Empathy in patient care: making a concept (1940-1959)\textsuperscript{1}

Empatia nella cura del paziente: formazione di un concetto (1940-1959)

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The paper contributes to the understanding of empathy by American psychosomatic medicine in the 1940s-1950s, the most important period in the development of this School. I will discuss what empathy is, how it works, and who is capable of performing it analysing stories of poliomyelitis patients and their parents.

I will focus the study on the management of the emotional impact of the diagnosis of poliomyelitis, then considered a tragic diagnosis, in both patients and their parents. I also will refer to how the professionals, especially nurses, perceived the experience of illness in hospitalized patients, because of the interesting and disturbing impacts of these perceptions, from an empathic point of view.

As we will know, narratives play a central role in the representation of empathy in the special link established between physicians and other health professionals and poliomyelitis patients, because of the relational quality of empathy. Thus, we will observe positive and negative aspects of the empathy in the clinical practices.

Key words: History of emotions, psychosomatic medicine, poliomyelitis, doctor-patient relationship, empathy, medical narratives


Concentrerò lo studio sulla gestione dell’impatto emotivo della diagnosi di poliomielite, all’epoca considerata infausta, sia nei pazienti che nei loro genitori. Descriverò anche come i professionisti della salute, in particolare gli infermieri, percepivano dal punto di vista empatico, l’esperienza della malattia nei pazienti ospedalizzati, per interessanti e inquietanti impatti di tali percezioni. Come verremo a sapere, le narrazioni giocano un ruolo fondamentale nella rappresentazione dell’empatia nella speciale relazione che si viene a stabilire tra medici e altri professionisti della salute e pazienti affetti da poliomielite, a causa della qualità relazionale dell’empatia. Infine, osserveremo gli aspetti positivi e quelli negativi dell’empatia nelle pratiche cliniche.

Parole chiave: Storia delle emozioni, medicina psicosomatica, poliomielite, relazione medico-paziente, empatia e narrazioni mediche

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Background: an “empathetic turn”

Empathy is the understanding of the other through an emotional identification with someone else’s the world of feelings and personal experiences. Empathy can be also defined as a natural need of human beings to share their sorrows and joys. It is therefore a condition for the existence of society itself. Martha Nussbaum’s widely quoted definition states that: “empathy is an imaginative reconstruction of another person’s experience, whether that experience is happy or sad, pleasant or painful or neutral, and whether the imaginer thinks the other person’s situation good, bad, or indifferent” (Nussbaum 2001: 302).

We commonly speak about an “emotional turn” that occurred in the 1990s in the social sciences and the humanities. I want to suggest that we can also speak about an “empathetic turn” in the health professions area.

Studies on empathy are rooted in Greek thought and there are numerous writings on “empathy” throughout history (Bulger and Barbato 2000), although the term “empathy” was coined over 100 years ago by Edward Titchener (1867-1927), as an adaptation of the German word Einfühlung (Cuff et al. 2014: 144). Ute Frevert (2014) also notes the interest on empathy during the eighteenth and nineteenth centuries and the contributions of Adam Smith (1723-1790) in The Theory of Moral Sentiments (ed. by Haakonssen 2002). Smith explained that “empathy was conditioned by an inherent theatricality that, by making persons into actors and spectators who distance themselves from each other and even from themselves, forestalls the possibility (the dream) of complete sympathetic merger or identification” (Leys 2014: 67).

In the early twentieth century, interest in empathy increased, partly due to the writings of Theodor Lipps (1851-1914). This German philosopher and psychologist worked on theory of art and aesthetics, formulating a theory on aesthetic empathy (Einfühlung) between 1903 and 1906. He established a process of affinity between the object and the subject, noting that this is the intersection where a person recognizes the “other” as itself and sympathizes with that other. This process allows the subject to find some knowledge of him or herself which, until that moment, he or she did not know. But Lipps himself criticized the theory of the analogy as a way of explaining the problem of the “other”. The term Einfühlung had already been used by the philosopher Robert Vischer (1845-1933) in the context of his aesthetic theory. Thus, Einfühlung became important for discussions on the problem of the “other”. Later on these questions become central to phenomenology by Stein (1891-1942) and Husserl (1859-1938) (Stein 1917-2004).

From this time, studies on empathy emerged from several academic disciplines, including neuroscience, sociology, education, psychology, philosophy, and literature, including medical narratives (Hammond,Kim 2014: 1; Assmann, Detmers 2016: 3). In an attempt to periodize these analyses, Meghan M. Hammond and Sue J. Kim have differentiated between “a history of empathy before the mid-twentieth century and a contemporary understanding of empathy: since the mid-twentieth century” (Hammond, Kim 2014: 2-3). Following a historical-medical perspective, my reading of polio patient’s narratives would be located at the beginning of the second stage.

A term and some concepts

But, in spite of the growth of the research on empathy in Medicine, and partly because of it, Amy Coplan observes that “there is no clear and agreed upon answer to the question of what empathy is” (Coplan 2011: 42). Definitions range from basic or lower-level empathy, also called “mirroring”, to higher-level empathy, also called “perspective shifting” (Hammond, Kim 2014: 7; Cuff et al. 2014: 144; Assman, Detmers 2016: 1). Following this idea, Elena Pulcini admits that the reference to the emotions remains generic and she proposes as distinction between the different emotions that motivate care (such as love, compassion, and generosity) (Pulcini 2016: 1). In a similar way, Assmann and Dettmers underline that “to better understand it [empathy] we can start by setting it off from other terms such as sympathy, pity, and compassion” (Assmann, Dettmers 2016: 3).

Moreover, as scholars such as Ruth Leys, Daniel Gross or Stephanie Preston explain, studies on empathy – also in medicine – reflect the tensions and the controversies between the so-called “two cultures”, that of experimental science, on the one hand, and the humanities, on the other (Gross, Preston 2014; Jensen 2014). Leys is especially critical of the exclusive neuroscientist vision, maintaining that “the implication of my analysis is that the issues confronting empathy theorists are as much theoretical or, say, philosophical as they are technical or scientific.” (Leys 2014: 67; Leys 2011). Therefore, although empathy is being studied through imaging techniques and in experimental laboratories, as a human phenomenon, we have to observe it in specific cultural and historical frameworks.

Physicians such as Kevin Browne and Paul Freeling, considered two of the most influential general practitioners during 1960s because of their studies on the doctor-patient relationship, underline the contribution of psychoanalysis to the increasing importance of empathy in medicine. However, at least initially, Freud expressed the difficulty of empathic experience because, according to him, “rivalry with the other is as inherent in human nature as is love and indeed is inseparable from love: the taming of these emotions is the necessary but endless task of civilization” (Kramer 1994). He made psychic ambivalence a constitutive impossibility in the separation of eros and thanatos, love and hate, immersion and distance—ideas central to his understanding of the sympathetic-identificatory phenomenon. Moreover, it appears that Freud rarely referred to “empathy” (Einfühlung), because, at
the beginning of the century, the term was reserved primarily for the feelings of an observer in relation to a work of art (Kramer 1994; Frevert 2014: 4). Freud later revised his ideas on empathy because of the development of psychotherapy (Spiro et al. 1994: 8 and 134). At that time, empathy was considered the “mechanism by means of which we are enabled to take up any attitude at all towards another mental life” (Freud 1955: 110; see Lunbeck 2011: 235-275).

Contributions of psychoanalysts such as Heinz Kohut (1913-1981) were crucial for the development of empathy in medicine. Kohut was part of the group of Central European psychiatrists who immigrated to the United States before World War II (Ash and Sollner 1996; Roelcke, Weindling, Westwood 2010). When Kohut reached the US in the 1940s, he became a member of the Chicago Institute for Psychoanalysis, where he met Franz Alexander (1891-1964), one of the founders of the American psychosomatic medicine. Kohut himself founded the school of psychoanalytic thought known as self psychology.

Kohut introduced the concept of empathy as “vicarious introspection” (Hammond and Kim 2014: 7; Lee et al. 2009: 26; Spiro et al. 1994). His notion of psychoanalytic empathy was focused on the experience of the patient; he held that “empathy is never an outside (objective) assessment by a psychotherapist, but a knowing of the patient from the patient’s point of view, that requires the patient’s active participation” (Lee et al. 2009: 31; Kohut 1984: 175). Kohut also pointed out that empathy was value-neutral: it could be used for kind and unkind purposes alike. Since then, empathy has been understood within psychoanalysis as a form of knowledge, as affective communication, as a capacity, as a process, as an expression, as an ability, as a mode of data gathering; as an experience, or a form of perceiving it (Reedd 1984: 12-13).

Later in this itinerary was Harry A. Wilmer, one of the pioneers of group therapy in North America. He trained in psychiatry at the Mayo Clinic where he also was on the staff, and later he was at the Faculty of Johns Hopkins University, Stanford, and the University of California, where he moved away from his Freudian roots to become a Jungian analyst. Wilmer explained that the empathic connection between doctor and patient was closer than other human relationship because through it: “we enter imaginatively into her/his life and feel as if it were our own.” (Wilmer 1968: 407).

In this context we can discuss some features of the concept of empathy that launched psychosomatic medicine in the 1940s and 1950s, the most important period in the development of this holistic movement and a time at which a new meaning of empathy developed in medicine. The early American psychosomatic doctors sought a middle ground between the organic-physiological aspects of illness and Freud’s theories. The term “psychosomatic” was used to describe the organic/biological diseases that could have a psychological etiopatogenic component (León-Sanz 2013b). In addition, specialists of this movement emphasized the influence of psychosocial and environmental factors as causes of disease and proposed clinical and therapeutic recommendations that were later incorporated into medical practice (Hitzer, León-Sanz 2016).

One of the most important promoters of this movement, Franz Alexander, considered that the empathic bond was instinctive and common to everyone: “We also know intuitively that a person who is overwhelmed by a threatening situation cannot use his reasoning faculties effectively and therefore we try to calm him down by giving him support” (Alexander 1946: 110). And that “the most of the therapeutic factors, such as emotional support, abreaction, insight, persuasion are consistently used by everyone in his everyday life” (Alexander 1946: 114).

I will use these ideas to think through what happens when the disease is caused by a “strictly” biological agent, such as poliomyelitis. Through the voices of polio patients and their parents, I will analyze what empathy signified for them, how it worked, and who was capable of performing it. To do this, I use the testimonies reported in a research project carried out by Dr Jacob Finesinger (1902-1959) and his colleagues at the Department of Psychiatry of the University of Maryland in 1956 (Cobb 1959).

His project focused on a group of children with spinal poliomyelitis, all with some degree of lower-extremity involvement, and attempted to study some of the circumstances and factors that appeared in the patients and their families and how they adjusted to the total experience of the disease and its consequences. The research team included psychiatrists, pediatricians, sociologists, psychologists, and psychiatric social workers. They designed a longitudinal investigation, with a series of observations and personal interviews to observe directly whatever changes occurred (Robinson et al. 1956).

Poliomyelitis (polio or infantile paralysis) is a disease caused by a poliovirus; in most of the cases, infection causes no symptoms or minor ones, but in a small percentage (0.5-1%) the neurological affection produces muscle weakness resulting in an inability to move. The weakness usually involves the legs but may affect muscles of the head, neck and diaphragm. People who recover may be severely handicapped. Further, post-polio syndrome – a slow development of muscle weakness similar to what the person had during the initial infection – may occur years after recovery (Atkinson et al. 2009; National Institutes of Health 2014; WHO 2014).

Various epidemics occurred in many countries in the twentieth century, particularly in the US, until the discovery
of the polio vaccine in the late 1950s. The first vaccine was
developed by Jonas Salk with inactivated or killed polioviruses; it was reported on April 12, 1955. The second vaccine
developed by Albert Sabin used oral attenuated polioviruses and it was authorized in 1962. Through these two vaccines,
polio has been eradicated in most of the world (Porras Gallo et al. 2013).

Contributions: the experience of poliomyelitis patients
and the meaning of empathy

The frightful course and aftermath of polio led psychosomatic doctors to separate the experience of patients -and
the people around them, family and professionals- from the experience [and involvement] of any other disease (Robinson et al. 1956: 975). The emotional impact was considered one of the most important aspects to be taken into account in the medical approach to polio patients and their parents. “In effect this is a study of the emotional changes that take place at the same time as, and are presumably associated with, the physical changes with which the orthopedic surgeon is familiar” (Robinson et al. 1956: 976). For this reason, Finesinger and his colleagues complained about the way that treatment of these patients generally focused only on the musculoskeletal system (Robinson et al. 1956: 976; see also: Berger 1952: 46-59; Bronson Crothers, Meyer 1946: 324-6).

I want to discuss the emotional impact at the moment of the diagnosis of polio, in both patients and their parents. Narratives played – and play – a central role in the definition and the debates on empathy, since as a culturally significant experience, it has to be observed, not only felt. And through polio stories, we will show how viewing this “feeling with the other” becomes a key form of understanding empathy. As Arthur W. Frank explains “empathy depends on the patient work of learning the stories that others tell about themselves and their world. Empathy is respecting how those stories lead that other person to act and why that action makes sense to someone who lives with those stories. And then, based on that knowledge, empathy includes imagining oneself as a character in that other person’s story, seeing that character’s actions within the narrative logic of that story” (Frank 2016: 164).

Fear of the term “Polio”: the need for empathy

A mother whose adolescent son had a residual paralysis from poliomyelitis, “when asked to tell how she thought
her son had contracted poliomyelitis, her reply was: “This may be a stupid theory of it, but I really think it comes from milk”. She went on to describe a violent altercation she had had with her milkman (Robinson et al. 1956: 975).

Poliomyelitis, the simple word itself – noted psychosomatic physicians – was loaded with strong emotions for most people and it was difficult for many people to overcome them. In the case presented, the mother was a woman of average intelligence, who had consulted many doctors, had read a good deal about polio and had tried to acquire as much information as possible about the disease (Robinson et al. 1956: 975-977). But, as in most cases, the stress and anxiety of the situation created misconceptions that were very difficult to challenge. Indeed, though she called her own explanation a “stupid theory”, she struggled to find an answer. Indeed, patients and parents generally manifested an extraordinary range of etiologic notions about the disease despite the wide dissemination of medical information about polio in the public press and through other media (Robinson et al. 1956: 975-7).

Doctors believed that neither patients (partly because of their age) nor their families could fully understand the medical information they provided. The emotional reactions caused by the diagnosis distorted medical knowledge in curious ways. Often, families were unable to share the rational and scientific knowledge about the disease. This situation produced a distance in the doctor-patient-parents relationship.

Helen Flanders Dunbar (1902-1959), another influential figure in American psychosomatic medicine of the 1930s and 1950s noted that unless there was a complete connection and an empathic understanding between doctor and patient, very little could be achieved. Empathy, in these cases, was evoked automatically by the doctor and was considered by Dunbar as a diagnostic (and therapeutic) instrument (Dunbar 1954: 685). In addition, the empathic connection should appear from the beginning of the relationship, as soon as the doctor and the patient met. Only thus could it be effective. “Treatment, claimed Dunbar, begins with the first gestures, words, glances exchanged between the patient and the doctor, not after the diagnosis had been made” (Dunbar 1959: 15). She stressed that providing substantial scientific data or many technical explanations did not imply a better understanding of such a shocking diagnosis. This aspect connects with the instinctive ability to give “emotional support” as Alexander noted, when he recommended that: “In such acute conditions, the primary aim of therapy consists in reducing the intensity of the disturbing emotions by emotional support” (Alexander 1946: 112).

The psychoanalyst Christine Olden (1888-1959), made similar observations. She was renowned for having studied empathy between adults and children and proposed that empathy was “the capacity of the subject instinctively and intuitively to feel as the object does” (1954: 111). She also explained that empathy was an experience of oneness: “Empathy trespasses defenses behind which the real feelings hide. […] Many who can empathize with young children cannot do so with adolescents and vice versa. Empathy is the capacity of the subject instinctively and intuitively to feel as the object does. Empathy trespasses defenses behind which the real feelings hide. Empathy is independent of love for the object. Blocks to empathy are self-complacency, aggressiveness, differences in ego structures of adult and child, and neurotic problems. Favoring empathy are passivity, patience, some belief in magic, slight anal fixation, some casualness about
destruction, all of which infantile traits do not dominate the personalities of the adults in point” (Olden 1954: 111-126).

However, the reaction of the mother in the patient’s case and other testimonies that we will see below, raised the convenience – or necessity – of also trying out the “corrective emotional experience” proposed by Alexander.

A six-year-old girl with a severe involvement of one leg and a minimal involvement of the other expressed at least eight distinct theories about the cause of her disease. At one time she suggested that she might have “caught it from a neighbor”. At other times she variously attributed significance to being lazy, to getting tired, to riding her bicycle, to an injection received in school and to been “beaten up” while walking home from school. On one occasion she expressed the idea that she had been poisoned by her teacher (Robinson et al. 1956: 977).

The child’s diverse explanations demonstrate that she believed that polio was basically a “kind of upset”. Shortly before she was discharged from the hospital, her mother told a research investigator “of her conviction that the poliomyelitis had been caused by water bugs in the basement of the home. The family dog had eaten the bugs, and then licked the child’s face” (Robinson et al. 1956: 977).

Interestingly, the child’s father had entirely different ideas. In a long interview some weeks later, he explained that he believed that: “their child’s infection had been caused by the pollution of air because of the plowing of a field nearby. He had observed that the rate of poliomyelitis in the city seemed to be highest in areas where new housing developments were being constructed, and had concluded that clearing land, digging foundations and the like were connected in some way with the spread of the disease” (Robinson et al. 1956: 977).

We detect a guilty feeling in the child that had been lazy and in the mother who did not clean the basement of the home, or had not been careful with the dog.

Another young patient said that “he caught polio because he had run and played too much” (Robinson et al. 1956: 978).

In these cases, according to Alexander, firstly, we should apply transference in order to identify and revive the original conflicts of the guilty feelings: “The transference situation gives the Ego a new opportunity to grapple with the unresolved conflicts of the past” (Alexander 1946: 110). Although, in our case, the original conflict would not be related to the cause of the disease, but with the way the patient or their parents understand the paralysis and live through suffering.

Through long and specific interviews with patients and parents, “the pathological effect of earlier emotional experiences is corrected by exposing the patient to the same type of emotional contacts in the therapeutic situation” (Alexander 1946: 112). For this physician, “independent of the form of this kind of therapeutic approach-whether it consists of prolonged daily interviews or briefer application of psychoanalytic principles-all uncovering psychotherapy is based on what might be called the principle of corrective emotional experience” (Alexander 1946: 112).

The importance of resolving feelings of guilt was greater because, in the case of polio, that impression was projected onto the future. Children and parents were afraid of the “punishment” which involved the residual paralysis that would determine the child’s future. For example, after being discharged from the hospital, a six-year old girl said that “she would return to the hospital if she became tired of walking or biking” (Robinson et al. 1956: 978).

At the time of polio diagnosis, professionals could not predict the evolution of the disease, or the severity of the sequelae from the infection, which introduced uncertainty as a complicating factor. Psychosomatic medicine generally considered that insecurity and uncertainty were specific aspects of medical practice that had great importance in establishing an empathetic relationship and communicating the diagnosis. At least in the case of polio, it was.

**Empathy as artifact: having the proper feelings or showing them in an appropriate manner**

One day, “after being returned from physical therapy, a child who ‘never complained’ about a frame, called the nurse’s attention to some loose straps that she had neglected to tighten” (Robinson et al. 1956: 977).

Nurses have commented that these children “never say a word about being on a frame,” and “never even ask for a pillow”. Often, the attitude of submission appears to be much more than that of passive compliance (Robinson et al. 1956: 977).

Health professionals attending children with polio commented that they were “good patients” because of they showed submission regarding immobilization/restrain and inactivation.

However, this vision shows that the empathic relationships were bidirectional, since we can see how children’s attitude affected nurse and physicians’ conduct. The children instinctively knew how nurses wanted them to be, so their submissiveness might be considered a performance. But this attitude can open a question about the authenticity or naturalness of the emotions expressed by the children.

The children’s behavior towards their caregivers might be said to be a response to what was expected of them. We need to take into account also that the patients lived inside an institution, in a closed, well controlled environment. Even unconsciously, patients could use a contained body language and articulated their feeling in a restrained way, thinking that their patience and stoicism would please those who cared for them. This seems to be reflected in the text we have read: they acted in an appropriate manner at the hospital, where they would have thought that a modest demeanor was expected.

This interpretation connects with the psychosomatic explanation about the lack of mobility. These physicians emphasized that the paralysis was the most important factor in the life and in the development of children and adults. The paralysis was linked with other physiological and psycholog-
Medical functions, such as respiratory or digestive function, and it was a cause of great anxiety.

**Environment influence**

Psychosomatic analysts underlined, that the way in which one feels not only depends upon one’s own nature, but is also altered by aspects like age, education level, style of life, the nature of one’s occupation. The mother of the child of six connected the polio diagnosis with house working; children, with life at school; the father, with the construction of new homes. So we can assume that each person tends to express emotions in a way that, ultimately, define her/his own identity. Furthermore, in the texts quoted, we perceive that personal experiences are, at the same time, social and inter-subjective realities.

These aspects led to the consideration of an open question discussed in the 1940s and 1950s, and which still concerns us today: if people – in our case, polio patients and their parents – had the capacity of expressing the same emotion in the same way. We find some answers in the patients’ words, where we notice distinctly ambivalent responses to this dilemma. On the one hand, the claim of universality could be maintained, and we can speak about a polio patients’ profile, as if they were a collective singular: it was often noted that many of these children they had a high IQ (Bronson Crothers and Meyer 1946: 324) and during their hospitalization, they seemed to adapt easily to the regimen of treatment and accept immobilization. Children who are rebellious or resistant to restraint were rare.

On the other hand, we quickly recognize evident different attitudes, for instance, when we think of some contrasting pairs: women and men, old and young, poor and wealthy, educated and uneducated. The diverse emotional expressions are rooted both in the embodiment and in the culture of each person (Frevert 2014: 267)). That is why, in the case of patients (not only of polio) we can speak about some universality and at the same time, of the particularity of each one.

In our case, psychosomatic doctors reckoned that the emotional component, rather than the infectious etiology, was the factor that would determine each polio patient’s ability to adapt to their physical limitation circumstances and to changing their life projects after the onset of the disease.

**Some thoughts on concluding:**

**Empathy as a new paradigm**

This research has allowed me to briefly discuss how empathy, considered as “one of the most important contributions to psychosomatic medicine school” (Balint 1957) has been “one of the traditional accompaniments of the healing art” (Browne, Freeling 1976: 4). Empathy has become a new paradigm in society in general and medicine in particular. Understanding the way patients and their relatives feel, think and act, is today a prerequisite for successful relationships and a demonstration of true humanity.

I would like to emphasize, briefly, two points. First, polio patients and their parents’ testimonies confirm that narratives – in our case medical narratives – are vital for the analysis of empathy. I have also tried to show the complexity of analysis of reading medical text connected with empathy. And, as Hammond and Kim suggest, instead of “all the complexities of literary and cultural studies, [they] have still to be brought to bear to truly understand the dynamics of literature and empathy” (Hammond, Kim 2014: 7).

Second, the new meanings of empathy in medicine support the historical development of the emotional turn: empathy is located in a particular, historical and cultural situation where we cannot take for granted the meanings of the term. As Assmann and Detmers explain: “Empathy is a complex mix of physical, cognitive, emotional, social, and ethical capacities, which can be triggered in everyday situations, developed in social contexts, and explored and trained in the reception of art. It comprises various forms, such as emotional contagion; understanding others by making sense of their actions, and reconstructing their intentions and meaning; feeling as others with the help of the imagination by projecting one’s emotions onto another person, by identifying with him or her or taking another’s perspective; feeling with others by imagining their emotions and seeing life from their point of view; feeling for others by taking action and making them part of our concern; feeling for others by generating awareness, a sense of similarity, compassion, and active concern across social distance and cultural difference” (Assmann and Detmers 2016: 7).

In addition, we have observed that the study of emotions leads us to the history of experience and of subjectivity of the experience. The analysis of the evolution of the meaning of empathy introduces us to the study of the clinical links between the professional and the patient, establishing a specific and complex emotional situation that leads to think about our own feelings in this relationship, and understand that a reflective stance toward one’s own emotions can be become an important part of caring for others.

**Bibliographical references**


