Skilled Empathy and the Possibility of Understanding Others' Experiences

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How does one come to know about the experiences of others? To what extent is it possible to understand another's first-personal perspective? These are perennial philosophical questions that have practical ramifications in contexts where aspects of one's first-personal experience are consequential and opaque (to others, and perhaps even to oneself). Consider, for example, the cases of pain, hallucination, and various forms of neurodivergent experience. In this paper, I consider the idea that empathy offers a route to knowledge of others' experiences. In doing so, I address questions about what empathy is, what kind of knowledge it offers, and to what extent this kind of knowledge can be integrated with other forms of scientific knowledge or experience.

I attempt to gain traction on these broad and perennial questions by situating the discussion in the context of clinical practice.[1] As a brief outline, I begin (Section 1) by discussing two questions. The first question is: What is empathy? I provide a brief overview of the conceptual landscape of empathy research before adopting a multidimensional view, on which empathy is a complex skill comprised of multiple sub-capacities that co-regulate with one another. The second question is: What role might empathy play in clinical practice? While scholars have highlighted various functions of empathy, I focus here on the epistemic one—that is, the idea that empathy provides a special form of knowledge of the other. In Section 2, I address two important critiques of the idea that empathy is epistemically valuable—first, that it is not possible to understand others via empathy, especially when they are very different from us; and relatedly, that empathic understanding is not desirable. I show that there are two desiderata that are often implicitly assumed in these critiques. In

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[1] However, I think that much of what I say here extends to empathic interactions and relationships more generally.

Section 3, I address concerns about the possibility and desirability of empathy by first, arguing that the epistemic goal of empathic engagement should be discovery. I then revise the assumed desiderata to bring them into line with this goal. In the conclusion, I begin to sketch out an account of how empathy yields knowledge. I illustrate that empathic practices that meet the revised desiderata and aim at the epistemic goal of discovery involve an ongoing practice of iterative updating. This practice involves creating a bridge between self and other by toggling between first-personal and second-personal knowledge. I briefly discuss how other forms of third-personal and scientific knowledge might intersect with this process of discovery via empathy.

Section 1: Empathy in Clinical Practice

Within contemporary medical ethics and practice, most people assume that empathy is a good thing. This view has become something of a consensus and we can see it reflected in statements by organizations such as the American Medical Association, which features a course on Empathetic Listening as part of its Continuing Medical Education offerings. The learning objectives of this course are as follows:

1. "Identify the benefits of listening with empathy";
2. "Demonstrate best practice techniques to listen for underlying feelings, needs, or values";
3. "Apply empathetic listening techniques to build trust and improve patient experience" (AMA, 2024).

Empathy training programs are also being developed by private companies, often with the input of academic clinicians. One example is the *Empathetics* training program, spearheaded by Helen Riess at Harvard, which aims to provide a neuroscience-based approach to empathy education to "empower people to stay human" in the face of a demanding healthcare system (Empathetics, n. d.). Beyond these practical interventions, there is a longstanding tradition of theoretical work on the value of empathy in medical education, much of it situated within the frameworks of humanistic and narrative medicine (see e.g., Halpern 2001/2011; Charon 2006).

Within psychotherapeutic practice, empathy is considered to be especially important. For example, within humanistic traditions such as the Rogerian school, empathy has long been seen as a necessary

condition for effective psychotherapy. Furthermore, in a now famous paper, Luborsky and colleagues (2002) demonstrated what is known as the "dodo bird effect"—that is, that the outcomes of different forms of psychotherapy are no different from one another. This finding suggests that it is not the tenets or techniques of particular schools of therapy that drive effectiveness. If specific tenets and techniques don't really matter, then what does? Since this finding, there has been increased interest in the idea that psychotherapeutic effectiveness is driven by non-specific interpersonal factors, such as empathy and the therapeutic alliance. This idea has been taken up by proponents of Evidence-Based Medicine and subjected to randomized controlled trials that seek to demonstrate the power of empathy not only within psychotherapy but within medicine more broadly (e.g., Howick 2018).

Amidst these affirmations of the value of empathy for clinical practice, in general, and psychotherapy, in particular, challenging questions remain unanswered, including: (1) What is empathy? (2) What is it good *for*? I discuss each of these questions in turn.

Question 1: What is empathy?

Empathy is very difficult to pin down conceptually. A recent review of empathy concepts identified 43 distinct definitions (Cuff et al. 2016). Frederique de Vignemont and Tania Singer, neuroscientists working within the field, write that there are "nearly as many definitions of empathy as people working on the topic" (2006, 35).

Broadly speaking, the various empathy concepts can be grouped into two main clusters: (1) "Emotional"; and (2) "Cognitive." Concepts in the emotional cluster view empathy as being primarily about feeling what other people are feeling; concepts in the cognitive cluster view empathy as being primarily about understanding what other people are thinking.[2] Within each of these clusters, conceptualizations vary along several dimensions, including directness, degree of accuracy, and proposed process or mechanism. Beyond variation within the two clusters, there is also disagreement about how emotional and cognitive empathies relate to one another. Some scholars

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[2] Cognitive concepts also sometimes focus on understanding what other people are feeling but take this to be a more distanced and inferential process. I count this as "cognitive" because the empathizer is not themselves engaging emotionally.

adopt a unidimensional account of empathy, according to which just one of the emotional or cognitive varieties is the "real" empathy (e.g. Coplan 2011). On this view, other concepts target related phenomena. Other scholars adopt multidimensional accounts, which typically hold that empathy is a complex phenomenon comprised of multiple sub-processes, including both emotional and cognitive ones (e.g., Zaki 2017; Zaki 2019; Weisz and Cikara 2021). A further point of disagreement among empathy researchers is about the relationship between cognitive and emotional empathies and care or concern. Some researchers consider other-oriented emotion (care, concern) to be *part* of empathy. Others take care and concern to be the *outcome* of empathic engagement.

See Figure 1 for a list of some common empathy concepts:

Type of Empathy	Core Characteristic	Related Concepts and Other Names
Emotional/Affective Empathy	Feeling what one takes another individual to be feeling	Sympathy; Fellow-feeling; Emotional Contagion
Cognitive Empathy	Knowing/understanding the thoughts, beliefs, and/or feelings of others	Theory of Mind; Perspective-Taking
Concern/Care	Other-oriented emotion consistent with the welfare of another	Sympathy; compassion
Compassion	Feelings of generalized other-related positivity and/or love	Care; concern; sympathy; love

Figure 1: Common Empathy Concepts

Conceptual diversity poses several challenges for empathy researchers when it comes to communication, collaboration, integration, and extrapolation of findings. Disagreement about the value of empathy for various social, political, and ethical pursuits frequently hinges on conceptual disagreement, as I have argued elsewhere (Betzler 2023). Conceptual diversity and disagreement also poses challenges for the measurement of empathy. For example, using a common measure of empathy developed in social psychology, researchers found (alarmingly!) that empathy declines over the course of medical education. The problem is that this measure targets an emotional variant of

empathy of interest in social psychological studies of altruism and prosocial behavior; it is an open question to what extent this concept tracks the kind of empathy relevant to medical practice (see e.g., Betzler; 2018; Pedersen 2009). In part due to this impact on measurement projects, conceptual diversity also creates challenges for the above-mentioned efforts to evidence the power of empathy using randomized controlled trials and meta-analyses. That there are various operationalizations in circulation, which target different phenomena, creates challenges for projects that need to combine results.

Addressing conceptual challenges is not the primary goal of this paper but it is important to acknowledge as a background consideration that affects all discussions of empathy. We must keep track of what we mean when we are talking about empathy. In this paper, I adopt a multidimensional view that takes empathy to be a complex skill comprised of multiple capacities or processes that co-regulate one another, as represented in Figure 2. Depending on context, exercising this skill can yield several outcomes, including prosocial ones like care, concern, and helping behaviors; as well as epistemic ones like insight, discovery, or understanding. This brings us to the question of what empathy is *for*.
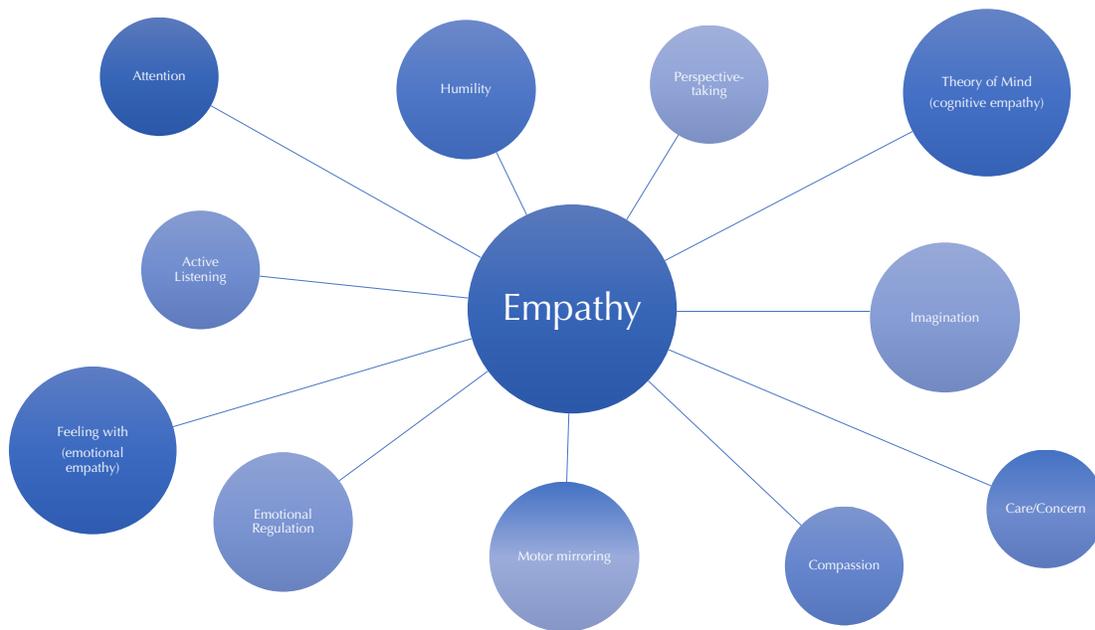

Figure 2: Network of Empathic and Related Capacities

Question 2: What is empathy (good) for?

A second question that arises for many projects concerning empathy is: What exactly does it do? What is it good for? This question is closely tied to the conceptual one discussed above. Especially if one adopts a kind of pluralism about empathy (as I do), questions about function might serve as the basis for principled decision-making about which concept of empathy is the right one for a particular domain, task, or question. There are two main types of function that empathy is frequently proposed to have. The first is a motivational one associated with the idea that empathy as an important driver of prosocial behaviors like helping. The second is an epistemic one associated with the idea that empathy gives rise to knowledge.[3] There are also deflationary approaches to empathy, which suggest that it just reduces to "niceness" or "positivity." I show here how these different ideas about the function of empathy are expressed in the clinical domain. Within the clinical domain, disagreement about what empathy is *for* tracks disagreement about the extent to which it is valuable and ought to be prioritized.

Let's start with deflationary accounts of what empathy is *for*. Within clinical contexts, the idea is that empathy makes healthcare "nicer"—that is, that an empathetic bedside manner increases the warmth of the encounter makes people feel cared for—but is not, by any means, necessary. Cynically, efforts to increase empathy within the clinical encounter are merely seen as part of a customer-service approach to medical practice; just as customers expect a smile from flight attendants upon boarding a plane, patients expect a warm, empathetic demeanor from their physicians.[4] This view makes it easy to dismiss empathy as fluff on top of the real work of medicine, which is grounded in technical prowess and scientific knowledge.[5] This idea filters into medical education, where the bulk of time is spent learning technical skills and information about physiological systems while empathy training modules are relegated to short, one-off workshops.

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[3] A further view is that empathy plays a substantive role in medical practice by directly enhancing healing, perhaps via mechanisms similar to the placebo effect (see e.g., Howick 2018). I unfortunately do not have the space to fully discuss this view here.

[4] See e.g., Hochschild 2012 on emotional labor. Note that there are highly gendered expectations here that are worth exploring. This view also raises questions about genuine empathy *versus* the mere performance of it, which I do not have the space to discuss in this paper.

[5] Note that there are also important issues about gender and expectations here, which I do not have the space to get into.

Other views take empathy to have a more substantive function within the clinical encounter. n the motivational account, empathy moves doctors to help, much in the same way as it motivates helping behaviors outside the clinic. The idea here is that when we see people in distress and feel an emotional connection with them—perhaps even experiencing their distress alongside them—we feel compelled to help. This idea has come under fire recently from critics who point out that empathy can itself be distressing and lead to burnout, thereby undermining its motivational power (e.g., Prinz 2011)

The epistemic account holds that empathy plays a substantive role within the clinical encounter by providing clinicians with a special kind of knowledge of the other—their experiences, thoughts, feelings, beliefs, values and needs. Empathy thereby facilitates "more effective and not just more pleasing care" (Halpern 2001/2011). The kind of enhanced information that empathy affords clinicians might be valuable in several ways. For example, it might help clinicians to reach an accurate diagnosis more quickly, or it might help them to facilitate patient decision-making about what treatment option(s) to pursue. On this view, empathy yields understanding—understanding that makes clinical care more effective.

While intriguing, this idea leaves several questions unanswered. What kind of knowledge does empathy provide? Is that knowledge first-personal, second-personal, or somewhere? And how does knowledge gained through empathy interact with other forms of clinical knowledge, especially third-personal scientific information? The idea that empathy is valuable because of its epistemic function is also open to critique, as I discuss in the next section.

Section 2: Critiques of Empathy in Clinical Practice and Beyond

Critiques of empathy have become increasingly prevalent in recent years, as exemplified by the enthusiastic reception of Paul Bloom's (2014) book *Against Empathy* and the rise of anti-empathy sentiment in contemporary American politics.[6] Many of these critiques pertain to a narrower concept than I adopt here—emotional empathy understood as "feeling what one takes another individual to be feeling" (Bloom 2014; Prinz 2011; see Betzler 2023 for a discussion). They also pertain primarily

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[6] Note that anti-empathy sentiment can be found on both the political right and the left. See Szalai 2025 for an overview.

to the motivational role of empathy. I leave those critiques aside here, instead focusing in on critiques that apply more obviously to multidimensional concepts of empathy which have both cognitive and epistemic component, like the one I adopt here, and that target its epistemic function. In particular, I focus on two interlocking critiques: (1) Empathy is not possible; and (2) Empathy is not desirable.

Is Empathic Understanding Possible?

The first critique expresses skepticism about the possibility of understanding other people's thoughts, feelings, or experiences via empathic engagement with them. It is challenging to understand other people even when they are similar to us and even under the best of circumstances. The challenge becomes especially acute when we consider the possibility of people whose lives are rather different from our own.[7] As Olivia Bailey writes:

> "Members of oppressed groups often claim that the prospect of real empathy with their position on the part of the privileged is not just difficult but impossible. So, we find David, a homeless person, asserting, 'You [well-off people] can't understand what it's like to be homeless,' and Terrell Jermaine Starr, a black [sic] racial justice activist, claiming that when it comes to 'a white [sic] supremacist system that oppresses us and excludes us in every area of American life—economic, educational, social, and political—even the most empathic white [sic] person is just not going to know what that's like" (Bailey 2018, 153).

The idea here is that people of privilege cannot come to know *what it is like* to live as a homeless person or as a member of an oppressed group via empathy.[8] As Starr points out, this may have to do with the magnitude and scope of the experiences to be understood; oppression affects every aspect of a person's life. It is not the sort of thing that one can step into and out of, in the way that the empathizer might be able to.

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[7] These challenges intersect closely with issues about empathic bias, or the idea that we tend to empathize more readily with some people than with others, especially those who are similar to us, in close proximity, within our in-group, or within our field of attention (see e.g., Bloom 2014; Prinz 2011). It is unfortunately outside the scope of this paper to discuss these biases here.

[8] Of course, this connects with larger debates in philosophy of mind.

Starr's critiques are similar to those levelled the educator Jane Elliott's efforts to teach people what it is like to experience racial discrimination. In 1968, Elliott divided her class into two groups based on their eye color. One day, the blue-eyed students were "on top" and received preferential treatment, while the brown-eyed students were treated as second-class citizens; the next day the roles were reversed. It did not take long for the kids to start treating their peers in the non-preferential group as inferior. When they debriefed, the kids expressed how bad it felt to be treated poorly just because of their eye color. This exercise became the basis of a series of workshops that Elliott led across the country, with both children and adults, and has been touted as a powerful intervention for cultivating empathy. The kind of empathy that this intervention is supposed to cultivate seems to have multiple components, both emotional and cognitive, and ultimately to yield a form of first-personal knowledge—that is, knowledge of *what it is like* to be racially discriminated against.

The problem is that it is not at all clear that it achieves this end. Elliott's students were discriminated because of aspects of their appearance that were outside of their control (eye color)—yes—but that is not all there is to racial discrimination. For Elliott's White midwestern students, the experience of maltreatment was confined to their classroom. They did not experience the deep systemic and structural components of racial discrimination. It was also temporary. As soon as the exercise was over, they could go back to their lives as normal. There is therefore an important difference of magnitude and temporality between the kind of thing that Elliott's students experienced and the kind of thing that Black children experience while growing up under oppression. What the White students experienced was highly memorable; when they were interviewed as adults, many of them reported that the exercise had a lasting impact on them. But arguably, that impact did not include obtaining knowledge of *what it is like* to experience racial discrimination. Reading the experiment charitably, it might have given them a taste of what it like to experience discrimination broadly construed and thereby to come to attend to and care about racial discrimination. But to the extent that it gave rise to epistemic empathy, it did so only weakly.

Parallel issues about the *possibility* of empathy arise in the medical context, especially in cases where patients experience things that are radically outside clinicians' experiences. Hallucinations provide a good example. There have been various attempts to help clinicians to better understand what it is like for these patients, one of which involves the use of VR (virtual reality) simulations. Clinicians don a VR headset and are taken through a simulation of what it is like to experience a particular set

of symptoms, such as auditory or visual hallucinations. The idea is that by experiencing these symptoms "firsthand," they may come to better understand the experience of patients with schizophrenia or psychosis. The VR simulation, in some sense, gives clinicians knowledge of *what it is like* to be schizophrenic. Clinicians can then translate this empathic understanding into better care. Such simulationist approaches have a long history of being used in the case of physical disability (see e.g., French 1992). They are now becoming increasingly popular in the field of mental health care (for reviews see Ando, Clement, Barley, and Thornicroft 2011; Wan and Lam 2019).

But these VR simulations at best offer clinicians a partial understanding of what it is like to experience conditions such as psychosis. For example, VR simulations might provide some insight into how intrusive auditory hallucinations interfere with daily tasks. They do not, however, provide insight into what it is like to live with those hallucinations in the long term. The clinician can always remove the headset and step back into their normal life. Beyond this, the symptomatology of mental disorders is highly variable; the experiences of one individual may not mirror those of another. This variability is compounded by the fact that many mental disorders are typically co-morbid with addiction. Furthermore, the mentally ill are a marginalized population; they face stigma and barriers to resources, care, and support that VR simulations do not represent. In short, to the extent that VR technologies offer empathetic understanding, it is limited. Similar epistemological concerns have been raised by disability rights advocates (e.g., French 1992).

These critiques suggest that certain types of experience are inaccessible via empathy.[9] They also express skepticism about whether and to what extent empathy yields knowledge, and especially knowledge of *what it is like*. In other words, to the extent that empathy yields knowledge at all, it cannot yield first-personal knowledge.

Is Empathic Understanding Desirable?

Many arguments against the desirability of empathy primarily target its motivational function and focus on concerns about the connection between empathy and action. For example, social justice advocates who doubt the possibility of empathy also sometimes express sentiments along the lines

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[9] Some would go further in their skepticism that *any* type of experience is accessible via empathy. Similar problems have been raised in the literature on transformative experience (e.g., Paul 2021).

of, "We don't need your empathy. We need your respect, solidarity, and action" (e.g., Parnell 2017). The worry here is that empathizing is sometimes taken as an action in itself, but one that does not yield real change. There are also critiques based in psychological literatures which show that empathizing can lead people to withdraw from a situation rather than to confront it. These kinds of arguments are also sometimes accompanied by calls for a different kind of emotional response—in particular, an angry one (e.g., Prinz 2011).

But is epistemic empathy also undesirable? It might be, if for example it leads people to assume that they know what another person is experience when they don't, as in the racial justice or mental health cases. Such an assumption might lead to failures of humility and shut down further inquiry and connection. Privacy is another concern that might arises in connection with questions about the desirability of empathy, but this hinges on what we imagine an ideal empathic connection to look like.

Assumed Desiderata for Empathy

Both of the above critiques raise questions about what it is that we hope to achieve by empathizing with one another and relatedly, what good empathic understanding looks like. Implicit within these critiques, and within much of the literature on empathy, are two assumed desiderata: (1) Exhaustiveness; and (2) Accuracy.[10]

Exhaustiveness is about the level of access that one has to one another's thoughts and feelings. The idea is that empathizers should strive for completeness of understanding—that is, they should be fully "in the head" of the other person and therefore know that person as well, if not better, than they know themselves. We can think of telepaths as the ideal exhaustive empathizers.[11] While exhaustive empathy might not be possible for beings like us, those who hold exhaustive empathy to be desirable suggest that we should strive to get at as close as we can to it.

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[10] In particular, these can be seen as implicit in simulationist accounts of empathy.
[11] Even here, though, imaginings of what telepathy entails vary. Star Trek, for example, presents us with different species whose telepathic abilities vary greatly. Betazoids can maintain some degree of privacy whereas the Cairn cannot.

Accuracy is about correctness. Accurate empathizers should be able to understand what others are *really* thinking and feeling, not what the empathizer imagines the other to be thinking and feeling. The extent to which people are capable of empathic accuracy has long been an open question for empathy researchers (see Ickes, ed., 1997). As a desideratum, it functions as a crucial point of distinction between empathy and projection, where projection involves placing ("projecting") one's own thoughts and feelings onto the other, rather than understanding the other's perspective, different as it might be from one's own even within the same circumstances.

Both desiderata—exhaustiveness and accuracy—express the idea that the empathizer should try to approach something like first-personal access to the other person's mind—or get as close to that as possible. As I will suggest in Section 3, I think that some of the critiques related to the undesirability of empathy are really about these desiderata. I will suggest some modifications to the desiderata as a way of circumventing the critiques.

Section 3: Towards Discovery via Empathy

The critiques levelled above about the possibility and desirability of empathy are serious ones. In this section, I address them by doing two things: (1) Arguing that the epistemic empathy ought to be focused on the goal of discovery; and (2) Revising the assumed desiderata to bring them into line with this goal.

Epistemic Empathy: Aiming at Discovery

Earlier, I addressed questions about the function of empathy: What is empathy good *for?* I suggested that it serves a key epistemic role, although it may have other functions as well, in particular a motivational one. This leaves open, however, questions about precisely what that means. What kind of epistemic project does empathy serve? What kind of knowledge should good epistemic empathy yield? In this section, I argue that empathy, of the skilled multidimensional type I discuss above, is best positioned as a vehicle of discovery, for both empathizer and empathizee.

We might consider this to be analogous to scientific discovery. There are different goals that might be at work in different scientific projects (measurement, replication, validation, exploration) and

different tools and methods that need to serve these goals.[12] Empathy, as a means of gaining an understanding of other people, is a tool that is well-suited for the epistemic goal of discovery or exploration because, when done right, it is open-ended. We also have other tools for understanding people, including simply talking to them and observing their behavior. These might augment our empathic processes. Other tools—for example, those of the human sciences—might be better suited to other projects such as measurement, replication, and validation.[13] Focusing on discovery or exploration as an end of epistemic empathy changes the desiderata associated with it.

Revised Desiderata

I now propose some revised desiderata for empathic practice that functions as a vehicle for ongoing discovery. These revised desiderata also better account for the limitations of our empathic capacities as humans.

Revision 1: Reject Exhaustiveness

First, I suggest that we reject exhaustiveness because it is both impossible and undesirable. Exhaustiveness sets an impossible standard for empathic practice because we are not the sort of beings who are capable of fully entering one another's minds. We do not have telepathic capacities. We are the sorts of creatures for whom a gap between self and other is an unavoidable part of life.[14] Empathy offers a way of bridging that gap. It does not, however, close it. Furthermore, there are temporal challenges associated with even the most complete forms of telepathy; we do not have the full backstory and therefore may still need to ask clarificatory questions to meet the desideratum of accuracy (which I suggest we retain).

Even if it *were* possible to completely close the gap between self and other through exhaustive empathy, I don't think this would be desirable. Imagine that in the future we manufacture, perhaps through technology, telepathic capacities. As so many science fiction imaginings show us, this would

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[12] I have in mind debates about the context of discovery versus the context of justification, but also more aptly, the ideas about exploration that Uljana Feest brings up in her discussions of methodological operationalism (2025).

[13] Although note that there are big questions here . . . This section is very sketchy but I'd like also to connect this with debates about stability, therapeutic change, and the goals of psychotherapy.

[14] [Question or fn about non-Western philosophy of mind – need to investigate]

come with significant costs, including: overwhelm (it's exhausting having someone in your head and being in someone else's head); privacy (do we really want others to have access to all of our thoughts?); and social cohesion (there are many things we do not say, and for good reason). Recognizing that there is a gap between self and other, that we are different people with different histories, is important. Rather than try to cultivate exhaustiveness, we should try to pair our empathy with humility, thereby recognizing that we don't know what it is like to be another person, but that we want to find out. If we reject exhaustiveness as a desideratum, the incompleteness of empathy is no longer a problem.

Revision 2: Retain accuracy but with some modifications

I suggest that we retain accuracy as a desideratum but with modifications. Specifically, we should acknowledge that accuracy is not static. Our understanding of others and their experiences requires constant updating because people's relationships with the world and with one another are dynamic. Thus, accuracy will look like an iterative process of empathizing and then opening up a dynamic conversation elaborated through open-ended questions. Thus, one might use one's empathic capacities to sense what another person is thinking and feeling and then, with curiosity and humility, open up a conversation about this. Importantly, this open-ended conversation might lead the person being empathized with to also engage in a process of self-discovery, prompted by these open questions.[15] Thus, the process through which empathy yields knowledge will end up looking very much like the iterative process of exploration and discovery that occurs in science (e.g., Chang 2004).[16]

Conclusion: What Discovery-Oriented Epistemic Empathy Looks Like, Remaining Questions

The humanistic psychotherapist Carl Rogers: "To sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (Rogers, 1957, 99). Empathy, on this view, involves engaging in a form of perception or sensing that allows one to step into another's world, but without becoming fully immersed in it. It enables the empathizer to occupy a unique position—both inside

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[15] I don't have the space to get into it here but I am thinking about reciprocity as well – possibly adding it in as a desideratum – but there are various issues about power dynamics.
[16] Perhaps add a note about perspectivalism/objectivity?

and outside of the other's perspective. In this sense, the form of knowledge empathy offers is both second- and first- personal. According to Rogers, this form of empathy is powerful, both therapeutically and as a means of discovery: "When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meaning in the client's experience of which the client is scarcely aware" (Rogers, 1957, 99). In other words, by engaging empathically with the client or patient, the clinician facilitates a process of discovery in which the client comes to know things about herself she might not have known before.

Rogers' description of empathy exemplifies the process that I have in mind here. Skilled empathizers engages in an activity that exercises multiple capacities (cognitive empathy, emotional empathy, attention, humility, listening) to resonate with another person's feelings and to place those feelings into their wider context. They furthermore engage in an ongoing process of refinement and discovery with their interlocutors; by placing the perspectives of clinician and client into dynamic, iterative interchange with one another, this form of facilitates a process of discovery that yields insight into what others are thinking and feeling—and perhaps insight into one's own thoughts and feelings as well.

There are several questions that remain and that I hope to be able to address in future work about how this process of discovery occurs even in the face of therapeutic change as well as about how the first- and second- personal knowledge interacts with other forms of knowledge, especially third-personal scientific knowledge. Nonetheless, I think that this way of approaching empathy and the knowledge it gives rise to can help us to understand the kind of work it does in interpersonal relationships more generally and especially in the therapeutic ones.

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