE), the Interpersonal Reactivity Index, and other questionnaires (Hojat et al. 2004, 935-936; Hojat et al. 2009).³ However, it should be made clear here that these

³ The JSPE is particularly important because it was specifically designed to measure empathy in medical practitioners. While there are other measures for empathy, this was the first developed specifically for the medical field (Hojat et al. 2004, 935-936; Hojat et al. 2009, 1183). The JSPE has two forms: one for measuring the ability to empathize in medical students (S-Version) and the other to measure the same ability in physicians (HP-Version) (Hojat et al. 2004, 936; Hojat et al. 2009, 1183-1184). In order to develop the JSPE, researchers first needed to settle on a specific definition for empathy, as well as an explanation of how we empathize (Hojat et al. 2004, 936). It is only with this in place that researchers were able to design a scale to measure empathy as it is defined. This scale was then tested and refined based on how well it actually measured empathy. The final result is a list of 20 items that medical students and physicians must answer. The answers to the questions are provided on a 7-point Likert scale,

different methods do not literally measure levels of empathy. In fact, the JSPE is sometimes criticized for discussing empathy too metaphorically as “levels” (Hooker 2015, 543). What it actually measures are the medical student’s and/or professional’s belief in the importance that empathy serves for medicine (Pedersen 2009). This is important because it indicates that empathy itself may not in fact be lacking, as some may fear. However, the significant drop in the belief that empathy is important is still telling. A lack of interest could lead to a lack of empathy, or at least a lack of attempts to empathize with patients. This seems to be the worry in the above mentioned studies, which do not themselves claim that the JPSE measures anything more than an interest in empathy. But, even if empathy itself is not lacking, what is causing this general disinterest in empathy?

In studies by Eikeland et al. and Hojat et al., it was argued that medical students are specifically trained to lack empathy; not explicitly in their curriculum, but rather as a side effect of the attitude required to get through medical school (Eikeland et al. 2014; Hojat et al. 2009). This drop in empathy appears to have something to do with the education of medical students, occurring around the third year of medical training (Eikeland et al. 2014; Hojat et al. 2009).⁴ These studies, as well as others, credit a number of features of medical education with leading to a student’s lack of interest in empathy. Among these are the limited amount of time for students to learn copious amounts of information (Eikeland et al. 2014, 4; Hojat et al. 2009, 1188), the belief that emotions distract physicians from making good decisions (Eikeland et al. 2014, 4), and the development of cynicism as a necessary coping technique to avoid attachment and professional burnout (Ekman and Halpern 2015; Eikeland et al. 2014, 5; Halpern 2011; Hooker

based on how strongly they either agree or disagree with the given statements (Hojat et al. 2004, 936; Hojat et al. 2009, 1183).

⁴ By testing medical students with the student version of the JSPE at both the beginning and the end of their third year, it was determined that this is when empathy seems to be the most affected (Hojat et al. 2004, 937).

2015, 542; Testerman et al. 1996).⁵ As a result of these different features, interest in empathy is not only set aside in favor of more pressing concerns; it is actively trained away. Empathy is understood as something extraneous and dangerous for physicians. There is little time to focus on cultivating emotional reactions and understanding, especially when emotions are viewed as no more than sources of bias and professional burnout.

However, the blame should not be placed entirely on the intensity of medical school. Others have also noted that empathy is weakened in medical students due to the lack of role models who exemplify the positive role of empathy in medicine (Eikeland et al. 2014; Marcus 1999; Skeff and Mutha 1998). There is already an established naturalistic attitude in the medical field that condemns empathy and encourages scientific objectivism. Traditional medicine is characterized by a drive to give objective advice to the patient, rather than to connect with the patient (Eikeland et al. 2014, 4; Singh 2005; Khanuja et al. 2011, 37; Pedersen 2010, 598-599). As such, the suppression of empathy is seen as a desirable skill for physicians, rather than as a problem to be solved. Physicians embody this naturalistic attitude, and students emulate these physicians. By following in these footsteps, students train themselves to have different dispositions—ones that do not cause them to react empathetically to their patients—entrapping medical students and physicians alike in a vicious circle. This points to the naturalistic attitude—as it has been adapted for medicine—as being an underlying cause of the lack of empathy (Eikeland et al. 2014, 3; Gelhaus 2012a; Halpern 2001; Halpern 2011; Hojat et al. 2009, 1188-9).⁶

⁵ Halpern call this “compassion fatigue” (Halpern 2014a, 301).

⁶ To be fair, it should be noted that “empathy did not decline for some students (a minority of 27%) [which] suggests that there may be certain protective factors that defuse the harmful influences” (Hojat et al. 2009, 1189). This could mean that some students did not adapt this attitude towards medicine and therefore continued to believe that empathy is important.

By naturalistic attitude, I mean that specific attitude noted above that focuses on objectivity and detachment in order to best understand and judge a situation (Carel 2011; Zahavi 2014a, 135; 2014b, 127). This attitude has undoubtedly been advantageous for medical science, aiding in the production of progressively improved technology and treatments. However, when applied to all medical practice, this attitude may be detrimental to good patient care. As it has been adapted for medicine, this equates to making medicine as much like science—and physicians as much like scientists—as possible.

In terms of the study of intersubjectivity, the naturalistic attitude is when we treat others as if they are composed of two parts: “the other's body is given to us as a material unity, and functionally dependent upon and located in this material object; the other's experiential life is then posited as a founded stratum” (Zahavi 2014b, 127). That is, others are studied in a scientific manner—divided into what can be directly observed and studied, and that which must be inferred from the observable. As a result, everything of importance in the process of understanding others is reduced to the physically observable. It is this attitude that is exemplified in the structure of medical education and the physicians that serve as role models for students. Assuming that there is an objective answer to every condition, students focus all of their efforts into accumulating information, often to the detriment of their affective lives.⁷

While this will be explained later when discussing the problem of detached concern, the general fear here can be summarized as follows: affective practices like empathy will lead to a close connection between patient and physician, and this connection to patients will cause

⁷ There is an additional background assumption here that affective practices cannot provide objective knowledge. They only allow for subjective understanding of oneself. As such, affects are traditionally seen as contrary to reason, and therefore will more often than not either mislead a physician's rational judgments or provide false information themselves (Eikeland et al. 2014, 4; Halpern 2001, 30). Though this view has not been entirely rejected, it is fairly outdated. Most philosophers accept that at least some affects, such as emotions, have rational components. Emotions do not act contrary to reason. On the contrary, they are essential to reason, either by acting as judgments of the world or by focusing our attention such that we can make judgments. This is addressed further in the final chapter.

emotional fatigue and professional burnout (Hooker 2015, 543-544). Additionally, if physicians become too emotionally invested in the patient's situation, they are more likely to exercise poor judgment with regard to treatment, as opposed to situations in which physicians maintain an emotional distance (Eikeland et al. 2014, 3-4; Hooker 2015, 544). Therefore, if empathy is avoided, then physicians will be able to maintain a professional distance from patients. The less of an emotional connection the physician shares with the patient, the easier it will be for the physician to approach and solve the patient's problems objectively. Essentially, students held the belief that physicians are supposed to be like scientists. They should be unbiased and capable of disinterested observation, which should lead to an objective answer concerning the patient's problems. As such, rather than feeling with the patient, medical students become cynical observers as a desired coping strategy (Eikeland et al. 2014, 5). By distancing themselves from patients, the students are not absorbed into the patients' lives and pains, and therefore are less burdened by the ways in which their decisions affect patients.

1.1.2 The Benefits of Empathy for Patients and Physicians

It has become more common in recent years to reject all of these negative views of empathy, and to see the benefits that empathy can have in clinical interactions. There has been a turn away from the characterization of a physician as a cold, detached observer of the facts. The naturalistic attitude is important and useful, but not the only relevant skill required for medicine. Specifically, the benefits of empathy, sympathy, and care are gaining increasingly more attention, and arguments are being made to revalue them in medicine (Gelhaus 2012a; 2012b; 2013).

It has been shown that physicians who can empathize with their patients provide better care than those who are unable to empathize (Eikeland et al. 2014; Derksen et al. 2013; Di Blasi

and Kleijnen 2003; Halpern 2001; Hojat et al. 2011, 2013; Hooker 2015; Pedersen 2008; Roter et al. 2006). Empathy greatly enhances the physician-patient interaction, allowing for the physician to better understand the patient's experiences, and therefore better understand how the patient should be treated. Much of the information given by a patient is hinted at nonverbally, meaning that physicians need to be able to understand these hints and know when to ask for more information (Finset and Mjaaland 2009; Halpern 2014a; Suchman et al. 1997). Doing so leads to patients sharing more information about their situations than they might have shared otherwise. Patients are more likely to trust empathic physicians and better understand the treatment options being offered because the patient perceives the physician as genuinely caring about the patient's situation (Halpern 2001; Halpern 2014a; Kim et al. 2004; Roter et al. 2006). Additionally, empathy decreases patients' anxiety and allows them to feel empowered (Derksen et al. 2013; Halpern 2014a, 303). Patients feel like they are part of the medical encounter, that their input matters, and that they have a say in what will happen to them. This, in turn, makes it more likely that the physician will be able to "correctly diagnose and effectively treat medical problems" (Halpern 2014a, 303). Therefore, it is argued that empathy will lead to a better understanding of patients, which will then lead to a better treatment of the patients.

It is also argued that empathy is beneficial for the health of the physician (Gleichgerrcht and Decety 2013; Eikeland et al. 2014; Halpern 2014a; Larson and Yao 2005; Roter et al. 2006). Among these benefits are "increased diagnostic accuracy, more meaningful work, an increased sense of well-being, and reduced symptoms of burnout" (Eikeland et al. 2014, 1). As noted in the previous section, the fear of professional burnout was one of the fears that led physicians to initially avoid empathy. However, as Halpern notes, they "are not protected from burn-out by emotional detachment" (Halpern 2001, 15-16). Additionally, physicians who experience

empathy for their patients feel more fulfilled by their work than those who are unable to empathize (Halpern 2014a, 304; Larson and Yao 2005, Shanafelt et al. 2005). This adds to the overall well-being of the physician and challenges the previous assumption that empathy is dangerous for the physician's mental health. While connections made through empathy do bring the risk of emotional attachment, empathy also allows physicians to value their work more while experiencing less fatigue.

If it is true that empathy will lead to better patient care and physician well-being, then it makes sense to argue that steps need to be taken to revalue empathy in medicine. It is strongly argued that the attitudes and practices that deaden empathy need to be removed, and that empathy needs to be retaught to those who have lost it (Hojat et al. 2009; Khanuja et al. 2011; Pedersen 2010; Singh 2005; Williams et al. 2015). Empathy training needs to be introduced as part of the curriculum so that it is perceived by students as a useful skill to be fostered, rather than an extraneous skill that can be neglected. Additionally, there needs to be a change in attitude for their physician role models. If their role models lack empathy, then students won't see empathy as an important skill. Therefore, physicians should also receive empathy training.⁸ This will serve to improve their own skills, as well as allow them to be positive role models for future physicians. However, even if it is accepted that empathy is both lacking and needed in medical practice, it still needs to be questioned what kind of empathy ought to be encouraged to bring about the desired benefits.

⁸ What this empathy training would entail is another question entirely. The accepted theory of empathy will dictate what kind of training is necessary, if training is possible at all.

1.1.3 Simulation and Projection

The previous section discussed the benefits of empathy, but this is slightly misleading, since the different individuals explaining these benefits have different opinions of how empathy should be understood. The term “empathy” is polysemic, making it difficult to argue that there is one correct definition. The discussion of empathy in different fields of research has attracted a large number of different definitions and explanations (Batson 2009; Gelhaus 2012a, 106; Lanzoni 2012; Pedersen 2008, 327). Various experiences have been defined as empathy—including what might also be called sympathy or emotional contagion—and then different explanations given for even the same definition.

As empathy is most commonly discussed in the medical field, it is an understanding of the other that is achieved through a kind of simulation of the other’s mental states (Cohen et al. 2011, 1639; Eikeland et al. 2014, 1; Hojat et al. 2001; Hojat et al. 2004, 935; Hojat et al. 2009, 1183; Khanuja et al. 2011, 37).⁹ In other words, empathy is understood as the physician’s ability to place himself or herself into another’s shoes (Pedersen 2010, 600; Williams et al. 2015, 1; Hojat et al. 2009, 1184). This is an example of what has come to be called simulation theory of empathy (ST) in the philosophy of mind. While this theory is very commonly used in medicine, it is also a theory with a rich tradition outside of medicine.

According to ST, we understand the mental states of others by simulating them (Gallese 2007; 2014; Gallese and Goldman 1998; Gallese and Sinigaglia 2011; Meltzoff 2006; Meltzoff and Brooks 2007; Meltzoff and Moore 1977; 1997). It is our ability to see the world from the other’s point of view, thereby gaining an understanding of the other’s experiences of the world

⁹ The belief that empathy is a simulation of the other is not new. ST has a rich tradition dating to Theodore Lipps, who adapted a theory of aesthetic empathy to be used in philosophy of mind (Lanzoni 2012, 306).

(Gladstein 1983, 472; Jackson et al., 2005; Rushton 1980, 37). We come to understand others “by putting ourselves in their situation in an unarticulated and imaginative way” (Nordby 2016, 232). When we observe the other acting in some way, we simulate the actions within ourselves, as if we had the other’s perspective. Following this simulation, we reflect on the mental states that arise within us, and then project these mental states into the other. This would mean that physicians understand their patients insofar as they are able to mimic the mental states of their patients, either consciously or subconsciously. If the patient is feeling a pain in his or her arm, physicians imagine what it would be like if they had a similar pain, then apply to the patient the sensations, fears, desires, and so on that arise with that pain. Physicians understand patients because they can be in a state like their patients. This allows for physicians to predict the behaviors and responses of their patients.

Simulations can be done explicitly, as conscious attempts to imagine what it would be like to be in the other’s shoes, or they can be unconscious, internal simulations of the other. The latter alternative for ST has gained a lot of support in recent years due to the advent of mirror neuron research, which some see as support for the unconscious, internal interpretation of ST (Gallese 2007; 2014; Gallese and Goldman 1998; Gallese and Sinigaglia 2011; Iacoboni 2009; Iacoboni and Dapretto 2006; Jackson et al., 2006; Marshall et al., 2011; Meltzoff 2006; Meltzoff and Brooks 2007; Meltzoff and Moore, 1997; Williams et al., 2001). Mirror neurons are neurons that fire both when the subject is performing an intentional action and when the subject perceives the other perform the same intentional action. It is a literal mirroring of neuron activity. This gives the ST of empathy neurological support that is appealing for the medical field.

In addition to the support from mirror neuron research, ST has some important advantages for medicine. For one, it is argued that this kind of experience provides a more

complete understanding of the patient's situation. That is, it explains how physicians are able to understand a patient's situation despite the limitations of sense experience and language (Nordby 2016, 233-234). Due to the prevailing naturalistic attitude in medicine, the other is taken to be a combination of an observable physical body and a hidden mind. The former can be observed, the latter cannot. ST is useful because it gives the physician access to mental states that cannot be empirically studied. It would be problematic if physicians had to accept that they could only understand their patients externally. A physician's understanding of the patient's experiences "cannot be reduced to a capacity to make empirical investigations" (Nordby 2016, 233). In other words, not everything that is important for the physician to know about the patient will be known through perceiving the patient's physical body and what the patient says about his or her condition. Much of what needs to be understood about the patient's conditions—his or her mental states—is hidden within the observable body. It must be discovered or inferred based on the empirical data. This is particularly important in situations where patients are unable to fully express their experiences or when time is too limited to speak with the patient at length, when the mental states cannot even be clarified through communication. Simulations are used to achieve a more contextual understanding of the other's experiences, in order to gain better insight into the patient's interpretation of their expressions.¹⁰

However, despite the advantages that ST has for medicine as a theory of clinical empathy, there are also some serious problems with this theory. If empathy is meant to improve patient care due to the way that it provides us with an understanding of the other, then we need to

¹⁰ The speed at which simulations can be performed makes them more useful in medicine than some other theories of empathy, such as theory theory. Theory construction and application takes more time than is allowed to physicians and nurses. As such, if TT is right about how we understand others, then physicians would rarely have time to do so. However, this is not actually the case. Physicians seem to understand their patients fairly well all the time, indicating that TT is not the right theory for the job (Nordby 2016, 240).

assess whether or not a simulation actually provides physicians with an understanding of their patients.

1.2 Three Problems for Clinical Empathy

In this section, I clarify three of the most serious problems that ST faces. The first is the problem of definition—not only that empathy could have been defined otherwise, but that there is a discrepancy between the definition and explanation of empathy. The second is the diversity problem, or that ST does not allow for the understanding of diverse others. The third is the problem of detached concern, which shows that ST does not even escape from the naturalistic attitude, and in effect merely perpetuates the affective disconnect caused by the naturalistic attitude. It is by examining these problems that the most important aspects of any theory of empathy will be revealed.

1.2.1 What is Clinical Empathy?

The first problem that arises for ST is the problem of definition. As already noted in an earlier section, the term empathy lacks any set definition. It tends to adopt a meaning that is most pragmatic for a field. This is because the term has a very rich history. It has been associated with many different experiences, and explained in many different ways.

As Susan Lanzoni notes in her work on its history, the term “empathy” itself is a translation of the German *Einfühlung*, but as is often the case with translation, it is debatable whether this is really accurate (Lanzoni 2012, 302). The German word was used in aesthetic theory, relating to the process by which we “feel into” the work of art. When experiencing a work of art, it was argued that we project a bit of ourselves—such as the feelings that the work excites in us—into the work itself. This use of the term was employed in the work of Friedrich

Theodor Vischer and Robert Vischer, but the roots of the term itself can even be traced back to Arthur Schopenhauer and Hermann Lotze (Lanzoni 2012, 302). As Lanzoni notes, *Einfühlung* has had “a complex history in German philosophy, aesthetics, and psychology,” such that it could be interpreted as a method of “re-experiencing (*Nacherleben*)” or a form of perspective-taking “(*Sich hineinversetzen*),” or in many additional ways depending on the field of study (Lanzoni 2012, 302-303).

It wasn't until 1909 that both Edward Titchener and James Ward translated *Einfühlung* as “empathy” (Lanzoni 2012, 303). Again, whether or not this is a good translation of the term is debatable, since both “empathy” and “*Einfühlung*” have their own histories and diverse meanings. In fact, it would be equally plausible to translate other German words, like *Mitgefühl*, as empathy.¹¹ As Lanzoni notes, in English articles that reviewed Theodore Lipps' work on *Einfühlung*, “the preferred term was most commonly ‘aesthetic sympathy’ and sometimes merely ‘sympathy,’” demonstrating the ease with which these two terms could have been translated otherwise (Lanzoni 2012, 306).¹²

This reveals the first problem with the explanation of clinical empathy as ST. While there is an accepted and commonly used definition, it is clear that it could have always been defined differently. Empathy could be defined as synonymous with sympathy or emotional contagion. Even in the specific discussion of clinical empathy, some explain empathy as an isolated experience, while others define it as a group of interrelated experiences that can be applied in different situations (Halpern 2014a, 304), and still others who think empathy alone is not

¹¹ This is the word that has been translated into English as “sympathy” in Max Scheler's works.

¹² Similarly, “empathy” has different meanings in English than simply the imaginative, projective empathy that Titchener and others discussed. For now, it is worth noting—as both Lanzoni and Andrea Pinotti note—that “there was never one simple psychological depiction of *Einfühlung* or empathy: projection, transfer, association, animation, personification, vivification, fusion, identification, among others were all possibilities” (Lanzoni 2012, 306; Pinotti 2010, 94). Philosophers and psychologists have been unable to agree to one use for the term. This has led to the debate concerning the true nature of empathy.

enough, and must be supplemented with other experiences like sympathy and care (De Vignemont and Jacob 2012; Gelhaus 2012a, 2012b, 2013; Svenaeus 2015).

As evidenced by the problems of translation here, it is important to not get distracted by the traditional and contemporary uses of the term. What needs to be identified and explained is what phenomenon or experience is actually being described when we are talking about empathy? If this cannot be done, then as Edith Stein says, we risk an inconsistency between “the phenomenon to be explained and that actually explained” (Stein 1989, 23). That is, if the initial target phenomenon is unclear, then we risk arguing that empathy is meant to be one kind of experience, but then describing it as an entirely different experience. This is the exact inconsistency that ST falls into.

To summarize, clinical empathy is defined very specifically as being an understanding of the patient. Then, given this definition, it is argued that this understanding of the other is accomplished through a simulation of the other’s mental states. One critique of this theory could be that it is too reductive. That is, empathy is more than a mere understanding of the other. However, due to the ambiguity of the term across many different fields, I maintain that it is unhelpful to simply disagree about definitions. The issue that is being addressed here is whether or not a simulation of the other actually explains how we understand the other. While some may not like to define empathy as an understanding, defining it in this way is not itself a problem. The problem arises when the phenomenon to be explained is not actually explained by the theory. If ST does not actually explain how we understand others, then it is inconsistent and should be rejected. The evidence for this inconsistency will be revealed in the next two sections.

1.2.2 The Diversity Problem

When it comes to the question of intersubjectivity, ST has a problem of being unable to bridge the gap between physician and patient. In line with the naturalistic attitude, the assumption in ST is that the physician and patient are separate subjects with their own private mental lives. The only way to gain access to the mental life of the patient is to use empathy in order to simulate that mental life. The physician must imagine what it is like to be the patient himself or herself. This can be taken in the sense of a conscious, explicit imagining of what it would be like to be in the other's situation, or it can be taken as an implicit, unconscious simulation, such as through mirror neurons. However, even in the neurological sense, simulations do not actually provide genuine intersubjective understanding.

The physician's understanding of the patient is entirely dependent on what the physician can understand about himself or herself. By simulating the patient's mental state, the physician gains an understanding of what it might be like for the physician to be in the patient's shoes. However, this does not imply that the physician actually knows what it is like to be the patient in the patient's shoes. In other words, when the physician simulates the patient's situation, the physician's understanding is limited to what the physician can imagine about the patient's experiences. This objection is what Shaun Gallagher has called the *diversity problem* (Gallagher 2012, 363). That is, if all I can understand of the other when I empathize with the other is what I can simulate within myself, then my understanding of diverse experiences is limited to what I have—or could have—experienced. Therefore, under this argument, there is no diversity in the world for the physician. There is only the spectrum of a single self: the empathizing physician.

As Gallagher notes, there may be ways for ST to address the diversity problem (Gallagher 2012, 370). Some simulation theorists may want to argue that my own experiences

must always be the basis of my understanding of others, and there is simply no way around this. That is, the need to use my understanding of myself in order to understand others is simply an unavoidable restriction of my ability to understand others. It is something that we must acknowledge and live with (Gallagher 2012, 370). However, this is a questionable conclusion. As Gallagher says, it is possible in at least some cases to “empathize with monsters or aliens from other planets, as portrayed in film, and we can empathize with humans who live in far away lands and who are very different” (Gallagher 2012, 370).¹³ ST, on the other hand, would have to argue that this understanding of very different others is not possible, since we cannot actually simulate the perspectives of monsters and aliens that are very different from us.

The diversity problem is particularly problematic in medicine, since it implies that the patient’s experiences are always understood from the physician’s perspective rather than that of the patient. As Claire Hooker notes, the physician’s simulated understandings of the patient “mostly turn out to be merely chimeric projections” (Hooker 2015, 542). They ignore the fundamental differences between the physician and the patient, as well as the differences between individual patients. The otherness of patients is lost in the projection of one’s own mental states onto the other. At best, the physician may luck into some similarities, but this is still a reduction of the other to oneself. Additional problems arise when there are few similarities, such as when the physician and patient are of different genders, races, cultures, economic classes, and so on. This is especially problematic because several of these factors are not directly observable. It is risky to assume that the physician can actually understand the patient via a simulation.

¹³ For Gallagher, this relies on us having good knowledge of their narrative, which will be explained further in the chapter 4.

A related problem is what some philosophers call the geocentric bias (Zahavi 2014b, 106-107). Essentially, ST also risks applying too much of our own situation to the other. It assumes that the other has knowledge, experiences, and skills like the subject, even when the assumption is not warranted. For instance, if the physician simulates the other, it is difficult for the physician to forget all of his or her own background knowledge learned during medical training. However, it would be dangerously inaccurate for any of this knowledge to slip into the physician's simulation. This would grant the patient far too much credit, especially when it is often the case that patients are very ignorant of relevant symptoms and possible treatments. An important aspect of the physician-patient interaction is a respect for different positions and experiences, but this is not accomplished in simulations. One example of this is when patients make use of medical terminology and physicians, assuming the patients understand the meaning of these words, use the patient testimonial in diagnosis. However, it is often the case that patients will misuse medical terms (Scannell 2012, 2). In instances where the terms are being misused, it is overly generous for physicians to project their knowledge and skills into their patients.

To summarize, the use of simulations in order to understand others will always have important limitations. Namely, the physician's understanding of the other will always be limited to what the physician can understand about himself or herself. This can be both deficient in the understanding of the other's actual mental states as explained in the diversity problem, and overly-generous in the projection of mental states as explained in the geocentric bias. Either way, the physician's understanding of the patient in ST is deeply convoluted. The problem of detached concern only serves to exacerbate this difficulty.

1.2.3 The Problem of Detached Concern

The final problem that needs to be addressed is what has come to be called the problem of detached concern in medicine. Or, more accurately, the ideal of detached concern that has taken hold of clinical practice, but that also causes a number of problems in the affective relationship between physician and patient.¹⁴ First, it causes a lack of understanding for the patient's affects. Second, it causes a lack of attunement to the physician's own affects. Third, it causes a lack of understanding for the way in which affects influence our perceptions, beliefs, and judgments. Finally, it causes an affective gap between physician and patient that damages trust and weakens physician effectiveness (Halpern 2001, 21).

The term detached concern comes from Renée Fox's work *Experiment Perilous* (1959), and was further addressed in a later article by Lief and Fox (1963). Though, as a professional approach to patients, detached concern was also encouraged by others (Merton 1957; Osler 1899; 1904a; 1904b; 1904c; 1904d; 1904e). As Fox argues, the physician is supposed to be both "sufficiently detached or objective toward the patient to exercise sound medical judgment and maintain his equanimity," as well as "sufficiently concerned about the welfare of the patient to give him compassionate care" (Fox 1959, 86). These are supposed to be maintained in a delicate balance (Fox 2003, 945; Lampert and Glaser 2016, 16; Underman and Hirshfield 2016, 95). Being entirely detached—both approaching the patient as an object of scientific study and lacking empathy—risked being too cold and misunderstanding the patient's condition. However, being overly concerned, and affectively engaged with the patient was understood to be equally as

¹⁴ This does not mean that these are the only problems with ST. Gallagher also highlights the "starting problem" (Gallagher 2012, 371-372), and the "developmental problem" (Gallagher 2001a; 2004; 2009; 2012, 364; Gallagher and Hutto 2008; Gallagher and Meltzoff 1996; Gallagher and Zahavi 2012), to name a few. The former asks how something such as a simulation starts before we have an understanding of the other such that we know what to simulate. The latter refers to the relatively "high-level versions of ST are too cognitively complex to account for the infant's ability to understand the intentions of others" (Gallagher 2012, 364).

risky. Additionally, medical practice is filled with “emotion-laden experiences” that can wear on physicians who are unable to detach from them (Lief and Fox 1963, 13).¹⁵ If emotional responses were allowed into medicine, then it was feared that they would corrupt the objectivity of the physician’s findings (Cadge and Hammonds 2012, 2690; Halpern 2001). The general goal as outlined by Lief and Fox was to set aside one’s affective responses to the patient, as well as properly manage the patient’s affects so as to acquire the best, objective understanding of the patient’s condition (Lampert and Glaser 2016, 3; Underman and Hirshfield 2016, 95; Yagil and Shnapper-Cohen 2016, 1694). At the same time, the physician needs to maintain an appearance of caring, so as to resist hardening one’s heart towards patients (Underman and Hirshfield 2016, 95).¹⁶ Physicians need to maintain affective distance while simultaneously appearing to be concerned about the patient's wellbeing (Fox 2003, 945; Halpern 2007, 696; Halpern 2012b, 41; Yagil and Shnapper-Cohen 2016, 1694).¹⁷ As Lief and Fox say, “the empathic physician is sufficiently detached or objective in his attitude toward the patient to exercise sound medical judgment and keep his equanimity, yet he also has enough concern for the patient to give him sensitive, understanding care” (Lief and Fox 1963, 12).

To be fair, Fox did stress the importance of both detachment *and* concern (Lief and Fox 1963), but the emphasis in contemporary medicine has become more focused on detachment, while discouraging concern (Cadge and Hammonds 2012, 267; Fox 2003, 945; Lampert and Glaser 2016, 1).¹⁸ At best, concern has become largely concern for resolving the patient’s

¹⁵ Lief and Fox list: “exploring, examining, and cutting into the human body; dealing with the fears, anger, sense of helplessness, and despair of patients; meeting emergency situations; accepting the limitations of medical science in dealing with chronic and incurable disease; being confronted with death itself” (Lief and Fox 1963, 13).

¹⁶ As Halpern says, it is “detachment with a veneer of generic tenderness” (Halpern 2001,

¹⁷ Detachment is trained to assist with emotional experiences, such as death and dying (Fox 2003, 945; Lief and Fox 1963, 13; Underman and Hirshfield 2016, 95). And it is argued that it taken on partly due to the examination of cadavers during autopsies (Underman and Hirshfield 2016, 95).

¹⁸ Again, this is understood to be a useful coping technique for students to learn. (Fox 2003, 945).

problems, and less specific concern for the patient as a patient. When medical students and physicians veer closer to concern than detachment, it is seen as a “failure to cope” (Cadge and Hammonds 2012, 267). As such, “students learned early on in their training that they cannot and should not talk about their emotions, especially not to faculty” (Underman and Hirshfield 2016, 95).¹⁹ This is primarily due to the primacy of the naturalistic attitude in medicine, which was one of the problems that the ST of empathy was presented to solve. However, as is evident by the prevalence of detached concern in medicine, ST only serves as an example of how predominant this attitude has become, such that it infects even the solutions to the problem.

The goal in medicine is to provide the best treatment, and it was assumed that affects would only cloud the physician’s judgment. With the shift towards revaluing empathy to aid in patient understanding, it was redefined in a way that allowed it to be easily accepted. Specifically, defining empathy in line with detached concern makes it easy to incorporate empathy into medicine. Recommending an entirely new and somewhat foreign skill would most likely be met with more resistance than a skill that already fits with the physician’s trained attitude. The physician’s methods already work well without the addition of affective skills that may risk attachment. As Halpern explains, “the fundamental justification given for detachment and medicine is the argument that it enables doctors to understand patients’ emotional experiences *accurately*, free from their own emotional bias” (Halpern 2001, 17). That is, medicine became focused on detached concern for patients—as opposed to a genuine empathetic connection with them—as a way to help doctors avoid bias and emotional investment in patients. The physician is meant to understand affects in an unaffected way.

¹⁹ These authors also note that students “made jokes or blamed the patient to reduce their anxiety. This kind of emotional socialization led to dehumanizing and objectifying patients” (Underman and Hirshfield 2016, 95). Relating back to earlier section, students foster detached concern as way to cope with emotion-laden experiences.

Trying to adopt a theory of empathy that fits this attitude perpetuates the problems caused by the lack of empathy rather than solves them. In other words, rather than escaping the naturalistic attitude, detached concern in general, and ST specifically, appropriates empathy into a purely cognitive skill that fits with the naturalistic attitude (Garden 2007; Halpern 2003; Macnaughton 2009; Pedersen 2008). Medicine has defined empathy in a way that is useful to its current attitude, maintaining the overall authority of the medical practitioner. It is just another scientific tool in the physician's naturalistic toolkit. In other words, even at a time when empathy is becoming a skill that is recommended for physicians, and even though ST is a theory of empathy that physicians can learn and improve, ST is not a theory of empathy that actually escapes the naturalistic attitude in which medicine is entrenched. Rather, it is an adaptation of empathy such that it fits the pre-established attitude. In this way, ST of clinical empathy can be shown to merely perpetuate the problem it was intended to solve.

To be fair, there is nothing wrong with the naturalistic attitude in itself. This attitude has been incredibly useful, especially in the medical field. It has allowed for the rapid improvement of medical technology, research, and treatments. It is hard to deny the importance of these improvements. The problem with this attitude only arises when it is taken to be the only important attitude, as if it is the only means of finding truths (Landes 2012, *xxxiii*; Merleau-Ponty 2012, *lxxii*, 452). When it comes to our understanding of others, it is important to not limit our understanding to the naturalistic approach (Zahavi 2014b, 127).

While the naturalistic attitude has allowed medicine to advance very rapidly, it has also locked medical professionals into a very specific way of viewing and interacting with patients. The naturalistic attitude causes us to break with our everyday experiences of the world, and experience all phenomena as things to be “methodically ‘observed’ and systematically

‘constructed’ as ‘facts’” (Vandenberghe 2008, 26). It causes us to explain things in ways that we have never experienced them, because we assume that they are more real under scientific observation than in our ordinary, everyday experience of them (Flaherty 2016, 115). Specifically, for detached concern, it treats the patient as only existing for the physician in an intellectual way that “denies the ongoing emotional field between patients and physicians” (Halpern 2001, 25). While this may be a good way to approach medical conditions in general, it is not the best way to approach the individuals who are suffering through those conditions. Medicine is an inherently intersubjective practice and to adopt an attitude towards patients that essentially strips them of their otherness and reduces them to something that can be methodically observed is not compatible with this intersubjectivity (Flaherty 2016, 113).

This, however, is exactly what happens in ST. Physicians are told that they need to empathize with their patients, that empathy will give them a better understanding of their patients, and that this understanding will lead to better care for their patients. Essentially, they are told that concern will lead to understanding. While this seems to bridge the gap between the physician and the subject, this is actually still an approach to the other as completely separate from oneself and only capable of being understood from one’s own perspective. When we see others as objects for scientific observation—especially when already entrenched in the naturalistic attitude—it seems obvious that simulations and inferences give us an understanding of the “real” other that is somehow missed in ordinary perception. While this may sometimes be a very useful way to understand others, it is not the only way and it should not be treated as such. In fact, empathy was supposed to be the experience that allowed physicians to acquire a more complete understanding of the other.

To summarize up to this point, ST is a theory of empathy presented as a way to overcome the problem of solipsism caused by the naturalistic attitude. However, as an example of empathy that collaborates with the ideal of detached concern, ST merely serves to perpetuate the problems of the naturalistic attitude rather than solve them. ST is an overly cognitive theory of empathy that maintains the isolation between physician and patient, as well as the primacy of the physician's judgment of the patient's conditions. It is not an empathy that affectively engages with the other. As a result, the lack of affectivity in detached concern causes four problems.

In order to demonstrate these, Halpern uses the case of Ms. G, a patient that she encountered when training for psychiatry service (Halpern 2001; 2012; 2014a). Ms. G was a fifty-six-year-old patient with diabetes. She had a history of kidney failure, and had just undergone her second above-the-knee amputation. When Halpern met Ms. G, she was refusing dialysis, even though she knew she would die without it. To further complicate the situation, she refused to tell any of the physicians or psychiatrists why she did not want treatment. At this point, all medical professionals involved held the belief that they must respect Ms. G's autonomy and let her die. By chance, Halpern received a hint from Ms. G's friends, which enabled her to learn more about Ms. G's background situation. In truth, Ms. G was distressed because her husband had recently left her, claiming that he could not be attracted to her anymore. However, even in light of this information, the care team was still intent on respecting Ms. G's wishes, which inevitably ended in her death. Halpern notes that the entire team had the best intentions and by all accounts seemed to be caring medical professionals. However, she still maintains that something went wrong in this case. Specifically, the lack of genuine empathy, and the negative effect of detached concern mixed with unacknowledged affective responses.

The first problem is related to the diversity problem addressed in the previous section, so I will only address it briefly here. Essentially, because detached concern sets aside the importance of affective engagement in favor of cognitive comprehension, there is less interest in the affects of the patient. However, it would be unfair to claim that ST completely disregards the patient's affects. The recent prescription of empathy is meant to help physicians better understand patients' mental states, both affective and otherwise. On the other hand, the detached method involved in ST, which only allows the physician to understand the patient from the physician's own perspective, results in the diversity problem—that the patient is only understood as what the physicians can simulate in themselves. While detached concern causes physicians to believe they are understanding their patients' affects, this is actually untrue and misleading (Flaherty 2016, 113).

The second problem, which is more specific to detached concern, is that detached concern causes a lack of attunement to one's own affects. Again, the ideal is that physicians understand their patients' affects while being unaffected themselves. They need to manage both theirs and their patients' affects. The result is a belief that physicians are capable of detaching themselves from their affects—approaching their patient's as both neutral and objective. This serves more as a flight from reality than an actual solution to the feared problem of affective bias. People are always enmeshed in some affect or other, even if it is only a mood (*BT* 389/340; Guignon 2009), or an ever-present feeling (Ratcliffe 2005; 2008; 2009a; 2009b; 2012). As Halpern says, “emotions influence even seemingly detached beliefs and decisions” (Halpern 2001, 34). To suppose that this is not the case and that one is actually in a detached, neutrally affective state, it not to actually be in this state. Rather, it is to ignore the affects that are still present, affecting one's perceptions and judgments. Training physicians in detached concern

weakens their abilities to attune to their affects, as well as the patient's affects (Green 2002, 255). Physicians are no more immune to their affects than anyone else and should not be treated as such.

When physicians fail to understand their own affective reactions to their patients, they risk projecting these affects onto their patients, thinking that they are being objective when they are not. When these reactions are negative, such as when patients are difficult and agitating, physicians “risk making poor decisions to alleviate their own distress” (Halpern 2014a, 305-306).²⁰ All of their background affects and aspects of their own personal history are simply ignored in ST, which takes subjects to be largely interchangeable. If they have negative affective responses to their patient, as with Ms. G, then they are likely to avoid their patient.

The lack of skilled affective attunement caused Ms. G's care team to ignore their own affective responses to Ms. G's situation, as well as how they were unknowingly projecting these feelings into Ms. G's view of her own situation. This caused further problems in the physician-patient relationship. Without attunement to their own affective reactions, this avoidance will be unintentional and therefore unlikely to be overcome. The physician will naturally try to avoid uncomfortable and difficult situations. Furthermore, if these negative affective responses continue unaddressed, then they can result in bias and prejudice. This can be problematic even with unacknowledged positive reactions to patients, but it is significantly more problematic when negative. The only way to overcome these problems is to be properly attuned to one's own affective responses and understand how these responses will affect their perceptions and

²⁰ Halpern warns against situations like this where there is a risk that “one person's irrational emotions are transmitted to others” (Halpern 2001, 9). This can happen when the patient is experiencing a strong emotion that is transmitted to the physician, but it can also happen when a physician transmits a strong emotion to the patient. It is the latter that is particularly troubling here.

judgments. As Halpern says, “recognizing how emotions influence judgment is part of a larger effort to cultivate skillful emotional communication in medical practice” (Halpern 2001, 29).

The third problem is that there is a lack of understanding for how affects influence our perceptions, beliefs, and judgments (Green 2002, 255; Halpern 2001, 27). This applies to both the physician and the patient. Concerning the physicians, their lack of understanding for their own affects likewise means that they are unaware of how these affects are influencing them. Concerning Ms. G, her care team did not realize their discomfort and annoyance towards their patient, and therefore did not realize that these affects could be causing them to care less about her situation. Members of the care team assumed they understood, while suspending their emotional reactions, but this was not actually the case. In actuality, the care team misunderstood their own affective responses to Ms. G—in the sense that they ignored the affective responses that they were still having—which were particularly problematic because Ms. G was a difficult patient who entered into conflict with most of her care team. When patients are difficult, inconvenient, or unlikeable, it can cause the physician to respond negatively (Coulehan et al. 2001, 222; Halpern 2007, 697). However, if they believe they are engaging with their patients in a detached, but caring way, while in fact they are being negatively affected by their own affective responses, then they will seriously risk treating their patients poorly without knowing it. Affects are ever-present. Ignoring them can cause physicians to avoid difficult patients, develop prejudices, and lead to errors in judgment (Halpern 2001, 2007).

Concerning patients, physicians are unable to understand how they are perceiving their own future possibilities and perceptions of their present state. As a simulation, even if it does luck into guessing the right affect to project onto the patient, there is still no further inclination to understand exactly how this affect is influencing the patient. Concerning Ms. G, the entire care

team thought that she was making an autonomous decision in refusing treatment. They thought this because they cared about her and tried to imagine what it would be like to be in her situation. They determined that, were they in a similar situation, they would also refuse treatment. However, this detached concern for Ms. G, and for her overall situation did not actually get to the bottom of Ms. G's problems. There was no affective engagement, no communication, and no genuine understanding. They may have failed to understand the way her strong negative emotions in her dire situation may have been seriously detracting from her autonomy.

Finally, detached concern leads to lack of trust and efficacy. As a result of the other three problems, as well as the continued primacy of the naturalistic attitude, we can generalize the problem of detached concern as the problematic lack of a genuine affective engagement with the patient. Detached concern carries the “the presumption that a neutral, standardizable approach exists to meet patients’ distress” (Halpern 2001, 25). It treats the patient as only existing for the physician in an intellectual way that “denies the ongoing emotional field between patients and physicians” (Halpern 2001, 25). The problem with this is that it “ignores the diverse needs of patients regarding emotional *interactions* with physicians” (Halpern 2001, 25). It assumes that the same rules and principles can be applied to each situation, but this is not the case.

This is evidenced by the case of Ms. G, in which the principle of respecting autonomy—which is founded on a concern for the patient’s wellbeing—is all that is followed, when other, more personal approaches may have been called for. Physicians were *concerned* for her autonomy, but they lacked any affective connection to Ms. G which could have caused them to care for more than just her abstract autonomy. There is no engagement with the patient’s affects, the physician’s own affects, nor how these affects influence the subjects. This lack of affective

engagement causes a disconnect between patient and physician. Patients feel judged and handled rather than heard, understood, and cared for.

From these problems, we can see that it is problematic and a complete distortion of the phenomenon of empathy to define it in absence of its affective aspects. According to Halpern, we need empathy to be genuine and not just a simulation (Halpern 2001, 88).

To summarize, there are three main problems when ST is used to explain clinical empathy. First, there is the problem that there is no agreement on how empathy should be defined. This means that there is no set understanding of what exactly empathy is. Empathy is defined for medicine in such a way that it is useful for the field, making it so the only way to assess this definition is to show that it either does or does not explain what it is supposed to explain. Second, ST does not go far enough in its explanation of how we understand others. As evidenced by the diversity problem and the geocentric bias, simulations do not actually provide an understanding of the other. As Halpern says, “it is often quite obvious that a patient is sad versus angry, and the crucial aim is to learn what in particular is bothering this individual” (Halpern 2014a, 303). This latter part is not achieved by a simulation, so a different theory of empathy is needed to reach this goal. Third, ST does not escape from the naturalistic attitude, but is rather appropriated by medicine to fit with this attitude. Adopted in this way, empathy perpetuates the problems listed in the first section rather than solves them. In other words, if the purpose of empathy was to reconnect us to others and allow us to overcome the purely naturalistic attitude, then ST fails to be the theory of empathy that is needed. The patient is still being treated as an object for observation and judgment, rather than a subject with whom physicians interact. This causes a lack of understanding for the patient’s and the physician’s own affects, how these affects influence them, leading to degrading of trust and efficacy. Therefore,

we need a different explanation of how empathy allows us to understand others—one that will best fit medicine and aid in producing better patient care.

1.3 Conclusion: Three Questions for Theories of Empathy

As should now be clear, there are many different ways that empathy can be understood, even if we are only focused on clinical empathy. However, this does not mean that the adopted explanation for empathy is in fact the best explanation for that field. We still need to assess whether or not the right definition for empathy is the one that is being applied. In medicine, if the wrong kind of ability is attached to the term, then we risk encouraging the wrong kind of behavior in physicians.

The overarching problem with explaining empathy is that describing it is not a single problem that can be addressed by describing empathy alone, but rather a group of interrelated problems, all of which need to be addressed if we are going to have a good understanding of it. As revealed by the three problems of clinical empathy, there are at least three questions that every theory of empathy needs to be answer:

1. What is the experience being described?
2. What is the intersubjective context of empathy?
3. What is the affective dimension of empathy?

Each of these questions is essential in its own way, and each question can be applied to different theories of empathy in order to acquire the best possible understanding of those theories.

The first question—*the explanation of empathy*—relates to the ambiguity of how empathy should be defined. Rather than asking for a definition, it is better to ask for the phenomenon or experience that is actually meant to be described by the proposed definitions and explanations. Again, different philosophers have discussed the topic of empathy in very different

ways. It is often the case that philosophers will present arguments for particular theories of empathy, without any agreement concerning whether or not the described phenomenon or experience is empathy. As such, they talk past one another, each arguing that his or her theory of empathy is correct because it best matches the *real* phenomenon of empathy. However, this *real* phenomenon is not defined well enough for there to be any solid consensus.

The second question—*the intersubjectivity of empathy*—is important to the overall discussion of empathy because empathy requires others with whom we can empathize. Simply put, empathy is not something that would occur in isolation, but rather necessarily requires others with whom we can empathize. Different theories of intersubjectivity will necessitate different theories of empathy. The problem that arises here is that the nature of the relationship between empathy and intersubjectivity is sometimes unclear. Whereas the first question of empathy relates to the possible discrepancy between the explanation given and the phenomenon to be explained, the second question of empathy relates to whether empathy is being used to solve a problem in intersubjectivity, or an experience that takes place in the context of an already established intersubjectivity. However, intersubjectivity is not the only context that determines a theory of empathy. Empathy must also be discussed in the context of affectivity—a dimension of empathy that is often overlooked.²¹

The third question—*the affectivity of empathy*—is important for two reasons. The first is that it is unclear whether or not empathy is an affect in the most prominent theories of empathy. Many philosophers fail to fully address the affective dimension of empathy and this is

²¹ I prefer to use the more general term “affect” when referring to affective phenomena like emotions, moods, and feelings, since all of these affects are actually intimately intertwined. They flow into and from one another in intimate way that are rarely discussed. It is better at this point in this project to talk about affects in general, rather than isolate myself to terms that have various definitions, which could affect the understanding of the overall argument. Occasionally, I will specifically identify emotions, feeling, and moods, when the context calls for it.

detrimental to their theories. This is odd given the origins of the term, but also evident given examples such as ST. The etymology of empathy is from the Greek *pathos*, meaning “feeling,” and *em*, meaning “in.” In German, *Einfühlung* is also a combination of words that can be translated as a “feeling into” (*Fühlung* meaning “feeling,” and *ein* meaning “into”). To further this point, even other words that could have been translated as empathy—such as *Mitgefühl*—still have a common base of feeling. Again, it is important not to be overly focused on the words used to identify a phenomenon, since the same word can be used to identify different phenomena and the same phenomena can be identified by different words. However, it is telling that all the words used to identify all the different phenomena have a common base of “feeling.” If nothing else, this indicates that affects exist in an important relationship with empathy. This relationship needs to be examined.

The other reason that the affectivity of empathy is important is due to the problems caused by non-affective theories of empathy, such as the problem of detached concern. Without the affective dimension of empathy, ST weakens the physician’s attunement to his or her own affective responses, as well as lacking an understanding of their patient’s affects. Additionally, there is an overall lack of affective engagement between physician and patient, which damages their relationship, as well as the trust and effectiveness that would accompany a good relationship between them. If clinical empathy is meant to improve patient care by departing from the paradigm of detached concern, then having a good understanding of the affectivity of empathy is essential. Lacking the affective dimensions of empathy, the current conception of clinical empathy is unsatisfactory and unlikely to lead to the desired benefits. As such, a new theory of empathy is needed in medicine if empathy is going to be a recommended skill for physicians.

What is needed is for a theory of empathy to be able to answer the three questions in a satisfactory way. While the overall project moving forward from this chapter is to answer these questions with respect to theories of empathy, there are too many theories for it to be a reasonable goal to address all of them. Therefore, I focus primarily on the phenomenological approach to empathy, only addressing non-phenomenological theories as they are relevant to the phenomenological ones. The decision to restrict the scope in this way is not arbitrary. Rather, the phenomenological approach is particularly well-prepared to answering the three questions in a very different way than the naturalistic approach.

In general, the phenomenological approach avoids the pitfalls of a purely naturalistic approach. This is especially useful when it comes to the medical field (Toombs 2001a; Waksler 2001). The application of the phenomenological approach is not new to medicine from the perspective of philosophy, but it is one that seems to be taking only a slow hold on the medical field.²² As Kay Toombs points out, “in eschewing abstraction in favor of a commitment to focus on ‘the things themselves’...phenomenology is thus particularly well suited for engaging in philosophical reflections that pertain to medicine” (Toombs 2001a, 19). Phenomenologists set aside their presuppositions, or at least train themselves to recognize their presuppositions, so as to allow the phenomenon to show up in itself. This is opposed to trying to fit the phenomenon into a field that fits the pre-established needs of that field, as is the case with ST. The goal is not to abandon the naturalistic attitude, but rather to supplement it with the insights from

²² Many have already noted the uses of the phenomenological approach for solving a number of different problems in the philosophy of medicine. This includes, but it is not limited to, the place of the body in medical interactions (Connolly 2001; Gallagher 2001b; Mazis 2001; Rudebeck 2001), the role of lived experience for both patient and physician (Frank 2001; Madjar 2001; Toombs 2001b; Walton 2001), and the very concepts of Health, illness, disease, and other medical conditions (Brough 2001; Sundström 2001; Svenaeus 2001).

phenomenological approaches in order to gain a better overall understanding of empathy “in all the richness and complexity” (Toombs 2001a, 19).

The goal in the remaining chapters is to answer the three questions of empathy with respect to both historical and contemporary phenomenological theories of empathy. Again, in the process of raising these questions to the various theories, it becomes clear that the third question is the most problematic. While the answers to the other two questions may be poor, unclear, or ill-matched to one another, they are at least easy to identify for the relevant theories. Even if they are not discussed in the same area of a philosopher’s work, it is never the case that a philosopher addresses one without somewhere addressing the other. On the other hand, the answer to the third question is often difficult to find, if it is ever addressed at all. The affectivity of empathy is an often neglected feature of empathy, that must be addressed. In chapter 5, I will return to the discussion of clinical empathy in order to show how the phenomenological theories can be applied to clinical empathy, as well as to demonstrate the ways in which a better understanding of the relationship between empathy and its two contexts leads to better theories of empathy.

Chapter Two: Empathy and Transcendental Intersubjectivity

In this chapter, I argue that the theories of Edmund Husserl and his student Edith Stein represent a traditional and enduring phenomenological theory of empathy, but one that is ultimately flawed due to the theory of intersubjectivity that it uses as its starting position. By starting from a strong separation between subject and other, as well as between empathy and affectivity, the Husserlian/Steinian approach to empathy is unable to reconcile these necessarily related concepts in a satisfactory way. This results in a poor ability to explain empathy as it is being defined by Stein—that is, as an experience of foreign consciousness. Therefore, these theories should be rejected in favor of theories that do not begin with such strict divides.

While Husserl does present his own theory of empathy, it would not be worthwhile to answer the three problems of empathy with respect to Husserl alone. To begin with, he presented different arguments for empathy throughout his works. Husserl was preoccupied with the question of intersubjectivity throughout most of his lifetime, which led to many different arguments being presented. These different arguments could be divided into very different theories of empathy, and then associated with either “early Husserl” or “late Husserl,” as is sometimes done with philosophers who have changed their minds over the course of their many works. Alternatively, we can try to find a common theme, as Dan Zahavi does, such that we can connect all of Husserl’s arguments into one larger theory of empathy (Zahavi 2014b, 124). However, the best interpretation may be directly connected to the mutual influence between his and Stein’s works.

Husserl's early theories greatly influenced Stein's work, but his later theories were clearly influenced by her work as well (Bornemark 2014, 260). As such, it makes sense to interpret Husserl's overall approach to empathy as being intertwined with Stein's, each enriching the other. Both philosophers address the explanation of empathy the same, defining empathy as an experience of foreign consciousness and explaining it in largely the same way. Additionally, they both address the intersubjectivity of empathy the same, starting from an experiencing subject, then trying to explain how the experience of foreign subjects is even possible. As a result, empathy is understood as a unique form of intentionality within the context of a transcendental intersubjectivity. Empathy allows us to experience others, but only given the intersubjective context in which others can exist. However, Husserl and Stein diverge on their answers to affectivity of empathy. On his own, Husserl failed to discuss the relationship between empathy and affectivity, and therefore his earlier theory of empathy is seriously lacking. While Stein picks up Husserl's project and does discuss the relationship between empathy and affectivity, her theory still has problems connecting empathy and affectivity due to its Husserlian origins. This argument takes place in three parts.

First I explain Husserl's theory of transcendental intersubjectivity, which serves as the context for their joint theory of empathy. Second, I explain their theory of empathy. Both argue that empathy is an irreducible form of intentionality that allows a subject to experience a foreign consciousness. As such, empathy is a special kind of perception in that it gives us something directly. However, it is also unlike perception in that the other's consciousness is not present in empathy in the same way that an object is present in perception. This makes empathy a unique form of intentionality that cannot be reduced to another form. Third, I explain Stein's theory of affectivity and how it affects her theory of empathy. This includes an explanation of Stein's

theory of affectivity in general, as well as an argument that Stein's theory is unable to reconcile empathy and affectivity. Regardless of whether we interpret empathy as being an affect or being paired with affects, Stein's theory will have problems. The interpretation would either be inconsistent with her overall theory of empathy, or it would leave an unnecessary gap between the experience of others and the way that we are affected by and with others—a gap that is not phenomenologically supported.

2.1 Transcendental Intersubjectivity

The question of intersubjectivity is important to any theory of empathy, and Husserl's is no exception.²³ The topic of intersubjectivity permeated most of Husserl's works. He tried to answer questions related not only to empathy and how we understand others in the world, but also how such a thing as intersubjectivity is even possible. In fact, it would be more accurate to argue, as some philosophers do, that explaining how my experience of intersubjectivity is possible is what serves as the "context for empathy" (Taipale 2013, 4). That is, the very experience of others must be possible before we can begin to discuss the more acute ways in which empathy allows us to experience and understand others (Husserl 1950, 78).²⁴ In order to understand the intersubjectivity of empathy, Husserl's transcendental ego must be explained. This is Husserl's foundation on which one's understanding of everything else must be based, especially when it concerns the transcendental other (Husserl 1950, 90).

²³ When we set aside the possibility of empathy, we still perceive a world that is other to us—a world that transcends my subjective perception (Husserl 1950, 104).

²⁴ Stein fully agrees with this starting position. She argues that our experience of other subjects must begin from a pure, transcendental ego subject, and that there is no such thing as "an experience present before 'I's' are constituted" (Stein 1989, 28). This is meant to be a support of the Husserlian approach and a critique of theories like Scheler's that argue for the existence of an intersubjective stream of undifferentiated consciousness prior to individual subjects. However, as Stein argues, the belief in a primary intersubjectivity is not phenomenologically supported, since we have no experience of undifferentiated consciousness prior to being a subject. Therefore this cannot be the basis of our ability to experience others.

According to Husserl, phenomenology should begin with a phenomenological reduction, or *epoche*. In this reduction, we are supposed to temporarily bracket and suspend our presuppositions. For instance, if we are talking about our understanding of others, we cannot begin by already assuming that they are purely physical beings, or that they have metaphysical minds, or any other assumptions from previous philosophical traditions. Rather, we need to set aside these assumptions so they do not influence our examination. The goal here is to “exclude from the thematic field everything now in question” (Husserl 1950, 93). I must temporarily suspend all of my current presuppositions so that I can experience and describe everything without bias. This applies equally to myself and others as it does to objects in the world.

By bracketing away everything that does not belong to me, I discover the transcendental ego. If the discussion stopped here, then Husserl would unquestionably have a problem with solipsism.²⁵ By abstracting everything away from the transcendental ego that is other, or “alien,” to it (Husserl 1950, 95, 100), we leave it separated from everything else. It becomes isolated, leaving Husserl with the difficult the task of describing how this transcendental ego experiences other subjects and the objective world. The inability to do so would leave the transcendental ego in a transcendental solipsism, but Husserl does not believe that the *epoche* commits one to solipsism. This is because the world still exists in such a way that it *could* be experienced by anyone, even if no one else actually exists (Husserl 1950, 93). In other words, Husserl’s approach to the possibility of intersubjective experience does not arise from a sole interest in

²⁵ In the *epoche*, the transcendental ego becomes a monad—isolated and complete in itself—while everything that is other to me “becomes constituted for me the new existence-sense that goes beyond my monadic very-ownness” (Husserl 1950, 94). Specifically related to other subjects (alter egos), “there becomes constituted an ego, not as ‘I myself’, but as mirrored in my own Ego, in my monad” (Husserl 1950, 94). The other becomes reflected in my own subjectivity. “The ‘Other’, according to his own constituted sense, points to me myself; the other is a ‘mirroring’ of my own self and yet not a mirroring proper” (Husserl 1950, 94). But this still makes it seem as if the transcendental ego is the only thing that can be known. He even compares the transcendental ego to the solipsistic *cogito* of Descartes’ *Meditations* (Husserl 1989, 109). It is in “the ‘thereness-for-me’ of others” that empathy arises (Husserl 1950, 92).

intersubjectivity, but rather from the ways in which transcendental intersubjectivity constitutes objectivity (Husserl 1950, 107-108)²⁶. As such, the transcendental ego's examination of objectivity must be explained before Husserl's theory of transcendental intersubjectivity.

By the time everything has been bracketed away from the transcendental ego, it is also true that everything that was bracketed—everything that is other to the ego—is the objective world, which must be understood as separate and not dependent on the ego (Husserl 1950, 100). The ego discovers itself by separating away everything that is other, and only maintaining that which absolutely cannot be separated. It is only “within and by means of this ownness [that] the transcendental ego constitutes, however, the ‘Objective’ world, as a universe of being that is other than himself—and constitutes, at the first level, the other in the mode: alter ego” (Husserl 1950, 100). The objective world is everything that the ego experiences that is not its own. It is from this standpoint—this divide between ownness and non-ownness—that we must establish the possibility of the other. The other serves as kind of link between the ego and the world that must exist independently of the ego. I am not the only one that perceives objects in the world, so I cannot approach them as if I were.

When I experience the world, I do not experience it as existing only for myself; I experience it as existing *before* me and for others *with* me. If I didn't experience the world in this way—that is, if I experience the world as only ever being experienced by me—then it “cannot be ascribed transcendence and objectivity” (Zahavi 2001, 159-160). My experiences of the world would only be my experiences, leaving me in solipsism. There would be no one to verify that the things I perceive are correct. However, this is not the case. I do not constitute the meaning of the

²⁶ Husserl criticizes Scheler for overlooking this (Zahavi 2014b, 124). Scheler takes intersubjectivity to be something that is inherent and fundamental to our experience of the world. It is a “basic and unanalyzable fact” (Zahavi 2001, 160-161). Husserl disagreed and thought that intersubjectivity could and should be analyzed.

world all on my own, but rather the world as I experience it is constituted intersubjectively (Husserl 1950, 87; Zahavi 2001, 159). It must at least be possible for others to experience the same world for the world to have objectivity (Husserl 1950, 130). In other words, if there are other subjects that experience the same world and communicate about the same world, then we can be confident of its objectivity. According to Husserl, “the other Ego makes constitutionally possible a new infinite domain of what is ‘other’: an Objective Nature and a whole Objective world, to which all other Egos and I myself belong” (Husserl 1950, 107). Though now the question needs to be phrased differently: our examination of the objective world reveals the need for other subjects to secure its objectivity, but how do we know that these other subjects actually exist? The answer to this question can be found in the ego’s perception.

The ego perceives a world and there are features of this experience that ensure the possibility of other subjects. At any given moment, I am unable to perceive every aspect of the world from every perspective. My perceptions on the world are very limited. One limitation of perception is that I only directly perceive one side of an object, but I perceive the object as a whole. For example, when I see my coffee mug, I only see the side that is facing me, but I perceive the entire coffee mug. More of the object is given to me in my perception than that which is directly disclosed. Husserl calls this *apperception* (Husserl 1950, 109). The object has *horizons* at the edge of what I can see that include all the other possible perceptions of the object. If I move around the object to gain a new perspective on the object, I will reveal new sides, while occluding other sides. I will never be able to directly see the object entirely, from all perspective at once, as if from a god’s eye point of view. My perception of the object will always be incomplete, but I still grasp the entire object through apperception.²⁷

²⁷ Apperception is not meant to be understood as a way in which we infer the rest of an object (or other subject) based on what we do perceive (Husserl 1950, 111). All perceptions apperceive the entire object even though only

This is where the other enters more directly into the problem of objectivity. While I may not be able to perceive all sides of the object at once, it would be possible for others to perceive other sides of the object while I am perceiving this one. Each ego perceives the same scene from different perspectives (Husserl 1989, 165). Others see the sides I do not see and I see the side that they do not see. One becomes acutely aware of this when another subject enters a room and is looking at an object from a different area of the room. One is aware that the other sees the object, as well as that the other perceives the object in a different way due to the other's different point of view. Each ego/alter ego helps constitute the objective world from a different but "harmonious" perspective (Husserl 1950, 108).

In short, the objective world outpaces my current perceptions of the world, so others help me to fill in the gaps. However, the others that help establish the objectivity of the world cannot be, for Husserl, actual others; they are only *possible* others. In this sense, the other is a transcendental other (Husserl 1950, 107)—an ideal other that exists before the experience of empathy. Together, ego and alter egos create "a community of Egos existing with each other and for each other—ultimately a community of monads, which, moreover, (in its communalized intentionality) constitutes the one identical world" (Husserl 1950, 107).²⁸ There need be no actual others around for those different perspectives of the object to be possible. All Husserl is arguing at this point is that there are other possible perspectives from which to view the object and that these perspectives *could* be filled by others. They could also be filled by myself were I

one side is directly perceived. On the other hand, this statement is oddly contradicted a few pages later in the same work when Husserl says that apperception of the other is an "analogizing modification" and that "another monad becomes constituted appresentatively in mine," where the other monad is the other subject (Husserl 1950, 115). This makes it seem as if it is through a kind of inference that we understand both the entire object and the entire other.

²⁸ Husserl often used the term monad to explain the situation of the transcendental ego, as well as its relation to alter egos (Husserl 1950, 94, 104, 108, 117, 119, 128, 140, 150; Husserl 1989, 118, 128).

to move to one of those perspectives. All I would need to do is change my *there* into a *here* and my *here* into a *there* (Husserl 1950, 111, 116-119; Husserl 1989, 166; Stein 1989, 42, 61).²⁹

As Merleau-Ponty notes, this makes the subject and the other interchangeable (Merleau-Ponty 2012, *lxxv*). The transcendental other is essentially just what I would be were I at a different perspective. As Husserl says, the other “brings to mind the way my body would look ‘if I were there’” (Husserl 1950, 118). I am the ego and the other is the *alter ego* (Husserl 1950, 110).³⁰ The other is another myself, but since I cannot be in all places at once, the possibility of other egos is the *possibility* of intersubjectivity. The actual experience of actual others will need to be left to empathy, as well as what Husserl calls *pairing*.³¹ Though, at this point, there are some other features of perception that strongly hint at the existence of actual others.

One of these features that Husserl appeals to is that of cultural objects, such as books, tools, works of art, and so on. Unlike other objects that are intersubjectively supported because they could exist for everyone, cultural objects are special in that they would not exist if others had not created them (Husserl 1950, 92). Specifically with these objects, we see that their meaning is not dependent on me alone, but rather necessarily points to others. Husserl says that these objects have “‘spiritual’ predicates,” and are known to be cultural objects because “their origin and sense... refer us to subjects, usually other subjects, and their actively constituting intentionality” (Husserl 1950, 92). I cannot even begin to understand the meaning of cultural objects in isolation, since they do not have close to the same meaning independently of others.

²⁹ This ends up being one of the more simple ways in which I am distinguished from other subjects. I am always here and the other is always there (Husserl 1950, 117). If I were to move to there, making it a here, then that can only be accomplished by the other moving to a new there.

³⁰ Husserl clarifies his terms by saying, “‘alter’ signifies alter ego. And the ego involved here is I myself” (Husserl 1950, 110). For every ego, all alter egos are implied in the horizon of each perception (Husserl 1950, 131).

³¹ Husserl argues that our experience of an intersubjective world and the actual others in this world are only possible through empathy, but that empathy presupposes the possibility of intersubjectively experienceable things and bodies (Husserl 1989, 101). Empathy attributes the other’s private, psychic, internal life to the other’s intersubjectively experienceable body (Husserl 1989, 102).

Therefore, if I am going to understand what is objective about these cultural objects, I need to assume that other egos actually exist to have created them.³²

Another feature of perception that points to the existence of actual others is the possible otherness of the ego itself. That is, the possibility of another subject's perception is not only true in regard to objects in the world, but is also true in regard to myself. This is due to the reversibility of my body, which can be found in perception (Husserl 1989, 155). I am both perceiving others and perceived by others. Though, reversibility is not limited to intersubjectivity. Reversibility takes place even in regard to simple perceptions too. When I touch something, I am both touching it and being touched by it. This becomes more obvious when we consider the act of touching both of my hands together. Here, I am both touching and being touched, since one of my hands is touching the other hand. If I focus on one hand, I can feel it touching the other. However, I can also shift my focus to my other hand, such that my touched hand becomes the touching hand and the touching hand becomes the touched hand. Though, to be accurate, it is not that only one hand is being felt while the other is not. Rather, one becomes foregrounded in our consciousness, even while both are touching and being touched.

What this reversibility allows me to do is “confront my own exteriority, and according to Husserl this experience is a crucial precondition for empathy” (Zahavi 2001, 161).³³ I experience the other both as an object and as a subject in the world, but it is also in perceiving the other that I come to understand myself as both an object and a subject in the world (Husserl 1950, 91).

³² This, however, may be a question-begging argument, since he is appealing to cultural objects as proof that there are actual others in the world, but the claim that they are cultural objects depends on the assumption that there are other subjects that created them. Without this assumption, they are merely objects and do not necessarily signify the existence of others in any way.

³³ Though, it is still unclear how the transcendental ego perceives others—especially human others—as other subjects, and not merely as the physical bodies that the transcendental ego experiences.

When I experience the other, I also experience the other experiencing myself. Since the other is an alter ego, I can imagine what it would be like for me to be in the other's positions, experiencing the other's perceptions of me.

This kind of 'original reciprocal co-existence' where I take over the other's objectifying apprehension of myself; that is, where my self-apprehension is mediated by the other, and where I experience myself as other; is also construed to be of decisive importance for the constitution of an objective world. (Zahavi 2001, 160)

I typically only experience myself in one way, as I live in the world. However, as a body, it is also possible to perceive me from different perspectives, like any other object in the world. In fact, I am not even given to myself as complete. I am given as incomplete, "with an open infinite horizon of still undiscovered internal features of my own" (Husserl 1950, 102). This is important because it allows me to perceive myself as an other and not merely as a pure subject. There is no "absolute difference between self and other" (Zahavi 2001, 160). We each perceive ourselves as the subject and the other as the other. The two are bound together. We exist in an "mutual being for one another" (Husserl 1950, 129). When I perceive the other, the other also perceives me, and I am revealed as an other to others in the same way that they are others to me (Husserl 1950, 129-130).³⁴³⁵

To summarize Husserl's theory, the transcendental ego overcomes the problem of solipsism by discovering transcendental intersubjectivity in the search for transcendental

³⁴ However, some things that he says seem to indicate that he thinks that the ego in itself is not really affected by the other. For instance, as on point he says, "the psychic life of my Ego (this 'psychophysical' Ego), including my whole world-experiencing life and therefore including my actual and possible experience of what is other, is wholly unaffected by screening off what is other" (Husserl 1950, 98). The psychic life of the ego remains distinct from what is other even as the other has an influence on my body. In other words, it is because of my body that I can be objectified, but my transcendental ego, which is not dependent on my body, can remain completely unaffected by others. This is because it has already been abstracted away from everything that is other.

³⁵ Understanding that I myself am an other to other subjects allows me to realize that "I am only one among many and that my perspective on the world is by no means privileged" (Zahavi Beyond Empathy, 160).

objectivity. The transcendental ego can be confident in the objectivity of the world because perceptions of the horizons in the world reveal that it could exist for more than the ego. The limitations of our perceptions reveal the existence of other possible perspectives of the objects that we perceive. These other perspectives in turn show the possibility of other subjects. This possibility of other subjects, however, is merely a transcendental intersubjectivity. It neither guarantees the existence of *actual* other subjects, nor does it give us access to them if they do exist. The perception of cultural objects and my own objectification as a result of my reversibility may give more of an objective standing to the existence of actual others, but even these do not allow me to experience others. All these do is provide phenomenological evidence that I am not alone in this world, and that it is very likely that other subjects like myself exist in the world. Therefore, intersubjectivity sets up for the possibly that is actualized by empathy—the experience of a foreign subject.

2.2 What is Empathy?

As defined by Husserl, empathy (*Einfühlung*) is the activity of “experiencing someone else” (Husserl 1950, 92), or in Stein’s terms empathy (*Einfühlung*) is “the experience of foreign consciousness in general” (Stein 1989, 11).³⁶ This identifies the experience that is being connected with the term, but the explanation of this very unique experience is complicated at best. There are many different aspects of empathy that need to be explained. The first is the phenomenon of pairing by which the other is linked with the subject within their already established co-presence (transcendental intersubjectivity). Second, it needs to be explained how empathy is both like and unlike perception, which explains the structure of the experience of the

³⁶ Husserl also uses similar phrasing to Stein’s when he says that empathy is meant to pertain to any individual thoughts or emotions, but rather “the person’s entire psychic life” (Husserl 1989, 175-176).

other, as well as why the other cannot be reduced to the subject. Finally, the different levels of empathy need to be explained such that empathy can be accomplished in different ways, and to different extents.

2.2.1 Pairing

Transcendental intersubjectivity—the possibility of other subjects in the world that are like the ego—has already been established. However, when I perceive another subject, what is it about the other that causes me to empathize with him or her, when I do not normally empathize with any other object in the world? That is, why do I immediately perceive the other as a subject of empathy, but I do not see my books or coffee mug as deserving of empathy? Husserl's answer is through the phenomenon of *pairing* (*Paarung*), or *coupling* (Husserl 1950, 111-113, 123). In other words, it is pairing that establishes our similarities with others, identifying individuals as *possible* other subjects with whom I may be able empathize. This warrants an explanation, beginning with why this is a problem at all.

It is obvious that any normal person will perceive other subjects as being other subjects that are similar to himself or herself. However, this is interesting because I cannot really perceive the other's consciousness in the same way that I perceive objects in the world. I perceive the other's body, but "the psychic" is something that is not available to perception—the psychological life of the other can only be perceived "in empathy" (*Einfühlung*) (Husserl 1989, 102, 173-174). But what is it that allows this connection to be made between the perceived body and the psychological life, such that the body is immediately perceived as a lived body? As with everything for Husserl, the examination must begin with the transcendental ego.

Husserl argues that I have a unique access to my own psychological life and its conjunction with my body. When I experience other bodies that are similar to my own, I perceive

them as bodies that are very much like my own. Because of this perceived similarity between my body (which I know is linked to a consciousness) and the other's body (which I do not know is linked to a consciousness), "I feel by empathy that in them there is an Ego-subject, along with everything that pertains to it" (Husserl 1989, 172). This is what Husserl refers to as pairing (*Paarung*) and it is the foundation for empathy (Husserl 1950, 111-113, 123). Unless we are capable of making this connection between my body and the other's body as having similar psychological lives, then the other will always only be perceived as an object.

According to Husserl, this connection of similarities is immediately given whenever I perceive another subject, since "ego and alter ego are always and necessarily given in an original 'pairing'" (Husserl 1950, 112). Whenever I perceive the other, our similarities are blindingly obvious to me, such that the other, even in a glance, is immediately associated with me as a subject (Husserl 1950, 112; Husserl 1989, 173-174, 358). I perceive the other's body as being shaped and functioning similar to my own, as well as observe the other acting in the world similarly to how I act. It is only because of these perceived similarities that the other and myself "found phenomenologically a unity of similarity and thus are always constituted precisely as a pair" (Husserl 1950, 112). However, it is important to note that pairing, while essential to empathy, is not something that is unique to my perception of other subjects (Husserl 1950, 112). Pairing occurs naturally in all our perceptions, when we group objects together as being of similar kind. Every time I perceive a pencil, I immediately and subconsciously pair it with other pencils that I have perceived. The same applies to all objects in the world, but it is not as simple as lumping similar things together into a stagnant grouping.

This process of pairing is made more influential by the way in which we continue to learn increasingly more about the objects that we pair together (Husserl 1989, 112-113). As we

continue to experience objects at different times, we increase and augment our understanding of those objects. When we then experience a new object that can be paired with the previously paired objects, all of our current understanding is also associated with the new paired object. When I perceive a pencil and learn that I can write with it, all future pencils that I pair with the first one will also be paired with this previous understanding of pencils. As I learn that pencils can be of different shapes, sizes, material, and so on, these meanings are also sedimented into the pairing of pencils.

This same process of pairing and sedimentation also applies to the subject and the other. I have an understanding of myself, and when I perceive another subject, I pair the other with myself and all of the meaning that I have accumulated concerning myself. As I experience increasingly more subjects, I sediment more and more meaning to be applied to the pairing of subjects.

One problem with the idea of pairing is that it doesn't seem to account for the differences between the ego's perceptions of itself and the ego's perceptions of others (Scheler 1954, 10-12). When I perceive pencils, I perceive each of them in a very similar way: out in the world, in the light, from a specific perspective, and so on. When I perceive the other and myself, I perceive the other from a third-person perspective—perceiving him or her the same as I do the pencils—but I perceive myself from a first-person perspective. I perceive the other's body, but I perceive *through* my body. At best, I am able to gain an understanding of my thoughts and feelings through introspection, but this is also something that I am unable to do concerning the others' thoughts and feelings. Ego and alter ego do not show up for me in the same way, or even a very similar way. This being the case, it is unclear how I am able to pair together two different

perceptions as being similar. It seems that Husserl fails to notice this problem (Husserl 1950, 113).

There are at least two ways to solve this problem. One would be to argue that we can have a first-person experience of the other's experiences. However, this would be a controversial move to make and it is not one that Husserl would be comfortable with (Husserl 1950, 109, 114, 121; Husserl 1989, 172-173). The alternative is to argue that I can approach myself from a third-person perspective, which seems more promising. I am capable of looking at myself, feeling myself, hearing myself, and so on. While I cannot normally perceive my body from any other perspective, I could always look in a mirror to understand what my body looks like from "over there." Additionally, it is not a problem that I can only perceive one perspective on my body at a time, since this is also true of the other, and really everything that we perceive. Because I can go through this process with regard to myself, it could be argued that pairing must involve an objectification of myself to some extent (De Preester 2008, 135-136; Reynaert 2001, 207-208). Since I only ever experience the other as a body, I must also perceive myself as a body in a more objective way. Thus, pairing is possible through a kind of self-objectification.

To be clear, this experience of myself in an objective way is important for my experience of the other because it allows for me to accumulate experiences that I then use to recognize the other as being similar. As stated earlier, when I perceive something that can be paired with other objects, the pairing causes me to associate all the experiences of the other objects in the pairing with the new object I am perceiving. As Dan Zahavi clarifies, "patterns of understanding are gradually established through a process of sedimentation and they thereby come to influence subsequent experiences" (Zahavi 2014b, 132). This sedimentation allows me to establish a unity

between the other and myself (Zahavi 2014b, 133), but only if I am capable of coming to an objective understanding of myself.

Like the way that the meaning of pencils goes through a process of sedimentation with each experience of different pencils, when I perceive another subject, the subject becomes associated with everything I have learned about myself. After I objectify myself, I perceive the other as similar to my objectified self in the same way that I perceive two pencils as similar to one another. Then, following the perception of the other as another subject like myself, comes a large transfer of psychic activities to the other:

Transferred over to the other Bodies thereby is first of all that “localization” I accomplish in various sense-fields (field of touch, warmth, coldness, smell, taste, pain, sensuous pleasure) and sense-regions (sensations of movement), and then in a similar way there is a transfer of my indirect localization of spiritual activities. (Husserl 1989, 172)

In perceiving another body that is similar to my own, our bodies are paired, not just in outward appearance, but also in terms of inner, psychological lives (Husserl 1989, 174). This is meant to be automatic, and not involve any sort of analogy, though this isn’t entirely clear, since there are areas of Husserl’s work where he does refer to this process as an analogy (Husserl 1989, 177).

Additionally, while Husserl does not want to argue that empathy is a kind of analogy, he seems to have trouble explaining how empathy works without it sounding like an analogy.³⁷

³⁷ For instance, there are times when he directly refers to empathy as relating to “transcendental aesthetics” (Husserl 1950, 146), where the aesthetic theory of empathy is very much analogical. That is, empathy helps us understand art by allowing us to project our feelings into the work of art. Furthermore, concerning the idea of empathy as a projection, there are times when Husserl similarly talks about empathy as a kind of projection. In a section of Cartesian Meditations when he is discussing how we can come to understand those from alien cultures, he says that an understanding of them “is accessible only by a kind of ‘experience of someone else,’ a kind of ‘empathy,’ by which we project ourselves into the alien cultural community and its culture” (Husserl 1950, 134-135, italics added). Granted, here he is not specifically talking about our understanding of all others—that is, he is not talking about the way in which we understand others in general, but rather only others in a very specific, alien context. However, that he uses the term empathy, then follows the term with a definition that includes the idea of projection is problematic if he does not want his theory to be taken as an argument from analogy.

The reason this is a problem for Husserl's theory is because it calls into question whether or not he is accurately explaining the phenomenon to be explained. If he wants to explain how we experience others as foreign subjects, then it seems like an analogy would fail to explain this. As explained with the diversity problem, if I can only really experience the other in ways that are analogous to me, then I am not experiencing the other in any way that is foreign to me.

To an extent, it does seem correct to interpret the subject's understanding of the other as an analogy (Husserl 1989, 174-175, 176, 179). Again, by observing actions, we can learn what psychological intentions are related to physical actions and gestures. Everything we learn in this way is sedimented in the pairing. Then, when we perceive the actions of the other's body, we form an instinctual analogy between my body with its psychological life, and the other's body with its similar psychological life. While I can objectify myself to experience myself in a similar way to the other, I cannot experience the other like I can experience myself, since I can never have a first person experience of the other's experiences. Based on the way that pairing works, it seems that drawing an analogy between subject and other is necessary (Husserl 1989, 175).

Additionally, the diversity problem may only be an issue for Husserl if pairing is the only important feature of empathy, which it is not. Pairing is simply the launching point for empathy (Zahavi 2014b, 138-139). It is that which establishes an initial similarity. It is not meant to be a process by which we perceive the actual foreign subjectivity of others. It is a middle step between the possibility of other subjects and the perception of the conscious life of the other in general. In other words, pairing is the perception of the other as a being like us with the *possibility* of a psychological life. The perception of the actual psychological life of the other is given directly in empathy. No analogy or pairing with my own mental states is needed. Though, it needs to be explained how exactly we *perceive* the psychological.

2.2.2 Similarity to Perception

Both Husserl and Stein make claims that empathy is a kind of perception of the other (Husserl 1989, 172; Stein 1989, 11). It is not a kind of inference or process that needs to be applied in order to understand the other. Empathy is direct and immediate. Theories that need to appeal to inferences and/or processes such as simulations suppose that the other's psychic life is hidden away from us, unable to be perceived by us. This, however, is not the case in our everyday perceptions of others (Stein 1989, 24). Husserl and Stein argue that empathy allows us to directly perceive the other's foreign consciousness. However, it should not be assumed that empathy perceives the psychological lives of others in exactly the same way as we perceive objects in the world. Empathy is unlike perception in important ways that make it unique.

For one, perception of an objects always has its object given to it directly, while empathy does not. In our perception of objects, the whole object is perceived, even though we only have visual access to one side of the object. That is, I can see one side of the object from my perspective, but I perceive the entire object, because all other sides are apperceived. Something similar happens in empathy (Jardine 2015, 575), but in such a way that the other's consciousness is apperceived (or appresented) in a much more elusive way than the unseen sides of my coffee mug (Husserl 1950, 109, 114-115, 119, 149-150; Husserl 1989, 175). The unseen sides of the mug could be made visible if I move to different perspectives or turn the mug over in my hand; but, the psychological life of the other can never be made physically present to me (Jardine 2015, 576). I can never move around the other in such a way that makes the other's psychological life visible to me as his or her body is. It is the "structure" and not merely the content of that which is apperceived that is different (Jardine 2015, 576).

To use Stein's example, the other's pain "is not a thing and is not given to me as a thing, even when I am aware of it 'in' the pained countenance. I perceive this countenance outwardly and the pain is given 'at once' with it" (Stein 1989, 6). Pain is something that empathy allows me to perceive in the other, and conjoined with the gestures of the other, but it is not perceived in the same way that the gestures are perceived (Stein 1989, 5). The feature that perception and empathy share is in the way that the object in perception and the other's psychological life in empathy are both "present here and now" (Stein 1989, 7). The experience is not mediated or analogical, but is rather given directly in the experience of the other.

Empathy is also unlike object-perception because I can never trade perspectives with the other in order to experience the intentional object in the same way that the other does. I can never experience the other's psychological life in the same way that the other does. Concerning objects, both Husserl and Stein hold that we can always move to the other's perspective in order to see the sides of the object that the other sees. However, when it comes to the other's psychological life, the other always has a first-person understanding of his or her experiences, while I can never gain that same perspective, no matter where I move. As Stein says, "just as our own individual is announced in our own perceived experiences, so the foreign individual is announced in empathized ones" (Stein 1989, 34). Or, as Jardine clarifies, there is a necessary difference between "empathy and self-awareness" (Jardine 2015, 576). The foreignness of the other's experience will always be an aspect of the empathized experience. Alternatively, one can argue that my experience of the other's psychological life always lacks something that would make the experience mine—a certain "selfness" or "for-me-ness," as some philosophers have argued (Jardine 2015, 576; Zahavi 2014b).

In Stein's terms, the other's experience is the unmediated intentional object of my empathizing, but it is never given to me "primordially" (*Originarität*), or as if it originated as my experience (Stein 1989, 5). For instance, my experience of happiness is a primordial experience for me and the other's experience of happiness is primordial for the other. In empathy, the other's experience is given to me "non-primordially" (*Nichtoriginarität*) (Stein 1989, 5), but in such a way that it announces a primordial experience (Stein 1989, 14). I don't directly experience the other's experience as being like my own experiences, but rather I experience the other's experience as revealing that the other is having an experience. This is what leads Stein to say that the empathized experience is "primordial as present experience" and "non-primordial in content" (Stein 1989, 10). It is an original experience for me about an experience that is not original for me. When I empathize with the other, such that I perceive the other as being happy, the empathizing is my own primordial experience, but the content of my empathy—the other's happiness—is given to me non-primordially. I experience the emotion as being the other's experience when I empathize with the other, since I do not (necessarily) experience that emotion myself at the same time.

This is similar to other experiences, like the experiences of remembering or imagining,³⁸ in which we have a primordial experience of something that is not-primordial. For instance, when I remember the first time I met my wife, the remembering is a primordial experience, but the experience of first meeting my wife is non-primordial. When I first met her, my experience was experienced as primordial (or as an original experience), but now when I remember it, it is only the non-primordial content of my primordial experience (remembering). I recall the old original content, but in a way that the remembered experience is no longer original. In terms of

³⁸ However, one of the important differences between empathy and these similar forms of experience is that the intentional object of empathy is still here and now (Jardine 2015, 576).

empathy, I do not feel the other's emotion the same way that I normally experience that emotion—"while I am living in the other's joy, I do not feel primordial joy. It does not issue live from my 'I'" (Stein 1989, 11). I experience the other's joy as still belonging to the other. It is still the other's joy that I am somehow perceiving.

This is the problem that Stein sees in any theory that must appeal to an argument from analogy. Specifically, when critiquing Lipps' theory, she says that he has a serious problem in the way that he fails to distinguish between "(1) being drawn into the experience at first given objectively and fulfilling its implied tendencies with (2) the transition from non-primordial to primordial experience" (Stein 1989, 13).³⁹ Lipps takes all empathetic experiences to be primordial experiences, when these are actually the highest level of empathy, which people rarely reach. Lipps assumes that I understand the other by feeling like the other, but this shift from being directed at the other's primordial experience to also primordially experiencing the same experience (through imitation) is neither necessary nor common for empathy.

I can be drawn into the other's experience such that I experience the other's foreign consciousness without ever needing to experience the same emotions as the other. In failing to make this distinction, Lipps fails to acknowledge the otherness of the other. Empathy for Lipps is not an experience of others as being other subjects, but rather a merger of subject and other where the subject is the dominant party. When there is no distinction between primordial and non-primordial experience in empathy, "there is no distinction between our own and the foreign 'I... they are one'" (Stein 1989, 16).

³⁹ Though, it is worth noting that Stein does see some minor similarities between Lipps' theory and her own theory. The place where Stein thinks that their theories correspond is when he "depicts empathy as an 'inner participation' in foreign experiences" (Stein 1989, 12). This corresponds to what she claims is the highest level of empathy, where the subject is with the other in the other's situation, and likewise directed at the world in the same way. This, however, is the only similarity between their theories.

To demonstrate this problem, consider Stein's example of watching an acrobat.⁴⁰ When the spectator watches the acrobat, the spectator becomes immersed in the acrobat's performance. The acrobat is continually moving and entering new experiences. If Lipps' theory of empathy and ST are right, then the spectator would need to continuously simulate the changing experiences of the acrobat in order to understand them. More specifically, the spectator's entire inner, conscious self must be imitating the acrobat, otherwise something would be missing from the understanding of the other.⁴¹ However, as Stein notes, when I am observing the acrobat, "I am not one with the acrobat but only 'at' him" (Stein 1989, 16). My experience of the acrobat does not cause me to merge with him such that we become one. Rather, empathy allows me to have my own experiences directed at the acrobat. Empathy is an intentionality directed at the other's experience, not my experience of the other's experience. It is not a duplication of the other's affect, but is rather "a *sui generis* form of intentionality directed at other experiencing subjects" (Zahavi 2014b, 125).

At this point, it is important to note that empathy *can* occur such that we experience the same emotion as the other. However, Stein argues that actually experiencing the same emotion as the other would be a higher level of empathic accomplishment, and this is not required for all experiences of empathy. This is why she distinguishes between "three levels or modalities of accomplishment" for empathy (Stein 1989, 10).⁴²

⁴⁰ This example is also used by Max Scheler (Scheler 1954, 18).

⁴¹ This critique admittedly derives a stronger claim from Lipps' theory than seems necessary. It seems equally possible for Lipps to argue that we only simulate and project specific behaviors and mental states of the other, rather than the entirety of the other's consciousness.

⁴² While never explicitly stated in Husserl's work, Zahavi argues that Husserl shared a similar view that there are levels of empathy, though his levels are not like Stein's levels (Zahavi Levels of empathy). According to Zahavi, Husserl's levels are based on the intentional structure of empathy, and his view that there are different "ways of intending an object" (Zahavi 2011, 226). These different ways of intending can be called *signitive*, *pictorial*, and *perceptual*. Signitive is when I talk about the intentional object, especially if I have never actually seen this object. Pictorial is when I perceive a representation of the intentional object, such as a picture or a painting of the object. Finally, perceptual is when I actually experience the object in person. For example, I can talk about the grand canyon (signitive), I can see a postcard with the picture of the grand canyon (pictorial), and I can go visit the grand

2.2.3 Levels of Empathy

According to Stein, the three levels of empathy are

- (1) the emergence of experience;
- (2) the fulfilling explication; and
- (3) the comprehensive objectification of the explained experience. (Stein 1989, 10)

The first level is when I perceive the other and immediately understand the other's experience.

Though, as Zahavi notes, the understanding here is "a vague and relatively empty comprehension of the other's experience" (Zahavi 2014b, 137). This is the experience that has been discussed up to this point. It is a primordial experience of the other's experience, which is non-primordial in content for me. In other words, empathy at the most basic level is the experience that someone is having experiences. It is my experience that the other feels joy, but without feeling joy myself nor knowing what it is that is bringing the other joy.⁴³

The second level is when I try to understand the other's experience better, and as a result am pulled along with the other's experience. Here, I understand what the intentional object is of the other's experience. When we perceive the sad faces of others, "we may turn toward the foreign experience and feel ourselves led by it" (Stein 1989, 19). In this way, as Jardine clarifies, "our empathic interest becomes not merely that the other is sad, but what she is sad about and

canyon to experience it in person. Each one of these experiences has the same intentional object, but it is intended in very different ways. Furthermore, these different ways are not all equal, but rather "there is a strict hierarchical relation between them, in the sense that the modes can be ranked according to their ability to give us the object as directly, originally and optimally as possible (Zahavi 2011, 226). The same is true to empathy. While an interesting interpretation of Husserl's theory, I do not address it further here because the levels (such as pairing and perception of foreign consciousness) have already been addressed. In fact, they have been addressed in the order that would correspond to the levels that Zahavi identifies.

⁴³ It could be asked here if one can perceive joy without having felt it. Stein is certainly arguing that joy does not need to be presently felt in order to be perceived, but she is vague as to whether we need to have at some time experienced joy to be able to understand joy, if only in a very empty way. Since, the experience here is more akin to a recognition of the other's affect, it would make sense the the subject would need to have some idea of the experience in order to recognize it.

why this state of affairs elicits sadness in her” (Jardine 2015, 577). In these instances, the other’s experience is no longer the intentional object of my empathy, but rather the other’s intentional object becomes the intentional object of my empathy—I am “at the subject of the content in the original subject’s place” (Stein 1989, 10). On the first level, empathy “exhibits the non-primordial parallel to perception, and on the second level it exhibits the non-primordial parallel to the having of the experience” (Stein 1989, 10).⁴⁴ I have a non-primordial experience of the same thing that the other is having a primordial experience of. Whereas the first level is other-directed, the second level is world-directed-with-the-other.

Only by reaching this second level of accomplishment can I reach the third level of accomplishment, in which the other’s experience is again the intentional object, but now I have an “increased comprehension” of the other’s experience (Zahavi 2014b, 137). That is, I am now experiencing the other’s experience and the intentional object of the other’s experience, with the addition of my experience of the intentional object from my perspective. This allows me to experience a “feeling of oneness” with the other. We are together in the world with a communal experience of the same object.

However, at this level of accomplishment—where we happen to feel the same emotion as the other in a primordial way—it would be more accurate to say that this is an experience that goes beyond empathy. Empathy itself “is not a feeling of oneness” (Stein 1989, 17). When I legitimately feel what the other is feeling, the other’s feeling “comes to life in my feeling, and from the ‘I’ and ‘you’ arises the ‘we’ as a subject of a higher level” (Stein 1989, 17). This, in turn, serves to “empathically enrich our feeling so that ‘we’ now feel a different joy from ‘I,’ ‘you,’ and ‘he’ in isolation” (Stein 1989, 18). It is not a feeling of oneness that makes empathy

⁴⁴ She also says that the third level “exhibits the non-primordial parallel to perception,” like the first level (Stein 1989, 10).

possible, but rather empathy that makes it possible for us the experience a feeling of oneness (Stein 1989, 18). That is, empathy is not supposed to reduce us to a single, same-feeling being, but rather allow for separate subjectivities to experience and understand one another. It is only because of empathy that a feeling of oneness is possible, but when a feeling of oneness is accomplished, the experience is no longer empathy.

The use of the term *feeling* here is interesting, since it shows the disconnect that exists between empathy and affectivity for Husserl and Stein. It is at the level where empathy becomes a feeling like the other that empathy ends and another experience begins. Is the feeling of oneness no longer empathy because the experience becomes a feeling or is it no longer empathy because one is experiencing the world like the other? The latter is unlikely, since the second level of empathy is also a state of experiencing the world like the other, but does not cease to be empathy. In the second level, the subject is directed at the world with the other, not merging into one, but taking a similar stance. The other option, that empathy cannot be an affect for Stein and Husserl may be the case, but this is a larger problem that needs to be addressed, since it seems odd to argue that perception is ever affectless.

To summarize their theory, empathy is an irreducible form of intentionality that is directed at foreign consciousness. While transcendental intersubjectivity reveals the possibility of the existence of others, empathy is the subject's actual experience of actual others. This begins with pairing, in which the other is paired with the subject due to similarities. This pairing allows the other to show up as a similar sensible body in the world that *may* be a subject. Following this initial pairing, empathy more or less directly perceives the psychological life of the other, here and now. This experience of the other's foreign consciousness is a primordial experience for the subject that is non-primordial in content, since the experience that empathy gives the subject is

not experienced as if it were actually the subject's. As such, pairing serves as the aspect of empathy that connects us to the other in similarities, while the perceptual aspects of empathy reveal the necessary divide that maintains the otherness of the other. As a result of this divide, empathy can be accomplished at three different levels. The most common is the perception of the other as a foreign consciousness. The second is when empathy pulls the subject along with the other's experience such that the subject experiences the same intentional object with the other. Finally, the third and highest level of empathy—the level that most people do not reach in everyday interactions—is when the subject's attention returns to the experience of the other with a better understanding of what it is like for the other to have the other's experience. With this idea of empathy in mind, empathy's connection to affectivity can now be assessed.

2.3 Bridging the Divide Between Empathy and Affectivity

As stated in the introduction, the relationship between empathy and affectivity is often something that is overlooked despite empathy's obvious roots in affectivity. Sometimes this neglect is intentional, when philosophers and psychologists assume that empathy has nothing to do with affects aside from giving the subject access to the other's affects. Other times, the neglect is accidental, when philosophers and psychologists simply overlook affectivity as being a relevant factor in empathy, focusing more on what is given in empathy and how it is given. Conversely, there are those philosophers who do see the importance of affectivity to the discussion of empathy, such as Stein.

However, it is not convincing on its own to claim that affectivity must be an aspect of any good theory of empathy, since it is not always the case that affective phenomena are the ones that are connected to the term *empathy*. In other words, the phenomenon that is being defined as empathy may not be an affect, but rather a cognitive skill or judgment. This is only possible in

philosophies that strongly divorce the cognitive from the affective, or those that argue for a theory of empathy that does not match their theory of affectivity, and therefore reduce empathy to merely its cognitive aspects.⁴⁵ For instance, Husserl seems to better fit this latter group that does not connect empathy to affectivity in a satisfactory way. At best, empathy is a perception of the other's affects, but is not necessarily an affect itself. This seems to be the case because Husserl neither discusses empathy as an affect nor as something that can be reduced to a kind of affect. Again, empathy is an irreducible, other-directed form of intentionality. Affects for Husserl are also unique forms of intentionality, but they cannot be reduced to empathy any more than empathy can be reduced to an affect. Empathy simply isn't an affect and is never defined as such.

The goal of this section is not to claim that empathy is an affect, then show how Husserl's and Stein's theory fails by not addressing it as such.⁴⁶ Rather, the goal in this section is to show the internal inconsistency of their theories of empathy, affectivity, and intersubjectivity in order to show that their theory of empathy is not sustainable and needs to be altered. As was done with the question of intersubjectivity, their theory of affectivity needs to be explained before its relationship to empathy and intersubjectivity can be assessed. Only based on the coherence of the different aspects of their theories, as well as their correspondence to the phenomenological evidence of empathy, can their theory be explicated. Therefore, the first step is to explain Stein's theory of affectivity. Then, the relationship between affectivity and empathy is addressed, including arguments that empathy is an affect. However, I argue contrary to these arguments that Stein is unable to reconcile empathy and affectivity in a satisfactory way due to the Husserlian

⁴⁵ Theories such as these will be addressed further in chapter 5.

⁴⁶ While I argue that empathy is an affect, and in such a way that Husserl and Stein do not account for it as such, this argument will be explained in chapter 5.

foundation for her theory of empathy. This means that empathy should not be understood as an affect for Stein, but rather as a middle step between general affectivity and intersubjective affectivity. However, this makes empathy a relatively hollow phenomenon, poorly supported by our actual experiences of others, as well as an unnecessary step in our intersubjective interactions.

2.3.1 Steinian Affectivity

For Stein, affects are perceptions of value of the world in the sense of conation (Stein 1989, 101). They reveal certain features of the world that would not be perceived if one were to somehow lack affects. As Ferran notes, “Stein was participating in a change of paradigm on affectivity that took place at the beginning of the twentieth century” (Ferran 2015, 486). Stein, like other phenomenologists of her time, moved away from the view that affects were purely subjective, bodily states that were essentially the antithesis of reason. Rather than taking reason to be objective and world-directed, and affects to be subjective and self-directed, Stein argued that affects have important cognitive components that make them rational as well (Stein 1989, 101). Affects are value-directed perceptions of the world (Ferran 2015, 486; Jardine 2015, 578).⁴⁷

The world-directedness of affects is important; it means that affects have a more varied intentional structure than was previously supposed. Affects are not merely about the body, they are also about the world. In Stein’s own words, “feelings are always feelings of something. Every time I feel, I am turned toward an object, something of an object is given to me, and I see a level of the object” (Stein 1989, 100). This feeling originates in a living body, and its

⁴⁷ This corresponds well to what is called cognitive theory in contemporary philosophy of emotion.

intentional object can either be some aspect of one's body, an object in the world, or another subject (Stein 1989, 99). Here she is focusing specifically on feelings, but this is not the only type of affect that she discusses. In fact, some have argued that she identifies five different types of affects (Ferran 2015, 489-490).

The first type is "sensations of feeling," which include sensations such as pleasure and pain (Stein 1989, 100). These affects have one's body foregrounded as the intentional object. The second type is "general feelings," which do not have specific intentional objects, but rather color the world in general (Stein 1989, 92). These include the feeling of being tired or alive, that "cannot be localized in a concrete part of the body despite affecting its general condition" (Ferran 2015, 490). The third type of affect, moods, also lack any specific intentional objects, instead coloring the world in certain ways. This includes the experiences of being cheerful or depressed, about which Stein says "for him who is cheerful, the world is bathed in a rosy glow; for him who is depressed, bathed in black. And all this is co--given with acts of feeling as belonging to them" (Stein 1989, 92). This "rosy glow" and "bathed in black" have no intentional object, but are rather general attunements to the world, serving as the context in which intentional affects can arise.⁴⁸ Moods are then distinguished from general feelings because moods are not centered and reliant on the body as general feelings are (Stein 1989, 100).⁴⁹ Additionally, general feelings (as well as moods) can be distinguished from other feelings because "they have no definite locality in the 'I'" (Stein 1989, 100).

The fourth type of affect is "feelings in the pregnant sense," though these feelings also correspond well to the contemporary discussion of emotions (Stein 1989, 100). This level

⁴⁸ This is in line with the way that most phenomenologists talk about moods. See chapter 5.

⁴⁹ This appears to be describing the same phenomenon that Ratcliffe calls existential feelings (Ratcliffe 2005; 2008; 2009a; 2009b).

includes when we feel joyous about some event or afraid of something in the world. This is the level at which the world is the intentional object and values are perceived (Stein 1989, 100-101). Finally, the fifth type of affect is what Stein calls the “sentiments” (*Gesinnungen*) (Stein 1989, 101). This includes experiences of “love and hatred, thankfulness, vengeance, animosity, etc.—feelings with other people for their object” (Stein 1989, 101/113). In other words, sentiments are intersubjective affects, in the sense that they are directed at other subjects. It is not that sentiments are literally shared, since sentiments are still considered subjective, private feelings for Stein. They are those affects that have the other as the intentional object and, like with feelings/emotions, they also reveal values. In fact, these last two types of affect are the only two that reveal values (Ferran 2015, 490, 496). What distinguishes the two is that feelings reveal values in the world while sentiments reveal values in others.

Specifically, examining our feelings—which are not inferences, but rather conations—discloses to us “essential relationships among the hierarchy of felt values, the depth classification of value feelings, and the level classification of the person exposed in these feelings” (Stein 1989, 101). I cannot perceive an object or other subject in the world without perceiving their values. This means that certain affects are “rational mental phenomena that play an important epistemic and ethical role” (Ferran 2015, 488). They have a large influence on how we interact with the world and with others in the world. We avoid those things that we value as frightening and embrace those who we love.

Two things need to be clarified here: the cognitive nature of our feelings as value-judgments and the objectivity of values. Concerning the first point, Stein presents a cognitive model, grounding emotions in “cognitive acts such as perceptions, fantasies, and beliefs” (Ferran 2015, 493). This basis of feelings and sentiments on things like perceptions will be important in

the next section when questioning whether or not empathy is an affect. For now, it is enough to note, as Stein does, that “the structure of all feelings requires theoretical acts” (Stein 1989, 101). They must be based on previous knowledge or beliefs. Though, to be clear, these background theoretical acts are not themselves the affect. Rather, they are the sedimented meaning that enables certain affects. In order to demonstrate this, she uses the following example:

When I am joyful over a good deed, this is how the deed’s goodness or its positive value faces me. But I must know about the deed in order to be joyful over it—knowledge is fundamental to joy. (Stein 1989, 101)

This means that I must understand things in the world before I can feel one way or another about them. We would see it as odd for someone to be afraid of a bear if that person knew nothing about bears, not even their appearance. One would at least need to know that teeth and claws are dangerous in order to value an encountered bear as frightening.

Some worry that this implies an “‘over-intellectualization’ of affectivity that contrasts with the spontaneity and quickness of our emotional occurrences” (Ferran 2015, 494). That is, we do not normally experience our affective states as set-by-step judgments of the world. They are experienced as immediate. Often, we are thrown into one affect or another without being conscious of any reason whatsoever. However, this critique doesn’t apply to Stein for at least two reasons. The first is that she has several different types of affects, some of which are not value-perceptions at all. Granted, the critique can still apply to the ones that do perceive values. The second reason she can avoid this critique is that she doesn’t claim any rational process needs to occur each and every time we are affected. Rather, the sedimentation of meaning acquired in our previous experiences of the world allows for us to directly and immediately perceive values. This leads to the second point of clarification.

Stein says that feelings and sentiments perceive values in the world, which also means that there are values in the world for us to perceive. Stein says,

As physical nature is constituted in perceptual acts, so a new object realm is constituted in feeling. This is the world of values. In joy the subject has something joyous facing him, in fright something frightening, in fear something frightening (Stein 1989, 92)

Affects are perceptions of objective values in the world.⁵⁰ Values are not created by us and projected into the world, but rather features of the world that can be perceived. There are actual values in the world and affects allow us to perceive them in the same way that our eyes allow us to perceive colors and empathy allows for us to perceive the psychological lives of others.⁵¹ Now the relationship between empathy and these different types of affects can be explained.

2.3.2 *Empathy and Valuing*

Since empathy is a perception of the other's psychological life, and affects are part of a subject's psychological life, it is clear that affects are among the mental states that empathy allows us to perceive in others (Ferran 2015, 484). However, this would mean that empathy is only really related to affectivity in the Husserlian sense noted above—it allows us to perceive the other's affects, as well as the intentional objects of those affects. If the other is in pain, I can empathize with the other such that I directly perceive the other's pain in the other, as well as that the other's body is the source of the other's pain. At a different level, if the other is joyous, I can directly perceive the other's joy in empathy, as well as the intentional object of that joy.

⁵⁰ She also says Stein's theory of affectivity "implies that there are suitable conditions for the disclosure of values in emotions (normal conditions); and also that our emotional reactions may be appropriate or inappropriate to the disclosed values (appropriateness of the emotional life)" (Ferran 2015, 496).

⁵¹ This is interesting because it means that values are not purely subjective, but it could still be possible for values to be relative, at least to cultures or groups. One group may feel that some situation is threatening or joyous that another group may not due to the different ways in which they are situated.

Because of this, Ferran argues that Stein is espousing empathy as “a special kind of ‘emotional sharing,’ i.e., an act that gives access to others as feeling beings” (Ferran 2015, 485).⁵² In this sense, empathy is affective because it reveals affects to us in the same way that affects reveal values to us. In other words, because empathy allows us to perceive the other’s psychological life, it also allows us to perceive the other’s affective states (Ferran 2015, 485). This doesn’t just apply to the value-centric types of affects (feelings and sentiments) but also to the other three types as well. We are capable of empathizing with all of the other’s affects (Ferran 2015, 490).

When we empathize with others, we perceive all of their different types of affective experiences (among other things) together. This amalgam of mental states makes up their consciousness and overall character, or “style,” which can be very difficult to articulate outside of empathy (Jardine 2015, 583-584).

As my own person is constituted in primordial spiritual acts, so the foreign person is constituted in empathically experienced acts. I experience his every action as proceeding from a will and this, in turn, from a feeling. Simultaneously with this, I am given a level of his person and a range of values in principle experienceable by him. This, in turn, meaningfully motivates the expectation of future possible volitions and actions.

Accordingly, a single action and also a single bodily expression, such as a look or a laugh, can give me a glimpse into the kernel of the person (Stein 1989, 109)

Empathy gives me access to the other’s consciousness, which includes the other’s feelings, which are in turn the other’s valuations of the world. Therefore, empathizing with the other gives

⁵² This is not meant to be taken in the same sense as Scheler’s emotional sharing. Scheler means that the subject and the other are experiencing one and the same emotional state. If Ferran is right, Stein would mean the subject shares the other’s emotion by having access to the emotional state of the other.

us access to the other's world of values, as well as what we can expect from the other based on this world of values.

Furthermore, in the same way that the possible existence of the other secures the objectivity of the world, the empathizing with the affects of others—which in turn are value-perceptions of the world—secures the objectivity of values in the world; or, at least “a shared realm of values” (Ferran 2015, 490-491). For example, if I feel a positive value in my friends because they make me happy, and I empathize with others' happiness around their friends, then I can be confident that friendship has an objectively positive value. This would be the same as when the existence of others secures the objective existence of my coffee mug because they could also see the coffee mug if they were here. In this sense, feelings and sentiments are especially important to our intersubjective lives, which also makes it very useful that empathy allows us to perceive them.

While it is clear that Steinian empathy allows us to perceive affects in others, it is significantly less clear whether or not empathy itself is an affect. There are those who have argued that it is an affect, largely based on the fact that we cannot help but empathize with others when we perceive them—at least on the most basic level—and we also cannot help but perceive value in the objects of our perceptions. Even though empathy is a unique kind of perception, it is still a kind of perception nonetheless. As Jardine says, “when we consider our directedness towards other persons in its totality, we discover that empathy is typically accompanied by emotive elements, such that the sense others have for us involves, from the outset, not only empathic apprehension but also affective valuation” (Jardine 2015, 583). In other words, every perception of the other is both a perception of foreign consciousness and a perception of value—both empathy and sentiment. However, since Stein has already set up her system discussing these

two phenomena independently, it is still questionable whether this means that empathy is an affect or that empathy and affectivity simply occur simultaneously. Both interpretations have problems in Stein's system. Consider first the argument that empathy is an affect.

Specifically, among the types of affect listed by Stein, it is clear that empathy would need to be a sentiment, since it has to do with other subjects. If empathy is meant to be a perception of value in the other, then this would mean that it corresponds to similar affects like love and hate, making it a sentiment. Both empathy and sentiments are affects that are "characterized by their uniquely targeting other persons" (Jardine 2015, 582).

Again, the key elements here are that we cannot perceive others without empathy causing us to perceive their foreign subjectivity, and we also cannot perceive others without being affected by them—that is, experiencing an affect in response to them. This means that I am always, and at the same time, grasping the other as a subject and responding affectively whenever I perceive the other. As Jardine says, "while empathically grasping another person's emotional state, we generally feel an immediate response of our own that contributes to the sense the state has for us, in that, for example, the other's anger strikes us frightening, her pride as irritating" (Jardine 2015, 583). Though, even given this point, it could still be argued that empathy and the emotional reaction here are actually two separate phenomena (Jardine 2015, 583). One could argue that we empathetically perceive the others anger, and then are frightened by it, just as we perceive a bear and are frightened by it.

Essentially, this is the problem with any argument that empathy is an affect in Stein's system. While there are areas that are possible to interpret empathy as an affect, she has already defined empathy as an irreducible form of intentionality—as a kind of perception of foreign

consciousness.⁵³ It cannot be reduced to affectivity. Jardine even admits, “while empathy permits a form of access to the other’s own emotional valuations and in so doing discloses the other in her personhood, it is in and of itself a non-emotional and evaluatively neutral form of experience” (Jardine 2015, 582).⁵⁴ This is empathy as an “elementary” form of recognition, whereas if we responded emotionally to the other’s emotion, then it would be “emotional recognition” (Jardine 2015, 582). Empathy is our perception of another subject that is capable of experiencing affects, while emotional recognition is an emotional response to the other, more akin to what Scheler would call sympathy (Jardine 2015, 582). In other words, empathy is a perception of another’s affectivity (among other things). It would be more accurate to say that affectivity influences the way in which we empathize with the other—in the same way that some affects influence the way that we perceive the world—than to argue that empathy is an affect.

Furthermore, Jardine’s attempt to solve this problem by expanding Stein’s theory of sympathy will not work. Even if sympathy (*Sympathie*) is understood as the “the most minimal affective interpersonal response... that arises when we feel ourselves being touched by or coming into contact with (*Berührtwerden*) another person” (Jardine 2015, 583), this would still not require that empathy is sympathy. Rather, empathy and sympathy go hand-in-hand, but with one preceding the other. It seems likely that empathy would need to be the prerequisite for sympathy, since we need to perceive others as actual subjects before we can be affected by them as subjects. In other words, because sympathy is still simply the most minimal *affective* response, it can still be argued that empathy is a more minimal response to the other than sympathy.

⁵³ For instance, she says “by a further equivocation of idea (which is an intellectual experience in contrast with an emotional one)” will cause one to arrive at “the absurd consequence of denying that empathized feelings involve emotion” (Stein 1989, 20).

⁵⁴ Empathy is simply that through which we experience others as affective beings. This is true not only for individual affects, but also of the other’s character—the other’s habit of being affected in certain ways (Jardine 2015, 579).

Since their theory of empathy makes it inconsistent to reduce empathy to a kind of affect, the only other alternative is that we empathize with others at the same time we are affected by them. In this sense, my initial perception of others causes me to empathize with them, immediately experiencing them as other subjects. However, when I reach the level of responding to their subjectivity in an affective way, I am either responding to their affects with a different affect of my own (sympathy) or I am experiencing the same affect as other (feeling of oneness). Either way—as was made clear in the section on empathy—this is no longer empathy, but rather something else. Stein’s position was very clear concerning this. Empathy is the perception of the other as a subject, to which we react affectively. When empathy progresses to an affective response, it is no longer empathy.

However, it should also be noted that affectivity also precedes empathy. Our experiences of other do not take place in a vacuum. As such, current affective states will affect the way in which one empathizes, which will influence affective states, and so on. This is not only true in regard to the sentiments, but also in regard to the other types of affectivity. My mood, general feelings, feelings, and so on are likely going to affect the way that I empathize with the other. Empathy will always be a perception of the other’s foreign consciousness, but my affect may alter my empathy in one of two ways.

One alteration is that my affects can alter the level to which I empathize with the other. One affect may cause me to advance into the second or third level of empathy, while another may cause me to glance over the other subject, only empathizing with him or her at the first level of empathy. For instance, if I am comfortable and in a good mood, I may be more inclined to be pulled along with the other’s empathized state into the second level of empathy, whereas if I am

uncomfortable and in a bad mood, I may be more inclined to pay as little attention to the other as possible.

The other alteration is that my affects can alter the way in which I respond to my experience of the other. That is, my affective state when I experience the affective states of the other may affect how I am affected by the other. For instance, a good mood may cause me to respond to the other's joy in a way that values it positively, while a bad mood may cause me to respond to the other's joy in a way that values it negatively. Depending on my current affects, I may respond with a similar joy or with jealousy and annoyance.

In short, their theory of empathy paints it as little more than a middle step between general affectivity and intersubjective affectivity. I experience sensations, general feelings, moods, and feelings (emotions), which then affect my empathy, which in turn leads to sentiments. However, empathy in this light is a fairly empty step in our intersubjective lives. The only reason it would seem necessary is if it is accepted that there is a gap between ego and alter ego that needs to be bridged, but is this extra step really supported by the phenomenological evidence?

2.4 Conclusion

At this point, Husserl's and Stein's answers to the three questions of empathy can be summarized:

Intersubjectivity: The starting position is the transcendental ego and everything concerning intersubjectivity must be discovered from this position. The ego discovers transcendental others—alter egos that can perceive the world from different perspectives—and as a result transcendental intersubjectivity—the possibility of other subjects in the world.

Empathy: Defined as an experience of foreign consciousness. This begins with pairing between subject and other, in which the other is taken as significantly similar to the subject, and thus as an actual other with possible consciousness like the subject's. From here, empathy directly perceives the consciousness of the other, such that there is a primordial experience that is non-primordial in content. This experience can, and most commonly does, stay at the basic level of experiencing the foreign consciousness as such. However, it can also pass into higher levels if the subject is pulled along with the other's experience to the intentional object of the other's experience (second level), or if the subject experiences the other's experience with the other, creating a feeling of oneness (third level).

Affectivity: Cognitive in nature, they are perceptions of value in the world. There are five different types: (1) Sensations; (2) General Feelings; (3) Moods; (4) Feelings/Emotions; and (5) Sentiments. Only the last two are value-perceptions with specific intentional objects—feelings about the objects and sentiments about other subjects.

This establishes empathy as an essential step in our understanding of others and our interactions with others, which fits well into the theory of intersubjectivity. Despite the possibility of others that is established by the egos examination of the objective world, transcendental idealism still leaves the ego largely isolated in the world. However, empathy allows the ego to singlehandedly fill in the gaps left by the transcendental other with actual others. It allows for others to stand out as other subjects to the ego and for the ego to directly experience the other's foreign consciousness. If the theory of intersubjectivity had been different (as will be the case with

Scheler in the next chapter) this theory of empathy would have been extraneous and unnecessary. Since their theory of intersubjectivity is entirely based on the transcendental ego, empathy must be an ability of the transcendental ego to bridge the established gap between subject and other.

The fit between empathy and affectivity, on the other hand, is not as obvious. Some argue that empathy is an affect because every perception is a value-perception, therefore empathy (as a kind of perception) must also be a value-perception. Since affects are value perceptions, this would mean that empathy is an affect. However, there is evidence in the works of both Stein and Husserl that empathy cannot be an affect, or at least that they ignored this as a possibility. To begin with, Husserl never even discussed empathy in the context of affectivity. This would seem to imply that he did not think the two were related in any other way than empathy allowing us to perceive the other's affects. Stein, on the other hand, did discuss affectivity, but in such a way that it would still not make sense to say empathy is an affect. Empathy would either be reduced to sympathy or a feeling of oneness, both of which Stein was against. Empathy is understood as being an irreducible form of intentionality rather than being irreducibly affective. Therefore, at best, empathy for Husserl and Stein is a middle step between the first four types of affectivity and the final type, the sentiments.

This theory of affectivity also fits well with the theory of intersubjectivity. Since the ego is initially taken separately from both others and the world, it makes sense that affects would be an ability of the ego to experience something that is other to it. It is an improvement over previous theories in that it acknowledges the cognitive nature of some affects as well as their bodily nature. However, it is this original, isolated position of the ego that causes problems for both their theory of empathy and Stein's theory of affectivity—as well as the way that these two

theories relate to one another. In other words, their answer to the intersubjectivity of empathy is what causes problems for their theory of empathy overall.

Without their theory of intersubjectivity, empathy's role in our intersubjective lives would become largely unimportant. That is, it is introduced as a solution to a problem that would not exist were the intersubjective starting position different. Because there is supposedly a divide between subject and other, empathy is introduced as the ability that magically allows us to bridge this divide. However, aside from being this bridge, it is nothing else. As shown in both the second and third sections, empathy is neither a perception nor an affect, meaning that it has no other standing other than to be the solution to the problem of intersubjectivity. It is specifically that which allows us to experience the other as another subject given that the other is so far from us that we need an ability to reach the other.

If we were to accept the theory of intersubjectivity that is being presented, then perception of foreign subjectivity would be necessary, and it might as well be called *empathy*. However, if the starting position of the transcendental ego is rejected—as is done by philosophers like Scheler, Heidegger, and Merleau-Ponty—then empathy as it is being defined becomes an unnecessary extra step. That is, if we begin from an intersubjective position rather than a strongly subjective position, then the problem of empathy falls away, and the problem of affectivity become the main focus.

Chapter Three: The Alternative of Fellow-Feeling

In this chapter, I argue that Max Scheler presents a theory of fellow-feeling as an alternative to theories of empathy. He does this by focusing on our primary intersubjectivity and the richness of our intersubjective, affective lives.⁵⁵ While this approach does serve to avoid many of the problems of the transcendental approach, it is also flawed due to the questionable phenomenological evidence for some of Scheler's core arguments.

Scheler's overall discussion of empathy is peculiar because empathy is not the centerpiece. If anything, it is a launching point for his discussion of intersubjectivity and affectivity. His main purpose in discussing empathy is to critique empathy as an improper practice to acquire a genuine understanding of the other. This is an approach to empathy that he shares with a number of other philosophers, including Heidegger and Merleau-Ponty.⁵⁶ In this way, he not only critiques Lipps, but also Husserl and Stein, for their theories of empathy. Scheler argues that Lipps is talking about emotional contagion rather than a genuine understanding of the other, while he argues that Husserl and Stein present an unnecessary theory of empathy as a primary understanding of the other. Their theory is unnecessary because we already have an understanding of others in our everyday interaction with them due to our primary intersubjectivity.⁵⁷

⁵⁵ Scheler does not use the term "primary intersubjectivity." I borrow this term from Shaun Gallagher.

⁵⁶ There are also a lot of similarities between Scheler's approach and Gallagher's approach, which is the focus of chapter 4.

⁵⁷ Though, this is admittedly a view of empathy that disregards the view held by some other philosophers that there can be different levels of empathy, or different theories of empathy that account for different levels of understanding. See the difference between the very basic empathy in Stein and Husserl (chapter 2), the more cognitive, higher-level empathy of ST (chapter 1), and the multi-leveled theory of empathy of Gallagher (chapter 4).

On this critique, empathy becomes a secondary ability rather than the primary means by which we can even understand others. The focus for how we understand others and experience them as other subjects shifts from empathy to the theory of intersubjectivity itself. In other words, if we want to understand how we experience and understand others, we need to focus on the intersubjective context that comes prior to empathy, rather than on empathy itself. He argues that we do not gain an understanding or experience of the other by beginning with a clear understanding of ourselves independent of the other, and then use empathy to bridge the intersubjective gap. Rather, there is initially an undifferentiated, intersubjective stream of experiences that belong to both subject and other, and from which both subject and other are slowly extracted and individuated.⁵⁸

With our understanding of others already being accomplished in our everyday interactions with them, the way in which we affect and are affected by others is an essential aspect of our intersubjective lives. For Stein, the experience of most (if not all) affects is independent of the existence of other subjects. For Scheler, most affects are made possible by our primordial intersubjectivity, and we experience them with others. As such, he sees love and fellow-feeling as fundamental features of the lives of persons. Affects are perceptions of values, and they can be divided into levels based on the things in which they perceive value, as well as how such value is perceived. Fellow-feeling—especially sympathy—allows us to experience affects with and for others, sometimes to the extent that we merge back into our primary intersubjectivity by achieving a feeling of oneness with each other. In this way, our affective lives are an important aspect of our intersubjective lives because they allow us to experience a valued world with others.

⁵⁸ This approach to intersubjectivity will be echoed in similar theories, such as Merleau-Ponty's flesh ontology (Merleau-Ponty 1968).

First I explain Scheler's critique of empathy. This focuses on his decision to maintain Lipps' theory of empathy and critique it as being no more than a case of emotional contagion. Second, I explain Scheler's theory of primary intersubjectivity, which he believes to be a better starting point than transcendental subjectivity. This discussion focuses on his critique of the theory of empathy presented by Husserl and Stein, as well as his argument for primary intersubjectivity as the source of our intersubjective understanding. Third, I explain Scheler's theories of affectivity and fellow-feeling. With affectivity assuming the role of utmost importance in our intersubjective lives, affectivity serves to connect us to others and the world by allowing us to perceive values in them. Fellow-feeling then serves as the way that we experience different affects with and for others. It explains the ways in which our subjectivity is always open to others and always capable of merging back into one with others.

3.1 Against Empathy

Scheler's purpose in discussing empathy was not to redefine the term, as Husserl and Stein did, but rather to reject empathy as an experience that actually allows us to understand others. Scheler's critique of empathy is primarily directed at Lipps. However, there is good evidence that he rejects Stein's theory as well, despite her claim that Scheler's "polemic against empathy" does not apply to her theory (Stein 1989, 27).⁵⁹ Focusing specifically on Lipps' theory, Scheler accepts the definition while rejecting the explanation. In other words, he does not call into question the definition of empathy as being an understanding of the other, but he does critique the explanation that we understand the other through a process of imitation and

⁵⁹ This is primarily because he rejects transcendental phenomenology, as will be explained in the next section.

projection (Scheler 1954, 11). If a description of empathy is meant to explain how we understand the other, then this is not accomplished by Lipps' theory for four reasons (Scheler 1954, 10-12).

First, infants and animals recognize and understand other subjects despite their inability to create analogies or inferences. They may not have a language with which to verbalize what they perceive in others, but they seem to understand others well enough to be able to interact with them. As Schuetz clarifies, our initial understanding and experience of others "is not based on acts of theoretical cognition. A person-like being, capable of all kinds of emotional acts like love, hate, will, etc., but incapable of theoretical acts—i.e., objectifying cognitions—would not at all lack any evidence of the existence of others" (Schuetz 1942, 329). For instance, infants also recognize other subjects fairly soon after birth and are able to interact with them—a point that will be discussed further in the next chapter. However, while Schuetz is talking specifically about "a person-like being," Scheler extends this ability to the experience of non-human animals as well. For instance, a dog seems to understand both when another dog is angry and when its owner is sad, and can respond accordingly.

Second, Scheler observes that we experience the other's body from a third-person perspective, while others experience their own bodies from a first-person perspective. This is the same critique that was raised against the theory of Husserl and Stein in the first chapter. There is a discrepancy between what the subject is experiencing of others and what others are experiencing of themselves. Additionally, there is a discrepancy between how the subject experiences others and how others experience themselves. If the goal is to form an analogy between my mind and the other's mind, then the argument already fails, since I do not experience the other's body in a way that would sanction an analogy. If nothing else, this at least demonstrates that "all inference by analogy to others' gestures already presupposes the psychical

existence of the others and our knowledge even of their experiences” (Schuetz 1942, 331). We would need to already be taking the other to be a subject with a psychological life before we try to empathize with him or her. We would also already need to predict the emotion that the other is experiencing before we can try to imitate it.⁶⁰ In this way, a very basic recognition and understanding of the other has already occurred before Lipps’ higher level, simulation-and-projection empathy, so empathy is not the experience that causes this initial understanding. If anything, it just further confirms and justifies the understanding.

Third, we are capable of empathizing with creatures that do not share our physiology, such as animals. Expanding on the first point, not only do animals understand each other and persons, but persons also recognize and (more or less) understand animals. Again, this understanding should not be possible if it is based on an analogy, since a necessary part of the analogy—the similarities between observed bodies—does not exist. At least with fellow persons who share very similar bodies, it seems plausible that an analogy can be drawn—assuming similar psychological lives for similar observed bodies. However, this similarity is missing for many of the animals that we understand and recognize as having psychological lives. Though, it is unclear how far Scheler would extend this argument, since it seems like we most commonly understand non-human animals that are still relatively similar to us—i.e. chimps, dog, cats, and so on. We then seem to have less empathy, or understanding, for those animals that are relatively dissimilar to humans, such as insects, echinoderms, and cnidarians. This is problematic for this specific critique.

Fourth, the argument from analogy in this instance is itself a logical fallacy. If I know the connection between my own mental states and my body, this doesn’t mean that I can infer the

⁶⁰ This is what Gallagher calls the starting problem (Gallagher 2012, 371-372).

connection between the other's mental states and the other's body. Rather, all I am warranted in inferring is that the other's body is also linked to my mental states. Similar to the transcendental other in Husserl's phenomenology, the other is simply another myself—an alter ego—"over there." It is another body which must also have my thoughts, since it behaves as if it has my thoughts. In order to assume that the analogized thoughts actually belong to the psychological life of the other, I would need to presuppose the psychological life of the other before I would even be able to form an analogy with the other. As Scheler says, "imitation, even as a mere 'tendency', already presupposes some kind of acquaintance with the other's experience, and therefore cannot explain what it is here supposed to do" (Scheler 1954, 10). Before I can imitate the expression and emotion of the other, I must already have an idea of what it is that I am imitating. For instance, if I see an expression of anger, how would I know what features of the other's face to imitate in order to simulate the anger unless I already knew that the expression was an angry one, and thus which features deserved my focus? What this shows is that there actually must be an understanding of the other (empathy), before we can imitate the other (Lipps' theory of empathy). This makes Lipps' theory circular.

As Scheler explains, these problems arise from a problematic theory of intersubjectivity that seems to call for empathy as a solution to the assumed divide between self and other. Beginning from such a divide requires one to form an analogy between subject and other, as well as requiring a projection of the simulated mental states back into the other (Scheler 1954, 238). However, this forces one to apply an aesthetic theory of empathy to our experiences of others. As Scheler says, Lipps is unable to distinguish "empathy as a source of our knowledge of other minds from the merely aesthetic projection of content and character on the part of the self, into a portrait, for instance, or the embodiment of Hamlet, a personage belonging to the world of art, in

the gestures of an actor” (Scheler 1954, 241). But, we do not experience other people in the world like we experience a painting or an actor in a play. Therefore, there is little reason to see the theory of aesthetic empathy as being relevant to the study of intersubjectivity.

Additionally, it is odd to assume that I would need to be in the same experience as the other in order to understand the other’s experience. The imitation-based empathy of Lipps assumes that I must mimic the other’s experience when I perceive the other, and that this is the foundation for my understanding of the other. As Scheler rebuts, “one who ‘understands’ the mortal terror of a drowning man has no need at all to undergo such terror, in a real, if weakened form... in the process of understanding, the thing understood is in no way experienced as real” (Scheler 1954, 11). Especially if I have experienced similar thoughts and emotions before, there is no need for me to mimic the other’s experiences in order to understand them. I can know my friend is angry, even if I am happy. We do not both need to be angry for me to understand this experience. This is why Scheler and others equate Lipps’ theory, and other theories based on an argument from analogy, with what Scheler calls emotional infection (contagion), rather than genuine empathy.⁶¹

At this point, Scheler does not intend to redefine empathy as Husserl and Stein do. Rather, the whole concept should be rejected from the discussion of intersubjectivity. Even if empathy were a way in which we understand the other, it would be unnecessary, since we already have a more primary means of understanding each other. As Zahavi clarifies, theories of empathy overlook “the extent to which we are able to grasp another person’s state of mind directly in the available expressive phenomena,” and if empathy in this sense was ever used in order to understand others, “it would be a source of error rather than a way to insight, since it

⁶¹ Emotional infection is also often called emotional contagion. This will be explained further in the section on fellow-feeling.

would lead to personal distress and egoistic drift” (Zahavi 2014b, 133). Empathy is only necessary if one assumes an initial divide between subject and other, in which the existence of the other must initially be taken for granted, but why should anyone make this assumption (Scheler 1954, 240)? If this assumption is rejected, then there is no real need for empathy.

Starting from a position of solipsism, theories are bound to end in failure. In fact, solipsism itself is just an illusion that we create ourselves, and one that is overcome “precisely in the act of fellow feeling” (Scheler 1954, 69). That is, from a very early age, we learn to extract and individuate ourselves from others in an abstract way—to pretend we are isolated subjects—but this abstraction is an illusion that we create, and one that is dissolved by fellow-feeling. For this reason, it would be better to suppose a primary intersubjectivity prior to individuation. That is, there is some communal stream of experience that is present before we abstract ourselves and others out of it.

3.2 Primary Intersubjectivity

Scheler rejected any theory of intersubjectivity that begins from a divide between subject and other. Due to their starting position, these theories usually argue that we understand the other by beginning with a clear understanding of ourselves, but this argument leads to many unnecessary problems in intersubjectivity. As he says, the problem with many theories of intersubjectivity is largely “self-engendered, owing to the assumption that each of us is ‘primarily’ aware only of his own self and its experiences, and that among these only a proportion of such experiences, images, etc., are related to other individuals” (Scheler 1954, 238). This view of the subject is clearly present in the works of both Husserl and Stein. They stress a phenomenological method that begins from a transcendental ego, which is initially only aware of itself. It has experiences of others and experiences that point to the existence of others,

but these are only a fraction of its experiences. Many of its experiences are related to only the transcendental ego itself.

For Scheler, this is simply the wrong approach to subjectivity and intersubjectivity, ultimately falling into solipsism like all of the traditional theories it was trying to avoid. The distinction between subject and other requires philosophers to go to great lengths to try to explain how it is that the subject is able to experience and understand the other, as well as how the perceptions of others and the perception of oneself are completely different experiences (Scheler 1954, 238). In order to actually overcome these solipsistic theories and establish a truly phenomenological theory of intersubjectivity, Scheler argues that we must overcome the unwarranted assumptions that subjects have very clear understandings of their own minds and that it is very difficult to understand other minds (Scheler 1954, 251). He does so by explaining why these assumptions are made, as well as why they are unwarranted and should be rejected.

3.2.1 Method

To begin with, these assumptions are made due to the phenomenological method being used. Scheler rejected transcendental phenomenology, and instead adopted an approach to phenomenology that was influenced by Eastern philosophies. The reason he rejected the phenomenological method of Husserl and Stein is that transcendental phenomenology distorts the phenomena it is studying. As Joon Bornemark explains, transcendental phenomenologists work “within a static phenomenology, which freezes the phenomenon as it investigates intersubjectivity in an already constituted subjectivity” (Bornemark 2014, 260).⁶² As set forth in Husserl’s phenomenological reduction, transcendental phenomenology essentially isolates

⁶² Bornemark also notes that, “through this changed focus, the experience of the child becomes more important,” and that Merleau-Ponty later expands on Scheler’s method (Bornemark 260).

phenomena from much of what makes them what they are. It suspends the everyday experience of the phenomena in order to gain a transcendental, pure understanding of them. However, we never actually experience any phenomena isolated in time or space, but rather in time and space as the phenomena change and we interact with them. To try to isolate and study a phenomenon does not allow it to appear as it does in everyday interactions. As such, transcendental phenomenology does not really overcome the phenomena-altering problems of the traditional approaches it is trying to overcome.

Unlike transcendental phenomenology, Scheler's approach to phenomenology is not a method that we use to examine phenomena, but more accurately an attitude of openness towards phenomena the way they are experienced (McCune 2014, 50-52; Vandenberghe 2008, 24). Frédéric Vandenberghe helps to clarify Scheler's method when he says, "the essences are there and do not need the constituting activities of the transcendental Ego to exist. Being precedes and grounds knowledge; knowledge is steeped in Life and partakes in Being" (Vandenberghe 2008, 29). In other words, phenomenology for Scheler is allowing phenomena to show up in our normal, everyday interactions with them. We do not need to isolate and examine phenomena to understand their being, since being is always already present. All we need to do is be open to them, rather than trying to constitute them.

It should not be assumed that this phenomenological attitude of openness is any less rigorous than Husserl's method. Of course it would be if people just happened to have the phenomenological attitude when they are in the everyday attitude through which they normally approach the world, but this is not often the case. The phenomenological attitude is, more often than not, very different from the everyday attitude, which is more in line with the naturalistic attitude—the attitude through which we approach phenomena by trying to isolate them and

examine them for objective facts. Therefore, the phenomenological attitude usually needs to be consciously adopted and trained into a habit. It is “an attitude of loving compassion” and it can be acquired “through meditative practice” in which we open ourselves up to the other experiences being given (McCune 2014, 50). This allows the phenomenon “disclosing itself to do so ‘in itself,’” and as such “to gain awareness of the overwhelming richness, complexity, and diversity of experience” (McCune 2014, 52). Scheler argues that, from within this phenomenological attitude, the subject is not the obvious starting position for a phenomenology of intersubjectivity. However, if this is the case, then why is it that so many philosophers are more than convinced that any discussion of intersubjectivity must begin with the subject?

3.2.2 Refuting Traditional Assumptions

Perhaps the problem is that the idea of intersubjectivity necessarily presupposes the idea of subjectivity. Arguing in this way, Zahavi even goes so far as to claim that any theory of intersubjectivity is very confused if it argues that one can begin from intersubjectivity before subjectivity (Zahavi 2014b). You must have a subject before you can have a community of subjects. In this statement, Zahavi captures the essence of why many philosophers have been convinced that we must begin with the subject. Simply put, it seems obviously true based on our introspection and the concept of intersubjectivity itself.

Consider again how Husserl ended up at the transcendental ego. According to him, the subject has experiences, such as introspection and object-perception, that are not specifically related to others. This seems to indicate that there is something of the ego that is not of the other. By excluding all that could not be attributed to only the ego, and identifying the features that can be attributed to only the ego, it seems obvious that there is an ego that is separate from all other things, including others. It is then only from this egoistic position that the subject is capable of

having a partial, mediated experience of the other. However, philosophers should be especially suspicious of any conclusions that seem obvious.

As Scheler says, though these features of our experiences seem obvious, these theories actually “misapprehend the facts and neglect the phenomena” (Scheler 1954, 253-254). In fact, if we really examine theories that begin with the primacy of the subject, we’ll notice two problematic assumptions: that I primarily have a clear understanding of myself and that I only have a confused understanding of the other based on the other’s body. By making these first two assumptions, philosophers “under-estimate the difficulty of self-knowledge, just as they over-estimate the difficulty of knowing other people” (Scheler 1954, 251). There is an exaggeration of our capacity for self-knowledge and an exaggerated difficulty in acquiring knowledge of others’ psychological lives (Scheler 1954, 253).

The first assumption is the idea that it is primarily my own self that is given to me in experience (Scheler 1954, 244). Is the self ever really given clearly in experience with no reference to the other? Does one ever experience a pure or transcendental self? Or, more accurately, can the world ever be experienced as a transcendental self? Scheler argues that this is a philosophical fiction. Philosophers like to suppose that there can be such an imaginary person as Robinson Crusoe, who exists with no knowledge of others and no context in a community, but yet still possesses the same mind, emotions, and “cognitive-theoretical faculties” that we do (Scheler 1992, 236). However, Scheler argues that no such person exists (Scheler 1992, 236). Someone so isolated and devoid of community would lack many of the faculties and concepts we would attribute to normal minds. We normally exist with others in the world, and our emotions, cognitive abilities, and theoretical skills all reflect a co-existence with others. Even if Robinson Crusoe never met another subject, so far as he has experiences like love and sympathy, “he

would nevertheless know for sure that somewhere and somehow a ‘Thou’ exists as a counterfactual member of a social community” (Vandenberghe 2008, 34-35).

The second problematic assumption being made is that I cannot experience anything of the other aside from the other’s physical body (Scheler 1954, 244). Placing such emphasis on the physical body causes philosophers to “rule out the internal perception of other minds,” leaving every person isolated in one’s own mental prison where they must “wait upon whatever the metaphysical causal nexus may spirit into it” (Scheler 1954, 253). Bodies become prisons and we can only guess whether there is actually someone in the neighboring cell. Scheler thinks that this is a very odd way to think about others as we experience them in everyday interactions.

Our immediate perceptions of our fellow-men do not relate to their bodies (unless we happen to be engaged in a medical examination), nor yet to their ‘selves’ or ‘souls’. What we perceive are integral wholes, whose intuitive content is not immediately resolved in terms of external or internal perception. From this stage of givenness we can then go on, in the second place, to adopt the attitude of internal or external perception. (Scheler 1954, 261)

Essentially, we need to stop interpreting the other as a physical body separate from its psychological life. The other is not merely a physical body (*Körper*), but rather a living body (*Leib*) (Cutting 2016, 222; Gallese 2003, 43; Merleau-Ponty 1968, 255; Stein 1989, 41-42, 47; Taipale 2013, 2; Vandenberghe 2008, 21). The only times that the other’s body is reduced to a *Körper* is when we purposefully objectify it for observation, whether it be scientific, medical, philosophical, or otherwise. In our average, everyday experience of an other, we do not perceive a physical body and a metaphysical mind. When we experience others, we experience them in their totality—both physical and psychological together as one. This is what Scheler called

“expressive unity,” because we experience the other as a unified subject (Scheler 1954, 262).⁶³

The immediacy of expressive unity “involves seeing the other not as a multitude of details that one subsequently puts together to create meaning, but rather as a meaningful whole first—an intentional consciousness with an experience of its own unique subjectivity” (Pienkos 2015, 197-198).

If it is true that we perceive the whole, unified other in our experiences of the other, then this reveals problems for the assumption that we have trouble recognizing and understanding others. In experiencing the other as a lived body, I have direct access to the other’s experiences because there is nothing hidden from me in my perception of the other. I do not experience and understand the other through inferences, but rather directly in experience (Scheler 1954, 262). Our ability to understand others’ feelings is “innate” (Scheler 1954, 48). The other’s mental states are given to me directly in my perception of the other: “it is in the blush that we perceive shame, in the laughter joy” (Scheler 1954, 10). So long as we understand the other’s body as a “field of expression” rather than merely a physical body, it will be easier to understand how we directly understand the other (Scheler 1954, 10). We do not merely perceive the expressions of a body, then infer the mental states that caused them; we perceive the expression and emotion together.

Again, philosophers tended to present these assumptions as if they are self-evident facts that could not be interpreted otherwise (Scheler 1954, 244). However, it is only because we have become so focused on what we can know about our own bodies and mental lives that it seems like we can only experience our own mental lives. As Scheler says, “to the extent, therefore, that a man is predominantly concerned with his own bodily states, he will remain cut off from the

⁶³ This is true of my perception of myself as well as my perceptions of others (Scheler 1954, 261-262).

mental life of his fellows (and indeed from his own)” (Scheler 1954, 255-256). This was Husserl’s problem. In trying to discover a transcendental ego, he let himself subtract everything that could be excluded from the ego. However, if the focus wasn’t initially on the ego, then there would have been no need to search for a way to distinguish it from the other. It is only by overcoming this self-absorption that “the facts of mental life in others will become increasingly visible” (Scheler 1954, 256). Instead of focusing on difference, we need to focus on the way we are always already with others in the world. If we retrain ourselves to be open to the mental lives of others, it will not seem so obvious that we only have a perfectly clear understanding of ourselves.

When these two assumptions are rejected and it is seen as both sometimes difficult to understand our own experiences and easy to understand other’s experiences, it also becomes harder to assume that all of the things that we experience are our own experiences. Scheler says we ought to be skeptical about this strict divide in our experiences.

Who can say that it is our own individual self and its experiences which are “immediately given” in that mode of intuition, by which alone the mental, a self and its experiences, can possibly be apprehended, namely in inner intuition or perception? Where is the phenomenological evidence for this assertion? (Scheler 1954, 244)

In his view, there is no good phenomenological evidence. On the contrary, Scheler thinks that is perfectly clear that we can and do “think the thoughts of others as well as our own, and can feel their feelings (in sympathy) as we do our own” (Scheler 1954, 245). It is more accurate to say that we are actually always struggling to separate our own thoughts and feelings from those of others.

It is often the case that we are too easily given over to the will of others (Scheler 1954, 246-247). It takes effort to re-remove myself from the communal stream of experience. Though he does use potentially outlandish examples to show that this is the case—examples like hypnosis, in which we completely succumb to the will of another—he still considers them important, since “even in these very trivial examples we find a string of ‘possible’ cases of what is supposed, on present assumptions, to be ‘self-evidently’ impossible” (Scheler 1954, 245).⁶⁴ But, he doesn’t just want to prove that it is possible in extreme cases to experience the thoughts and feelings of other. He wants to go so far as to say that “there is, at bottom, no very crucial difference between self-awareness and the perception of mind in other” (Scheler 1954, 251). Again, this really only occurs in scientific and medical observations in which the body of the other is intentionally objectified. In our ordinary, everyday interactions, internal perception could either be referring to my own experiences or to others (Scheler 1954, 249). I am capable of directly experiencing others’ experiences, just as I am capable of experiencing my own experiences. It must now be explained how this intersubjective consciousness is possible.

3.2.3 Primary Intersubjectivity

According to Scheler, it is possible to experience thoughts and feelings of others, and for others to experience ours, because experiences begin in an undifferentiated stream that belongs to both subject and other. There is “an immediate flow of experiences, undifferentiated as between mine and thine, which actually contains both our own and others’ experiences intermingled and without distinction from one another” (Scheler 1954, 246). Then, from this communal stream of experience, we find a way to extract and individuate ourselves.

⁶⁴ There are addressed further in the section on fellow-feeling, since hypnosis and other examples he uses to show the existence of an intersubjective stream of experiences are examples of a feeling of oneness (*Einsföhlung*).

Scheler compares this to the way that one's present self appears out of the "background of our whole temporal experience" (Scheler 1954, 250). In other words, while this undifferentiated flow of experiences may initially seem highly unlikely, it is no stranger than when "our inner perception embraces not only our present state of mind but also the whole past of our stream of thought" (Schuetz 1942, 333). The way in which we perceive ourselves and others against the background of intersubjectivity is similar to the way in which I perceive my present self against a background of my past. I do not need to synthesize or infer my current self based on present and past perceptions. Rather, I show up for myself in experience as the foregrounded subject against the background of my past.

Likewise, "we always apprehend our own self against the background of an ever-vaguer all-embracing consciousness in which our own existence and the experiences of everyone else are presented, in principle, as included together" (Scheler 1954, 250). Similar to my present self, my experience of intersubjectivity is not constructed out of individual experiences of myself and others, nor is it the case that myself and others are constructed by isolated perceptions and inferences. Rather, subject and other only stand out in the foreground because they exist against the background of an undifferentiated stream of consciousness to which subject and other both always already belong. It could be said that there is a "sphere of the 'We'" that precedes the "sphere of the Self" and out of which the self is eventually extracted (Schuetz 1942, 335).

It is from this undifferentiated flow of experiences, in which I initially live "from the beginning rather 'in' other people's experiences than in [my own] individual sphere," that individuals are formed (Schuetz 1942, 332). The individuality of the subject does not form immediately after birth, but is rather formed by a gradual process in which experiences are slowly drawn together and identified with an individual (Bornemark 2014, 363; Scheler 1954,

246). As a result of this process, Scheler argues that *a* self is given in an experience, and it is an individual self, but this does not mean that it is necessarily *my* self (Scheler 1954, 246). Since all experiences form from the initial intersubjective stream of consciousness, the experience can sometimes be attributed to me and sometimes attributed to others. The point is that I can experience both of these to an extent because they arise from the same communal stream.

In fact, it may make more sense to argue that we actually more readily have access to the other's psychological life than our own. This is evidenced by the fact that I experience and understand "the other's stream of thought, and this means the subjectivity of the alter ego in its vivid present, whereas I cannot grasp my own self but by way of reflection in its past" (Schuetz 1942, 343). We directly experience the thoughts and experiences of others when we perceive the others, but we only have access to our own thoughts in the same way when we stop for introspection. Knowledge of oneself is always past-directed, whereas knowledge of the other is in the "vivid present" (Schuetz 1942, 344). However, this is also what seems to be a limit of our experiences of the other—a limit that makes it seem like the self is more primary than the "we"—because I can introspect about my own experiences in a way that I cannot about the other's experiences (Schuetz 1942, 343). However, when we examine this, it is revealed that it is often the opposite that is actually true: "In so far as each of us can experience the other's thoughts and acts in the vivid present whereas either can grasp his own only as a past by way of reflection, I know more of the other and he knows more of me than either of us knows of his own stream of consciousness" (Schuetz 1942, 343). If this is true, then it would make sense to agree with Scheler that there is an initial undifferentiated stream of consciousness prior to individuation (Schuetz 1942, 343-344).

This primary intersubjectivity, however, does not mean that we are unable to distinguish between subject and other. We can still make this distinction because subjects experience themselves in a different way than they experience others; and the way that subjects experience others is different from the way that the others experience themselves. Additionally, “it is only because of this difference that foreign subjectivity is at all experienced as foreign” (Zahavi 2001, 153).

One objection raised against Scheler’s theory is that it lacks good phenomenological evidence (Bornemark 2014, 363; Stein 1989, 28-29; Svenaeus 2014a, 246). Do we really ever have an experience of an undifferentiated stream of consciousness in which subject and other cannot be distinguished? We cannot even appeal to an infant’s initial experience of this we-consciousness, since we can neither remember what it was like when we were infants nor can infants relay their experiences to us.

While it is true we lack phenomenological evidence from infancy, some have found evidence for primary intersubjectivity in the cases of breakdowns of subjectivity, such as those that occur in schizophrenia. Some schizophrenics describe experiences in which they feel that their subjectivity invades or is invaded by others (Pienkos 2015, 201). In fact, these experiences in which there are “feelings of confusion between self and other are relatively common among persons with schizophrenia” (Pienkos 2015, 202). As a result of their condition, their subjective framework breaks down. Their experiences either lose “the quality of mineness” that they usually possess or they believe that their thoughts originate from others rather than themselves (Pienkos 2015, 202).

In terms of more mundane experiences, Fredrik Svenaeus counter-argues that, “although we do not remember how it feels to be a fetus, we do seem to have an understanding of what it

means to share the world with another person in intimate ways. Not only mothers (and perhaps fathers) and infants do this, but lovers, dancers and other couples or groups of people who are attuned to each other in sharing the same activity” (Svenaesus 2014a, 246). In their intimacy, these relationships show the way in which the other does not need to be the intentional object—as would be the case with empathy—but rather that the *experiences with* the other are the intentional objects (Svenaesus 2014a, 246-247). As will be further evidenced when explaining fellow-feeling, there is a common affective experience that binds us together with others and serves to return us to our initial being-with others.

3.3 Fellow-Feeling

As a result of his theory of intersubjectivity, Scheler was far more interested in the role that affects, such as love and fellow-feeling, play in connecting us to others and interacting with others than in cognitive and theoretical acts like inferences and empathy (Vandenberghe 2008, 18; Zahavi 2001, 152). While empathy may have a feeling to it, it may be called a “cold feeling” when compared to the “heat” of other affects that fuse us back together with others (Vandenberghe 2008, 36). Furthermore, empathy and inferences require an already established experience of fellow-feeling and a feeling of oneness with a community in order to even be possible (Svenaesus 2014a, 246; Vandenberghe 2008, 36). This path from primary intersubjectivity to a feeling of oneness (*Einsföhlung*) involves a few steps through his theory of affectivity.

Beginning from a transcendental standpoint, or at least something comparable to that, it is easy to see affects as secondary to our theoretical understanding of others. Affects allow us to see the world as valuable, therefore understanding them helps us to understand our connections

to others and the world (McCune 2014, 50; Vandenberghe 2008, 18).⁶⁵ They are our most “primordial relation to the self, the other, the world and God” and thus serve as the context for all of the knowledge that we gain about these topics (Vandenberghe 2008, 21). Therefore, any examination of our intersubjective lives must focus on our affective lives, including the different levels of feeling and the different forms of fellow-feeling. In short, affectivity not only serves as the context for all understanding, it also serves as the means for returning us to our primary intersubjectivity.

3.3.1 Affectivity

Scheler, like Stein, thinks that there are different types of affects, or as he calls them, “deep levels of feeling” (Scheler 1992, 85). These are:

1. *Sensations*... localized throughout the organism—pain, sensual pleasure, itching, and tickling.
2. *Vital feelings*... restricted to the whole of the organism and its particular Life center—weakness, vigor, weak and strong life feeling, restfulness and tension, fear, sense of health, sense of sickness.
3. *Psychic feelings*... immediately self-relating and, at the same time, related functionally to prominent fantasy items, to persons of the environment, and to external or personal things.... On this level, emotion is “intentional” and values are grasped cognitively.

⁶⁵ He also notes that Scheler’s focus on our affective experiences of the world helps to correct “the cognitivism of the philosophy of mind with a due emphasis on the primacy of ethics” (Vandenberghe 18).

4. *Purely spiritual*... religious-metaphysical feelings, the “feelings of salvation,” which relate to the core of the spiritual person as to an indivisible whole—happiness, despair, security, pangs of conscience, peace, etc. (Scheler 1992, 85)

These correspond very well with Stein’s types of emotion, with only a few alterations needed to match Scheler’s level system. Each level is a specific kind of feeling and corresponds to a specific level of values (Cutting 2016, 222).⁶⁶

His first level, sensations, matches to Stein’s bodily sensations. They are the physical sensations that have some part of the body, or the body as a whole, as their intentional object. Vital feelings are akin to what Stein calls general feelings. They are general sensations like a feeling of tiredness that have no specific intentional object. We can say that they permeate the body and are that through which we experience the world. These “manifest a unity unlike the patchy disposition of sensible feelings, and they have an intentional nature that can reveal advantages or dangers yet to come (think of anxiety)” (Cutting 2016, 222). However, this is the point where Scheler’s theory differs from Stein’s.

Psychic feelings are the level of affectivity at which we perceive values in the world and others, but here he does not distinguish between our perception of values in the world and in others. Stein called the former “feelings” or “emotions,” and the latter “sentiments.” Scheler, on the other hand does not see any significant difference between the perception of value in one as opposed to the other. Even love can be experienced towards both subjects and objects. Additionally, psychic feelings have the self as their origin, but are intentionally directed at the world (Cutting 2016, 222).

⁶⁶ Psychic feelings and spiritual feelings are important for Scheler because they are our distinctly human affects. Animals are capable of experiencing sensations and vital feelings, but not psychic and purely spiritual feelings (Cutting 221).

His final level, purely spiritual feelings, seems to correspond to Stein's moods. While meant in a religious sense for him, these could also be understood in a secular way as existential moods. These are similar to psychic feelings, but even more general, extending beyond our relation to our own body to our relation to the world and others. These feelings are not intentional in the way that psychic feelings are, but rather "bathe everything in inner and outer worlds with their effects" (Cutting 2016, 222). They permeate all of our perception of the world, and affect even the experience of other affects.

The values perceived in each of these levels of feeling are not meant to be understood as subjective values (McCune 2014, 64). Rather, like Stein, Scheler argues that each affect "presents objective evaluations of states of affairs, of an activity or certain fate that may befall us, or of an anticipated value of such an event" (Scheler 1992, 82). This is especially true for "those sharing a collective ethos," and is likely why some thinkers believe that "values are objective or exist independently" (McCune 2014, 64). In other words, those with similar relations to the world—similar cultures, genders, characters, and so on—are likely to perceive the world as valued in the same way, making those values objective for them.

Laying out affects in layers like this allows Scheler to explain the limits of empathy and understanding. This is especially relevant when it comes to sensations (Scheler 1954, 255). This is the one level that Scheler specifically focuses on as being a limitation of what we can genuinely understand of the other. I can only understand a sensation if I have experienced the same kind of sensation before. What I cannot do is directly perceive the other's sensations in the way that I can emotions. As Zahavi explains, "if I observe a man enjoying his dinner or a woman in labour pains, what I am able to empathically and experientially comprehend, on Scheler's model, is not the specific taste of, say, smoked salmon or the specificity of the pain sensation,

but rather the general state of enjoyment or suffering” (Zahavi 2014b, 134). Therefore, there is a certain understanding of the other that is immediately grasped in our interactions with others—which is an effect of our primary intersubjectivity—and there are those sensations and specific experiences of the other that I cannot understand unless I have experienced something very similar.

3.3.2 *The Four Forms of Fellow-Feeling*

The importance of his different forms of fellow-feeling is that they “establish the scheme of reference of society as an ever-present element of his consciousness” (Schuetz 1942, 329-330). That we are able to feel with others presupposes a situation in which we already exist with others.

Scheler distinguishes four forms of fellow-feeling:

1. Immediate community of feeling, e.g. of one and the same sorrow, ‘with someone’.
2. Fellow-feeling ‘about something’; rejoicing in his joy and commiseration with his sorrow.
3. Mere emotional infection.
4. True emotional identification. (Scheler 1954, 12)

We can say that these are the phenomenon to be described by each form of fellow-feeling, and that the more common terms for each of these phenomena are:

1. Emotional Sharing (*Mitfühlen*)
2. Sympathy, Fellow-feeling proper (*Mitgefühl*)⁶⁷
3. Emotional Contagion (*Gefühlsansteckung*)

⁶⁷ *Sympathie* is also translated as sympathy, but in a more generic sense (Scheler 1954, liii).

4. A Feeling of Oneness (*Einsfühlung*)⁶⁸ (Scheler 1954, liii, 12; Scheler 1992, 59)

The first form of fellow-feeling—emotional sharing—is when one is in the same emotional state as the other. It is not the case that each is merely directed at the same object in a similar way. Rather, the emotional state is fully shared by each person, such that one person’s experience of the emotion is reliant on the other person also experiencing the emotion. It is a “*feeling-in-common*” (Scheler 1954, 13). The example Scheler uses to explain this phenomenon is that of grieving parents (Scheler 1954, 12). Imagine a morbid situation in which a child has died and both parents of the child feel grief. Scheler argues that it would not usually be right to say that the mother feels grief and the father feels a different grief. The child is the focus of both of their intentions, they both have the same past (more or less) with the child, and they are both confronted with the same experience of knowing that the child is dead. Accordingly, the mother and father share their grief.

Additionally, Scheler argues that it would be inaccurate to say that the father or mother is only feeling grief because the other is feeling grief, which will be closer to Scheler’s description of emotional contagion. Their grief is something that they share. It is a state that they are both in, and that they are both sustaining. Though, to be fair, Scheler doesn’t give much of an explanation as to why we should not just interpret this as two very similar, but still independent emotional reactions. He expects it to be obvious that the parents’ grief is one and the same.

The second form of fellow-feeling Scheler discusses—sympathy—is an understanding of the other’s emotional state with the addition of an emotional response. Specifically, one’s own emotion has the other’s emotional state as its intentional object. For instance, if my friend gets a promotion and he is joyous about it, then a sympathetic reaction from me may be to feel happy

⁶⁸ *Einsfühlung*, while close to *Einfühlung*, is an entirely different word. *Einfühlung* is commonly translated as empathy, whereas *Einsfühlung* (with an *s*) is more accurately translated as a sense of unity.

for my friend's happiness. However, this example may be a little misleading, since there need be no matching between the emotions (Scheler 1954, 13-14). One could also be sad or angry about the other's happiness and it would still fall into the realm of sympathy. Hence, sympathy is distinguished from emotional sharing because, in sympathy, "*my* commiseration and *his* suffering are phenomenologically *two different facts*, not *one fact*," as opposed to what is happening in emotional sharing (Scheler 1954, 13).

Additionally, in order to understand the nature of sympathy, Scheler stresses the need for a distinction between "vicariously visualized feeling, and participation in feeling" (Scheler 1954, 14). In other words, it is possible to understand the other's emotional state without experiencing that emotional state oneself. For instance, I can see that the other is angry and fully understand that the other is angry, without ever needing to feel anger myself. The feeling of the other's feeling (in either emotional sharing or emotional contagion) is a separate phenomenon from the understanding of the other. If this distinction is not made, then sympathy could easily be confused with either emotional sharing or emotional contagion.

To further demonstrate this distinction, Scheler uses the example of "the cruel man" (Scheler 1954, 14). This is actually an example of the opposite of genuine sympathy (Scheler 1954, 14),⁶⁹ but it still shares the same structure as sympathy. The cruel man's enjoyment is based on the suffering of the other. He must understand the suffering of the other, as well as care about the other's suffering, in order to enjoy the other's suffering. However, because he is feeling enjoyment while the other is suffering, this shows that there is a distinct disconnect between the understanding of the other's mental state and experiencing the same state as the other. In other words, the understanding and the participation in the emotional state are separate.

⁶⁹ Genuine sympathy is sympathy guided by love—when it is "embedded in, and sublated by, love" (Vandenbergh 39).

The third form of fellow-feeling is emotional contagion, when one automatically adopts the intentional state of the other (Scheler 1954, 14-15).⁷⁰ This is different from sympathy for two reasons. The first is that, in emotional contagion, the emotional state actually is the same kind of emotional state being experienced by the other. Whereas with sympathy, one can feel sad about another's anger, emotional contagion involves one being happy because the other is happy and sad because the other is sad. As Scheler says, "here there is neither a directing of feeling towards the other's joy or suffering, nor any participation in her experience. On the contrary, it is characteristic of emotional infection that it occurs only as a transference of the state of feeling" (Scheler 1954, 15). The other's state is transferred to me and I adopt it as my own. In fact, it is often the case that I fully believe the emotion to be my own, and never think to attribute its source to the other.

The second reason that emotional contagion is different from sympathy is that it doesn't require an understanding of the other's emotional state (Scheler 1954, 15).⁷¹ In sympathy, it is necessary that I understand the other's emotional state, since it is the intentional object of the emotion. This understanding doesn't need to be a deep understanding, such as when one has undergone, or is currently undergoing, the emotion oneself. Rather, understanding here is meant in a weaker sense of being able to attribute the emotion to the other. In emotional contagion, the other's emotion overcomes me, without my needing to acknowledge that the other is in the same emotional state. I often believe that the emotion is entirely my own—not being shared with or adopted from anyone else—even if I had no experience to warrant the emotion. For instance,

⁷⁰ Emotional contagion is a topic often examined by psychologists, and has also often been equated with empathy itself. For a detailed overview of emotional contagion, see Teresa Brennan's work *The Transmission of Affect* (2004).

⁷¹ This is the phenomenon that Scheler thinks Lipps' is actually talking about when he thinks he is talking about empathy. As Scheler says, "It also seems clear that what [Lipps'] theory could explain for us is the very opposite of genuine 'understanding' [empathy]. This opposite is that infection by others' emotions, which occurs in its most elementary form in the behaviour of herds and crowds" (Scheler 1954, 11-12).

after a long day, I may be grouchy and upset, but after talking to a friend who is in a much better mood than myself, I notice my mood has significantly improved. I find myself happy, even though nothing has changed about my long, tiring day. I could easily attribute my happiness to my friend's happiness, but this is not necessary.⁷²

On the other hand, even though he carefully explains the differences between emotional contagion and sympathy, he does not exactly explain how we distinguish between emotional contagion and emotional sharing. Since it is the case that both are an experience of the same emotion as the other, there is a strong need for a distinction here. It seems as if the only relevant difference is that the other experienced the emotion first in emotional contagion, while the other experiences it at the same time in emotional sharing. However, this seems to be an arbitrary difference with which to sharply distinguish two phenomena.

Consider Scheler's grieving parents. Say the mother is there when the child passes, while the father arrives a few minutes later to find that the child has passed. Is his grief still the same as the mother's grief or should we say that he caught the mother's grief? Or, a third option, is his grief his own emotional reaction itself? If we are talking about the way that they experience the grief, it seems like there is no way to distinguish between emotional sharing, emotional contagion, and ordinary emotional reaction. If instead we are talking about the intentional object as being the relevant reason for the distinction—both mother and father are grieving about the same child with which they had a similar relationship—then we face a different problem.

Emotional contagion, as it is defined by Scheler, can also have the same intentional object for the

⁷² Scheler also argues that it is not necessary that another person be in the emotional state that I have caught (Scheler 1954, 15). In other words, it is not necessary that I catch the emotion from another person. Scheler explicitly notes that one can catch an emotion from objects or the environment, "such as the serenity of a spring landscape, the melancholy of a rainy day, the wretchedness of a room" (Scheler 1954, 15). In these examples, we adopt the emotion from the environment in the same way we catch it from others, even if we do not explicitly attribute that emotion to the landscape and we think that the emotion is entirely our own. This, however, is debatable and not directly relevant to the discussion of empathy in intersubjectivity.

source and the infected. If the father feels grief for the child because the mother feels grief for the child, then it is still grief for the child. Experientially, there doesn't seem to be a definite way to distinguish between emotional sharing and emotional contagion.

Finally, the fourth form of fellow-feeling is true emotional identification (Scheler 1954, 18). It is “the act of identifying one’s own self with that of another... it is not only the separate process of feeling in another that is unconsciously taken as one’s own, but his self (in all its basic attitudes), that is identified with one’s own self” (Scheler 1954, 18). As Bornemark explains it, *Einsfühlung* is “an act where a unity between oneself and the other is experienced. It is a rare experience where the other is identified with what is one’s own in a pre-conscious and unconditional way” (Bornemark 2014, 363). All of the other’s basic attitudes—all of the other’s intentions and desires, emotions and feelings, and so on—are identified with my own. In this sense, Scheler calls emotional identification a “limiting case” of emotional contagion, since the latter only involves the other’s feeling being taken as one’s own, but not identification between selves (Scheler 1954, 18). What he means here is that I take more than merely the other’s emotions as being associated with my own (Scheler 1954, 18). In emotional contagion, the other’s emotion is adopted as if it were my own. In emotional identification, the other’s entire self is involuntarily taken as being identified with my own.⁷³

This feeling of oneness is evidence of why we do not need theories or inferences to understand others. It is the experience that Scheler believes proves primary intersubjectivity as explained in the previous section. As Svenaeus summarizes, “I only know the other because I have once been united with him in a feeling that precedes the I and the you” (Svenaeus 246).

⁷³ This experience is not unique to humans, and if anything is actually harder to identify in humans than in animals. For instance, it is a far more distinct phenomenon in herd animals (Scheler 1954, 12, 37). In humans, this experience becomes “obscured” by other kinds of affectivity (Bornemark 2014, 363).

That is, *Einsfühlung* is merely a returning to our communal stream of undifferentiated experience with an other (or multiple others). In fact, the rarity of this experience in adults is what makes them turn to experiences like empathy to fill the gap between subject and other. As Scheler says, “what is empathy in the adult is self-identification for the child. What is only ‘play’ to the adult is ‘in earnest’ to the child” (Scheler 1954, 24).⁷⁴ Whereas children have a greater affinity for feeling a oneness with others—because they have not been fully extracted from the communal stream of primary intersubjectivity—adults need empathy and sympathy in order to reconnect with others and understand them.

It has already been explained that emotional identification is unlike emotional contagion in that it causes us to associate ourselves with more than just the emotions of the other. These two forms of fellow-feeling can also be distinguished from each other based on the imitation involved in emotional contagion. The identification we experience in emotional identification is not the same as the imitated experience of emotional contagion, since identification does not require me to actually be presently experiencing the same experience as the other. Emotional contagion requires that I feel fear like the other when I experience the other as being afraid. Emotional identification requires that I identify the other with myself, even if we do not feel the same. In fact, in this identification, it is more likely that we lose track of who is feeling what.

As Scheler notes, there are different ways that we can associate with the other in emotional identification. While some have argued that only partial identification is possible—such as in aesthetic empathy, wherein we identify partly with the other by projecting ourselves into the other—Scheler argues that there are clearly certain cases “in which such identification is undoubtedly complete” (Scheler 1954, 18). There are two opposite kinds of emotional

⁷⁴ While translations tend to say “self-identification,” it would also be correct to say “emotional identification” for the same German term that Scheler uses, which is “*Einsfühlung*.”

identification in which emotional identification is complete: the *idiopathic* and the *heteropathic* (Scheler 1954, 18). In the first case, the other's self is completely absorbed and eclipsed by my own. This leaves the other's self as completely subservient to my own. In the second case, my self becomes "hypnotically bound and fettered by the other," such that my self becomes entirely subservient to the other, and I only really live in the other (Scheler 1954, 19). It is also possible for the identification to be only partial, such that subject and other do not become reduced to one another.

Relating to this point, emotional identification can be distinguished from sympathy due to the distance that sympathy allows between the self and other (Scheler 1954, 23). Emotional identification is not an emotional reaction to the other's emotional reaction, since this would mean that my identification with the other is completely separate from the other. In sympathy, I can feel a wide variety of emotions towards others, but this doesn't mean that I truly identify myself with them.⁷⁵

It is clear in his work that Scheler sees all four of forms of fellow-feeling as interesting, important, and in need of being described. Each form has a very important role that it plays in our intersubjective lives. Emotional sharing allows us to genuinely share an emotion with the other. It is our ability to enter into the same situation as the other in the world—to literally "be with" others in an affect. Sympathy allows us to be affected by other's affects. We do not neutrally approach other's affective lives, but have our own affective reactions to them. They matter to us like anything else in the world can matter to us. Emotional contagion has a special role in the way that it bonds us to the world with others. It shows how we are pulled into the

⁷⁵ Scheler does not say much to distinguish a feeling of oneness from emotional sharing.

same affective world with others, even if we do not realize it happening. Finally, a feeling of oneness brings us back to our primary intersubjectivity.

3.4 Conclusion

Scheler's answers to the three questions of empathy can be summarized as follows:

Empathy: Defined as an understanding of the other's mental states, it is achieved through an imitation of the other. He critiques this, arguing that this does not provide a genuine understanding of the other.

Intersubjectivity: The starting position is primary intersubjectivity, which is the communal, undifferentiated flow of experiences from which individuals extract and individuate themselves. From birth, the subject gradually forms out of the background of communal consciousness. It is only within this context that it is possible for subjects to be able to understand one another.

Affectivity: They are perceptions of value in the world that can be divided into different levels. There are four different types: (1) Sensations; (2) Vital Feelings; (3) Psychic Feelings; and (4) Purely Spiritual Feelings. We are also capable of experiencing these different affects with and for others, establishing the different forms of fellow-feeling. These are: (1) Emotional Sharing; (2) Sympathy; (3) Emotional Infection; and (4) A Feeling of Oneness.

This establishes affectivity as an essential part of our intersubjective lives. Fellow-feeling specifically allows us to overcome the illusion of our isolated subjectivity by revealing our connections to others. While empathy can be used to gain a partial, flawed understanding of the

other's situation, it is really only needed if our more primary means of understanding others fails. We already understand others fairly well in our everyday interactions with them due to the primary intersubjectivity from which both subject and other are extracted. It is precisely fellow-feeling that allow us to surpass this abstract division of subject and other and experience our being-with-others again.

A serious problem I find in his theory is his rejection of empathy. If we wanted to maintain the theory of empathy that he is critiquing, then it makes sense for him to want to reject it and instead support other affective experiences. However, if this theory of empathy is so problematic, why should we not redefine it? It would be possible to redefine empathy as being what he would call fellow-feeling, or even just a specific form of fellow-feeling. Additionally, he could define sympathy and/or a feeling of oneness as *affective empathy*, while defining the theories of Lipps, Husserl, and Stein as invoking *cognitive empathy*. This is an approach that has been taken by some contemporary philosophers (Aaltola 2014). Or he could argue that empathy is a multilayered phenomenon, with imitation being one of the lowest levels of understanding others and progressing to a feeling of oneness as being the most complete way in which we can understand others. This is also becoming a more common approach for discussing empathy, though not necessarily in the same terms that Scheler is using (Ekman and Halpern 2015; Gallagher 2009; Halpern 2001; Halpern 2014a; Taipale 2015).

The main problem that Scheler's theory faces is the lack of phenomenological evidence for his theory of primary subjectivity, which serves as the context of his entire theory (much in the same way that Husserl's theory of intersubjectivity does for his theory of empathy). While he may be able to find some support in adult experiences of fellow-feeling and the occasional breakdown of subjectivity experienced in some psychological disorders, these do not exactly

prove that we begin at birth in an undifferentiated stream of consciousness. If Scheler's theories are to be implemented into contemporary, applied fields such as biomedical ethics, they will require additional (and likely non-phenomenological) support.

Chapter Four: Interaction Theory⁷⁶

Given the three very different approaches to empathy that were addressed in the first three chapters, there exists a large gap in between simulation theory (ST) and the two phenomenological theories. Since the phenomenological theories are being appealed to in hopes of solving the problems with the equation between ST and clinical empathy, what is needed now is an approach that can bridge this divide. In order to connect the phenomenological theories of empathy back into clinical empathy, the insights of these theories will need to be applied back into the debate from which ST originated—the theory of mind debate. I argue that the theory that best ties together the phenomenological approaches and the theory of mind approaches is Shaun Gallagher’s interaction theory (henceforth IT) (Gallagher 2001 a, 2004, 2009, 2012; Gallagher and Hutto 2008; Gallagher and Zahavi 2012; Varga and Gallagher 2011).

This bridging of the gap between the phenomenology of empathy and clinical empathy is only one of the purposes of addressing IT in this chapter. The other purpose is that IT serves as a more moderate approach to the relation between empathy and intersubjectivity than the previous two phenomenological theories of empathy. While Husserl and Stein begin from an isolated, transcendental subject that needs empathy to bridge the gap between itself and others, Scheler begins from a primary intersubjectivity in which self and other are undifferentiated, making empathy a largely useless skill. Both of these are relatively extreme theories of intersubjectivity, and this can be seen in the problems they cause for their theories of empathy. Gallagher draws on

⁷⁶ Portions of this chapter have been previously published in *Medicine, Health Care and Philosophy*, 2017, 20(2): 237-248, and have been reproduced with permission from Springer Publishing.

the insights of these theories, but conceives of empathy as a multi-leveled phenomenon that allows for an understanding of others. However, while this theory does aid in addressing the intersubjective context of empathy in a way that helps solve the first two problems with clinical empathy, it still fails to fully address the affectivity of empathy.

In this chapter, I explain IT, emphasizing the ways that it fits into the same discussion as ST, as well as the ways that it draws on insights from the phenomenology of empathy. This explanation will follow the same framework established in the previous chapters, by answering the three questions presented for theories of empathy. First, I explain the definition that Gallagher gives for empathy as it has been situated in the context of the theory of mind debate. Second, I explain the intersubjective context for empathy, which Gallagher argues consists of three levels: primary intersubjectivity, secondary intersubjectivity, and narrative competency. In this section, I explain each of these levels, including supporting arguments. Finally, I address the role affectivity plays in IT, focusing primarily on Anya Daly's argument that empathy is affective reversibility. By expanding on Merleau-Ponty's theories of intersubjectivity, reversibility, and affectivity, Daly presents a theory of affectivity that is consistent with Gallagher's theory.

4.1 The Theory of Mind Debate

Gallagher presents IT in response to what has been called the “theory of mind debate” (Alegre et al. 2011; Davies and Stone 1995; Ferran 2015; Gallagher 2001a, 2004, 2008; Goldman 1993; Gopnik 1988, 1993; Karmiloff-Smith 1988; Kitcher 1988; Szanto and Moran 2015; Wellman et al. 2001; Zahavi 2014). A theory of mind is a set of principles or rules that a subject possesses that can be applied in order to gain an understanding of an other's mental states. These are primarily epistemological theories concerning how we can know of the

existence of other minds, as well as the contents of these minds. As such, the theories of intersubjectivity presented in the theory of mind debate do not need to be seen as synonymous with empathy. Despite this, however, there has been a strong connection between the two.⁷⁷

There are two major opposing theories in this debate.⁷⁸

The first is simulation theory (ST), which was addressed in chapter 1. To briefly summarize here, ST argues that our understanding of others is a process of simulation and projection (Gallese 2001, 2003; Goldman and Sripada 2005; Goldman 2006; Meltzoff 2006). As Goldman says, ST is a “strategy of imagining one’s own thoughts, feelings or behaviours in a situation similar to the target, which involves using self-reflection as a tool to understand... mental states” (Goldman 2006, 162). While there are several different varieties of ST, the main idea remains the same, that we create simulated models to understand the minds of others (Gallagher 2012, 355; Hutto 2008b, 176). As evidenced by its prominence in the medical field, ST has gained a lot of support in recent years, largely due to the growing body of mirror neuron research. Some have argued that this research definitely proves what ST is arguing. However, despite the promising appearance of ST, it is susceptible to a number of problematic criticisms, including the diversity problem and the problem of detached concern.⁷⁹

While Gallagher’s presentation of IT is most often presented in opposition to ST (Gallagher 2001a, 2004, 2009, 2012; Gallagher and Hutto 2008), it is important to note that ST is not the only theory in the theory of mind debate. In fact, it is not even the originating theory of the debate. ST was actually presented as an alternative to theory theory (henceforth TT), to

⁷⁷ As such, this debate connects empathy back to its roots in the aesthetic discussion of *Einfühlung* in Lipps’ work, likewise defining empathy as an understanding of the other.

⁷⁸ There have also been attempts to meld the two approaches together into a hybrid theory-simulation-theory approach.

⁷⁹ These are explained fully in chapter 1.

which the theory of mind debate owes its namesake. The reason it is worth addressing TT briefly here is because it gives greater insight into the problems that Gallagher is trying to address with IT, and thus how he is defining empathy in IT.

TT argues that we understand the other's mental states by either implicitly or explicitly appealing to a theory (Baron-Cohen 1993, 1995; Gopnik 1988, 1992, 1993, 1996; Gopnik and Meltzoff 1998; Gopnik and Schulz 2004; Gopnik and Wellman 1992; Karmiloff-Smith 1988; Kitcher 1988; Wellman 1990; 2001). When I observe another person's actions, I use a specific theory in order to interpret and predict the mental states that correspond to those actions.⁸⁰ I then apply the findings of this appeal to the other. Essentially, theory-theorists argue that children are basically little scientists (Gopnik 1988, 1996; Gopnik and Wellman 1992; Karmiloff-Smith 1988; Kitcher 1988). The way children understand others is the same as the way that scientists try to understand the world. In fact, this analogy is meant to cut both ways. Gopnik says it is "not that children are little scientists but that scientists are big children" (Gopnik 1996, 486). Children develop these theories as ways to predict and explain the way that others are acting. Developed theories are then checked against the evidence to see if predictions were correct or incorrect. When the theory is applied and found to be incorrect, children rework their theories or develop entirely new theories (Gopnik and Wellman 1992, 145). This development and alteration of theories is a quick and continuous process, that can happen many times within only a few months (Gopnik 1996, 486-487). Furthermore, this is a constant process still being refined throughout our lives. In this sense, scientists are simply applying a refined method to the world and others, that they were already naturally using when they were children.

⁸⁰ It should be noted that theory theory does not just apply to the way in which we understand others, but also to the way in which we understand our own mental states (Gallagher and Zahavi 2012, 192-193). This is because all mental states are supposed to be theoretical postulates, and therefore we do not have any more direct perceptions of our own mental states as we do of others' mental states.

To help explain this process, consider a classic example and experiment used by theory theorists: the false-belief test. These tests come in many forms, but the theme of all of them is generally the same. Here is an example:

A child is asked by a scientist to observe a scene. In the scene, Mary enters the room, places her doll in a toy box, and then leaves the room. Next, Tom enters the room, takes Mary's doll out of the box, places it in a basket, then leaves the room. Finally, Mary reenters the room and the child is asked, "Where will Mary look for the doll?"

The goal of these tests is to see if the child can apply mental states to the other that the child would not attribute to herself. That is, if the child says that Mary will look for the doll in the box, then the child has passed the false-belief test. The child is able to attribute beliefs to Mary that the child knows are false. However, if the child says that Mary will look in the basket, then the child fails. The child is unable to understand that Mary can have beliefs that are different from the child's beliefs. In other words, the child does not have a theory of other minds.

Using these tests, theory-theorists have made predictions concerning the development of a child's theory (Gopnik and Wellman 1992, 149). Children under 2 1/2 do not usually pass false-belief tests. This means that they do not have a theory of other minds. At around age 2 1/2, children begin to develop basic theories that they can test for correctness. However, it isn't usually until around age 4 that children develop theories sophisticated enough to understand other minds and pass false-belief tests.

These theories that we develop in order to understand others have a few important characteristics. The first is their abstractness; "they postulate entities and analyses that explain the data but are not simply restatements of the data" (Gopnik and Wellman 1992, 146). They do not seek to simply describe what is happening as is. To give a simple example, theories do not

try to explain happiness as mere behavior. If we observe a person laughing and smiling, then say that the behavior—laughing and smiling—is all that there is, then this would not be a theory for TT. That would merely be an observation. A theory postulates that there is something called happiness, and happiness is a mental state that causes smiling and laughter. We can then use the theory to make the corresponding predictions concerning the other’s mental state—a process that would be unnecessary if they were merely observations.

The second characteristic of these theories is their coherence; “the theoretical entities and terms postulated by a theory are closely, ‘lawfully’, interrelated with one another” (Gopnik and Wellman 1992, 147). Theories do not exist in a vacuum. They are meant to explain multiple phenomena in the same world, therefore they should not contradict one another. For instance, if I have one theory that predicts people will smile when happy and one that predicts people will not smile when happy, then there is a problem. One (or both) of my theories needs to be altered. This, of course, is an oversimplified example, as theories can be very complex and conflict with each other in many subtle ways. The point is simply that, once problems between theories are found, they either need to be resolved, or one of the theories needs to be rejected.

The third characteristic of these theories is that “they produce interpretations of evidence, not simply descriptions of evidence and generalizations about it. Indeed, theories influence which pieces of evidence we consider salient or important” (Gopnik and Wellman 1992, 148). The theories that I hold are going to attune me to specific kinds of evidence. Again, if I have a specific theory of happiness, then I’m not going to spend time looking at a person’s stomach or feet when trying to determine whether or not they are happy. I’m going to focus on the person’s face and overall bodily comportment to search for things like a smile, bright eyes, laughing, and so on.

TT has been subject to a number of criticisms, not all of which can be addressed here. One criticism is that TT is not accurate to our actual experiences. It predicts that we do not understand others until relatively late in our early development (around 4 years), but there seems to be plenty of evidence that we understand other well before this. This is shown through examples of neonate imitation (Gallagher 2004, 205; Gallagher 2009, 292-293; Gallagher and Meltzoff 1996; Meltzoff, 2006; Meltzoff and Moore 1977), as well as the initial attunement of infants to the gestures and expressions of their caretakers (Falk 2004; Herrmann et al. 2007). By demonstrating these forms of recognition, infants show that they have at least a very basic understanding of others well before they have the ability to form theories (at least according to false-belief tests).

Additionally, some have argued that the children who fail the false-belief experiments have no problem understanding the experimenter, indicating that there is an understanding of the other at a time when TT judges a failure in understanding. That is, the children may not be able to answer the questions asked by the experimenter in a way that would indicate a theory of false beliefs, but they are still able to understand that the experimenter is asking them a question and that they should respond. They understand who is talking to them, that they should communicate back, and that certain responses are more acceptable than others. In other words, they may fail at the application of a theory in a third-person observation of a scene, but they do not fail in communicating during first-person interactions with the experimenter.

Furthermore, some critique TT of viewing “the attribution of mental states as a matter of inference to best explanation and prediction of behavioural data and... that mental states are unobservable and theoretically postulated entities” (Gallagher and Zahavi 2012, 192). We cannot observe mental states. We only perceive the physical body, as well as its movements and

gestures. Therefore, it is only by appealing to a theory and applying the results to the other that we are able to “transcend what is given in experience” (Gallagher and Zahavi 2012, 192). If we were unable to form a theory of mind, then TT predicts that we would not be able to understand anything beyond our immediate experience of the other. This means that TT is only necessary so long as we can only experience the physical body of the other, and have no direct experience of their mental states. However, if we actually perceive the other as a lived body, as was argued by Husserl, Stein, and Scheler, then TT is not needed.

Merleau-Ponty presents a similar argument against theories like TT. To be clear, in Merleau-Ponty’s critique he is targeting Descartes, Kant, and the general goal of science to reduce the body into a merely physical object of observation, but these critiques apply equally well to TT (Merleau-Ponty 2012, *lxxi-lxxv*). He says,

I cannot think of myself as a part of the world, like the simple object of biology, psychology, and sociology; I cannot enclose myself within the universe of science. Everything that I know about the world, even through science, I know from a perspective that is my own or from an experience of the world without which scientific symbols would be meaningless. The entire universe of science is constructed upon the lived world, and if we wish to think science rigorously, to appreciate precisely its sense and its scope, we must first awaken that experience of the world of which science is the second-order expression... I am not a “living being,” a “man,” nor even a “consciousness,” possessing all of the characteristics that zoology, social anatomy, and inductive psychology acknowledge in these products of nature or history. Rather, I am the absolute source. My existence does not come from my antecedents, nor from my physical and social

surroundings; it moves out toward them and sustains them. (Merleau-Ponty 2012, *lxxi-lxxii*)

We should not reduce our understanding of ourselves and others to any one characteristic of our being. Doing so ignores the many different facets of our existence that need to be understood in order to understand ourselves and each other. Reducing subjects in this way only results in philosophers needing to go to great lengths in trying to explain how to put subjects back together again.

In terms of understanding others, if we approach them as if we can fully understand them from merely our own perspective—that we understand other’s by projecting our theories or thoughts into their observable bodies—then we eliminate the problem of others (Merleau-Ponty 2012, *lxxv*). This is because “from the first flicker of consciousness it grants me the power to go toward a truth that is universal by right, and since the other is himself without *haecceity* [thisness], without place, and without a body, the Alter and the Ego are one and the same in the true world, which is the unifier of minds” (Merleau-Ponty 2012, *lxxv*). This gives the subject too much control over what can be known about the world and other. When the subject is given this overly-privileged position, “nothing is hidden behind these faces or these gestures, and there are no landscapes that remain inaccessible to me; there is but a touch of shadow that owes its existence to the light” (Merleau-Ponty 2012, *lxxv*).⁸¹ We need to revalue the perception of others and not make them interchangeable with us, even though this has been the common theme in many traditional theories of mind (Merleau-Ponty 2012, *lxxvi*). If the other is to actually be an other, but also an accessible other, then the other needs to be open to me, but not so much so that they become reducible to me.

⁸¹ Merleau-Ponty also critiques Husserl’s theory of intersubjectivity for making subject and other interchangeable (Merleau-Ponty 2012, *lxxvi*).

To summarize, there is no necessary connection between the theories of mind and empathy, but they have been almost entirely equated in recent years. This is the context of the debate as it currently stands, especially in medicine with clinical empathy. However, both TT and ST are vulnerable to a number of critiques, and the common theme undercutting all of these critiques is that TT and ST are both “overly mentalistic” (Daly 2014, 229). They both suppose that empathy is a highly-cognitive skill that must be applied in order to understand others, while ignoring that there is a more primary way in which we understand others. Again, this understanding of others is present much earlier in life than the development of theories and simulations.⁸² By responding to the theories in this debate, Gallagher adopts a similar definition of empathy, if only as a means of refuting these currently dominant theories of empathy. While Gallagher presents many critiques against these theories, he still often refers to empathy as an understanding of the other (Gallagher 2012, 374-375, 377). It is a process by which mental states are ascribed to the other, if only in a very basic way (Gallagher 2012, 376-377).⁸³ Gallagher, however, offers an alternative explanation for this definition that is influenced by phenomenology. According to him, we do not need theories and simulations in order to understand others. Rather, our understanding of others is achieved through our interactions with them.

⁸² It should be noted that there are versions of ST that are less susceptible to this critique, but those have other problems that will be addressed later.

⁸³ He says “one can conceive of empathy as being (1) a primary, non-reducible, other-directed feeling of concern or interest that (2) is characterized by a clear distinction between empathizer and the other person, that (3) targets the other's situated experience and (4) consciously ascribes that experience specifically to that other” (Gallagher 2012, 376-377).

4.2 Interaction Theory: Intersubjectivity Through Interaction

IT seeks to draw on insights from phenomenology in order to provide a better explanation of how we understand others. As should be clear by now, many approaches to empathy and intersubjectivity focus on the how the subject comes to understand that others are equally minded, while having no direct access to the mind of the other. This means that understanding the other relies on some sort of interrogation of the other, and “for the most part such interrogations have been pursued in a mentalistic manner, through philosophical frameworks which valorize representation, inference and cognition as being the only reliable and legitimate modes of intersubjective access” (Daly 2014, 227). Many philosophers are now rejecting this supposed strong separation between subject and other, and arguing instead for a more direct access to the mental lives of others (Gallagher 2005; Gallagher et al., 2013; Varela et al. 1991; Zahavi 2005). Gallagher is one of these philosophers who attempts to get away from the mentalistic framework of TT and ST by combining the phenomenological approach with cognitive science and developmental psychology.

IT consists of three levels: primary intersubjectivity, secondary intersubjectivity, and narrative competency (Gallagher 2009, 292). Primary intersubjectivity serves as the most basic way in which we experience and understand others; secondary intersubjectivity opens us up to the world with others, establishing an understanding of a mutually accessible world; and narrative competency builds on the foundation of the first two levels, developing a more complex understanding of diverse others (Gallagher 2004, 204; Gallagher and Hutto, 2008; Varga and Gallagher 2011, 254-255).⁸⁴

⁸⁴ As such, it is the third level that is the most relevant for the discussion of clinical empathy. Since primary and secondary intersubjectivity are foundational for our everyday social interactions, it is unlikely that they can be easily lost or gained. It would likely take some kind of physical or psychological trauma for them to be lost. Narrative

4.2.1 Primary Intersubjectivity

Well before we are able to apply theories or simulate others, as well as before we are able to make sense of the world with others (which will be addressed in the next section), we already have a very basic understanding of the other as being another subject (Gallagher 2001a, 2004, 2006, 2008, 2009; Gallagher and Hutto 2008; Varga and Gallagher 2011, 253; Trevarthen 1979, 1998, 2007, 2013, 2015a, 2015b; Trevarthen and Aitken 2001). Infants are able to acknowledge and interact with others, if only in very simple ways. This is what Gallagher and others have referred to as primary intersubjectivity.

Primary intersubjectivity “includes some basic sensory-motor capacities that motivate a complex interaction between the child and others” (Gallagher 2009, 292). It develops very shortly after birth, as evidenced by the phenomenon of neonate imitation (Gallagher 2004, 205; Gallagher 2009, 292-293; Gallagher and Meltzoff 1996; Meltzoff, 2006; Meltzoff and Moore 1977). Even a few hours after birth, infants are capable of mimicking the gestures and expressions of others. This is an impressive skill that demonstrates the infant’s very basic understanding of others.⁸⁵ The infant can see the other’s expression, somehow know that its face is similar, and then move its face to match. No simulation is needed in order for the infant to understand the other, since infants are incapable of running simulations (Gallagher 2004, 206).⁸⁶ They cannot abstract themselves from interactions with others in the way that adults can

competency, on the other hand, can be lost or gained. Depending on our effort to learn other narratives, we can either possess many, diverse narratives or few, similar narratives. Additionally, we can be better or worse at constructing narratives with others. Therefore, if there is a concern that physicians lack empathy, then narrative competency would be the skill that needs to be retained.

⁸⁵ Merleau-Ponty also notes the sensitivity of children to facial expressions, noting that “this complicated process would seem to be incompatible with the relative precociousness of the perception of others.” (Merleau-Ponty 1964a, 115)

⁸⁶ ST may be able to provide an answer to this problem by appealing to mirror neurons—as noted in previous footnotes—but this is still unclear. More research will need to be done concerning the mirror neurons of infants.

(Gallagher 2009, 293). The recognition involved in neonate imitation is rather “fast, automatic, irresistible and highly stimulus-driven” (Scholl and Tremoulet 2000, 299). Infants initially come to understand others because they are enmeshed in interactions with others, not because they can observe and simulate others.

Additionally, it should be noted that the “level of intersubjectivity involved in mimesis is more basic and lacks cognitive components. Indeed, it involves a primary sense of others that can be described as a form of basic relatedness” (Varga and Gallagher 2011, 250). However, while the recognition in neonate imitation is very basic, it does serve to show that infants are able to distinguish other subjects from mere objects in their surroundings. They are able to attend to the “micro-level affective behaviors” of others, especially caregivers like their parents (Feldman 2007, 602). In a sense, this form of very basic relatedness is primary intersubjectivity. It is that which allows us to establish and maintain “concrete face-to-face interactions in an undistorted manner” (Varga and Gallagher 2011, 250).

The claim here is not that “primary intersubjectivity... [is] fully formed at birth or incapable of being shaped by development” (Varga and Gallagher 2011, 255). The claim is merely that there is some recognition of other subjects as being like oneself. Over the course of one’s development, this recognition changes, becoming more complex and skilled, especially as it intertwines with the other levels of intersubjectivity. Furthermore, the role played by primary intersubjectivity is “not primary simply in developmental terms” (Gallagher 2001a, 91). Rather, the ability to understand others gained at this level is still present once the other levels have been reached, except that this ability is further refined (Gallagher 2001a, 91).

While cases of neonate imitation show that there is some understanding of the other very early on in life—as well as that the other theories are not particularly well equipped to explain

this understanding—the exact nature of this access still needs to be explained by IT. This is one area where the phenomenological approach is very helpful. Specifically, Scheler shared the same view as Gallagher that there is a primary intersubjectivity (Scheler 1954, 246), though they talk about this in slightly different ways. Scheler discussed primary intersubjectivity as a time when there is no differentiation between self and other, while Gallagher discusses it as a time when there is already an understanding of others before higher-level processes like theories and simulations. However, there is no reason that the two cannot go hand-in-hand, such that Scheler’s initial, undifferentiated stream of consciousness may be the reason that newborn infants understand others at a very basic level. On the other hand, despite the similarities between their approaches, Scheler is not particularly helpful in further developing IT. This is because he fails to give a positive argument for the nature of primary intersubjectivity. Instead, he provides a negative argument for why we cannot begin in isolated subjectivities (see chapter 3). Therefore, it is necessary to look to other phenomenologists that also supports the idea of primary intersubjectivity.

While never referring to his theory as primary intersubjectivity, Merleau-Ponty’s theory of intersubjectivity is very useful for the discussion of primary intersubjectivity. What is especially of interest in Merleau-Ponty’s theory is his reversibility thesis, which he appeals to throughout his works to argue for intersubjectivity (Merleau-Ponty 1968, 199, 203-204, 214-215, 239, 264; 2012, 95). As Merleau-Ponty says, reversibility “(seeing seen), (touching touched in the handshake) is the major and perfect case, where there is quasi-reflection (*Einfühlung*)... the general case is the adjustment of a visible for me to a tangible for me and of this visible for me to a visible for the other” (Merleau-Ponty 1968, 245). This reversibility of being able to be “perceiving-perceived” is empathy (Merleau-Ponty 1968, 248). It is an ability to vacillate

between touched and toucher, seen and seer, which opens oneself up to the other by recognizing otherness as already being an aspect of oneself (Merleau-Ponty 1968, 249).⁸⁷ As Daly says, “the first person has intrinsic to its very structure the shifting identification between the ‘I’ and ‘we’ perspectives” (Daly 2014, 235). In my experiences of even my own body, I have experiences of both subject and otherness. I am never so far from the other because otherness is already part of my being.

One of the problems with other theories of empathy that Merleau-Ponty seeks to avoid is the starting point of a strong divide between self and other. As Scheler also argues, once this divide is established, it is not possible for anything to truly bridge this divide. As was also noted in Scheler’s theory, the other is not merely given as a physical body with a hidden mental life, but rather as a lived body. In this same vein, Merleau-Ponty says,

We must reject the prejudice which makes “inner realities” out of love, hate or anger, leaving them accessible to one single witness: the person who feels them. Anger, shame, hate, and love are not psychic facts hidden at the bottom of another’s consciousness: they are types of behavior or styles of conduct which are visible from the outside. They exist on this face or in those gestures, not hidden behind them. (Merleau-Ponty 1964b, 52-53)

Mental states are not things that are encapsulated inside impenetrable bodies. Instead they are modes of behavior, or styles of being that are lived by the other, and able to be experienced by the subject.

This also means that empathy is not a “substantive reality, as a special state apart from subjectivity itself” (Daly 2014, 232). Just because it is possible to conceive of empathy in this way—much the same as it is possible to conceive of love and hate in this way—does not make it

⁸⁷ According to Merleau-Ponty, the source of our reversibility, as well as empathy, is that subject, other, and world are all made of the same “flesh” (Merleau-Ponty 1968, 248-249).

accurate. Rather, empathy is also a mode of being; it is “a relational manner of being, a general orientation towards the world and others, reflected in types of behavior and styles of conduct” (Daly 2014, 233) Though, in addition to being a mode of being towards the world and others, it is also a mode of being towards the world with others. It is not some additional thing in the world or in the head that accompanies being. It is tied up in being. In this way, we really only become aware of empathy when it is somehow lacking, such as in instances of breakdowns (Daly 2014, 234; Zahavi 2001, 155). As Daly explains, “empathy is lived largely unreflectively... The very fact that we do understand each other well enough testifies to empathy being primary, therefore pre-existing any break-down; and so empathy is intrinsic to the original engagement, to the original relation” (Daly 2014, 234). Empathy is always already part of our experience of other and the world with others. It is a pre-reflective mode of being towards others (Daly 2014, 234).

It is important to note in the reversibility thesis that the traditional arguments for intersubjectivity are being turned on their heads. Rather than arguing that we have a complete understanding of ourselves, and that we understand others by injecting them with some of this self-knowledge, the reversibility thesis argues that “otherness is constitutive of the self, so that openness to the other is built-in” (Daly 2014, 235). The other is never so far from me, since otherness is already an essential part of me. That is, the otherness of myself opens me up to others. The problem of the other arises when all attention becomes fixated on the subject, as can be seen in the theory of mind approaches.

If the identification remains fixedly on the ‘I’, the orientation is dominated by individualism and competition. If this sense of subjectivity/intersubjectivity embraces the ‘we’, the values become collective ones and the orientation is characterized by

cooperation. The more the circle of ‘we’ is widened, the more empathically available is the subject to other sentient beings. (Daly 2014, 235)

So long as the subject is secured as being isolated from others and totally self-determined, then it cannot be open to others. The wider the overlapping “we” of self and other, the more room for empathy. However, even if primary intersubjectivity is the core of empathy, this level alone may not be enough to encompass full-fledged empathy.

4.2.2 Secondary Intersubjectivity

Secondary intersubjectivity (which develops around 9 months to 1 year of age) is based on “the development of joint attention, and motivates contextual engagement, and acting with others” (Gallagher 2009, 292; see also Trevarthen 1998, 2009, 2015b; Trevarthen and Aitken 2001). It is at this level that “cooperative task performance becomes both possible and attractive for the infant, who now shows ‘person-person-object’ awareness” (Trevarthen 1998, 18). At this level, we start to understand others in the context of a world, and the world begins to take some of the focus of our interactions with others (Gallagher 2009, 294). Social situations, environment, and the objects around infants create a context in which they can understand others in a specific way (Gallagher 2004, 207; Gallagher 2009, 294). They pay attention to and make reference to the things around them, such that the environment is an essential part of how they understand others. Additionally, others are an essential part of how infants understand the environment. The intentions of another person’s gestures as they relate to the local environment and their intentional objects in the local environment come together in our understanding.

The main difference between primary and secondary intersubjectivity here is that “the latter involves triadic relations among self, other, and world,” rather than just the relationship between self and other (Varga and Gallagher 2011, 234). It is at this level that the subject, other,

and world finally intertwine for the infant in the way that Merleau-Ponty predicts in his flesh ontology (Merleau-Ponty 1968). There begins to be an interplay between individuals and the world, in which the other is acknowledged as also perceiving the world with the subject, and reciprocating the meaning being given to the world. This reciprocity is necessary. As Merleau-Ponty says, “without reciprocity there is no alter ego, since one person’s world would thereby envelop the other’s, and since one would feel alienated to the benefit of the other” (Merleau-Ponty 2012, 373). This is a point he is echoing from his earlier work (Merleau-Ponty 2012, *lxxv-lxxvi*). In other words, without reciprocity, the world, including others in the world, would only be given as belonging to the subject, and this would in turn reduce the other to no more than the subject (or at least only existing for the subject). Instead, the other is understood as setting up a reciprocal claim of subjectivity in the world, providing a coexistence concerning everything that is perceived. Furthermore, this “coexistence must be in each case lived by each person” (Merleau-Ponty 2012, 373). This last point is important, since it also signals that there is no merger between subject and other. At the secondary level of intersubjectivity, “subjects are alongside each other, and their focused attention is directed beyond them, but implicit in this secondary engagement are both the recognition of the self and the other as distinct collaborators, as counterparts, as competitors, as interlocutors and the recognition of the context” (Daly 2014, 237). The relationship between the subject and other is not a single existence, where one overcomes and absorbs the other; it is a coexistence.

As Gallagher notes, drawing on the work of De Jaegher and Di Paolo, this coexistence that we experience with others in secondary intersubjectivity is a form of *participatory sense-making* (Gallagher 2009; Varga and Gallagher 254). Participatory sense-making is “the coordination of intentional activity in interaction, whereby individual sense-making processes

are affected and new domains of social sense-making can be generated that were not available to each individual on her own” (De Jaegher and Di Paolo 2007, 13). While primary intersubjectivity is our recognition of others, and at this level we can at any time make sense of the world all on our own, what is needed at the secondary level is “to move beyond recognition and work out what the interaction process does for social cognition” (De Jaegher and Di Paolo 2007, 2). More often than not, we are confronted with a world in which things either already have a sense established by others, or the sense given to things by us is confirmed or denied by others.

This phenomenon of participatory sense-making builds on “the enactive notion of sense-making” (De Jaegher and Di Paolo 2007, 2). As De Jaegher and Di Paolo say, “exchanges with the world are inherently significant for the cogniser and this is a definitional property of a cognitive system: the creation and appreciation of meaning or sense-making in short” (De Jaegher and Di Paolo 2007, 4). We naturally give meaning to the world in such a way that it matters to us, which allows for us to make sense of the world for ourselves. While we are always encountering the world in a physical way, we are also able to approach specific things in our environment in a cognitive way by giving them a sense (De Jaegher and Di Paolo 2007, 4). As De Jaegher and Di Paolo clarify, “natural cognitive systems are simply not in the business of accessing their world in order to build accurate pictures of it. They actively participate in the generation of meaning in what matters to them; they enact a world” (De Jaegher and Di Paolo 2007, 4).

Participatory sense-making happens when the subject also takes into account the sense-making abilities of others. In this way, there is a needed coordination between competing senses. In our everyday life with others, “coordination is typically easily achieved by simple mechanical

means and, when cognitive systems are involved, it does not generally require any cognitively sophisticated skill. On the contrary, it is often hard to avoid” (De Jaegher and Di Paolo 2007, 6). We tend to coordinate with each other, even if we do not want to. There is not much difference between this and the coordination of sense-making into participatory sense-making.

If regulation of social coupling takes place through coordination of movements, and if movements—including utterances—are the tools of sense-making, then our proposal is: social agents can coordinate their sense-making in social encounters. This means that the sense-making of interactors acquires a coherence through their interaction and not just in their physical manifestation, but also in their significance. This is what we call participatory sense-making. (De Jaegher and Di Paolo 2007, 13)

This means that participatory sense-making need not occur at higher levels when language can be used to help with coordination. Rather, coordination is achieved through interaction between subjects and the environment. Because participatory sense-making does not require the use of language, this means that we are capable of perceiving “meaning in their emotions, gestures, intentions, postures and actions,” well before we are able to use language to form theories (Varga and Gallagher 2011, 254). Furthermore, once language is implemented into the infant’s development, there are better ways to explain its use in intersubjective understanding than simulations and theories. Gallagher and others appeal to the use of narratives.

4.2.3 Narrative Competency

Narrative competency is the level of intersubjectivity that “involves narrative practices that capture intersubjective interactions, motives, and reasons” (Gallagher 2009, 292). Built on secondary intersubjectivity, language acquisition, and the stories that we tell children, narratives expand on the already established understanding of others, and start to “provide more subtle and

sophisticated ways of framing the meaning of the other's intentions and actions" (Gallagher 2009, 294). Narratives allow us to interact with others in more complex ways, allowing both oneself and others to make sense of the world with joint-narratives (Gallagher 2012, 369-370). We then use these complex, communally established narratives to understand the actions and intentions of both others and ourselves (Gallagher 2009, 294; Hutto 2004, 2007, 2008a, 2008b).

Narrative competency is part of what some have called tertiary intersubjectivity, carrying the theme of the previous two levels (Daly 2014, 237-238). This level in general concerns "third person engagements, involving he, she, it or they; at this level, the self and others become public representations, able to be discussed and judged by other parties" (Daly 2014, 237-238). While never entirely leaving the influence of the other two levels behind, we step out of the second person interactions with others in order to situate them into a more detailed and complex description of their actions. This also includes our ability step out of our first-person perspectives and situate ourselves into stories to better understand our reasons and motives for our own actions. Using narratives, we can gain a larger context, stretching into past actions and even future plans.

Early in childhood (around 2-4 years of age) children tend to adopt the stories of others, and later (around 4 years of age) they begin to contrast others' stories with their own experiences to create more diverse narratives (Gallagher 2012, 370; Hutto 2008b, 186). Using merely my own understanding of myself as a means of understanding others, it can always be asked whether I actually understand the other, or I really only understand myself (Gallagher 2012, 370, 373). Narratives on the other hand are not limited to my narrow perspective. I have the narratives that I created as well as those learned from others. Hutto says, "children get a handle on the individual attitudes and, slowly, by engaging with narratives, begin to weave together a new composite way

of making sense of actions in terms of reasons” (Hutto 2008b, 185). Through my interactions with others, these narratives and the ways that they relate to one another intertwine, refining my narratives to apply to increasingly more complex situations. These refined narratives become essential for explaining the reasons behind actions and behavior (Gallagher 2012, 371). And, while an explicitly stated narrative is not necessary for understanding others, this understanding does require “the ability to recognize others in their detailed pragmatic and social contexts that are other than my own, and to understand the other’s actions and affective states in that context, in a narrative way” (Gallagher 2012, 377).

In addition to narratives, the tertiary level may “take the form of complex projects involving more than two people, or the discussion of thoughts and feelings... It is at this level that language attains especial significance as the vehicle whereby the past and future are presented” (Daly 2014, 238). In fact, as Daly notes, this is the level that has become the focus of the theory of mind debate (Daly 2014, 238). This is the level at which we begin to talk about others in the third person, such as when we apply theories about other people’s behaviors in false-belief tests. This is when children start to learn about deception, both in others and in their own abilities (Daly 2014, 238). The tertiary level is focused on our cognitive abilities, which can also serve to distance us from others—“to stand back, evaluate and to appraise” (Daly 2014, 238).

However, Hutto maintains that it is not by internally developing theories that we acquire an understanding of other’s mental states, but rather by “engaging in socially supported storytelling activities” (Hutto 2008b, 177). Children must learn stories from others, develop their own stories, and then test these stories with others to see whether they are supported, rejected, or altered—“hence the emphasis on ‘practice’ in the [narrative practice hypothesis] moniker”

(Hutto 2008b, 177). Additionally, while we can present many different kind of narratives, including narratives about the world and others in general, the ones of most interest at the level of tertiary intersubjectivity are those that assign mental states to others (Hutto 2008b, 178).

It is important to note here, especially in the face of theories of mind, that the acknowledgement of the cognitive skills at the tertiary level does not mean that they are on their own sufficient for understanding others. As Hutto explains in depth,

To avoid misunderstanding, it is important to stress that the [narrative practice hypothesis] supposes that... narratives do crucially important but nonetheless limited work. They are not responsible for introducing an understanding of mental concepts, such as desire and belief for the first time, rather, being complex linguistic representations of particular events, they put on show how these attitudes can integrate with one another (and also how they fit with other mental states and stand with respect to other contextual factors). The [narrative practice hypothesis] assumes that kids already have a practical grasp on what it is to have a desire or belief before learning how to integrate their discrete understanding of these concepts in making sense of actions in terms of reasons. (Hutto 2008b, 178)

Narratives show how basic mental states such as beliefs work in actual situations, as well as providing “norms of giving and asking for reasons” (Hutto 2008b, 178). They allow for more detailed understandings and interactions. This is the problem with TT—it assumes that this level of understanding the other is exactly what is needed, and that anything less would fall short of an understanding. ST shares a similar issue. As Daly notes, what is ignored in ST approaches “is the primary level which underpins these processes and in fact makes them viable” (Daly 2014, 232).

In other words, they fail to acknowledge the important roles that primary and secondary intersubjectivity always play in intersubjective understanding.

The influence of the relationship between the first two levels of intersubjectivity and the tertiary level actually cuts both ways. While primary and secondary intersubjectivity serve as the foundation for narratives and therefore influence the development of narratives, it is at the tertiary level that other levels of intersubjectivity can be negatively affected. Even though lower levels of intersubjectivity are present after gaining later levels, it is still possible to interfere with these levels. As Daly says, “top-down processes from this tertiary level can serve to block or corrupt primary empathy, through the mechanisms of dehumanization and demonization, and so humans have repeatedly throughout history done and continue to do horrible things to each other” (Daly 2014, 238). That is, people can use narrative, such a propaganda, to train themselves to disregard their more basic levels of understanding. They can use narratives to form prejudices that devalue others, such as racist and sexist views. In extreme cases, these narratives can cause individuals to not even perceive some others as persons.

4.2.4 The Strengths of Interaction Theory

There are a number of benefits to IT as compared to the theories of mind. To begin with, IT is able to overcome what has been called the developmental problem (Gallagher 2012, 364). According to some versions of simulation theory, the simulation that needs to occur is a fairly high-level cognitive process (Gallagher 2012, 364). As shown in cases of neonate imitations, infants can understand others in a very basic way, much earlier in their development than either TT or ST predict. This problem may be able to be addressed by an appeal to mirror neuron research, since mirror neurons would be active early in the infant’s development. However, as noted in other section as well, mirror neuron research is still relatively new, making it unclear at

this time how mirror neurons will help address this and other problems with ST. IT, on the other hand, avoids the developmental problem, as well as other problems explained below, by allowing for more basic experiences in which we understand others—that is, at the level of primary intersubjectivity.

For instance, IT also overcomes what Gallagher calls the “starting problem” (Gallagher 2012, 371-372). For ST, we understand others by simulating their mental states within ourselves, but it is unclear how we know what to simulate before we understand the others’ mental states. How does the understanding of the other—the simulation—start if we do not already understand the other?⁸⁸ This is not a problem for IT, since it argues that “I draw on a rich store of narratives, and on the massive hermeneutical background that informs my understanding” (Gallagher 2012, 372). In other words, when we are interacting with others, we can gain an understanding of their mental states by situating them into narratives, which we have acquired throughout our lives. These narratives tell us what to expect from others given their actions and situations (Gallagher 2012, 371). We do not need simulations to create some new understanding; we already possess a wide variety of narratives that can be applied based on perceived actions. When we interact with others, we already have a basic understanding of them based on primary and secondary intersubjectivity. Based on this immediate understanding, we can situate others into narratives that tell us what actions and reasons to expect and why to expect them.

Even more important than the starting problem, IT is able to overcome both the diversity problem and the geocentric bias. As already explained, ST can only accept the diversity problem as a necessary flaw in our ability to understand others. However, as Gallagher said, we are at least sometimes able to understand others that are very different from us, such as aliens and

⁸⁸ This is similar to Scheler’s critique of Lipps’ theory, as explained in chapter 3.

monsters (from movies), and people from different cultures (Gallagher 2012, 370). What allows us to do this, however, is not a simulation, but rather the knowledge we have of their stories. We only understand these aliens and foreigners when we are able to “frame their behavior in a narrative that informs us about their history or their situation” (Gallagher 2012, 370). We have diverse narratives that allow us to understand others in diverse contexts—ones that are not limited to the experiences that we have had in our individual lives (Gallagher 2012, 370). This also helps to show why we are better able to understand those who are close or similar to us, and reciprocally why it is more difficult to empathize with nonhuman animals and aliens. We share similar narratives to those close and similar to us—we “already know the general lines of their stories”—making it easier for me to see how they fit into that narrative (Gallagher 2012, 370).

The reason IT is able to overcome these problems is because it differs from the other theories of mind in its most basic assumptions. To begin with, it does not start from the perspective that other minds are entirely inaccessible to me (Gallagher 2004, 204, 206; Gallagher 2009, 292). Whereas TT and ST argue in favor of an ability to understand other inaccessible minds, which cannot be perceived by us—for instance, by trying to simulate and take the perspective of what those minds would be like—IT argues, in agreement with Husserl, Stein, Scheler, and other phenomenologists, that “we directly perceive the other person’s intentions, emotions, and dispositions in their embodied behavior” (Gallagher 2009, 292). This is what is explained by primary and secondary intersubjectivity. We already understand others intentions and desires in a very basic way (Gallagher 2004, 208-209).

Additionally, unlike ST, IT maintains our context of being with others, rather than separating ourselves as observers (Daly 2014, 232; Gallagher 2004, 207-208; Gallagher 2009, 292). For ST, I separate myself from the other in order to understand the other. I turn the other

into an object of study, so that I can approach the other scientifically. IT argues that we do not normally understand others in third-person observation, but rather in “second-person interaction” (Gallagher 2009, 292). We are always interacting with others in some context, and it is in these interactions that we come to understand others.

To summarize, there are many benefits to adopting IT. It provides an explanation of empathy that matches and actually explains the way that empathy physicians to understand patients. Primary and secondary intersubjectivity provide a very basic understanding of others and narrative competency provides a more complex understanding of others. Additionally, possessing narratives allows for others to be immediately situated into narratives, allowing for initial understanding. This overcomes the starting problem and creates a foundation on which further interaction can build narratives and understanding. Furthermore, these levels of IT allow us to understand others from different backgrounds and in various situations. Narratives allow others to be part of the understanding, making the understanding more other-focused and capable of being more diverse than the subject’s narratives alone.

At least one problem that should be noted with IT, however, is that it is difficult to understand where empathy fits into its levels. Based on the way that empathy is being defined—as an understanding of the other—it may be best to interpret the entire theory as explaining empathy, which can be accomplished more or less at different levels. There are the more basic understandings of others accomplished at the primary level and the more complex ones accomplished at the tertiary level. It is not that any single step in this process is empathy, but rather that all of the levels are empathy, accomplished to a greater or lesser degree. We can see strangers on the street and merely acknowledge that they are upbeat or gloomy, and we can also sit down with our friends and discuss our thoughts and feelings, such that we know what they are

doing in their lives, why they are doing such things, and how they feel about them. All of this is empathy.

On the other hand, some have argued that empathy itself is a separate experience—it is “an essential mode of intentionality, integral to the primary level of subjectivity/intersubjectivity” (Daly 2014, 229). It is not so vague of an experience that it can be melded into or equated with all other ways of understanding the world and others in the world. Rather, empathy is a “direct, irreducible intentionality separable in thought from the other primary intentional modes of perception, rationality, memory and imagination, but co-arising with these” (Daly 2014, 229). It is at the level of primary intersubjectivity with these other forms of intentionality, but it cannot be reduced to them. If this is the case, then only primary intersubjectivity would be the level at which empathy occurs, while the others would be built on this empathy. The best way to interpret this remains unclear until we can clarify the affectivity of empathy.

4.3 Affective Reversibility

One of the major limitations of Gallagher’s approach is his lack of a solid explanation for the affective aspects of empathy. This is largely due to the contemporary argument in which he is framing his theory. However, that is not to say that he never discusses the affectivity of empathy and intersubjectivity, nor is it to say that others have not been able to offer theories of affectivity that are compatible with IT. Gallagher does talk about affectivity in other works, and others have also built on the insights of IT to demonstrate how affectivity plays into this theory as a whole.

To begin with, he argues that empathy is not just the intellectual apprehension that the other has a mind like one’s own; it is affective at its core (Gallagher 2012, 374). Though, Gallagher has worries about the way in which we argue that empathy is affective. As he says,

“one could easily trivialize [the condition that empathy must include an affective experience] by maintaining that in any case a person is always in some affective state or other” (Gallagher 2012, 374). For an experience to count as empathy, it cannot be that one must simply experience some affect while simultaneously understanding the other. This would make the affectivity of empathy completely arbitrary, since we are always in one affective state or another, thus making every experience and understanding empathic because they are always accompanied by some affect. Rather than arguing that the affective aspect of empathy is something that accompanies empathy, it would be better to argue that empathy is an affective state itself (Gallagher 2012, 374-375). This is already importantly different from TT, in which understanding the other is purely theoretical, with no affect needed. It is also importantly different from ST, in which the simulation is one experience and the affective response is another—as demonstrated in the problem of detached concern (see chapter 1). Furthermore, it is also different from the ST approach that would argue that empathy is the mirroring of the other's affect, in the vein of emotional contagion, since Gallagher wants to argue that empathy is itself a unique affect, not that empathy is a mirroring of the other's affect.

In this way, Gallagher distinguishes between empathy and sympathy in a way that is different from Scheler's distinction. Scheler defined sympathy as a feeling for another's feeling, while empathy was a cognitive state of understanding. As should be clear by now, Gallagher is willing to maintain the definition of empathy in much the same way as Scheler, but is not so ready as Scheler to reject empathy itself. Even though he agrees with Scheler that ST explanation for empathy needs to be rejected, he diverges from Scheler by presenting a new explanation for empathy. In doing so, he is able to maintain both the definition of empathy and the usefulness of

empathy in a way that Scheler could not. Given this strategy, Gallagher can explain empathy as being an affect itself, so long as it fits with his explanation.

Within his explanation for empathy as an understanding of the other, Gallagher suspends the idea that empathy is simply some affective response to the other's affect, instead arguing that empathy is itself a special kind of intersubjective affect.

Isn't empathy, regardless of whatever other affective state it may involve, itself an affective state? That is, one can understand empathy not as necessarily taking up a secondary affective state—e.g., the sadness or outrage I feel along with you—but as being its own primary and irreducible affective state—the state of feeling empathy. In this regard empathy is a kind of *intersubjective affect*...⁸⁹ That empathy involves its own primary and irreducible affective state of feeling with another frees it from the requirement that it also must involve some secondary affective state - e.g., the real or simulated copy of the other person's affective state of sadness, outrage, etc. One could experience empathy for the other person's intellectual difficulty in solving a mathematical problem, and this empathy would itself still be a feeling. (Gallagher 2012, 375, my italics)

Anytime that one empathizes with another, it is an affect, even if one is empathizing with something that is not an affect. This is echoed in his other works as well. In an article written with Varga, Gallagher says, one's interaction with others is itself "affectively shaped", and that these affective aspects are more than just "the 'icing on the cake': they are not something added

⁸⁹ He continues, "similar to the feeling of solidarity. Whereas the feeling of solidarity may involve my feeling of being with you in the spirit of a certain project, the feeling of empathy involves my feeling of being with you with respect to your situated experience. Solidarity, however, unlike empathy, may involve the expectation of reciprocity; if I feel solidarity with you, then I would expect you to feel solidarity with me. Also, solidarity may be transitive—if I feel solidarity with you, and you feel solidarity with a third person, then, as long as the solidarity is about the same type of project, I should feel solidarity with the third person also. Empathy involves neither reciprocity nor transitivity" (Gallagher 2012, 375).

to interaction” (Varga and Gallagher 2011, 254). Again, affectivity is an essential part of the interactions that takes part in IT. It is not the case that the other is understood, and then this understanding is followed by “an affective response, which informs and motivates any subsequent action towards this Other” (Daly 2014, 228). Rather, affectivity is at the core of empathy. However, even given that empathy is a unique kind of affect, it should be asked at what level affectivity occurs. Is a specific level of intersubjectivity affective, or are all of them affective in different ways?

Anya Daly offers an answer to this question by reinterpreting Merleau-Ponty’s reversibility thesis in terms of affectivity. To reiterate from the above section on primary intersubjectivity, the reversibility thesis is very important to his argument for intersubjectivity (Merleau-Ponty 1968; 2012). In his later works, he bases reversibility in his flesh ontology, which is not presented as a solution to the problem of the other, but rather as a “transformation of the problem” (Merleau-Ponty 1968, 269). While this would be great if it is true, several of these aspects of his theory require further explanation to have a good understanding of what affective reversibility is for Merleau-Ponty, as well as how it relates to his theories of intersubjectivity and empathy.

Beginning with a brief overview of his theory of intersubjectivity, Merleau-Ponty seems to be in agreement with both Scheler and Gallagher, at least in the sense that he argues that ST empathy cannot be the basis for intersubjectivity (Bornemark 2014, 264). His argument is that any theory that begins from isolated subjects will always fail to move beyond that solipsism. So long as we begin from separated individuals—subjects and others—then we will never be able to establish intersubjectivity. Instead, he says that we need to accept the reality of a “state of pre-communication (Max Scheler), wherein the other’s intentions somehow plays across my body

while my intentions play across his” (Merleau-Ponty 1964a, 119). Directly referencing Scheler in his claim, Merleau-Ponty agrees that we need to accept a primary intersubjectivity in which there is no differentiation between subject and other—“an anonymous collectivity, an undifferentiated group life [*vie à plusieurs*]” (Merleau-Ponty 1964a, 119). It is then from this communal beginning that “there occurs a segregation, a distinction of individuals—a process which, moreover, as we shall see, is never completely finished” (Merleau-Ponty 1964a, 119).

However, even given these similarities, Merleau-Ponty does not fully support Scheler’s argument. If Scheler’s theory was fully accepted, then the differences between self and other would completely dissolve, which is just as problematic as having a strict divide between the two (Bornemark 2014, 264). A theory of intersubjectivity cannot be correct if it completely dissolves all subjects into one. Merleau-Ponty uses the reversibility thesis to overcome both of these alternatives.

Merleau-Ponty’s reversibility thesis is presented in much the same way as it was addressed with Husserl in chapter 2.⁹⁰ My hands touch and are capable of being touched; my eyes see, and are capable of being seen (Merleau-Ponty 1968, 143). He argues that my body is reversible with itself, the world, and others (Merleau-Ponty 1968, 148, 215).

[W]e situate ourselves in ourselves *and* in the things, in ourselves *and* in the other, at the point where, by a sort of *chiasm*, we become the others and we become world. (Merleau-Ponty 1968, 160)

⁹⁰ He even uses the same example of two hands touching one another: “Already in the ‘touch’ we have just found three distinct experiences Which subtend one another, three dimensions which overlap but are distinct: a touching of the sleek and of the rough, a touching of the things—a passive sentiment of the body and of its space —and finally a veritable touching of the touch, when my right hand touches my left hand while it is palpating the things, where the ‘touching subject’ passes over to the rank of the touched, descends into the things, such that the touch is formed in the midst of the world and as it were in the things” (Merleau-Ponty 1968, 133-134). He also relates this to the way that handshakes between two subjects are reversible, such that “I can feel myself touched as well and at the same time as touching” (Merleau-Ponty 1968, 142).

Reversibility creates chiasms where experiences intertwine with one another.⁹¹ This can be merely with myself—such as when my two hands touch one another—or experiences can also intertwine in the chiasm between self and world, and self and other.⁹² It is in this experience of reversibility with the other—the intertwining in the chiasm between self and other—that intersubjectivity is experienced. This corresponds well to primary intersubjectivity which demarcates an experiential understanding of the other in a very basic way.⁹³ In this sense, Merleau-Ponty argues that empathy cannot be the basis of intersubjectivity, but rather that reversibility is the basis for derived intersubjective experiences like empathy [*Einfühlung*] (Merleau-Ponty 1968, 245).

What differentiates Merleau-Ponty's approach from Husserl's is his continued focus on the importance of the otherness of the other. In fact, we are only able to experience others because "the self-experience of subjectivity must contain a dimension of otherness" (Zahavi 2001, 162). It is the otherness that I experience in myself (through reversibility) that opens me up to experiencing the otherness of the other. As Merleau-Ponty says, "others can be evident because I am not transparent for myself, and because my subjectivity draws its body along behind itself (Merleau-Ponty 2012, 368). I am both subject and object (Merleau-Ponty 1968, 137), making it such that I am never completely transparent to myself, and the other is never so opaque. There is a necessary relationship between subject and other that can neither be

⁹¹ These chiasms are established in depth, which is the most existential dimension for Merleau-Ponty (Merleau-Ponty 1968, 219).

⁹² He also argues that these reversibility's form chiasms, and that one of the intertwining of these chiasms includes the crisscrossing between senses, such as the visible and the tangible (Merleau-Ponty 1968, 133-134, 214-215). As he says, "since the same body sees and touches, visible and tangible belong to the same world... There is double and crossed situating of the visible in the tangible and of the tangible in the visible; the two maps are complete, and yet they do not merge into one" (Merleau-Ponty 1968, 134).

⁹³ This may also mean that secondary intersubjectivity corresponds to the three intertwining chiasms between self, world, and other.

transcended nor dissolved. He argues that, “the experience of my own body and the experience of the other are themselves the two sides of one same Being” (Merleau-Ponty 1968, 225).

One more important point about Merleau-Ponty’s theory is that the reversibility is only possible because subject, world, and other are all made of the same “flesh” [*la chair*] (Merleau-Ponty 1968, 205-206, 248-251), which he claims is the “element” of being (Merleau-Ponty 1968, 139). What is often called Merleau-Ponty’s *flesh ontology* is a controversial theory, the discussion of which is made even more difficult by the fact that he only really discusses it in his final, unfinished work *The Visible and the Invisible* (1968). He uses the terms “flesh” in order to denote something that has yet to be discussed in philosophy, and refers to this as an “element” to avoid equating flesh to things like matter, mind, and substance (Merleau-Ponty 1968, 139, 146-147).⁹⁴ The flesh of the body, which is “sensible for itself,” is what he calls an “exemplar sensible” (Merleau-Ponty 1968, 135). It is only because everything is of the same element of flesh that its reversibility is possible.

If it touches them and sees them, this is only because, being of their family, itself visible and tangible, it uses its own being as a means to participate in theirs, because each of the two beings is an archetype for the other, because the body belongs to the order of the things as the world is universal flesh. (Merleau-Ponty 1968, 137)

Everything being entirely of the universal flesh means that nothing transcends and is incapable of being experienced. The other is not some foreign substance that I am unable to experience and must struggle to understand. Self and other are of the same element and therefore always open to one another. Again, in this sense, there is no problem of the other “because it is not I who sees,

⁹⁴ He says, “the flesh is not matter, is not mind, is not substance. To designate it, we should need the old term “element,” in the sense it was used to speak of water, air, earth, and fire, that is, in the sense of a general thing, midway between the spatio-temporal individual and the idea, a sort of incarnate principle that brings a style of being wherever there is a fragment of being.” (Merleau-Ponty 1968, 139)

not he who sees, because an anonymous visibility inhabits both of us, a vision in general, in virtue of that primordial property that belongs to the flesh, being here and now, of radiating everywhere and forever, being an individual, of being also a dimension and a universal” (Merleau-Ponty 1968, 142).

In the context of this theory, Daly connects the affectivity of empathy with reversibility, arguing that “affective reversibility is the capacity for empathy” (Daly 2014, 228).⁹⁵ Essentially, she is arguing that our affects, which have an embodied foundation in our feelings, are reversible in the exact same way that our tactile sensations are reversible. As she says, “it is the affective reversibility internal to the subject, self-affection, which lays the grounds for affective reversibility between subjects” (Daly 2014, 234), where self-affection is “the affective reversibility internal to the subject... the empathy or fellow-feeling within the self” (Daly 2014, 235). We can imagine situations in which we sympathize in Scheler’s sense towards our own situation. I can feel sad that I was unable to spend time with a friend, but also frustrated by the same sadness when it is hindering my work. It is this self-affection that opens us up to the affects of others in affective reversibility. Additionally, world-directed emotions can be understood as reversible in the sense that, for example, my happiness about seeing my wife and my being made happy by this meeting. That is, I am both making the situation happy and being made happy by the situation. Both sides feed into the relationship, intertwining into a chiasm of affectivity. Because this cannot be avoided, Daly argues that “as soon as contact is established between subjects, apprehension of an-Other is immediately affectively charged” (Daly 2014, 236).⁹⁶

⁹⁵ Sue Cataldi also argues for an interpretation of affective reversibility (Cataldi 1993).

⁹⁶ However, Daly also notes that “the expression of this affective charge is not guaranteed” (Daly 2014, 236). That is, there need be no gestures or facial expressions in the affective relationship between subject and other.

Fitting with Gallagher's argument, this affectivity is then at the core of all of our empathizing. Or, to be more accurate, the affective reversibility at the core of our primary intersubjectivity is empathy. However, we need to be careful with the way that this argument is applied to Gallagher's theory. It seems consistent with his theory to argue that empathy is affective at its core, but not necessarily that empathy should be entirely reduced to this core. Given this, it makes the most sense to argue that all of IT is empathy for Gallagher in the sense that empathy is an understanding of the other, but that affective reversibility is the most basic level of empathy. If this is true, then it means that affectivity is always already at the core of primary intersubjectivity, which is what prompts Daly to call this kind of empathy—or affective reversibility—"primary empathy" (Daly 2014, 228, 231, 234, 237).⁹⁷

Furthermore, it is this primary empathy that strongly influences our interactions at the secondary and tertiary levels. Affective reversibility "establishes a basis of responsiveness and receptivity to others, without which interactions at the secondary level would remain mechanical and cerebral, never attaining warmth, spontaneity and virtuosity. So too at the tertiary level, without primary empathic responsiveness, subjects become vulnerable to the lure of dubious ideologies, to the seductions of power and all its corruptions" (Daly 2014, 237). This echoes the fears of Sartre that my gaze always objectifies the other, while the gaze of the other always necessarily objectifies me. However, while this is possible, neither Merleau-Ponty nor Daly think that this is the norm, especially not at the level of primary intersubjectivity, where affective reversibility takes place. As Merleau-Ponty says,

⁹⁷ What this means is that intersubjectivity is established immediately in our perceptions of others, and all of our perceptions are also affectively shaped. As Daly says, "when there is co-perception there is also empathy; perception, affect and empathy are co-arising modes within a single process of engaging with the world and others" (Daly 2014, 232). Furthermore, primary empathy serves as the foundation upon which all other intersubjective affective engagements are established, such as "pity, sympathy, affective matching, perspective taking etc., [which] arise at the secondary level" (Daly 2014, 231).

It is said that a choice must be made between others and myself. But one is chosen over the other, and thus both are affirmed. It is said that the other transforms me into an object and negates me, and that I transform the other into an object and negate him. But in fact, the other's gaze does not transform me into an object, and my gaze does not transform him into an object, unless both gazes draw us back into the background of our thinking nature, unless we both establish an inhuman gaze, and unless each senses his actions, not as taken up and understood, but rather as observed like the actions of an insect. This is what happens, for example, when I suffer the gaze of a stranger. But even then the objectification of each by the other's gaze is only harmful because it takes the place of a possible communication. (Merleau-Ponty 2012, 378)

In our ordinary, everyday experiences of others and interactions with them, we experience them as subjects. We do not instinctually reduce them to objects. It is only when we intellectualize and over-think our intersubjectivity that others can be objectified. In other words, it is only when we adopt theories about others and try to apply them that others become objectified. This can be as innocent as trying to understand others by applying theories, but also as damaging as applying racist or sexist narratives that can corrupt the genuine understanding of others as subjects.

Even if this theory of affective reversibility is accepted, the nature of affectivity itself still needs to be explained.⁹⁸ What exactly are affects such that they can be reversible? Does the explanation of empathy correspond with this theory of affectivity? Sadly, Gallagher does not offer any more information about affectivity than he does the affectivity of empathy. At best, it is

⁹⁸ As Svenaeus says, “Getting beyond the feeling or thinking dispute of empathy we still have to answer the important question of exactly what sort of feeling empathy is. Empathy is potentially rich in cognitive content, but as an emotion it does not appear to be of one certain type, such as love, hate, jealousy, pride, etc. Taking our starting point in the experiential characteristic of empathy—how it feels—it seems to be hard to pin point what sort of feeling it truly is” (Svenaeus 2014b, 296)

clear that he does not want to characterize empathy as being a value-judgment, even though it is an affect (Varga and Gallagher 2011, 251-252, 255). In this sense, affectivity is different from the theories of Scheler and Stein, both of whom thought that affects were value-judgments. A further discussion of the phenomenology of affectivity in general, as well as how it might apply to this theory occurs in the next chapter. For now, it is sufficient to note that this aspect of empathy is still not fully addressed in Gallagher's IT.

4.4 Conclusion

Gallagher's answers to the three questions of empathy can be summarized as follows:

Empathy: Defined in line with the theory of mind debate, it is an understanding of the other, which can be achieved at different levels. Rather than being based on theories or simulations, this understanding is accomplished in our interactions with others.

Intersubjectivity: There are three different levels: primary intersubjectivity, secondary intersubjectivity, and narrative competency (tertiary intersubjectivity). The starting position is primary intersubjectivity, which is immediate and pre-reflective, and serves as the most basic way in which we experience and understand others; secondary intersubjectivity opens us up to the world with others, establishing an understanding of a mutually accessible world; and narrative competency includes both the store of narratives and the skills for constructing narratives with others that help to develop a more complex understanding of diverse others.

Affectivity: While at the core of empathy, his views concerning the relationship between affectivity and empathy are not entirely clear. Applying Daly's alteration of Merleau-

Ponty's theory of reversibility into affective reversibility, it can be argued that there is a very basic felt experience of our reversibility with others. In this sense, empathy is a unique kind of affect, because it is an experience of the reversibility of our affectivity with others.

This establishes intersubjectivity and empathy as more intimately intertwined than in the previous two phenomenological theories. Again, Husserl and Stein isolated the subject in transcendental solipsism and needed empathy to solve the problem of intersubjectivity, while Scheler melded all subjects into an undifferentiated stream, making empathy a secondary skill that was not necessary (and maybe even detrimental) to intersubjective understanding. Gallagher's theory, on the other hand, begins in a similar primary intersubjectivity as Scheler, but one that is far more influenced by Merleau-Ponty. There is evidence of a very early understanding of others—of a primary intersubjectivity. However, this is not the only level at which other can be empathically understood.

By adding secondary and tertiary levels of intersubjectivity, and intertwining them with empathy as an understanding of the other, Gallagher presents a theory of intersubjectivity that does not need empathy to solve its problems, while also maintaining empathy as an important skill. Empathy is a multi-leveled understanding of the other that can either be experienced in a very basic way at the primary level, or pursued to a more complex understanding at the tertiary level. However, while I argue that Gallagher best answers the first two questions for theories of empathy, his answer to the third questions is still lacking. In other words, the problem that remains with Gallagher's theory is the lack of emphasis that is given to the affectivity of empathy.

While he does say things that seem to indicate that he thinks empathy is an affective experience, he does not take the sufficient time to explain how it is affective. Additionally, he does not have a specific theory of affectivity that can be used to help solve this problem. For this reason, I turned to Daly's work on Merleau-Ponty, intersubjectivity and affectivity as a reasonable means to fill this gap in IT. Affective reversibility does seem to fit Gallagher's theory nicely, but the lingering problem is the lack of a clear understanding of affectivity itself and how it plays into empathy. In other words, even if affects are reversible and this is at the core of empathy, it still needs to be asked exactly what are affects here such that they are reversible. There are many theories of affectivity for which this claim of reversibility would simply not make any sense. It is this continuously neglected question of the affectivity of empathy that I pursue further in the final chapter.

Chapter Five: Clinical Empathy Beyond Detached Concern

In chapter 1, three different problems were addressed concerning the traditional ST view of empathy in medicine. They were the arbitrariness of the definition of empathy, the epistemological problem of how physicians understand patients, and the problem of detached concern. From these, three intertwining aspects of empathy were identified, such that any theory of empathy would be incomplete if it failed to address them. These are the explanation, intersubjectivity, and affectivity of empathy. The previous chapters have all explained prominent phenomenological approaches to the topic of empathy, revealing their strengths and weaknesses based on how well they address these three aspects of empathy.

In these chapters the primary focus was on the close connection between the explanation for empathy and the intersubjective context of this explanation, while revealing how the affective dimension of empathy is either left poorly addressed or addressed as an entirely separate topic. In other words, the discussion of empathy is at the intersection of two separate discussions—intersubjectivity and affectivity—such that the theories presented in both of these areas should be equally important to the definition and explanation of empathy. Instead, however, the discussion of empathy has been focused almost entirely on the discussion of intersubjectivity, sometimes to the point that there two are seen as synonymous. I maintain that this is a serious deficiency in attempts to explain empathy.

While some may not see the affectivity of empathy as important to the concept, or claim that we are simply talking about two very different experiences, I object that these are merely attempts to sidestep a serious issue in the discussion of empathy, and do so in the face of our

lived experience of empathy. This is revealed in the problem of detached concern that arises in medicine, in which the disregard for the affectivity of empathy would still allow for the acceptance of non-affective theories of empathy, but only at the cost of serious problems in patient care. Because empathy has been implemented and understood as a largely cognitive skill, when adopted as important for clinical interactions, the result is a largely cognitive clinical empathy. Therefore, I argue that the theories of empathy addressed in the previous chapters, while providing promising theories for the first two aspects of empathy, in failing to address the affectivity of empathy, they have still failed to provide a promising solution to the problem of detached concern. In fact, it is clear that the affectivity of empathy has been a continuous issue in the history of the topic of empathy as a whole. As such, the affectivity of empathy needs to take the forefront of the discussion in order to regain equal footing with the intersubjectivity of empathy. In order to build on the insights that IT brought to intersubjective understanding, I address the affectivity of empathy by examining contemporary theories of clinical empathy and how they discuss affectively-aligned empathy as the solution to the problem of detached concern. This is divided into two parts.

In the first part, I explain phenomenological insights in the philosophy of affectivity and how these relate to the problems that arise in the affectivity of empathy. I begin by briefly reviewing the problem of detached concern in medicine and how it affects the physician's understanding of the patient. Following the problems caused by detached concern outlined in chapter 1, I explain the shift that empathy made in medicine from being equated with the overly-affective experience—what some now call sympathy, in the place of empathy—to being equated with the overly-cognitive skill of detached concern. This divide between sympathy and detached concern in medicine is rooted in the feeling/cognitive divide commonly discussed in the

philosophy of emotion. I explain this divide, as well as explain some important insights from the phenomenology of emotion that have helped to overcome this false dichotomy in the philosophy of emotion.

In the second part, I examine three different contemporary approaches to defining clinical empathy, and assess them as they relate to both the phenomenology of affectivity and the phenomenological theories addressed in the previous chapters.⁹⁹ This will serve to highlight their common strengths and weaknesses, and thus the improvements that are needed for theories of clinical empathy. First, I explain the application of IT to clinical empathy. Narrative medicine has gained favor in recent years, and has useful applications beyond the insights of IT in the phenomenology of mind. Second, I explain Halpern's theory of empathy as engaged curiosity. Halpern researched the problem of detached concern in great detail and her theory of empathy is a direct response to the problem as it has been outlined here. Her theory also serves as a way to expand on the insights of narrative medicine that better accounts for the affectivity of empathy. Finally, I explain Petra Gelhaus' approach to the clinical empathy, which I call *clinical affectivity*. This is because she discusses empathy without making it the primary focus. Rather, she focuses on multiple, interrelated affects, all of which physicians need to cultivate. I argue that none of these theories is sufficient on their own to account for clinical empathy, but each has its own insights that can be used to develop a better theory.

⁹⁹ This is not meant to be a survey of all contemporary theories of clinical empathy. Instead, I limit the scope of this chapter to those theories that directly tackle the problem of detached concern by presenting theories of empathy as an affect.

5.1 The Problem of Detached Concern, Revisited

To reiterate from the first chapter, the ideal of detached concern, which is enmeshed in the naturalistic attitude, results in four problems for physicians.

- (1) There is a lack of understanding for the patient's affects;
- (2) There is a lack an attunement to the physician's own affective reactions to patients;
- (3) There is a lack of understanding for the relationship between affects and beliefs; and
- (4) There is a lack of affective engagement with the patient.

All of these problems can be attributed to the lack of concern for the affective aspects of our lives, including the devaluing of affective ways of knowing in general. This can be shown through the shift in the conception of clinical empathy, as demonstrated by the advent of the ideal of detached concern. While empathy itself is revalued in this shift, affectivity remains devalued. It is still understood as a problematic experience that physicians should avoid.

5.1.1 The Feeling/Cognitive Divide

As Halpern notes, the problem with the naturalistic attitude of traditional medicine is that it leads to a problematic dichotomy between detached concern and sympathy (Halpern 2001, 15, 67). While she does not talk specifically about the naturalistic attitude, she does explain the way that traditional medicine developed such that detached concern was championed over affective engagement (Halpern 2001). Before empathy was equated with detached concern, it was initially understood to be a risky, purely subjective, affective response to the patient. This led to the traditional rejection of empathy due to the fear that even calm emotions are unreliable sources of information, disrupt thinking, and therefore only negatively influence medical judgment (Halpern 2001, 30).

With the increasing desire for physicians who are more than just scientists, empathy was recommended as a skill that many thought would improve the relationship between physicians and patients. However, unwilling to reject the predominantly negative view of affectivity, empathy was merely appropriated into medicine, stripped of its affective dimension. This causes a tension between “whether empathy is an emotional engagement between patient and physician or is a purely intellectual form understanding patients” (Halpern 2001, 17). It is the latter that was the goal in medicine: a skill that can help the physician understand patients without any risk of the emotional attachments of sympathy (Aring 1958). This solves the problems of the lack of empathy, but in such a way that maintains the supposed objectivity of the field. As Halpern says, “the ideal of detached concern is justified by the argument that only an unemotional physician is free to discern and meet patients’ emotional needs without imposing his own” (Halpern 2001, 25). In effect, clinical empathy became the overly-cognitive detached concern, and sympathy became relegated to the overly-affective position empathy once held—as the subjective, affective response to the patient (Aring 1958; Blumgart 1964; Halpern 2001, 18).

However, this is really only a shift in terms and not a genuine solution to the problems caused by the lack of empathy in medicine. The way in which physicians approach their patients is still as objects of scientific observation. It creates an environment in which patients are meant to be studied in order to learn the objective facts of their conditions. People, however, are not merely physical bodies, and they cannot be understood as such. Empathy as detached concern causes a false sense of understanding that can cause problems in diagnosis and treatment, as well as the other problems explained in chapter 1. In short, within the context of the dichotomy between detached concern and sympathy, the prescription of empathy became tainted. Rather than trying to describe empathy as it actually is or define it as an affect in any way, the goal was

to “distinguish a special kind of detached ‘empathy’ from sympathy” (Halpern 2001, 17). The traditional divide between the affective and the cognitive—between the subjective and the objective—is maintained even in the prescription of empathy.

This division in the conception of affectivity is not a new one. While the discussion of this dichotomy in the conception of clinical empathy is a relatively new one in, it is a well-known divide in the philosophy of emotion. For most of the recent history of western philosophy, there have been two dominant theories in the philosophy of emotion: feeling theory and cognitive theory (Griffiths 1997; Solomon 1973, 2003, 2006). Though there have always been promising alternatives to this dichotomy, it wasn’t until recently that they have gained any significant attention. This divide directly mirrors the sympathy/detached concern divide in clinical empathy and examining it will be useful in revaluing the genuine affective engagement of clinical empathy.

Traditional feeling theory argues that emotions can be reduced to the sensations that we feel and the behaviors that we exhibit when in an emotional state.¹⁰⁰ William James, one of the first major proponents of feeling theory, argued that if we were to abstract away all of the physical manifestations of an emotion, then there would be nothing left of the emotion. When we think of emotions as things that are actually “in the head” we are making a mistake. James’ view is that “the bodily changes follow directly the perception of the exciting fact, and that our feeling of the same changes as they occur is the emotion” (James 1884, 189-190). The physical manifestations are not simply coincidental side-effects of the mental emotion. The perception of the manifestations itself simply is the emotion.¹⁰¹ Take fear for example. If we try to describe

¹⁰⁰ I say “traditional” here to distinguish it from more recent attempts to rethink feeling theory within phenomenology, as well as attempts to merge and find a compromise between feeling theory and cognitive theory.

¹⁰¹ He has a very simple thought experiment that one can use to highlight that which is necessary for an emotion: “If we fancy some emotion, and then try to abstract from our consciousness of it all of its characteristic bodily

fear, we would not be able to do so without describing the increased heart rate, shortness of breath, trembling, urge to run, and so on. If we then slowly abstract away all of these manifestations of the emotion, what is left? What can we describe? James' answer is "nothing." If we did not have the trembling and urge to run from a bear, then we have nothing of which to be conscious, and therefore would not be afraid.¹⁰²

Many use James' theory as a launching pad, giving his theory a poor characterization (Ratcliffe 2008, 17, 20, 219). This theory effectively equates emotions with merely bodily states, making them seem as if they can only provide us with subjective knowledge of ourselves. At best, when I perceive my feeling, my awareness of them alerts me to my own interpretation of the world. They tell me how I feel about the world, but not how the world *actually is*, in an objective sense. This view of emotions as mere feelings has often been used to argue against the value and use of all emotions. Emotions are merely non-cognitive, bodily reactions to the world that more often than not confuse and derail proper reasoning and other cognitive processes. In the same sense, sympathy is depicted in medicine as being merely my feeling some way towards the other's situation. It is a subjective reading of my reaction to the other. However, in the same way that philosophers of medicine sought to revalue empathy by distancing it from sympathy, philosophers of emotion sought to revalue emotions by distancing them from feelings.

symptoms, we find that we have nothing left behind, no 'mind-stuff' out of which the emotion can be constituted, and that a cold and neutral state of intellectual perception is all that remains" (James 1884, 193).

¹⁰² This does not mean that he is denying all cognitive aspects of emotion, but he does not think that our emotions would be at all the same if we abstract away the bodily manifestations. As he says, "Without the bodily states following on the perception, the latter would be purely cognitive in form, pale, colourless, destitute of emotional warmth. We might then see the bear, and judge it best to run, receive the insult and deem it right to strike, but we could not actually feel afraid or angry" (Quote)[James 67]. The emotion would be hollow without the feeling. It would be no different than when we judge that vegetables are healthy. A judgement is being made about the world, but it wouldn't matter to me in the same way as when I feel happy, or disgusted, or frustrated about the situation in question.

Cognitive theories of emotion have become much more popular in recent years in response to feeling theories (Damasio 1999; De Sousa 1989; Lazarus 1994; Nussbaum, 1997; Schachter and Singer 1962; Solomon 1973), arguing that emotions are more than mere feelings. There are several different kinds of cognitive theories of emotion, but they share the argument that feeling theory makes emotions seem like dumb, brute sensations that are no different from any other sensation. Cognitive theorists argue that emotions may correspond to certain feelings or have certain necessary felt aspects, but these feelings are not the entirety of the emotion. They are not even the most important aspect. When emotions are understood as nothing more than feelings, emotions are taken as being opposed to reason, and therefore something that should be avoided. In contrast, cognitive-theorists argue that emotions are not contrary to reason; they are necessary for proper reasoning. They do so in a few different, but similar ways.

To begin with, cognitive theorists have accepted and incorporated the phenomenological insight that emotions have intentionality (De Sousa 2007, 326; Lazarus 1994; Solomon 1988, 185; 1995, 191). They are not merely about oneself or one's body in the sense of feelings. They are about things in the world. This allows emotions to be possible sources for objective knowledge. Additionally, many cognitive theorists argue that emotions serve as judgments or appraisals of the world (De Sousa 2001; 2007; Lazarus 1982; 1984; 1991; 1994; 2006; Nussbaum, 1997; Solomon 1973; 1988; 1992; 1995; 2002). This is similar to what Stein and Scheler argue about perceiving objective values in the world. However, the discussion of emotions by these philosophers often makes emotion sound more like highly-cognitive processes of judging the world than conation of objective value relationships. That is, rather than being understood as bodily (in the sense of feelings) emotions are understood as being things in the head. They are understood as being processes of the brain that are directed at the world as a

means of making sense of the world. In the same way, ST and other cognitive theories of empathy convert empathy into a process that we run either consciously or subconsciously in order to understand the other. It is not a feeling in the body in response to the other. Rather, it is a cognitive process intended to provide an understanding of the other.

Additionally, most cognitive theorists also argue that emotions are rational (or at least important to reason) (Damasio 1999; 2003; 2005; De Sousa 1978; 1987; 1989; 2001; 2007; Lazarus 1982; 2006, 19; Solomon 1973; 1988; 1992; 2002). For example, consider the examples of Phineas Gage and Elliot that Antonio Damasio uses in his book *Descartes' Error* (Damasio 2005).¹⁰³ In both cases, damage to the prefrontal cortices of the brain resulted in a loss of emotion. While both seemed to have little effect on the abstract intelligence—as measured by IQ, social aptitude, and ethical response tests—their everyday interactions were drastically altered, and both subjects' lives fell apart in spite of their best efforts. Through these examples, Damasio argues that damage done to the emotional centers of the brain can drastically alter the way in which people reason in everyday life. The only noticeable changes were a loss of emotion and a deficiency in their everyday reasoning abilities. Emotions cause us to focus on only that information, and those tasks, which are best suited to our goals. Without emotions, we are unable

¹⁰³ The first is a historical case of Phineas Gage. While working one day, he accidentally hammered his tamping rod directly against some gun powder, causing an explosion that sent the rod straight through his skull. He survived, but with serious damage done to his prefrontal cortices. All things considered, Gage seemed to be fine. His intelligence appeared to be intact. However, despite what appeared to be a full recovery, he found himself unable to function in normal life. He couldn't accurately prioritize things at work, nor could he interact properly with his family and friends. It was as if Gage had both survive and not survived the accident. He physically survived, but some key aspects of him were missing. The second case is a more contemporary version of the historical case. Elliot had a tumor that grew to the point that it crushed his prefrontal cortices and, like Gage, his life was greatly affected. He was unable to prioritize tasks at work, often obsessing over a single task for hours. His wife divorced him because he no longer seemed able to empathize with her. He remarried and lost all of his money to another woman, despite the pleas from his friends that he was making a mistake. In addition, he discussed all of this with others with an air of disconnection, as if it had not happened to him. Tests revealed that he still had an average—if not a little above average—IQ, and that he retained all knowledge of how he ought to act in social situations. By all accounts, it would seem that his rationality was entirely unaffected by the damage to his brain. However, when it came to acting in everyday situations, his ability to reason properly was hindered.

to see one task as more important than another at work, or understand the possible pitfalls in some of our social dealings.

All of these theories sought to revalue emotions by bringing them into the dominant view that reasons should trump our brute feelings (rather than trying to revalue the importance of feelings).¹⁰⁴ The result of this debate is a divide between the useful, rational emotions and the brute, irrational feelings. Emotions were viewed as no more than feelings—physical reactions to the world—then, in order to revalue emotions, they were reinterpreted as primarily cognitive phenomena. This directly parallels the shift in medicine from understanding empathy to be purely affective engagement with the other to understanding it as a purely cognitive engagement with the other. Drawing this parallel is important for two reasons. First, it establishes the problem of the affectivity of empathy to be grounded in the already established discussion of the nature of affectivity itself. Second, it better reveals possible solutions to describing the affectivity of empathy (and clinical empathy) where there is not much literature on the topic itself. In the next section, I examine the phenomenology of affectivity as a way to overcome this base dichotomy in the philosophy of emotion that is causing problems for the affectivity of empathy.

5.1.2 Phenomenology of Affectivity

There is a rich history of discussing affectivity in phenomenology, and it is one of the few philosophical traditions that genuinely appreciated the importance of affects to our epistemologies, ontologies, and ethics. However, due to this rich tradition, it would be inaccurate to group all phenomenologists under a single theory. While there are a few features of affectivity

¹⁰⁴ Not all responses to cognitive theories have been positive (Calhoun 2003), some philosophers arguing that the discussion of emotions in terms of cognitions fails to grasp their diversity (Greenspan 1988; Stocker 1996). In the next section, I focus specifically on phenomenological alternatives to cognitive theories.

that have a significant consensus among phenomenologists, they do not all agree with each other on the nature of affectivity or even the nature of specific affects like emotions, moods, and feelings. For instance, as already discussed in previous chapters, Scheler and Stein argued that affects are perceptions of value in the world (Scheler 1992, 85; Stein 1989, 101). However, other phenomenologists, such as Merleau-Ponty, argue that (at least some) affects precede what could be called a valuation (Merleau-Ponty 2012, 166). As a result of this disagreement, as well as other disagreements like it, it is not possible to address every phenomenologist's views on every affect.¹⁰⁵ Instead, I will limit the discussion to the most important insights from the philosophy of affectivity, especially as they relate to the discussion of empathy.

To begin with, traditional philosophy of emotion is just that—a philosophy of *emotion*. The focus was on emotions and what distinguished them from other experiences, whether they be cognitions or felt sensations. The problem with this focus is that other affects, such as feelings and moods, become lost in the discussion. They are at best reduced to emotions or seen as special kinds of emotions, and at worst distinguished from emotions and seen as unimportant. This is the problem that Ratcliffe sees in the discussion of feelings in traditional philosophy of emotion (Ratcliffe 2005, 2008). As he argues, both feeling-theorists and cognitive-theorists are wrong in the way that they talk about feelings. Both see feelings as no more than physical sensations and gestures. The only difference between the two theories is that feeling-theorists then argue that this is what emotions are as well, while cognitive-theorists argue that emotions are different from feelings. Contrary to these theories, Ratcliffe argues that feelings are a much more nuanced set of phenomena (Ratcliffe 2008, 219).¹⁰⁶ These theories misunderstand the intentional structure of

¹⁰⁵ I do, however, recommend this for future works exploring the affectivity of empathy.

¹⁰⁶ He also notes that James noticed this as well, and is often mischaracterized when people talk about his philosophy (Ratcliffe 2008, 219).

feelings (Ratcliffe 2005, 48-49). Instead, feelings should be understood as (more or less) separate phenomena from emotions, but no less important as concerns our experiences of the world.¹⁰⁷

In addition to feelings, moods are understood as very important affects in phenomenology (Guignon 2003; Ratcliffe 2002; 2012; Slaby 2012; 2014b; Solomon 2006). Like feelings, they are unique in the way that we experience them and should neither be reduced to nor entirely divided from emotions. The discussion of moods, or attunements, in phenomenology most often traces back to Heidegger (BT 172-179/134-140). Attunement was a topic that was important to Heidegger, as evidenced by the extent to which he focused on moods, rather than on emotions and feelings. However, while Heidegger's terms are often translated as "mood" and he is often appealed to in the discussion of moods, it should be noted that "mood" may not be the best translation of the term being used by Heidegger. For instance, both *Befindlichkeit* and *Stimmung* have been translated as "mood," but both may be better translated otherwise.

As Jan Slaby notes, *Befindlichkeit* might be better translated as "findingness" (Slaby, 2014, 5; see also Ratcliffe 2013, 157). Translating it as "mood" is too narrow of an English term to capture exactly what is meant by *Befindlichkeit*. Slaby says, "moods, in brief, are the ontical concretions of the ontological structure 'findingness'. So that Dasein in 'finding' (ontologically)

¹⁰⁷ Ratcliffe expands on Heidegger's theory of moods with his own theory of existential feelings. Existential feelings are "feelings in the body, which are experienced as one's relationship with the world as a whole" (Ratcliffe 2005, 49). These include feelings of being "'at home' in the world, 'absorbed' in it or 'at one with life,'" in which "the body often drifts into the background" (Ratcliffe 2005, 49). Ratcliffe often uses the Capgras delusion as a way of explaining existential feelings. In this delusion, patients believe that their loved one's have been replaced by impostors. Patients acknowledge that their loved ones look and act the exact same, but swear that they are not really them. Ratcliffe argues that patients with this delusion suffer from a breakdown of their existential feelings (Ratcliffe 2005, 55; 2009a, 207; 2009b, 188). In other words, the patient still perceives her loved ones, but she perceives them without the feelings through which she normally perceives them. There is a certain felt relationship with loved others, and without it, they appear empty and fake. This example demonstrates how essential existential feelings are for us in the way that they, like moods, "shape the various ways in which things can be experienced" (Ratcliffe 2005, 46). In general, they can be defined as "ways of finding oneself in the world" (Ratcliffe 2005, 45). These can be either foregrounded in the body such that I explicitly feel my "'belonging," "completeness," and "feeling of being an American," or they can be foregrounded in the world such that others appear to be loved ones or strangers in the feeling.

means that it is constantly attuned to its surroundings” (Slaby, 2014, 5). In other words, moods are manifestations of findingness. When we describe what is going on in a mood, we do so “in terms of findingness” (Slaby, personal correspondence). Likewise, Charles Guignon notes the problems with translating *Stimmung* as “mood.” As he says, “The word *Stimmung* is derived from the verb *stimmen*, which means ‘to tune,’ as in tuning a piano, and it is clearly related to *bestimmen*, meaning ‘to determine’” (Guignon 2009, 196). For this reason, as he notes, it may be better to translate *Stimmung* as “attunement,” rather than mood, since it is “our way of being ‘tuned in’ to the current situation” (Guignon 2009, 196). A mood is an attunement to the significant features of the world.

However, despite this terminological confusion, the discussion of moods in the phenomenology of affectivity has remained prominent. Whereas emotions may come and go, and we will sometimes lack an emotional response to the world, we are always in one mood or another (BT 173/134). Moods change, but they are always present. There is no time in which I lack a mood, and with good reason. As Ratcliffe notes, “in the absence of mood, we would not find ourselves in a world at all and would therefore cease to be *Dasein*” (Ratcliffe 2012, 157). This is because moods are the way in which the world is capable of showing up for us as significant (Ratcliffe 2013, 159). If I was not in one mood or another, then nothing would be able to show up as significant to me, and therefore I would not find myself in a world.

In addition to the needed inclusion of multiple affects in the discussion of affectivity, one of the most important features of affects that originates from phenomenology is their intentionality (Brentano 1971; Husserl 1989, 117; Merleau-Ponty 2012, 88; Slaby 2007; 2010; 2014c; Solomon 2006). Intentionality is the aboutness of any thought, desire, perception, emotion, and so on. However, when talking about the intentionality of affects, it is important to

not interpret this as something that the subject possesses that it literally pointing at something in the world. As Sartre argued in his attempt to get away from the view that emotions were things in our heads that we directed at the world, emotions are transformations of the world (Sartre 1962, 27, 39). To be clear, he is not arguing that emotions are things we do to transform the world. It would actually be more accurate to say that the transformation of the world itself *is* the emotion. The emotion is not an object in us or in the world—it is not some subjective action that alters the perception of the objective world. The emotion is a mode of being in the world (Sartre 1962, 35). It is our relationship to the world, that we can change at any moment, as if by *magic* (Sartre 1962, 40). It is “a sudden fall of the consciousness into magic; or, if you will, emotion arises when the world of the utilizable vanishes abruptly and the world of magic appears in its place” (Sartre 1962, 60-61).¹⁰⁸ Though, as something that happens to consciousness, Sartre does see emotions as either originating in the subject or in the world (Sartre 1962, 57).¹⁰⁹

Furthermore, intentionality can also be used to distinguish among different affects. For instance, emotions are usually seen as being directed at the world, while feelings are more commonly understood as having one’s own body as their intentional object (Solomon 2006, 414). That is, feelings, which are felt in the body, must be about the body because that is where the feelings direct our attention (Ratcliffe 2005, 44). Alternatively, emotions can be experienced

¹⁰⁸ True emotions involve genuinely believing in one’s relation to the world. As he says, “during emotion, it is the body which, directed by the consciousness, changes its relation with the world so that the world should change its qualities. If emotion is play-acting, the play is one that we believe in” (Sartre 1962, 41). It is not merely the behavior of the body, which would be play-acting, but is rather “the behaviour of a body that is in a specific state” (Sartre 1962, 50). Both are required. Behavior without the belief state is just play-acting, but belief without the behavior is not the emotion either, since the state itself may not actually cause any behavior. To have a true emotion, one must believe in their magical behavior, and “to believe in magical behaviour one must be physically upset” (Sartre 1962, 50).

¹⁰⁹ In order to clarify situations when the subject magically alters the world, consider Sartre’s grape example (Sartre 1962, 41-42). A person sees grapes that she initially wants because they look ripe and delicious, but when she discovers that they are hopelessly out of reach, she shrugs her shoulders, says that the grapes are “too green,” and gives up the pursuit. In this example, her frustration and upset are transformations of the world such that the once appealing grapes are no longer appealing. She is no longer pulled to the grapes in the same way that she previously was. He argues that all emotions are like this.

even when they are not felt (Merleau-Ponty 2012, 88). However, there are those who have critiqued this view, arguing that feelings are also intentionally directed at the world (Ratcliffe 2005).¹¹⁰ Moods, on the other hand, are usually understood as either lacking intentionality or having a more general intentionality—that is, being about one’s relation to the world in general (Guignon 2003, 188; Solomon 2006, 417). In fact, they tend to inform what will even show up as intentional objects in our perceptions of the world. This includes what emotions and feelings we will be susceptible to.

This view of intentionality should be expanded, such that it would be inaccurate to see them as originating in specifically the subject or the world (Merleau-Ponty 2012, 88). It is true that affects should be acknowledged as embodied experiences, but that does not mean that they originate in the body, and then are directed at the world. Rather, it means that they cannot be understood as world-directed and *disembodied* (Slaby 2014c; Zahavi 2010). They are the relationship between one’s embodied self and the world (and other subjects) (Merleau-Ponty 2012, 88; Sartre 1962). They are in the depth between subject and world (Cataldi 1993; Merleau-Ponty 1968), but not specifically possessed by either.

Additionally, as embodied experiences, the intentionality of affects should not be understood as a stationary intentionality, but rather a motor intentionality (Merleau-Ponty 2012, 88; Sartre 1962, 50; Schmitz 2011, 256-257; Slaby 2014c; Solomon 2006, 419). Especially when it comes to emotions, it is argued that emotions have motor intentionality in ways that other affects do not, such that their intentional objects call for some actions over others based on what

¹¹⁰ Essentially, the problem is that philosophers have traditionally characterized feelings as being merely bodily sensations that one is always conscious of, and have niobium’s intentionality aside from that directed at one’s own body (Ratcliffe 2005, 44). Ratcliffe argues that this characterization of feelings is based on a common misconception between where a feeling is located in the body and what the feeling is of (Ratcliffe 2005, 48). That is, “feelings of the body and feelings towards objects in the world are two sides of the same coin, although one or the other will usually be foregrounded in experience” (Ratcliffe 2005, 48-49). As such, we are not always conscious of our feelings, which do have intentionality, but can be directed either at the body or the world (Ratcliffe 2005, 44).

we can and cannot do in the world (Merleau-Ponty 2012, 88). They are transformations of the world such that it calls for certain actions. In his work, Merleau-Ponty makes a necessary move from thought-based intentionality to motor intentionality. Merleau-Ponty claims that I am not even an “I think that,” but rather an “I can” (Merleau-Ponty 2012, 139). In being a body, I cannot be reduced to my thoughts. My thinking is not my original manner of existing in a world. The body aims at the world and is directed toward things in the world (Merleau-Ponty 2012, 140). We do not perceive the world in the Cartesian sense, by representing it in our minds and then acting in it with our bodies. Intentionality is not stationary in this way. When we perceive a thing, we perceive it as something we can move towards, away from, around, and so on. It is something with which we can interact.¹¹¹

Our freedom and control over our affects is also important to the overall understanding of affectivity, especially as it will relate to clinical empathy. While there are exceptions in the phenomenological tradition (Sartre 1962), most phenomenologists appreciate that affects occur prior to our willing and reasoning.¹¹² Specifically, Merleau-Ponty argues that emotions must be acknowledged as “beneath the level of ‘will’” (Merleau-Ponty 2012, 166).¹¹³ They are already

¹¹¹ Schmitz expands on this idea with his own philosophy of “the vital drive.” This is “formed by the intertwining of tendencies towards contraction and expansion (*Weitung*) running counter to one another” (Schmitz 2011, 249). One is either pulled towards movement in the world or contracted back towards themselves. This is especially the case with an emotion, which “moves corporeally by stirring the vital drive composed of expansion and contraction” (Schmitz 2011, 257).

¹¹² Freedom is a very important aspect of emotion for Sartre. One chooses to be in one motion or another—one chooses to change the world in order to better cope with it (Sartre 1962, 25). This makes emotion a kind of escape behavior (Sartre 1962, 42). As he says, “lacking both the ability and the will to carry out the projects I formerly entertained, I behave in such a manner that the universe requires nothing more from me” (Sartre 1962, 44). It is a magical “abandonment of responsibility” (Sartre 1962, 45). And any denial of freedom and responsibility for Sartre is a sign of “bad faith” (Solomon 2006, 318). In this sense, emotions are a kind of willful escape from reality (Sartre 1962, 26, 30). When one becomes angry at a situation, one is choosing to respond to the situation in this way. The anger is a symbolic response; it “is an abrupt solution of conflict, a way of cutting the gordian knot” (Sartre 1962, 25). When one finds oneself in a situation with which one is unable to cope, the emotion acts as the simple solution to one’s struggle.

¹¹³ Consider his example of someone with a phantom limb. As he defines it, phantom limb is a way in which I am still directed at the world as if I have an arm (Merleau-Ponty 2012, 83-84). I can reach for objects or reach to balance myself with limbs that no longer have a felt existence, which demonstrates the more ambiguous existence of the phantom limb. The deficiency only becomes apparent when my directedness with the missing limb fails

being experienced and affecting the way that we perceive the world well before we become aware of them. We do not possess the high level of agency and free will that philosophers like Sartre grant us over our emotions (Merleau-Ponty 2012, 166; Schmitz 2011, 254). Nor do affects function like judgments, inferences, and/or valuations in the way that cognitive theorists and, to an extent, Scheler and Stein argued. Rather, as Merleau-Ponty says in a discussion of a particularly strong emotion, a person in an emotional state “plunges into it as if into a shelter, he scarcely hears any longer, he scarcely sees any longer, and he has almost become this spastic and breathless existence... For every moment that goes by, freedom degrades and becomes less likely” (Merleau-Ponty 2012, 166). Emotions, as well as moods and feelings, affect the way in which we perceive the world and the way in which we reason. As Schmitz argues, we always find ourselves already in an emotion, which then makes it much harder to locate, identify, and describe than other corporeal stirrings (Schmitz 2011, 254). When I am thirsty, I am usually immediately aware that I am thirsty, such that I feel my need for some water. When I am sad, my perceptions of the world are usually always already transformed before I become aware of my sadness (if I ever become aware of it at all).

Finally, while I am discussing the differences between affects based largely on their intentionality, I argue that it would be incorrect to do so too strongly. While a controversial way to approach affectivity, the temporality of affectivity may reveal features and an interrelatedness

(Merleau-Ponty 2012, 84). For instance, if I have lost an arm, I will still be directed at my cup as if I still had that arm. Concerning emotion, he highlights the way in which my emotions move me to act in the world with my missing arm before I can even realize that I am moving to act in an impossible way. It is only when my action fails—when I’m already being affected by my emotions—that I realize how I was being moved. When I try to reach for the cup with my amputated arm, my deficiency will become apparent because I will fail to grab the cup. But, prior to realizing my deficiency, my mode of being in the world—my emotion, as Merleau-Ponty defines it—would have been different (Merleau-Ponty 2012, 88). When I fail to grab the cup, my mode of being in the world is suddenly changed and I become frustrated by my folly. In this example, Merleau-Ponty subtly shows why both feeling-theorists and Sartre are wrong when it comes to the intentionality of emotions. Concerning the feeling theorists, he shows that emotions are not just perceptions of one’s own body. Emotions are not merely sensations, but rather ways of being directed at the world that are foundational for perception. They are prenoetic— affecting the way that we perceive the world prior to perception.

between affective experiences that is missing in a purely intentionality-based approach to affects.¹¹⁴ As Jan Slaby argues in his paper concerning the temporality of affectivity in Heidegger's work "time is the horizon against which affectivity takes on its peculiar character as a core enabling structure of human existence" (Slaby 2014b, 3).¹¹⁵ The temporality of affectivity adds another perspective to discussion of affectivity. While intentionality alone has trouble accounting for the differences and connections that exist between different affects, temporality reveals the different dimensions of affectivity as being intimately intertwined with one another. In other words, assessing the intentional structures of affects reveals that they can either have the same intentional objects or they cannot. If they cannot, then they appear to be different experiences. However, if they can have the same intentional objects, then it is difficult to distinguish between them using intentionality alone. Temporality shows that affects can have the same intentional objects, but still be different experiences of the world. However, this is also accomplished in such a way that that different affects cannot be sharply divided from one another, because they are all temporally reliant on one another. Again, however, this is a relatively new discussion in phenomenology that will need to be further explored before it can be useful to the discussion of empathy.

¹¹⁴ To be clear, temporality is not the spatialized, objective time that is more common in everyday discussion. Rather, it is "lived time"—the way that we live the past, present, and future within our present experiences. More accurately, temporality is the temporal structure of our being-in-the-world that makes it possible to have experiences the way that we do. The problem here is what we might call a temporal solipsism of affectivity, by which I mean that affects occur now—they may have taken place at other nows, or be directed at other nows, but they are still isolated in the spatial now. In other words, affects do not have a temporal structure themselves, but are only at best about things in time. This temporal solipsism is caused by the strong focus of the philosophy of emotion on the intentionality of affects.

¹¹⁵ He makes this argument drawing on Heidegger's discussion of temporality in his *Being and Time* (BT 370-380/323-331). Slaby confines himself to talking specifically about Heidegger's "I-am-as-having-been" as it relates moods, but Slaby's argument could be expanded by appealing to Heidegger's additional discussion of other dimensions of temporality, as well as Merleau-Ponty's discussion of temporality (Merleau-Ponty 2012, 432-457; see also Hoy 2012).

In short, affectivity is a group of interrelated experiences such as emotions, moods, and feelings. They are embodied and move us in the world, with respect to things in the world. They are not like objects in our heads, and therefore should not be treated as such. They are our relations to the world, with specific intentional structures that can be identified. As relations to the world, they cannot be attributed to either the subject or the world. Additionally, they exist below the level of the will, making it such that we are always already in one affect or another before we are aware of them. They are always already affecting our perceptions and judgments.

This is helpful for the discussion of empathy because, as an affect, empathy should also not be entirely understood as something that we do. It is not something that we control because affects are not things that we control. It would be best to interpret it as our relation to the other, at least at its core, or most basic level. This is especially important because the phenomena that we are empathizing with are also not things in the world or in the other's head. The other's affective states are also the other's relations to the world. While surely not exclusive in its coverage of the important aspects of affectivity, this at least provides a foundation for the affectivity of empathy that can now be used to examine some contemporary theories of clinical empathy.

5.2 Contemporary Approaches to Clinical Empathy

With this phenomenology of affectivity in mind, it is worth examining some theories of empathy that are promising alternatives to ST. While these are not the only alternative theories of clinical empathy, there is not enough space here to explore all the possible options. Instead, I focus specifically on three theories that both correspond well to the phenomenological theories in the previous chapters and attempt to overcome the problem of detached concern by revaluing affective interaction. This includes narrative empathy, empathy as engaged curiosity, and (what I call) clinical affectivity. Here, I explain each theory, how it corresponds to the phenomenology

of empathy and affectivity, and how it overcomes the lack of affective engagement caused by detached concern.

5.2.1 Narrative Medicine

The insights of IT, as it was addressed in the previous chapter, are not limited to the philosophy of mind, but have branched out into other areas as well. Especially in the medical field, narrative approaches to empathy and clinical encounters have started to gain favor (Arntfield et al. 2013; Balla Kohn 2016; Branch and Malik 1993; Cenci 2016; Charon 2001, 2004, 2005, 2006, 2009, 2011, 2013, 2014; Coulehan et al. 2001; Halpern 2003; Halpern 2014b; Justman 2015; Lewis 2011; 2016; Murphy and Franz 2016; Ratcliffe 2014; Rian and Hammer 2013; Scannell 2012; Vannatta and Vannatta 2013). However, these approaches do not often go into as much depth concerning primary and secondary intersubjective relations as IT does. While IT provided explanations for our most basic understanding and being-with others, narrative approaches in medicine focus almost exclusively on the level of narrative competency. Understandably, physicians are more interested in the ways in which narratives can be utilized to acquire a better understanding of their patients.

This, of course, does not mean that the earlier levels of intersubjectivity are unimportant to narrative medicine. In fact, the lack of discussion of these levels makes them even more important. If they are not understood, it is possible to interpret the use of narratives as just another tool physicians apply to understand inaccessible others. This is why it is important for narrative medicine to be accompanied with other intersubjective skills, such as lower, more primary levels of empathy. This will be explained further at the end of this section. At this point, it is important to acknowledge the method of narrative medicine and its benefits, especially as they relate to affectivity and the problem of detached concern.

Narrative-based medicine (NBM) is presented as being a necessary supplement to evidence-based medicine (EBM) (Balla Kohn 2016, 10; Cenci 2016; Justman 2015, 512; Lewis 2011, 17; Vannatta and Vannatta 2013, 33, 40-41). In line with the naturalistic attitude, EBM has taken position of being the primary way of knowing in medicine. As with the primacy of the naturalistic attitude and science in medicine, these approaches to patients, illnesses, and treatments have been undeniably useful in advancing medical practice. However, the problem arises when these approaches are taken as the only valuable ways of knowing (Garden 2008; Vannatta and Vannatta 2013, 37). NBM is presented as a way to contest the primacy of these approaches and to solve the problem of detached concern caused by them. One of the leading writers on the narrative approach, Rita Charon, defines it as “medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness” (Charon, 2006, vii; see also Charon 2001, 83; Charon, 2005 262).

However, NBM is not presented with the purpose of rejecting the importance of EBM (Cenci 2016, 23; Balla Kohn 2016, 10; Cenci 2016; Justman 2015, 512; Lewis 2011, 17; Vannatta and Vannatta 2013, 33, 40-41). That is, when patients are treated as no more than a bundle of evidence to be picked apart and analyzed, it is easy to miss aspects of the patient's subjective experience—such as the patient's first-person experience of his or her condition—that may be important to diagnosis and treatment (Cenci 2016, 23; Lewis 2011, 12). The open communication of NBM accepts the limitations of the physician—it acknowledges that the physician cannot have a perfect understanding of what the patient is going through (Coulehan et al. 2001, 222). NBM is meant to make clinical encounters more patient-centered—to find a balance between clinical expertise and the patient's experiences (Charon 2005; 2006; 2009, 119; Lewis 2011, 14; Rian and Hammer 2013, 671). Charon says, “the therapeutic potential of

narrative medicine expands when we encourage patients to join us in writing their own medical charts, for patients are, or should be, the co-authors and curators of whatever records are kept about them” (Charon, 2005 262). In this way, the concern involved in clinical encounters is engaging, not detached.

There are at least two ways in which narratives can be used in medicine to improve patient care.¹¹⁶ The first is in the use of patients’ stories to educate both physicians and patients about unfamiliar experiences. The second is the development of an interview method to help physician and patient construct a comprehensive narrative together. These should not be understood as two opposing narrative methods, but rather as equally useful methods that should both be implemented. Each has its own benefits and serves to enhance the other’s effectiveness.

The reading of older narratives has a number of uses for both physicians and patients. As Gallagher noted in his discussion of IT, we do not enter into our interactions with others as if they are blank slates. Narrative competency does not entail that the construction of narratives always begins anew. Rather, the construction of narratives to understand others builds on our current narrative competency—our current store of narratives (Charon 2006, 108; Lewis 2011, 17; Vannatta and Vannatta 2013, 41-42). This means that physicians will be able to better understand their patients and better understand how to begin the narrative interview if they already have a good store of narratives in which to initially place the patient. The current store of narratives already possessed by physicians allows for an initial understanding of patients by immediately situating them into such narratives. Physicians can then use these narratives as the launching points to refine specific narratives with their patients. Since patients come from

¹¹⁶ Additionally, many different kinds of narratives can be useful in medicine, including “medical fiction, the lay exposition, medical autobiography, stories from practice, and writing exercises of medical training” (Charon 2001, 83).

various backgrounds and can be afflicted by various problems, physicians need a wide variety of narratives and narrative-building skills in order to best understand their patients.¹¹⁷

The review of narratives can also be helpful for patients in distressing situations, when they are overwhelmed with negative affects and seem to be unable to cope with them. Halpern and Arnold call this “affective forecasting,” and note that people are very poor at predicting the ways in which they can (and likely will) adapt to serious changes in their health and physical abilities (Halpern 2014b, S27; Halpern and Arnold 2008, 1708). If a patient believes she will be in perpetual, emotional suffering, this will affect her judgment concerning her future. It is one of the physician’s jobs to ensure that patients are able to “form realistic beliefs about their future quality of life to make adequately informed decisions” (Halpern and Arnold 2008, 1708). Halpern and Arnold argue that physicians can use narratives to help patients better understand their own abilities to cope.

While Halpern and Arnold note three ways in which people are poor at affective forecasting, the one that best benefits from the review of narratives is the problem of adaptation. That is, following a serious illness or new disability, people are especially poor at predicting how they will form “new values, replacing lost sources of meaning with new ones” (Halpern and Arnold 2008, 1710). They fail to understand how they will adapt to their new situation. Accordingly, the best way to overcome this problem may be with narratives (Halpern and Arnold 2008, 1710). By reading the stories of other patients who have gone through similar changes, patients can better understand their own emotional responses and how they will likely adapt. In

¹¹⁷ Some also recommend having medical students write narratives from the perspective of patients in order to better understand their situations (Garden 2008, 123). The review of narratives has been show to improve the “emotive and cognitive aspects of empathy” (Garden 2008, 123).

other words, reading patient narratives help patient better understand themselves over time, rather than as temporally isolated in their current affects.

The other two problems of affective forecasting are focalism and immune neglect, which are better resolved by narrative-building interviews. Focalism is referring to when one is “focusing narrowly on what will change in one’s life while ignoring how much of what one enjoys daily can still be continued,” while immune neglect is when “people generally fail to recognize the extent to which their defense, or coping, mechanisms will buffer them (provide ‘immunity’) from emotional suffering” (Halpern and Arnold 2008, 1709). A mere restatement of facts and possible treatments is not enough to refocus patients and help them understand their natural coping abilities. Rather, open communication is needed to help patients construct narratives for themselves, extending into the past and future. Specifically, the building of narratives should cause them to focus on how they have coped with distressing situations in the past, as well as all of the activities that they will still be able to enjoy despite their illness or disability (Halpern and Arnold 2008, 1709-1710).

In addition to the narrative method helping patient’s better understand and cope with their affective responses, narrative-building interviews are meant to help the physician better understand the patient’s entire situation, including his or her affective responses.¹¹⁸ This will, in turn, help to improve diagnostic accuracy and prescription of treatments. Charon recounts her experiences applying the narrative approach:

The more I wrote about my patients and myself, the more confident I became that the act of narrative writing granted me access to knowledge—about the patient and about

¹¹⁸ Halpern notes that this is especially the case then patients are in states of transition, such that they do not have well-established narratives (Halpern 2014b, S26). In these instances, it is important for physicians to have the skills to help their patient build the necessary narratives.

myself—that would otherwise have remained out of reach. I also realized that writing about patients changed my relationships with them. I became more invested in them, more curious, more engaged, more on their side. (Charon 2001, 84)

For instance, in support of narrative medicine, Kate Scannell recounts her own experience with a case about fatigue.

In this case, other physicians were having trouble helping a patient by using traditional methods. Scannell, on the other hand, approached the patient using the alternative approach of NBM. She says, “I had learned from experience that whenever a wealth of diagnostic points proved to be utterly pointless, it was highly probable that we physicians were inaccurately pinpointing that patient’s story” (Scannell 2012, 1). There are often times when the “facts” about the patient’s condition are not enough to truly understand the patient’s situation. Instead, physicians need to get to the root of the problem by inquiring into the patient’s narrative. This notes the limits of physician expertise.

Scannell summarizes her approach in this case as follows.

Encouraging a patient to frame his illness within his own experience of its beginning, its current middle, and its imagined ending will often expose clarifying diagnostic clues. That’s because patients frequently situate their illnesses within contexts of time and events that don’t match those documented in their medical records (where, for example, the beginning of an illness is frequently tethered to the sentinel date of a clinic visit or an abnormal lab report). The revised historical timelines allow previously ignored but germane symptoms to be newly included within the diagnostic analysis. Also, a patient’s telling of his imagined future, living with the uncertainty of an ambiguous disorder, often reveals his projections or fears—illness expressions that you can sometimes trace back to

inchoate somatic murmurings in the present that translate into useful clues. (Scannell 2012, 1)

Where EBM typically focuses narrowly on the facts, often isolating the analysis of the patient in the present, NBM broadens the snapshot of the patient's conditions to perceived past and future of the patient's illness. Even when EBM looks to the patient's past, this is typically to find specific facts that could affect diagnosis and treatment—how long the symptoms have been present, past medical history, and so on—but it is not to understand the patient's perspective on the history of the illness. By understanding the patient's narrative as the patient understands it, from beginning to perceived end, more facts can be illuminated than focusing on present symptoms alone. Doing so in Scannell's case allowed her to pinpoint the affective cause of her patient's fatigue (the inability to sleep based on the fear of a dead neighbor's apparition) and offer new solutions. Listening to the patient's narrative enabled a better understanding and established trust that did not exist between the patient and his previous physicians.

Coulehan et al. outline five guidelines for the narrative approach, or what they call the components of "empathic communication" (Coulehan et al. 2001, 222). These include active listening, framing or sign posting, reflecting on content, identifying and calibrating the emotion, requesting and accepting correction (Coulehan et al. 2001, 222-223). The first two correspond well to what Charon calls "attention" (Charon, 2005 263). Active listening involves maintaining eye contact, and using verbal cues and gesture to show patients that they are being heard (Branch and Malik 1993, 1668). This allows physicians to take advantage of "windows of opportunities," such that they can ask the right questions and better build a comprehensive narrative (Branch and Malik 1993). Sign posting and reflecting on content go hand in hand, the latter being used to check back with patients to make sure the physician is understanding their stories correctly, and

the former being used to let patients know what the physician is doing before he or she reflects on the content. The idea of sign posting here is that patients are not typically accustomed to the physician responding empathically, so it is important briefly here the reflection on content with statements such as “Let’s see if I have this right” and “Sounds like what you’re telling me is…” (Coulehan et al. 2001, 222). Then, physicians can reflect on the content to see if they are understanding correctly (Branch and Malik 1993, 1668).

The last three components correspond to what Charon calls “representation” (Charon, 2005 265).¹¹⁹ This includes checking for confusions, the identifying of emotion, and accepting corrections. Concerning the first point, Scannell notes that patients often misuse terms (Scannell 2012, 1-2). Reflecting on content allows for the physician to check the use of medical terminology, as well as other aspects of the narrative that may have been misinterpreted (Murphy and Franz 2016, 549). Concerning the second point, in reviewing the content, physicians need to make sure they understand the intricacies of the patients’ affective states—more than a superficial statement that the patient is upset or in pain (Murphy and Franz 2016, 547). Reflecting on the content in this way allows the patient to correct the physician when there is a misunderstanding or gaps in the understanding, which is the fifth component. By revaluing the patient’s views, NBM opts to communicate and discuss narratives with patients, such that “successive cycles may lead to a clearer, more accurate ‘fix’ on the patient’s perspective and feelings” (Coulehan et al. 2001, 222).¹²⁰ Doing so requires physicians to be open to correction (Merritt 2002, 46). They need to “accept patients’ feedback, even when it is negative and

¹¹⁹ She says, “This is an example of the ways in which representation follows from attention in direct patient care. Sometimes, the acts of representation are accomplished privately by the clinician, producing texts not for the patient to read but in order for the clinician-writer to discover thoughts, feelings, perceptions. In our narrative medicine practice, we are finding that the clinician must represent what he or she has witnessed” (Charon, 2005 265).

¹²⁰ Coulehan et al. argue that empathy in this sense is not a one-sided judgment, but rather interpersonal communication in which physicians are continuously “checking back with the patient” (Coulehan et al. 2001, 221).

blaming” (Halpern 2007, 698). This allows the patient to be an equally important part of the physician’s understanding, correcting the physician’s narratives when incorrect, as well as establishing a bond that fosters trust (Balla Kohn 2016, 10; Coulehan et al. 2001, 221, 224).¹²¹ This is bond created through attention and representation is what Charon calls “affiliation,” or that we can “know in earthy, rich detail that we are affiliated as humans, all of us humble in the face of time, ready to suffer our portion, and brave enough to help one another on our shared journeys” (Charon, 2005 269).

5.2.2 Objections to Narrative Medicine

While IT, NBM, and similar approaches have started to gain some support, both philosophically and in the medical field, it is vulnerable to some objections. I address three here. First, some have argued that the narrative approach does not actually overcome the problem of paternalism. If the goal in supplementing EBM with NBM was to ensure that the patient’s views were being respected in the face of clinical expertise, then it needs to be questioned whether or not this is actually achieved with NBM. Some have argued that the power relationships that this approach was supposed to overcome are instead “rendered omnipresent, subtle and productive of new forms of selfhood and of patient-doctor relations” (Hooker 2015, 546). There is still the risk that the physician will be taking a pastoral position with regard to the patient (Mayes 2009). The patient is seen as a “confessing subject and requires that the doctor elicit, listen to, and ultimately interpret, the patient’s ‘story,’” as if the patient was giving a confession (Hooker 2015, 546-547). However, in defense of NBM, this is not necessarily the case. This would only be true with a

¹²¹ Both Scannell and Coulehan et al. also emphasize the importance of embracing silences, rather than trying to fill time with conversation and further questioning (Coulehan et al. 2001, 223; Scannell 2012, 2). While these silences may seem uncomfortable, they create a “welcoming space for the patient to articulate what has remained unsaid or unsayable” (Scannell 2012, 2). Additionally, embracing silences is therapeutic for the physician, giving the physician time to rest and reflect on the patient’s narrative (Coulehan et al. 2001, 223; Scannell 2012, 2).

reductive version of NBM, in which the patient is subjected to a one-sided experience and subsequent judgment. In the establishment of the narrative, patient and physician should communicate back and forth, growing and focusing the narrative together (Coulehan et al. 2001, 222; Ratcliffe 2014, 276). Again, in this way, empathy remains a more other-directed practice (Coulehan et al. 2001, 221, 224; Ratcliffe 2014, 271).

As a second objection, some have argued that the narrative approach can “run the risk of sounding romantic or lacking in rigour” (Hooker 543). The presentation of this approach often come across as lacking in any determinant structure or guarantee of good results. Additionally, in terms of intersubjectivity, the levels of primary and secondary intersubjectivity argue that we have a basic understanding of others well before the application of theories or simulations, but they do not explain how this understanding happens. In Gallagher’s work, the argument is largely a negative one—that ST cannot explain this basic understanding, but that this basic understanding does exist—albeit with support for the negative argument.

Some have argued that ST is actually still the foundation for primary and secondary intersubjectivity, based on mirror neuron research. In other words, it might be that ST provides the explanation for primary intersubjectivity that is needed. This would not work if the simulation needs to be an explicit process—a conscious taking of the other’s perspective. As explained in chapters 1 and 4, this is because infants are capable of understanding very basic similarities about self and other, but are not capable of running a highly cognitive process like a simulation. On the other hand, ST might be able to overcome the problem of infant simulation by appealing to mirror neuron or some other neurological research (Brothers 1989, 13; Chakrabarti and Baron-Cohen 2006; Gallese 2003; Iacoboni 2009; Iacobini and Dapretto 2006; Preston and De Waal 2002). Mirror neurons are special neurons that people (as well as several other animals)

possess that regularly fire both when I perform an action and when I observe others performing a similar action. For instance, my mirror neurons will fire when I reach for my mug to take a sip of coffee, as well as when I watch my friend reach for a mug to take a sip of coffee. The intention of the action is important here. The neurons won't fire if I simply observe my friend's hand on a desk. They will only fire if there is an intentional action that is similar to my own (Iacoboni 2009, 75-77). This has been taken to be good support for the existence of immediate simulations taking place below the level of consciousness. As far as physicians are concerned, this would mean that they empathize with their patients so far as their mirror neurons fire, matching the intention of their patient's actions. Furthermore, infants can have mirror neurons from birth, allowing them to subconsciously simulate and understand the expressions of others.

On the other hand, I am hesitant to say that mirror neurons support ST, and by extension that ST, can fit the role of explaining primary intersubjectivity.¹²² For one, mirror neuron research is still very much in its adolescence and it is hard to say whether or not it has the implications for empathy that some predict. The results of mirror neuron research as it applies to simulation theory is contentious (Turner 2012). Therefore, caution should be taken with regard to this research for the time being. Furthermore, there may be less similarity between the firing of neurons and mirror neurons than it is initially made to seem (Gallagher and Zahavi 2012, 200-201).¹²³ There is some correlation, but it might not be enough to say that it is a sufficient mirroring of the other's mental states. Therefore, even though ST may be able to fulfill the role of basic and immediate understanding of the other, it cannot do so based on conscious

¹²² In fact, it seems possible for someone to argue that mirror neurons might support the affective reversibility thesis for than ST.

¹²³ They also note several other problems with internal, unconscious simulation in this work

simulation, and there is also not enough support for it to do so via unconscious simulation. Perhaps when more research is done, a better answer will be able to be given.

The other option, which seems more plausible, is that simulations are based on narrative competency.¹²⁴ There is no denying that we sometimes make use of simulations, specifically when we do not have the ability to communicate with others to construct narratives. Since even implicit simulation is not able to overcome the starting problem, any simulations of the other would already need to be based on some level of narrative competency Gallagher 2012, 371-372. That is, our imaginings of other's situations must already be grounded in narratives (Gallagher 2012, 370). In this way, simulations can be seen as useful in some situations, but only so far as we simulate being in narratives that we have already constructed.

The third objection, and one that is commonly raised against the narrative approach, is that it is simply impractical. It seems to be a difficult and time-consuming process, but physicians are under serious time-constraints (Branch and Malik 1993, 1668; Cenci 2016, 24; Halpern 2014a, 304; Mansel 2014; Murphy and Franz 2016, 545). The worry is that IT is not a practical theory of empathy to endorse, since physicians do not have the amount of time available to construct narratives for every one of their patients. This is at least true in time sensitive dilemmas, such as when trying to decide whether or not to perform an urgent surgery (Halpern 2014b, S27). While patients complain about physicians not really listening to them, physicians complain that they simply do not have enough time to spend with patients (Coulehan et al. 2001, 221). If true, this would be very problematic for IT, since it would not actually fit

¹²⁴ If this is true, then it also makes sense that simulations would be based on affective reversibility. There needs to be an experience of the other as a locus of affects before we can suppose that they are something with affects that we can try to simulate.

well with the requirements of a physician. However, three things can be said against this argument.

First, it can be argued that the physician's actual lack of time does not necessarily mean that they should not spend more time and establish narratives. In other words, it is true that the current structure of medical interactions does not allow for the proper amount of time to establish narratives, but this may be more of a problem with the expectation of the medical interaction than the theory of empathy (Halpern 2001, 16). It may be that the structure of the medical interaction needs to be restructured to allow for empathy. As Halpern argues, "the current time and effort demands of practice can be dehumanizing for physicians, and therefore for patients as well" (Halpern 2014a, 310). While spending more time with patients will make it difficult to see the same number of patients, the improved diagnostic accuracy and therapeutic benefits of building narratives will likely outweigh the costs. Some even argue that it saves time in the long run (Wilcock 2003). Proper empathetic interaction requires more time than is currently allowed. However, that the current structure of medical interactions does not allow for the best amount of time to be spent on physician-patient interactions does not mean that this objection can be dismissed. It is still a real problem for IT that time is limited.

A second argument is that empathy for IT does not always require one to go through all the levels of empathy. For physicians, primary intersubjectivity, secondary intersubjectivity, and narrative competency provide a structure and a context in which they can understand patients (Gallagher 2012, 371). Primary and secondary intersubjectivity provide physicians with a very basic understanding of patients in their everyday interactions with their patients. Without this basic understanding, interactions with patients would not even be possible. In this context, it is often the case that understanding a patient's situation and prescribing a treatment can be

achieved at the levels of primary and secondary intersubjectivity, which are automatic and less time-consuming. These levels of empathy allow for an “immediate appreciation of someone’s experience, rather than a two-step process involving simulation and inference” (Ratcliffe 2014, 271). This is one of the strengths of IT, in that it allows for different levels of empathic engagement depending on the situation. Empathy should not be viewed as one overarching skill that must be achieved in every interaction. Rather, it is a multi-leveled skill that can be accomplished more or less in depth.

Third, it can be argued that establishing a narrative is not as time consuming as it may initially seem (Branch and Malik 1993, 1668; Cenci 2016, 24; Mansel 2014; Murphy and Franz 2016, 546). The worry is that physicians will need to sit down and have long conversations with patients in order to develop a sufficient narrative to warrant an understanding. However, this is not the case. It has been shown that allowing the patient to establish a narrative by explaining his or her situation takes approximately two minutes for 80% of those patients (Langewitz et al. 2002). Others report that it takes somewhere between 3 and 7 minutes (Branch and Malik 1993, 1668). There are some that take more or less time, but two minutes is a short amount of time to establish an empathic understanding of the patient. Additionally, the narrative does not need to be a complete narrative of the entire person’s life, which would be far too time consuming. Rather, following the narrative method outlined above, physicians should ask specific questions to allow patients to fill in the information the physician already has based on their previous narratives. This allows for the most complete and relevant narrative, in the shortest amount of time.

Aside from these common objections, the problem that I find in the narrative approach to both to empathy in general and clinical empathy is that it is a highly cognitive process that can be performed even in the absence of affects, and therefore does not fit empathy as it is experienced.

In other words, clinical empathy is commonly defined as an understanding of the patient, and NBM allows for an understanding of the patient's affects in a way that EBM alone does not, but it does not account for the affective nature of empathy itself. In line with my argument from chapter 4, it would seem more accurate to argue that the narrative approach helps establish a high-level understanding of the other, which can foster better empathy, and that empathy in turn inclines one to interact with others, perhaps to create narratives. But this means that there must be a more primary level of empathy at play in NBM. IT provides the foundation for this with the levels of primary intersubjectivity and secondary intersubjectivity, but to address this in terms of clinical empathy, and in a way that ties empathy into NBM, it is useful to look at Halpern's theory of clinical empathy as engaged curiosity.

5.2.3 Engaged Curiosity

Halpern sympathizes with the narrative approach, and directly supports it in several of her works (Halpern 2001, 130-131; 2007, 698; 2012b, 44; 2014a, 309; 2014b; Halpern and Arnold 2008, 1710). Her approach to empathy should not be taken as an outright alternative to the narrative approach, but rather a supplement that more fully details the hidden aspects of NBM. By directly targeting the problem of detached concern, she focuses on the various affective aspects of clinical empathy. This includes the comprehensive understanding it provides of the other's affects—as addressed but the narrative approach in the previous section—as well as the attunement to the physician's own affective responses and a better understanding of how affects influence beliefs and judgments. In other words, NBM addresses some of the problems caused by detached concern, but Halpern's theory serves to fill in the gaps of remaining problems by accounting for the affectivity of clinical empathy itself.

Halpern defines empathy as engaged curiosity (Halpern 2001, 2003, 2007, 2013), which she presents as an alternative to “scientific curiosity about a patient’s state of mind” (Halpern 2001, 12). The latter represents the ideal of detached concern in which the physician attempts to study the patient to gain an understanding. The former, engaged curiosity, forgoes detachment in favor of affective engagement with the patient. She says, “physicians need to cultivate openness to the painful emotional states that patients communicate by having an emotional impact on them” (Halpern 2001, 12). Rather than closing off from patients, physicians need to open up to their patients, engaging with both their own and the patients’ affective responses.

To begin with, clinical empathy as a professional skill needs to be distinguished from basic, everyday empathy (Ekman and Halpern 2015; Halpern 2003). This separates empathy as it has been discussed in the previous chapters from specifically clinical empathy, since Husserl, Stein, Scheler, and even Gallagher are interested in empathy as it experienced in the everyday sense. Professional empathy is presented as being more demanding and requires a more active role to be played by the empathizing subject (Ekman and Halpern 2015, 635). Accordingly, she defines basic empathy as an emotional response/engagement with the other. However, this should not be taken as her rejecting basic empathy as a whole, or even in part. Rather, professional empathy is meant to build upon basic empathy. Basic empathy serves as the foundation for professional empathy—a foundation that is often ignored. It is the basic affective recognition and engagement that sparks professional empathy. Professional, clinical empathy, in contrast, responds to the other with a curiosity and a drive to interact with the other, which is intended to build further understanding (Ekman and Halpern 2015, 635; Halpern 2001, 12, 129-136; 2003; 2009; 2012; 2014). In other words, professional empathy is trainable and more demanding because it does not stop at the level of basic empathy, as opposed to in our everyday

lives when it is very common (even necessary) to end at the basic level. There are three important aspects to clinical empathy as engaged curiosity.

The first important aspect of empathy, and the foundation of empathy, is its affectivity (Ekman and Halpern 2015, 635). In order to overcome the problem of detached concern, it is important that she maintain empathy as being both cognitive and affective (Garden 2008, 124). Her specific description of the affectivity of empathy is that it is an emotional resonance, by which she means that we literally resonate with the other's affective state—feeling pain with the other who is in pain, fear with the other who is afraid (2003, 671, 673; 2007, 698; 2014a, 301, 303-304, 308; 2012b, 42). Every emotional resonance is an opportunity for clinical empathy (Ekman and Halpern 2015, 634; Halpern 201, 10). Emotional resonances also have the risk of leading to emotional contagion in which the physician suffers with the patient (Ekman and Halpern 2015, 634), or sympathetic connections that may overly invest the physician's own affects in the patient's affects. Rather than falling prey to these problems—which physicians often do by ignoring their affective resonances—Halpern's argues that physicians need to take the emotional resonances that they experience with their patients and use them as an opportunity to reflect on their emotional responses, and learn more skillful emotional responses (Charon 2003, 1123; Frank 2003, 2069; Halpern 2001, 10, 136)¹²⁵ In this sense, emotional resonance is the physician's first clue to understanding the patient's "emotional point of view" (Halpern 2001, 16). It is the physician's attunement to the patient's relationship to the world It immediately established the patient's affects "as presences, rather than as mere possibilities" (Halpern 2001, 74). The physician can feel the patient's affects, giving them a real existence that needs to be accounted for.

¹²⁵ More skillful emotional responses are learned through practicing the narrative approach and actively reflecting on one's own emotional responses.

This may initially seem problematic, since it sounds very similar to a simulation. In fact, the resonance she is referring to is a mimicry of the patient's emotional state in the physician (Charon 2003, 1123; Flaherty 2016, 116; Halpern 2001, 136; Ross 2003, 310). While this simulated emotional state is not the entirety of empathy for Halpern (Flaherty 2016, 116), it is still a problematic foundation for empathy if we are trying to avoid the simulation theory. In line with the need for this avoidance, she stresses the need to maintain the difference between one's own experience of empathy and the other's experience of suffering (Ekman and Halpern 2015, 635; Halpern 2001, 68; Halpern 2014, 305). In fact, it is very important for the physician to understand that patients' experiences of their illnesses, as well as the affective responses to these illnesses, can never fully be grasped by the physician (Ekman and Halpern 2015, 635; Halpern 2007, 697; Svenaeus 2014b, 297). This is why more is needed in clinical empathy than merely emotional resonance. It is an experience that is needed to have a general understanding of the patient's emotional state, but it is at best a clue that the empathizing physician should explore (Suchman 1997, 678).¹²⁶ However, many physician's pass over and ignore the opportunity to explore this clue because they focus too narrowly on facts, rather than to "the emotional meanings of patients' words" (Halpern 2007, 697).¹²⁷ Emotional resonances serve as "conduits toward doctors' richer and more accurate perceptions of patients' total reality" (Charon 2003, 1122). It is important that physicians recognize and embrace these opportunities (Suchman 1997, 678). Without this affective engagement with the patient, physicians are more prone to "diagnostic and therapeutic error" (Charon 2003, 1123).

¹²⁶ This is important because patient's "seldom verbalize their emotions directly and spontaneously, tending to offer clues instead" (Suchman 1997, 678). Physicians need to be attuned to these clues so that they can inquire further when needed. Suchman notes the frequency at which physicians allow "both clues and direct expressions of affect to pass without acknowledgment" (Suchman 1997, 678).

¹²⁷ See also: Coulehan et al. 2001, 223; Ekman and Halpern 2015, 634; Suchman et al., 37; Branch and Malik, 51.

The second important aspect of empathy is that it is a “cognitive appraisal” (Ekman and Halpern 2015, 635). Even when acknowledging the importance of the affectivity of empathy, that does not mean that we should overlook or reject the cognitive aspect of empathy. It would be equally problematic in clinical encounters if the physician were to rely solely on affects like sympathy and emotional contagion, which some may view as entirely affective in nature (Coulehan et al. 2001, 222; Halpern 2007, 697).¹²⁸ Instead, empathy relies on a combination of affective and cognitive interests in patients (Halpern 2007, 697). Mere affective resonances, such as with sympathy, need to be distinguished from the curiosity involved in empathy. As Halpern says, “this distinction is crucial because empathy pushes one to appreciate that another sees things differently, whereas sympathy may blur such differences” (Halpern 2007, 697). In other words, where detached concern makes the patient too distant from the physician, sympathy makes the patient too close to the physician. It becomes hard to separate the patient’s emotions and situation from the physician’s. Empathy maintains both an affective connection and a cognitive distance. It is a kind of emotional reasoning.

The third important aspect of empathy is that it is a motivation to act guided by the “cognitive-affective understanding” (Ekman and Halpern 2015, 635). Built on emotional resonance and the reflection on this emotional resonance, there needs to be an inclination to want to know more about the patient—to want to have a more comprehensive understanding of the patient. This makes empathy “more akin to investigating” (Ekman and Halpern 2015, 640). This engaged curiosity causes physicians to approach their patients’ situations with an openness that is missing in both detached concern and mere emotional resonance (Halpern 2012b, 42). This is important because, as Charon says, “if the physician is able to wonder about and, perhaps then,

¹²⁸ Given the phenomenology of affectivity, however, this view is likely incorrect. All affects have a combination of cognitive and felt aspects.

recognize the patient's emotions, the patient in turn need not deny or turn away from his or her own experience" (Charon 2003, 1122). That is, investigating the patient's affects validates them as being important. When physicians approach patients through detached concern, emotions are often viewed as unimportant and a hindrance which may prompt patients to feel shameful about their emotions. On the other hand, when physicians investigate affects, patients can see that their own affects—regardless of what they may be—are important and need to be explored.

Though, to be clear, this motivation to act guided by the cognitive-affective understand does not only apply to the patient, but also to the physician's own affects. Engaged curiosity involves emotional engagement with all aspects of the patient-physician relationship. Empathy requires that physicians be properly "emotionally attuned," as well as further engage with patients based on this attunement (Halpern 2007, 696). This allows physicians to properly curate their engagement with their patients. This is important because it is at this level that NBM becomes important in Halpern's theory (Merritt 2002, 46). She directly appeals to the work of Sheldon Margen, Howard Brody, and Rita Charon to demonstrate the importance of communication when trying to understand the patient (Halpern 2001, 130-131). While sometimes this attunement will cause physicians to inquire further, there are also other times it will cause them to remain silent, allowing the patient to have a greater control over the encounter (Halpern 2012b, 42).¹²⁹

In her various works, Halpern explains the many benefits of this approach—which combines affective reversibility and NBM into a clinical skill—such that empathy helps physicians deal with the problems caused by detached concern. Because some of these benefits

¹²⁹ Remaining silent at certain points in the interaction has been shown to prevent stress and encourages reflection, further communication, and a feeling of control for the patient. In other words, silence can create a positive affective space for building the narrative further.

are due to the narrative approach, which has already been addressed, I attempt to avoid redundancy by focusing on the specifically affective-related benefits. This includes a better understanding of how affects influence physician and patient alike, whether it has to do with conflicts and a physician's own negative emotional reactions to patients (Halpern 2007), or when a patient's autonomy is undermined by emotional irrationality (Halpern 2014b; Halpern and Arnold 2008). Reviewing the case of Ms. G, we can see how these benefits were missing with the extremes of detached concern (overly-cognitive engagement) and sympathy (overly-affective engagement), as well as how these benefits could have been implemented with genuine empathy.

When it comes to detached concern, there is an assumption that one can set aside their emotions and become detached. As shown in chapter 1, this leads to problems when there are conflicts between patients and physicians. In these situations, physicians respond to patients with negative affects, but they assume that they can become detached and therefore avoid the influences of their negative emotional responses (Halpern 2007, 696, 697). However, this is incorrect. Detached concern assumes wrongly that we can get away from our affects and that our cognitive abilities are somehow unaffected by conflicts (Halpern 2007, 697). On the contrary, it has been shown that it becomes more of a struggle to see things from the patient's perspective in conflicts, which either means that conflicts also influence our cognitive abilities to understand others (Halpern 2007, 697), or that physicians are not actually able to set aside their affects, which are in turn making it difficult to understand their patient. This latter point seems the most convincing, as it corresponds to the phenomenology of affectivity.

When physicians are trained in the ideals of detached concern, they never actually escape their emotional involvements with others. They are ignoring their affective responses while still being affected by them—causing them to unknowingly respond defensively according to their

negative emotions, but with no means to recognize and correct this problem. Rather than pretending to be emotionally disconnected in these situations, Halpern argues that physicians should “stay fully emotionally engaged during conflicts, in part by recognizing how even their negative feelings can be put to good therapeutic use” (Halpern 2007, 697). They need to pay attention to their emotional resonances (which may be inhibited by negative emotions), cognitively reflect on them, and use them as clues to engage the patient. In other words, recognizing their emotional reactions and relationships, physicians can then move to the level of engaged curiosity regarding the emotions (Halpern 2007, 697). This will help to acknowledge the conflicts caused by negative affects, and hopefully resolve them (Halpern 2007, 697).

However, the step to engaged curiosity is not an obvious one when there is conflict, especially for physicians who are “socialized against self-reflection” (Halpern 2007, 697). Physicians need to retrain themselves to be more reflective about their own emotional reactions (Halpern 2007, 697). By taking time to pursue the initial emotional resonance—or failure of emotional resonance—and discuss it with the patient, the physician can recalibrate the initial resonance to be more accurate, which in turn also better guides the further discussion with the patient.

Aside from an attunement to the physician’s own emotions that can help resolve conflicts, Halpern’s theory helps with affective forecasting and shared decision-making, both of which require physicians to engage with the patient autonomy’s. With detached concern, the goal is to best identify objective features of the patient’s experiences, then apply ethical principles to guide the physician’s actions in accordance with these features. The respect for patient autonomy is among the most important of these principles. In fact, Halpern claims that a “respect for autonomy is perhaps the dominant principle in American bioethics” (Halpern 2014b, S25).

Typically, if it can be argued that patients have autonomy, then it must be respected, taking any concrete decisions about treatment out of the physician's hands. If it can be argued that patients lack autonomy, then the decision concerning treatment must be given to a surrogate who is able to give valid consent—preferably someone endorsed by the patient. However, as a principle, this approach to patient care is rigid and can lead to situations when autonomy is respected even when it ought to be called into question. This is especially problematic when patients are affected by strong emotions like Ms. G (Halpern 2001; 2012a), when they are unable to foresee how their affects will change with time (affective forecasting) (Halpern and Arnold 2008), and when they are in states of transition in their identity (Halpern 2014b). In such situations, it is not as clear that a patient either has autonomy or lacks it. Autonomy is not all-or-nothing, and therefore required less rigid ways to assess it and engage with it.

In Halpern's theory, in which physicians are more aware of the patient's affects, they are also able to better deal with the patient's "concretized emotion-belief complexes" (Halpern 2012a, 114).¹³⁰ That there is a relation between emotions and beliefs is an uncontroversial claim. Beliefs affect emotions, which then affect beliefs, and so on. Emotions and other affects generate salience in order to focus people on what they believe to be important (Halpern 2012a, 111). This can serve to either aid our beliefs or to derail them, distorting our perceptions of the world (Halpern 2012a, 111). However, the interplay between affects and beliefs often balance each other (Halpern 2012a, 112). The problem of their mutual influence only arises when the emotion-belief complexes become "concretized" such that the problematic beliefs are self-sustaining, and resistant to any disconfirming evidence" (Halpern 2012a, 112).¹³¹ This seems to be what is

¹³⁰ She says "I use the phrase 'emotion-belief complex' to refer, in this paper, not to a discrete emotion episode, but to an intricately connected combination of emotions and beliefs" (Halpern 2012a, 111).

¹³¹ She notes that "concretized emotion-belief complexes involve being subject to an unrelenting emotional state, unpunctuated by moments of feeling otherwise" (Halpern 2012a, 112).

happening with Ms. G. She is so distressed by her husband leaving her that her affective state is blocking her “ability to respond cognitively to evidence, and therefore the ability to think through alternatives” (Halpern 2012a, 114).

Being in such a state, Halpern argues that Ms. G is not in the right state of mind to give valid consent—at least concerning decisions that will dramatically affect her future (Halpern 2012a, 114).¹³² This applies to other patients in similar situations as well. These patients find themselves in situations where they are unable to see the evidence that contradicts their beliefs, while focusing strongly on the evidence that may support them (Halpern 2012a, 112). It is in situations like this that Halpern thinks a “temporary paternalistic intervention is warranted” (Halpern 2012a, 114). Though, this is only until autonomy can be restored (Halpern 2012a, 115; Ross 2003, 310).

This attention to affectivity on both sides of the patient-physician relationship leads to a strengthening of the relationship, and an alteration in the structure of shared decision-making. When it comes to current models of shared decision-making in medicine, there is a presupposed “division of labor in which doctors are experts about the medical facts and patients supply values or preferences regarding outcomes” (Halpern and Arnold 2008, 1708). With empathy as engaged curiosity, there is a better attunement to affects, a better understanding of their influences, and a better understanding of the patients’ abilities to “adapt emotionally, which, along with their values, determine their decisions” (Halpern and Arnold 2008, 1708). This helps physicians understand when and how to apply the narrative approach. In this way, empathy serves to “serve an important ethical goal by helping patients regain psychological autonomy” (Green 2002, 255).

¹³² Halpern says, “we need to carefully distinguish between someone who cannot imagine alternatives for the future because she lacks any real options or the options she has present an unacceptable threat to her deepest values, and someone who is subject to a concretized emotion-belief complex that is derailing her deliberative capacity” (Halpern 2012a, 112).

That is, it encourages autonomy in the patient, rather than merely respecting it. Again, affects are always influencing decisions, even if we are ignorant of them.

One objection is that Halpern's approach does not explain how to achieve accuracy in the cognitive-affective engagement that is empathy (Charon 2003, 1122). That is, it is unclear how physicians know if their emotional resonance is accurate, or that their prescription of irrational emotions to the patient are accurate. At best, the hope is that narrative practice will eventually establish better ways to identify affects and their influences. However, the best response to this objection may be that there is no way to guarantee accuracy with emotional resonance. This may simply be one of the drawbacks of empathy, making not only the narrative approach, but also other form of fellow-feeling necessary to good treatment of the patient.

5.2.4 Clinical Affectivity: The Desired Moral Attitude of the Physician

Both NBM and engaged curiosity fall short of a full understanding of the limits of empathy and the range of other affective experiences that are necessary for good patient care. As a way to overcome the reductive understanding of the other acquired through detached concern, IT and narrative medicine provided an explanation for how physicians can understand their patients beyond the information of EBM. However, they neither clarified which aspects of the narrative approach are empathy nor which aspects are affectivity. On the one hand, engaged curiosity provided a promising solution to this problem, so long as emotional resonance is reconceptualized as affective reversibility. On the other hand, while this approach does emphasize the affectivity of empathy and motor intentionality as an inherent part of this affectivity, it does not note the limitations of empathy. Given these limitations, empathy alone is not enough to lead to good patient care. While it is essential to our experience and understanding of others, it does not necessarily lead to the ethical treatment of the other. In order to fill in the

gap left between clinical empathy and ethical care, an understanding of other intersubjective and moral affects need to be understood.

In the same spirit of accepting the limitations of empathy, Petra Gelhaus presents a more inclusive theory of what I call clinical affectivity, of which empathy is only one aspect. Specifically, Gelhaus argues for the importance of clinical empathy, but also notes that empathy alone is not enough. It does not itself cause the physician to feel anything about the patient's situation nor does it drive the physician to action. In her sequence of articles "The Desired Moral Attitude of the Physician" she rejects the ideal of detached concern by arguing that physicians need a combination of empathy, compassion, and care—taken together as "empathic compassionate care"—if they are going to respond to patient needs in the best way possible (Gelhaus 2012a, 2012b, 2013).¹³³ On their own, each of these skills is not enough to properly treat patients. In fact, when taken in isolation, these skills can often be very detrimental to patient care. The goal then is to train physicians in all three of these skills such that they become part of the clinical character with which physicians approach all their patients.

Gelhaus' focus on character here is meant to be an alternative to bioethical approaches that center on principles or rules (Gelhaus 2012b, 398). In this way, she focuses on a more Aristotelian approach to ethics than a utilitarian, Kantian, or similar approach. This is not an uncommon approach to bioethics (Svenaeus 2014b), but it is one that has less favor than approaches that fit better with the naturalistic attitude. Unlike principles, which can be static, "a character is the stable core of a person, not unchangeable, not expressed in every utterance or action, but it describes how a person tends to be, to act, to value—and also to feel" (Gelhaus 2012b, 398). Character can be developed and retrained when it has been developed poorly. If

¹³³ Though, she also notes that these are not the only abilities or character traits required for a physician (Gelhaus 2013, 132).

empathy is an aspect of the moral character of physicians, then it makes sense that it could be trained away by current medical education, as well as retrained when found lacking.

Gelhaus begins with empathy, which she defines this as an understanding of the patient along the same lines as the theory of mind debate (Gelhaus 2012a, 105-106). While she does often emphasize the primarily cognitive nature of empathy (Gelhaus 2012a, 108), she also makes it clear that empathy is as affective as it is cognitive (Gelhaus 2012a, 111; 2012b, 397). However, it is unclear exactly what she means when she says that empathy is affective. Drawing on Zahavi's work on empathy and intersubjectivity (Gelhaus 2012a, 110), which expands of Husserl's theories, she seems to argue that empathy is a unique affective response to the other (though, as noted in chapter 2, not in the sense that we would normally think of something as being an affect). She also seems to share Stein's view that affects are rational judgments of the world (Gelhaus 2012a, 106). However, as explained in the first chapter, the reconciliation of these two kind of theories is problematic. This will need to be solved before her theory can be viable.

According to Gelhaus, there are three different, interrelated aspects of empathy. The first aspect is "the emotional involvement of the physician and the degree of emotional parallelism with the patient that is sufficient for understanding" (Gelhaus 2012a, 106). This is similar to Halpern's emotional resonance aspect of empathy. It is a parallel feeling of the patient's feeling, if only just enough that the physician has a very basic understanding of the patient. As such, it faces similar problems to Halpern's theory in that this sets up the affectivity of empathy as being simulationist. This, however, can be overcome in with the idea of affective reversibility, as also done in the previous section with Halpern. It also seems that Gelhaus would be sympathetic to this solution, since she is clear that the affectivity of empathy should not be taken in the strong

since of being a mere mimicry (Gelhaus 2012a, 108). In fact, she cautions against being too closely emotionally involved in a patient's life (Gelhaus 2012a, 107). This is because too strong of an emotional pull can cause one to act towards patients in a way that may be overly paternalistic and/or harmful. Gelhaus believes that this may happen if physicians only possesses compassion, but not empathy (Gelhaus 2012b).¹³⁴

The goal is to avoid both extremes. Empathy is not entirely emotional resonance, but neither should it be understood as entirely lacking emotional resonance. Resonance leads to a better understanding of affectivity than detached concern, but pure emotional resonance would simply be emotional contagion, which also does not qualify as an understanding of the patient. Gelhaus argues that “without any experience of and reference to one's own feelings it will be impossible to understand the feelings of another person” (Gelhaus 2012a, 107). To be clear, all Gelhaus is arguing here is that physicians need to be able to reference when they had a similar emotional experience in order to have an inkling of the patient's current affective state. She is not arguing that physicians actually need to be feeling the same affects as their patients. However, if the affective aspect of empathy here is the emotional resonance, but the resonance does not need to be experienced affectively when empathy is being experienced, then it would seem that empathy itself is not an affect. It is merely a cognitive recall of a previous affect. This is why I argue that emotional resonance needs to be reconceptualized as affective reversibility, since it maintains empathy as an affect, while empathy does not need to be a mirroring of affect.

¹³⁴ This goes back to the divide between detached concern and sympathy discussed in the first section of this chapter. These are established as extremes in medicine, where sympathy is an overly strong emotional engagement with the patient and detached concern is devoid of emotional engagement. Detached concern can easily lead to unwarranted paternalism, whereas sympathy risks leading to either paternalism or avoidance, based on the physician's affective response to the other.

The second aspect of empathy is the role played by the physician's subjectivity in his or her experience of empathy (Gelhaus 2012a, 106). It is often treated as if the empathizing subject is somehow abstracted out of the empathizing experience, and the other is merely understood by an unaffected individual, but this is never actually the case (Pedersen 2008, 327). Gelhaus is correct to note that the empathizer is always part of the experience of empathy. The subject's background knowledge and experiences are present in the experience of the other, such that "one's own authentic person cannot be totally removed"—they can only be acknowledged and accommodated (Gelhaus 2012a, 110). As should be clear from the sections on detached concern, the physician's affective state cannot be totally removed from his or her experience of the patient. In a similar vein, we can expand on Gelhaus point by arguing that there are aspects of the foreign subjectivity that cannot be totally experienced or acquired (Slaby 2014a). While it would be incorrect to argue that the other is entirely inaccessible to me, it is important to acknowledge that there are some "blindspots" for empathy. One important blindspot of empathy is that each "person's conscious perspective has a background/foreground or projection/baseline structure that is virtually impossible to emulate by another" (Slaby 2014a, 253). Slaby argues that the other is not "a passive container filled with an array of 'mental items' that might then somehow be 'mirrored', 'simulated' or otherwise 'represented' by another" (Slaby 2014a, 257). In terms of physician and patient, the patient has a history and background beliefs that are not grasped, even in empathy. More is required of the empathizing physician if these are to be accessed and understood.

Finally, Gelhaus argues that there is a necessarily moral dimension to empathy (Gelhaus 2012a, 106). What she means here is that empathy is a necessary component of a moral attitude—"an anthropological precondition for morality, a necessary skill for good clinical action

and decision-making, and also a moral-pragmatic activity” (Gelhaus 2012a, 111). Without empathy, there would be no basic understanding of the other from which to build more complex understandings, and therefore no basis for moral action with respect to the other. It is worth cautioning here against taking the opposite track and arguing that empathy is necessarily moral. In fact, Gelhaus argues that empathy on its own will not make a physician moral.

Whereas Gelhaus is worried that a lack of empathy could lead to physicians being overly emotionally invested in their patients, she is also worried that “a perfect empathic understanding may very well be used for selfish or even malicious intentions” (Gelhaus 2012a, 110). Empathy, as an understanding of the other, could be used to either help people or harm them (or even to do nothing at all) (Gelhaus 2012b, 399). Scheler offers similar words of warning in his work. In his discussions of sympathy, he argues that an understanding of the other can also be useful to the cruel man who understands the other’s suffering and uses this understanding to inflict more suffering (Scheler 1954, 14). A good understanding of the other can be used for well or ill. This is one of the reasons that Scheler argues for the importance of fellow-feeling, and why Gelhaus argues that compassion is equally as important as empathy for the moral attitude of the physician.

Gelhaus defines compassion as “a certain emotional response to the experienced suffering of another person” (Gelhaus 2012b, 399). Though, it is important to distinguish between everyday compassion and professional compassion. Everyday compassion is characterized as being a warm, spontaneous emotional response to the other (Gelhaus 2012b, 399). This is when we feel very strongly for or about others and their emotional states.¹³⁵ However, even when

¹³⁵ While Gelhaus uses the term “compassion” here to relate to this affective experience, it is important to note that this is essentially the same phenomenon that Scheler calls “sympathy.” It is an affective experience directed at the other’s affective experience. The only difference here is that Gelhaus thinks there is a necessary aspect of benevolence to compassion (Gelhaus 2012b, 399), while Scheler thinks that sympathy can be either benevolent or

interpreted as an entirely benevolent experience—as Gelhaus does (Gelhaus 2012b, 399)—she does not think that this is the right kind of compassion for medical professionals.

There are three problems that arise for everyday compassion: “the fear of overstraining, of condescension and of injustice” (Gelhaus 2012b, 402). Overstraining refers to the problem of professional burnout, such as when physicians become too emotionally invested in their patients, and become emotionally strained when they are unable to help. Condescension refers to the way that a compassionate attitude could become, or at least be perceived as, pity. Finally, the problem of injustice refers to the inability to express the same level of compassion towards all patients in the same way (Gelhaus 2012b, 402). Physicians will often feel more compassion towards some patients than others, but how can this be morally permissible?

Gelhaus argues that it may be possible to overcome some of these problems if we set aside the idea of compassion in the everyday sense, as the “usual spontaneous unprocessed emotion” (Gelhaus 2012b, 402). Gelhaus recommends that physicians need to maintain the morally useful aspects of everyday compassion and use them to create a more professional attitude (Gelhaus 2012b, 399, 403). The important difference between compassion as an everyday attitude and a professional virtue is that the latter is “calmer and influenced by the goals and duties of medical practice” (Gelhaus 2012b, 399). This avoids the overstraining nature of everyday compassion, since professional compassion will not cause such a strong emotional connection (Gelhaus 2012b, 403).

However, as a professional attitude, this conception of compassion still has two problems. The first is that there is a problem with requiring physicians to experience affects. As Gelhaus

malevolent—the subject can either feel sadness or joy at the other’s suffering. It is also worth noting that Gelhaus defines sympathy in the way that Scheler defines emotional contagion—“sharing the same feelings with the other” (Gelhaus 2012b, 399).

says, “though we might prefer persons as healthcare professionals who are talented for compassion and feel it rather often for their patients, it is useless to demand it in the cases when it is absent” (Gelhaus 2012b, 402). Requiring affects can lead to physicians simply acting like they are experiencing compassion, or cause them to become resentful and annoyed at forcing an affective experience. It is very difficult to simply will oneself into a new affect, and it would be unrealistic to require physicians to do so.

The second problem is the asymmetry involved in compassion and “its possibly condescending implications” (Gelhaus 2012b, 404). Due to the nature of the clinical encounter, compassion is set up to be an experience that physicians have for their patients, but not the other way around. However, this seems to be an unavoidable consequence of compassion. As Gelhaus says, “there is no chance to guard the morally good aspects of compassion and at the same time to make it something symmetrical that focuses on direct mutuality” (Gelhaus 2012b, 404). Because compassion leads one to approach the other in a benevolent way regardless of the patient’s actions, it must be one-sided—or it at least cannot be required that the patient reciprocate. To require it to be symmetrical, or reciprocated, would take away the inherent benevolence of compassion.¹³⁶

At this point, as with empathy, compassion alone is not enough (Gelhaus 2012b, 406). On its own, compassion can lead to paternalistic actions that do not fully understand the patient’s views on his or her own situation. For instance, there is the risk of “death angels” who end the lives of patients for whom they are very sympathetic (Foss 2006). They do this because they feel so deeply for their patients that they cannot bear to see their patients suffer any longer, but that does not make the taking of a life any less ethically problematic. When combined with empathy,

¹³⁶ While this is a risk for professional compassion, Gelhaus also argues that it is an even bigger risk for everyday compassion (Gelhaus 2012b, 404).

however, “compassion recognizes needs and moves the doctor to react in a kind and respectful way in order to help” (Gelhaus 2012b, 406). Together, they provide physicians with both an understanding of their patients and a benevolent emotional connection to their patients. However, even when taken together, they are still deficient in an important regard: they are not in themselves calls to action (Gelhaus 2012b, 400). This is why care is also needed.

Taken in the most general sense, care can be either about or for anything, though Gelhaus is of course interested in the care specifically about other subjects (Gelhaus 2013, 128).¹³⁷ Accordingly, she argues that when physicians care for their patients, there is a call to action—specifically actions that are intended to help the patient (Gelhaus 2013, 128-130).¹³⁸ She says,

If I care for somebody, I really want and intend to help him. It is more than a benevolent inclination or a mere tendency... A caring attitude demands a caring activity from me, and though I can be caring even if I have no practical opportunity to help, there must be forces that inhibit me in order to prevent my activity. A caring attitude is an impulse to act. (Gelhaus 2013, 130)

When physicians care about their patients, they want to help them in the fullest way possible. Thought, this drive towards action would be empty without the influences of compassion and empathy.

Compassion serves as the background against which care is properly guided (Gelhaus 2013, 131). In the absence of compassion, there is a risk of “insensitivity and inadequate activism” (Gelhaus 2013, 131), as if acting with respect to the patient were merely a routine that

¹³⁷ Especially when it comes to clinical encounters, it is important to distinguish between “caring for” and “caring about” (Gelhaus 2013, 129). The former refers to when medical professionals provide treatments, without any additional emotional connections, such as compassion (Gelhaus 2013, 129). It refers to the activity of merely providing care for the patient. Caring about, on the other hand, is more inclusive, relating to whole subjects. This is the care in which she is interested.

¹³⁸ In a moral sense, care is about intentions—it “is no consequentialist concept” (Gelhaus 2013, 129).

one is required to follow. This makes compassionate care a “morally valuable” kind of care (Gelhaus 2013, 132), because it is an emotional connection to the other that drives us to help the other. It is compassionate care that leads to the benevolent actions of physicians towards their patients, such as “history-taking, diagnostics, therapy, information, acquiescence, consoling, as well as all activities of nursing” (Gelhaus 2013, 132). Compassion establishes the emotional connection to the patient and the patient’s situation, and care inclines the physician to help the patient.

Empathy is the final important ingredient of the moral attitude because it provides the necessary understanding of the patient that focuses benevolent action of compassionate care at the best treatments. Empathy “directs the benevolent attention to the special, unique person of the patient, and it guides the developing relationship between patient and doctor to gain the adequate balance between nearness and respectful distance” (Gelhaus 2013, 132). That is, empathy provides the genuine understanding of the other and the other’s situation that best guides the physician’s emotional connection and therapeutic actions. Combined into a moral attitude, “empathic compassionate care” serves to guide physicians in every situation (Gelhaus 2013, 133).

5.3 Conclusion

Following the discussions of the previous chapters, empathy has been defined and explained in a number of ways, largely pending on the theories of intersubjectivity being employed. While Husserl and Stein focused on transcendental approaches to intersubjectivity and thus needed empathy to bridge the gap between subject and other, Scheler focused on an undifferentiated stream of intersubjective consciousness before individual subjects, making empathy an unnecessary skill. In terms of explanation and intersubjectivity alone, there is

nothing inherently wrong with these theories of empathy. In fact, it can be argued that these theories of intersubjectivity necessitate these theories of empathy. However, it is only when additionally assessed with the corresponding theories of affectivity that these theories seem to be problematic. That is, their theories of empathy are either inconsistent with their theories of affectivity or they exclude empathy as an affect all together. Even Gallagher's theory which presents a more moderate, multi-leveled approach to intersubjectivity and acknowledges that empathy is affective at its core, does not explain the affectivity of empathy. At best, he merely leaves sufficient room in his explanation of empathy for it to be an affect.

Especially when examining the problem of detached concern, it can be seen that empathy only came to be associated with detached concern as a way to incorporate it into the already established preference for cognitive approaches over affective (felt) approaches. That is, empathy was explained as a mere subjective feeling in traditional medicine, but was eventually redefined as a cognitive skill when it was needed for better patient care. This then left sympathy to fill the affective void left by empathy. Paralleling and directly connected to the feeling/cognitive divide in the philosophy of emotion, this dichotomy between subjective feelings and objective cognitions can be shown to be both untrue and problematic. There is a need to overcome this divide and see both emotions and empathy as affective phenomena that are important in and of themselves.

The phenomenology of affectivity explains the various features of affects that make them important to our lives, even if we do not equate them to things like reasons, appraisals, and judgments. Affects are our relations to the world, some of which possess motor intentionality such that they move us in the world, while others allow for the world, others, and other affects to show up for us at all. In this way, affects cannot be reduced to any one affect—such as emotions,

moods, or feelings—but rather encompasses all of these affects as temporally intertwining relations to the world. Additionally, they are below the level of the will meaning that affects are already influencing us before we judge or reason.

In the context of this phenomenology of affectivity, I explained three possible alternative theories for clinical empathy, chosen because all three aim to revalue the role of affects in clinical practice. Narrative medicine, like IT, does provide an excellent supplemental framework to evidence-based medicine in which patients can be best understood. However, if taken as a theory of empathy, it focuses too strongly on the higher-level, cognitive means by which we understand others affects, but not enough on the affectivity of empathy itself. Halpern's theory of empathy as engaged curiosity is both compatible with the narrative approach, while also addressing the affectivity of empathy in the form of affective resonance. There is a problem in the way that Halpern characterizes the affective aspect of empathy as being an emotional resonance, but if we reconceptualize emotional resonance as affective reversibility rooted in primary intersubjectivity, then we can avoid the problems of simulation. This allows for clinical empathy to be both affective at its core in a way that corresponds well with the phenomenology of affectivity, and include the attunement to the physician's own affects as well as the patient's affective forecasting. Additionally, it helps repair trust and establish a method of shared decision making.

The remaining problem with this theory is not necessarily a problem with the theory of empathy, but rather a limitation of empathy. Clinical empathy, now defined as more akin to what Daly called primary empathy, establishes the primary emotional connection to the patient, but not much else. It serves as the clue that guides our further inquiries into the patient's experiences and the shared decisions concerning treatment. However, it does not account for all of the other

affective engagements that can and should take place between patient and physician. In other words, while it is important in the way that it connects us to others and may drive us to inquire more into the other's situation, I share Gelhaus' doubts that it will be enough to drive moral actions on its own. I agree that there are many different intersubjective affects that need to be fostered in order to ensure ethical behavior. Empathy cannot encompass the diversity of ways in which we interact with others, nor should it. Empathy is at the core of our intersubjective interactions. Built on empathy are other affects such as sympathy and care, but also Scheler's emotional contagion, emotional sharing, and emotional identification (feeling of oneness). We need to know which ones are warranted in clinical encounters and which ones would be detrimental.

Conclusion

If clinical empathy is going to be encouraged, then we need to be sure that physicians are being trained in the correct theory of empathy, where the correct theory of clinical empathy is measured by whether or not it leads to the best possible patient care. As stated in the introduction, finding this theory is easier said than done. Approaches to empathy have been divided, and divided again. Different theories compete with each other, but only within their respective analytic and continental traditions. The result is two largely-isolated approaches to empathy: the analytic, understanding-based theories and continental, recognition-based theories. This division has caused a serious difficulty in creating a consensus in the empathy literature.

To further problem of this divide, there are several aspects of empathy that have been neglected by both analytic and continental approaches. Ideally, it would be best to work equally with the theories of both approaches to overcome these common problems and create a better, hybrid theory of empathy. However, since the goal in this work is to provide a better theory of specifically clinical empathy, and simulation theory (ST) has been shown to be the dominant theory for clinical empathy, I primarily focused on the phenomenological (continental) theories of empathy. Phenomenological theories of empathy have been neglected in medicine, thus making the examination of their strengths and weaknesses helpful in improving contemporary theories of clinical empathy.

In the traditional analytic approaches that interpret empathy as an understanding of the other, theories were presented as methods that were used to understand others from the subject's secluded position. Subjects are isolated from one another, meaning that they only have access to

their own mental states. The mental states of others are inaccessible to us, and therefore we need empathy—a means of understanding others—to bridge the epistemological gap between subject and other. While there have been a number of theories presented in this tradition, simulation theory (ST) is the one that has taken the strongest hold in medicine, and is therefore the one that most needs to be engaged with in discussing clinical empathy. In this theory, empathy is explained as a method that we apply to determine the other’s mental states. In its original presentations, it is a process of perspective-taking, in which the subject places himself or herself “in the others shoes.” This is how empathy is most often characterized in medicine and it is easy to see why. In terms of understanding the patient, this theory presents empathy as a method that any student can learn. Additionally, it is a method for empathy that a physician can apply in all circumstances.

Despite these perceived advantages, ST is vulnerable to several problems. One is the diversity problem, or that simulations do not provide a genuine understanding of diverse others. If better patient care is achieved through a better understanding of patients, and clinical empathy is supposed to help provide this better understanding, then ST fails to fit as a theory of clinical empathy. It does not actually lead to a genuine understanding of the other. Rather, it only allows physicians to project themselves onto their patients.

The other problem that arises for ST in particular, is that the affective aspects of our intersubjective relationships are neglected. Empathy is presented as an important method with which to derive the mental states of patients, including their affective states, but it is unimportant to empathy how the physician is affected by these states. There is no need for the simulation to include the physician’s affective connection to the patient, his or her affective responses to the patient, nor an understanding of how exactly these affects influence judgments and perceptions.

It is both possible and recommended that the empathizing physician disregard all of these affective states, rather than risk the understanding of the patient being affected by emotions. However, without an understanding of these important, affective aspects of our intersubjective lives, how can empathy be said to provide a genuine understanding of others?

In response to these problems, I argued that the discussion of empathy is at the intersection of two larger discussions: one in the philosophy of intersubjectivity and the other in the philosophy of affectivity. When either of these contexts is left out of the discussion of empathy, the overall theory of empathy will be lacking. This is demonstrated by the tight connection that exists between all theories of empathy and the theories of intersubjectivity that serve as their contexts. In fact, this connection is so tight that the two have often been seen as synonymous. Regardless of the tradition, the theory of intersubjectivity strongly influences the theory of empathy being presented. This is true whether the theory of intersubjectivity begins with isolated subjects that need empathy to understand others or it begins with an undifferentiated stream of communal consciousness in which empathy as an understanding is completely unnecessary. As such, it would be wrong to claim that one tradition is correct while the other is incorrect. Rather, it is important to address empathy holistically—not only as an intersubjective, cognitive processes, but also as an affective experience in which we always already find ourselves.

While this discussion of the relationship between empathy and intersubjectivity is essential to understanding empathy, it is also important that we understand the relationship between empathy and affectivity. This is shown by the problem of detached concern that arises in medicine. When theories of empathy are presented as if they only need to solve the problems of intersubjectivity, it is easy to neglect our affectivity, which is one of the most important,

influential dimensions of our everyday experiences of the world. For instance, as concerns clinical empathy, we see that ST lacks many of the affective aspects of empathy that make it a genuinely useful experience. It is possible, and currently recommended, to simulate the other in a neutral and detached way. The physician's affective experience is at best not important, and at worst needs to be entirely removed from the equation. This lack of a requirement for affective experience allows affects and their influences to be further devalued. Therefore, even if ST does help the physician obtain some limited understanding of what it might be like to be the patient, it does not contribute to the affective engagement between physician and patient. If anything, it further detaches physicians from their patients, which damages trust.

This approach is not only relevant to clinical empathy, but also empathy in general. To summarize, it was revealed in the examination of clinical empathy that defining it in terms of simulation and projection creates at least three problems. These are the discrepancy between the way empathy is defined and the way it is explained, the lack of diversity that this theory of empathy allows in our understanding of others, and the lack of affective understanding and affective engagement involved in the patient-physician interaction—also referred to as the problem of detached concern. These problems were used to derive three questions that are important for any theory of empathy, whether analytic or continental: (1) What is the process or experience being explained? (2) What is the intersubjective context of empathy? (3) What is the affective dimension of empathy? Various problems appear in theories when they are explained in such a way that they fail to address one or more of these in a consistent way. When we understand all three of these, we can work towards hybrid theories of empathy that are stronger than merely analytic or continental theories.

In response to the problems that arise for ST, I addressed two phenomenological theories

that approach empathy in a very different way from ST. Addressing these theories served three purposes. First, it demonstrated how the three questions of empathy can be applied to theories of empathy in order to assess them. Second, it allowed for phenomenological theories to offer insights into how it would be best to answer these questions, especially as these theories can be useful to the discussion of clinical empathy. Finally, it allowed me to critique these theories based on the answers given for the three questions of empathy.

While Husserl and Stein presented a theory of empathy that arguably epitomizes the primary nature of the experience of empathy, it is flawed due to its phenomenology of intersubjectivity. Husserl and Stein began from an isolated, transcendental subject that needs empathy to bridge the gap between itself and others. This effectively isolated individuals, making empathy merely a tool used by the transcendental ego in order to perceive others as subjects. As such, empathy was reduced to the point that it was unable to be reconciled with their theory of affectivity. On the other end of the spectrum, Scheler emphasized the truly primary nature of our intersubjective being with others, but in such a way that empathy became unnecessary. Empathy was rejected in favor of other intersubjective affects, such as sympathy. This primacy of the affective aspects of our lives, while a step in the right direction, is wrong in the way that it characterizes and rejects empathy. Additionally, both of these theories are inevitably inconsistent in the way they would need to address the affectivity of empathy. Husserl and Stein leave no room in empathy for it to be an affect—at least not when affects are understood as perceptions of value—while Scheler prioritizes affects that reunite subjects, but leaves empathy itself as a non-affective skill.

Thus, phenomenological theories, while offering new insights for popular, analytic theories, still fail to present a theory of empathy that could answer the three questions of

empathy in a satisfactory way. In order to best address these theories, especially as they relate to the intersubjectivity of empathy, we need a hybrid theory. This is why Gallagher's interaction theory (IT) is so useful to this discussion. He combines phenomenological insights with the insights from the analytic theories in the theory of mind debate. As such, he presents a theory of empathy that is both an experience of the other and a process of understanding the other. He begins with a theory of primary intersubjectivity in which we have a primary recognition of the other, then he builds on this by adding the levels of secondary intersubjectivity and narrative competency. To briefly summarize these different levels, primary intersubjectivity is our most basic experience and recognition of others, secondary intersubjectivity situates us in a communal world with others, and narrative competency allows for us to understand both others and ourselves in complex ways.

The additional advantage of this hybrid theory is that it opens for affectivity to be an essential aspect of empathy. This is something that is being further discussed in contemporary narrative approaches to clinical empathy, as addressed in chapter five. By engaging with the problem of detached concern in medicine, Halpern, Gelhaus, and others build on narrative approaches to make them affective, as well as cognitive. They do so in such a way that they demonstrate the importance of affectively-aligned empathy in practically improving patient care. Specifically, like Gallagher, they note that empathy must have a core of affectivity. While none of them are entirely clear on what this affective core is, it is possible to fill in this gap in the explanation. I appeal to Daly's application of Merleau-Ponty's reversibility thesis to affectivity, which can be consistently applied to IT and narrative-based approaches.

According to this thesis, affects are reversible in the same way that all of our perceptions are reversible. The chiasms formed in this reversibility reveal us as intimately intertwined with

others, the world, and the world with others. Affective reversibility is our immediate, affective recognition of the other's affects. This is like Scheler's feeling of oneness, but to a lesser degree. Whereas a feeling of oneness associates one's entire being with the other, empathy is a feeling of merely the other's feelings. This is also not meant in terms of emotional contagion or sympathy, since empathy is not a feeling like or about the other. It is a feeling *of* the other. Furthermore, if affects are understood as one's relation to others and the world, as is explained in chapter five, then empathy as affective reversibility is the feeling of the other's relationship to us and the world. In this sense, affective reversibility is the affective core of empathy, and this occurs at the levels of primary and secondary intersubjectivity. For this reason, I will call this primary affective recognition *primary empathy*, since it is the most basic level of empathizing.

At this point, we can conclude that the best ways to explain the two contexts of empathy and define empathy itself are as follows:

Intersubjectivity: In line with IT, there are three different levels: primary intersubjectivity, secondary intersubjectivity, and tertiary intersubjectivity (narrative competency). Primary intersubjectivity is our immediate and pre-reflective experience of other subjects; secondary intersubjectivity establishes an understanding of a mutually accessible world with others; and tertiary intersubjectivity includes both the store of narratives and the skills for constructing narratives with others that help to develop a more complex understanding of diverse others.

Affectivity: In line with the phenomenology of affectivity, affects are our relations to the world, some of which possess motor intentionality such that they move us in the world, while others allow for the world, others, and other affects to show up for us at all. In

addition, affects are reversible in the same way that all of our perceptions are reversible, such that we can feel others affective relations.

Empathy: Based in these two contexts, I define empathy as a multi-leveled understanding of the other, where “understanding” is taken in the broadest sense possible—including both basic, affective recognition and complex, high-level understanding. The most basic level of empathy, *primary empathy*, is the subject’s affective reversibility with the other in which there is an immediate affective recognition of the other’s affects. It is the subject’s feeling of his or her relation to the other, as well as their mutual relation to the world. The most complex level of empathy, which can be called *narrative empathy*, is a higher-level understanding accomplished by applying narratives and narrative-building exercises. Narrative empathy is based on primary empathy, and both levels of empathy are based on an already established primary intersubjectivity.

In short, this establishes the combination of Gallagher’s IT and primary empathy (affective reversibility) as being the theory of empathy that best answers the three questions presented for theories of empathy. Furthermore, it is important to note that empathy requires both levels explained above, especially in the sense of clinical empathy.

While primary empathy is the core of empathy, it would be problematic to leave theories of empathy at merely the primary level. For example, defining clinical empathy as primary empathy would not be a very useful theory for medicine, since it would not be something that physicians can learn, apply, and improve. The only effect that they can have on this kind of empathy is the way in which they use narratives to improve their ability to empathize (which then improves their inclination to build narratives.) In other words, primary empathy answers the

intersubjectivity and affectivity of empathy is a satisfactory way, but it does not answer the explanation of empathy in a way that fits well with medicine. Clinical empathy builds on this primary empathy, incorporating narrative competency into a higher-level understanding of patients.

This theory of empathy is a step in the right direction, but it is at best the beginning of a very long path. While presenting the three questions provides the best method for explaining empathy, and answering them helps to unite opposing theories with hybrid theories like IT, there are still many questions that need to be answered concerning this theory and empathy itself. To begin with, more research needs to be done on primary empathy. While I agree with Scheler, Merleau-Ponty, and Daly that there is a primary affective recognition of the other, the literature on how exactly this works is very limited. More research needs to be done on affective reversibility, particularly in newborns and children.

Furthermore, because this theory presents empathy as multi-leveled, the relationships between these levels should be further researched and explained. Specifically, in what ways do primary empathy and narrative competency influence one another? It seems equally likely for primary empathy to lead to sympathy or emotional contagion as it does for empathy to lead to narratives. This makes sense, since we need to be able to recognize others as emotional beings before we can sympathize with their emotions, catch their emotions, or build narratives. In other words, primary empathy is a prerequisite for both sympathy and narrative-building. However, it needs to be explained why some affective recognitions lead us to try to understand the other better through narratives, while others cause us to respond with additional affects towards others.

Along these same lines, it needs to be better understood how narratives are able to affect our primary empathy. It seems consistent with the theory of empathy presented here that

narratives can alter the ways in which we initially empathize with others, sometimes reconditioning us to not even recognize some others as other subjects. But, how is this possible? To what extent can our narratives affect our primary empathy? These are especially important questions for medicine.

When it comes to clinical empathy and medicine, especially with regard to the lack of interest that physicians and students have in empathy, it is important to explain how students can be trained to empathize. The likely answer following the provided definition is that they should be trained in how to apply and build narratives. The reasoning for this is that primary empathy, like an emotional reaction, cannot be directly controlled. Rather, it can only be acknowledged, understood, and accommodated. However, also like emotional responses, primary empathy can be trained into better habits. The way to do this with empathy is to learn how to build and apply narratives, which then makes it more likely to experience and attune to one's primary empathy in the future. This method of using narrative-building methods to train empathy will need to be the focus of future works on clinical empathy and medical education.

Finally, because empathy does have its limitations as concerns our intersubjective, affective lives, it is important that research also be done into other intersubjective affects. Empathy, while an important and useful experience in the way that it connects us to others, is not the only important intersubjective experience we have. Gelhaus is correct to argue that it cannot do all the work in guiding our intersubjective interactions. We need other affects, such as sympathy and care to ensure our interactions with others will be ethical. If we really want our physicians to provide the best possible care, then they need to foster a number of intersubjective affects. That is, physicians need more than just clinical empathy; they need clinical affectivity.

In conclusion, while the primary goal in this dissertation was to argue that all three questions of empathy need to be discussed—that both the intersubjectivity of empathy and the affectivity of empathy are vitally important—I also argue that the combination of IT and primary empathy create the best theory of clinical empathy. Especially when combined with clinical affectivity, this theory of empathy is most likely to lead to a better understanding of patients and, in turn, contribute to better patient care. Again, this is not to say that there are no problems with this theory of empathy, but simply that it is the one that does the best at addressing the intersubjective and affective contexts of empathy in a way that other theories have failed. It is my hope that this will encourage others to discuss hybrid theories of empathy—especially clinical empathy—in respect to its two contexts so as to further this discussion.

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