Empathy, Asymmetrical Reciprocity, and the Ethics of Mental Health Care

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<center>**Section 1: Paper 4**</center>

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Abstract: I discuss Young's "asymmetrical reciprocity" and apply it to an ethics of mental health care. Due to its emphasis on engaging with others through respectful dialogue in an inclusive manner, asymmetrical reciprocity serves as an appropriate framework for guiding caregivers to interact with their patients and to understand them in a morally responsible and appropriate manner. In Section 1, I define empathy and explain its benefits in the context of mental health care. In Section 2, I discuss two potential problems surrounding empathy: the difficulty of perspective-taking and "compassion fatigue." In Section 3, I argue that these issues can be resolved if examined through the lens of an ethics of care. Reciprocal relationships between patients and caregivers are an important element in the development of an ethics of care. In Section 4, I introduce two models of reciprocity that can be applied to a health care context: Benhabib's symmetrical reciprocity and Young's asymmetrical reciprocity. In Section 5, I demonstrate how asymmetrical reciprocity cultivates empathy and, in Section 6 and Section 7, I show how it overcomes the objections of empathy and improves therapeutic relationships.

1. The Benefits and Aims of Empathy in Mental Health Care

Empathy is the ability to identify with the experiences and feelings of someone else and it indicates an opportunity for engaging with another person affectively and experientially. Empathy has been described as having a "curative effect" in psychotherapy and empathetic relationships between caregivers and care receivers can sometimes be more important to a patient's clinical outcome than the type of treatment administered.[2] In terms of its aims, Mercer and Reynolds (2002) argue that the goal(s) of empathy should be to initiate supportive, interpersonal communication with a patient in order to understand their needs; empathy should be used to empower the patient to learn or cope more effectively with their environment and condition; finally, empathy in therapeutic relationships should aim to reduce or resolve the patient's problems.[3] Although one of the main

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responsibilities for therapists is to help treat patients with their illnesses, Code (1995) maintains that empathy often figures as a "taken-for-granted component of care" and that a society which does not possess empathy—and actively tries to minimize its significance—is poorer in quality because of that deficiency.[4] But even though the cultivation of empathy is an integral component of good care, and has several benefits for patients, there are a few problems associated with it.

2.1 The Limits of Perspective-Taking

For Coplan (2011), empathy requires a complex imaginative process of taking another's perspective and, through this process, one "constructs" another's subjective experience by "simulating" the experience of being in the other's situation.[5] While empathy can allow for a genuine mutual understanding between individuals, and can also help towards understanding the perspectives of other people, Hollan and Throop (2008) explain that the "'first-person-like knowledge of others'" typically found in empathetic exchanges is "'rarely, if ever, considered an unambiguously good thing.'"[6] As Karp and Tanarugsachock (2000) argue, genuinely caring for others presumes efforts to empathize with them, "to feel what they feel, to try to see the world from their standpoint, and to take their role."[7] Depending on the type of illness in question (e.g. schizophrenia, bi-polar disorder, clinical depression) and the severity of the symptoms a patient is experiencing (e.g. delusions, paranoia, hallucinations), it may be very challenging, if not impossible, for a caregiver to actively try to empathetically engage with someone who is living with mental health challenges. Role taking requires us to shift between our perspective and "the imagined point of view of the speaker" in order to understand her.[8] But while *all* role taking is approximate because we can never *fully* understand what another person is experiencing, the problem of *accurate* role taking in caregivers' engagement with persons living with mental health

challenges is that it becomes extremely difficult to *understand* what they are going through. To that end, while it is hard enough for a 'healthy' person to empathize with someone who is experiencing a *physical* illness (e.g. someone who is living with mobility limitations), it is even more difficult to understand someone "whose mind is thoroughly inaccessible."[9]

2.2 Empathic Over-Arousal and "Compassion Fatigue"

According to Simmons (2014), empathy in its fullest form "is typically if not always essential to caring for another's well-being."[10] Unlike Coplan, Simmons argues that empathy does not necessarily need to involve a complex and difficult process of perspective-taking. Instead he maintains that sharing in others' emotions by observing the emotional cues in their behaviours is an empathetic process that can occur rather quickly, and naturally, in a variety of situations.[11] For instance, if I see someone whose eyes are teary, whose shoulders are slumped forward, and whose face is frowned, I can tell that this person has been crying and is visibly upset. By observing these emotional and behavioural cues I can *empathize* with this person and realize that something may be troubling them. I do not have to "simulate" the other's experiences, or take their perspective as my own, to understand that this person is sad. But since empathy, under this account, involves having the feelings of another "aroused in ourselves" involuntarily, one of the problems with empathy is that it can result in "empathic over-arousal."[12]

Hoffman (2000) explains that if a person's empathetic experience of another's situation becomes intolerable it can result in "'an intense feeling of personal distress'" which may move that person out of their "'empathetic mode'" and drive them to alleviate their own personal distress rather than attending to the needs of others.[13] The implications for mental health care is clear: the repeated experience of empathetic over-arousal can lead to "compassion fatigue" which results in

that person's capacity for feeling compassion for others diminishing over time.[14] For instance, imagine a therapist who is engaging with a person living with severe clinical depression on a daily basis. Suppose at the beginning of the therapeutic exchange the caregiver is invested fully in the care and well-being of the other person. At the beginning of this therapeutic process, the caregiver is attentively listening to their patient's struggles with daily life, the caregiver is genuinely concerned for the health and safety, and actively seeks to provide coping strategies to support the recovery of the other person. During the first few meetings with the patient, the caregiver approaches this person's life and situation with a set of fresh eyes; there is a high level of hope and optimism and the caregiver ensures that they will do whatever it takes to help support their patient because this is the career path they have chosen. But suppose that, after several weeks of therapeutic exchanges, and after devoting significant amounts of time and energy in thinking *about* the patient's circumstances, the caregiver notices that the patient's depression is not getting any better. In fact, suppose that their depression has worsened and they have been unable to follow the caregiver's advice and strategies for coping with depression. More importantly imagine that, perhaps due to other life stresses and/or dealing with other patients in the medical facility, the caregiver gradually becomes less interested in supporting this particular patient's distress. Given the heavy subject matter of listening to this person's experiences of battling severe depression, the caregiver becomes more callous and distanced and less engaged in their subsequent therapeutic exchanges. If the patient's condition is starting to affect the caregiver in a detrimental way, this emotional exhaustion felt by the caregiver can jeopardize the therapeutic relationship because she may neglect her patients' needs and may not be as emotionally invested as she should be in order to help them. Since empathy involves *some* emotional identification with the experiences of others, *too much* empathy can negatively impact the quality of mental health care services being provided.

While empathy does play a beneficial role in improving the lives of persons living with mental health challenges, without proper guidance or instruction on when and how to implement it, empathy's intended purpose can backfire and leave both patients and therapists at a disadvantage. One way to address the problems of empathy is by examining empathetic practices through the lens of the ethics of care.

3. The Ethics of Care and the Role of Reciprocity in Therapeutic Relationships

Held (2006) maintains that the central focus of the ethics of care is on the "compelling moral salience of attending to and meeting the needs of the particular others" for whom we take responsibility.[15] She argues that the ethics of care starts with the moral claims of particular others.[16] One of the advantages of an ethics of care in the context of mental health care is that it works with a conception of persons as *relational* and *interdependent* rather than as "the self-sufficient independent individuals" of other dominant moral theories.[17] In the ethics of care, the values of solidarity, mutual concern between participants, trust, and "*empathetic responsiveness*" towards others have priority and, in practices of care, relationships are cultivated, the needs of others are responded to, and sensitivity between individuals is demonstrated.[18]

When it comes to acting in a morally appropriate way, Noddings (1984) argues that genuine acts of care involve an emotional and motivational sensitivity to particular other people.[19] In the mental health context, the primary responsibility of caregivers is to attend to the needs of their patients. Since the circumstances of each patient will inevitably be different, it is necessary that caregivers are sensitive to detail and pay close attention to their patients' needs in order to understand their situations and care for them in a responsible way.[20] For many care ethicists this "face-to-face" aspect of care is central because the act of caring is about recognizing the worth of

the person in front of you and engaging with them in a respectful manner.[21] A key component of Noddings' view is her emphasis on the *reciprocity* involved in the development of caring relationships. Reciprocity is not only helpful for governing *interpersonal* relationships but it is a recurring element found in *therapeutic* relationships as well.

Within the context of professional mental health care, Sandhu et al. (2015) explain that reciprocity is understood as the presence of "shared interactions" or "shared exchanges" where caregivers and care recipients behave and respond to each other and, through this process, they remain engaged in the interaction with an awareness of the other while meeting their own personal needs.[22] One of the core values of reciprocity is its commitment to "mutual respect and co-operation" between caregivers and patients, and one way caregivers can offer this respect is by giving patients opportunities to participate in mental health care planning and treatment.[23] By including them in this process, patients are more likely to feel like "valued and normal human being[s]" and denying them this opportunity for participation can make the patients "feel of less value than other people."[24] It is important to note that reciprocity in the context of mental health care is not a one-off occurrence. To be effective, practitioners of reciprocity must build these relationships with their patients gradually over time. Practicing reciprocity is good for fostering trusting, caring, and mutually beneficial relationships between patients and caregivers, which can result in positive patient outcomes. But in constructing a model of reciprocity that can be applied to an ethics of mental health care, specifically, there are two alternatives: Benhabib's *symmetrical reciprocity* and Young's *asymmetrical reciprocity*.

4. The Differences Between Symmetrical and Asymmetrical Reciprocity

Benhabib (1991) argues that relations of moral respect between individuals arise from dialogue in which persons aim to reach an understanding with one another. To help move this dialogical process forward she outlines her position called *symmetrical reciprocity*. Symmetrical reciprocity is a view which claims that moral respect consists in a "symmetrical relation of reversibility" where we take the perspective of the other person by "imaginatively representing their perspective to ourselves."[25] At first glance, symmetrical reciprocity shares some of the key features of empathy that I discussed above. Symmetrical reciprocity takes a 'mirroring' approach by assuming that both sides are equally capable of being known and understood by the other person.[26] For Benhabib, the stance of moral respect arises from "putting oneself in the place of others" and equal respect for the situation and point of view of others requires being able to "reverse positions" with them.[27] This ability to reverse perspectives is essential to the "ties of reciprocity that bind communities together" and that the more we are able to think from the perspective of others, "all the more can we make vivid to ourselves the narrative histories of others involved."[28]

While the motivation behind Benhabib's position demonstrates a willingness to engage in dialogue with others, and attempts to bridge distances between groups by dissolving superficial differences which divide people and are sources of discrimination and injustice (e.g. ability, race, gender), Young (1997) and La Caze (2008) maintain that symmetrical reciprocity is problematic because it "obscures difference," it is "impossible to reverse positions" and it is "politically suspect" for one person/group of people to identify with the experiences of others.[29] Young argues that these images of reflection and substitutability between ourselves and others support a "conceptual projection of sameness among people and perspectives at the expense of their differences."[30] Her worry with Benhabib's view of identifying moral respect and reciprocity through relations of symmetry and reversibility of perspectives is that it tends to "close off the

differentiation among subjects."[31] This is ethically significant because, as Clohesy (2013) argues, focusing on the "*lived experience* of difference" allows persons in positions of privilege to see how they have "denied the singularity of those [they do] not recognize" and shows them how they have "committed violence" to others in order to "sustain the unity of [their] own identities..."[32]

Given the inequalities and differences in power relations which exist between people (e.g. between a patient and her therapist), Young worries that if someone tries to put themselves in the position of others in order to understand them they too often "put *themselves,* with their own particular experiences and privileges" in the positions they see the others being in; her worry is that the assumptions derived from their position of power and privilege "often allow them unknowingly to misrepresent the other's situation" by imposing their own view upon the other.[33] In other words, instead of viewing the world from the other person's view point, symmetrical reciprocity involves imagining how *you*, given *your* situated knowledge,[34] would view the world if *you* were in that position, not how the other person *does* view the world from *their* perspective. In this process of imaginatively trying to represent to themselves the perspectives of others, Young maintains that too often those representations "carry projections and fantasies" through which privileged groups "reinforce a complementary image of themselves."[35] Within the context of mental health care, I believe one worry is that these projections on the part of caregivers may reinforce harmful stereotypes or preconceptions about what mental illness *is* and this can be used to further discriminate against the care recipients and/or silence their perspectives.

As I have discussed elsewhere, the stigma surrounding mental illness is often enough to reinforce negative stereotypes of people who fall under the category 'mentally ill', and the mark of stigma is often enough to discourage people from taking the claims of the other person seriously. To illustrate with an example taken from patient-caregiver interviews, Schulze and Angermeyer

(2003) note that some patients with mental health challenges, such as schizophrenia, are reluctant to disclose their information to their health care providers when seeking treatment for somatic, bodily illnesses. The reason for doing this is because these patients feel that their complaints and reports on their physical health and well-being are taken less seriously than are the complaints of people who do not have schizophrenia and that, on such occasions, their doctors "immediately considered transferring [them] to the psychiatric unit."[36] Moreover, if caregivers already (think they) know how their patients feel because they have "imaginatively represented" their patients' perspectives to themselves, then caregivers may not *listen* to their patient's expression of their perspective very openly and this is a concern for Young.[37] Because there *are* differences and complexities which exist between persons, I doubt that symmetrical reciprocity can be used by caregivers in an ethics of mental health care because they cannot substitute their position for someone else's and so their interaction misses its intended purpose.[38]

5. Can Asymmetrical Reciprocity Improve Therapeutic Relationships?
Due to its insistence on the reversibility of positions between ourselves and others, symmetrical reciprocity's 'mirroring' approach can lead to inaccurate perspective-taking. Moreover, even if it could be practiced in a manner which does not co-opt or misrepresent the experiences of others, too much identification with others can potentially result in empathetic burnout. By contrast, I believe Young's theory of *asymmetrical reciprocity* serves as a more appropriate framework for an ethics of mental health care, and can help caregivers better relate with their patients in a non-invasive way, because it attempts to understand others across differences "without reversing perspectives or identifying with each other."[39] The motivation behind asymmetrical reciprocity is that we can take others' views into account without imaginatively occupying their position or

putting ourselves in their place.[40] In this sense asymmetrical reciprocity is not quite the same thing as role-taking because we are not trying to understand the other's experiences from *their* perspective. Rather I understand this approach as the acknowledgement that there *are* differences between individuals and yet there is a willingness to engage with others *on their own terms*. I believe asymmetrical reciprocity is useful for interpersonal engagement because we are not trying to take over others' perspectives or mold their experiences to fit our own conceptual frameworks. Instead we are trying to recognize, appreciate, and respect difference and diversity, and in order to do this we need to approach others with a sense of *wonder*.[41] Young describes the sense of wonder as the "openness to the newness and mystery of the other person."[42] Within the mental health context, I think wonder can be a useful starting point for initiating relationships between patients and caregivers. For example, suppose a caregiver is interacting with a person who has schizophrenia and is experiencing delusional thoughts.[43] Even though the patient's utterances may appear to be nonsensical, and may be a source of confusion for the caregiver's interpretation, a stance of wonder would involve engaging with that person and trying to do the best they can to interact with them in a meaningful manner.

Although Young believes that we should cultivate a stance of wonder and create a respectful distance between ourselves and others when engaging with them, La Caze notes that wonder, on its own, is insufficient for achieving this goal. This is because wonder can be interpreted as "a kind of distant awe" before the other that "turns their transcendence into a human inscrutability" and wonder can become "a kind of prurient curiosity" which results in the adoption of a "probing, investigative mode" towards others.[44] As she notes, wonder can become "dangerous" because it transforms the other person into something "exotic" and, by doing so, it converts wonder's openness into a "dominative desire to know and master the other person."[45]

This worry is particularly pressing in mental health care because there may be a tendency for caregivers to become *too* involved in their patients lives and this can lead to patient resistance or the fear that caregivers are overstepping their professional boundaries.

To overcome this problem, wonder must still focus on being open-minded and non-judgmental but it must include an element of *respect*.[46] Wonder needs to be united with respect because wonder involves an openness to the unfamiliar but respect involves the acknowledgment of similarity and/or common humanity with others and I believe this is one of the key features of asymmetrical reciprocity.[47] While respect and wonder provide the means of initiating contact with others in a morally appropriate way, Young's primary method for engaging with others is by asking questions. Questions are generally a harmless way for someone to identify with another person, or to express an interest in receiving their viewpoint on any subject matter. If I have an interest in getting to know someone I am unfamiliar with, asking questions allows me to build a connection with another person and interact with that person in interpersonal dialogue. Although asking questions is a way of admitting that we do not already know the other person's perspective, and that we are curious to understand them better, La Caze maintains that we must still proceed with caution and ensure that our questioning does not become "intrusive, invasive" or makes the other person feel "uncomfortable."[48] I think this is where the sensitivity of an ethics of care can help. By taking their patients' perspectives into account by listening to the patient's personal narrative, and by treating their patients with dignity, a caregiver's influence can go a long way in helping improve the lives of their patients. Respect limits our questioning of others and if caregivers wish to respect their patients they should accept their differences by adopting a stance of moral humility and must not attempt to "espouse their standpoint" and speak on their patients' behalf.[49] Acknowledging the limits of understanding another person's perspective, and realizing that we cannot project our own

experiences onto others, is recognition of the other person's self–respect and it provides a firm foundation for interpersonal, empathetic engagement to occur.[50]

6. How Asymmetrical Reciprocity Cultivates Empathy and Relationships of Trust

The development of our empathetic capacities is something that allows us to connect with others and learn about their personal narrative histories.[51] Perhaps the best way for caregivers to establish, and abide by, responsible empathetic knowing in the context of professional mental health care is to build trust with their patients. Building trusting relationships between caregivers and care recipients is very important because if a patient feels safe to discuss things with her caregivers, that increased interaction can be valuable in the diagnostic process and, ultimately, be beneficial for the patient's health and well-being. Building trust with patients requires caregivers to practice empathy by showing a willingness to listen to the patient's voice. It requires caregivers to be open-minded and to learn from their patients. And it requires caregivers to be accepting of the patients' feelings and to not force their own opinion or view point on them.[52] By cultivating empathy caregivers can learn to value and respect their patients as *persons* rather than just viewing them as 'patients' with 'illnesses.'

One way to develop trust and empathy is through open dialogue with others. Through dialogue Young argues that we construct an account of the "web of social relations that surrounds us and within which we act"[53] and this image of connection reinforces the emphasis on relationality evidenced in the ethics of care. As Code argues empathy is important because it "resists closure, [it] *invites conversation*" and it "fosters and requires second-person relations."[54] Good communication exhibited between both parties forms a part of the therapeutic treatment itself and can result in improved patient outcomes and greater satisfaction with healthcare services.

Conversations can be integral for defining problems and goals in a collaborative manner and engaging with patients in dialogue results in patients feeling as if their voices mattered and it allows patients to have some input on their care options.[55] Conversely, poor communication and lack of reciprocity can result in disengagement from mental health services.[56] Good caregivers *listen* to their patients and will take the time and effort to reach out to them and provide opportunities for participation and collaboration. But if caregivers are impatient, or dismiss their patients' narrative accounts, or do anything which shuts down intersubjective dialogue from happening, patients will feel neglected and this is a serious problem. Given the systemic barriers and the negative impact of social stigma on mental illness, it is very likely that persons living with mental health issues have, at some point, been disrespected, disregarded and/or dehumanized. These attitudes towards mental illness need to change, especially in professional health care settings, and stances of asymmetrical reciprocity can begin to help overcome it.

7.1 How Asymmetrical Reciprocity Overcomes the Limits of Perspective-Taking

Reciprocity and mutual recognition are inherent in the concept of care.[57] But the ability to shift perspectives and take the other person's experiences into account in a caring, empathetic manner does not necessarily lead to, or require, the mirroring approach that Benhabib's symmetrical reciprocity endorses. While practices of care must be reciprocal, asymmetrical reciprocity overcomes some of the issues associated with empathy in a therapeutic context. An ethics of care is more compatible with Young's position of asymmetrical reciprocity because it is sensitive both to the inequalities which exist between people and/or groups of people and it also recognizes the "interconnectedness of moral agents."[58]

In response to the first objection concerning the limits of perspective-taking in empathy, Code notes that even though good empathetic practices involves *some* kind of identification with the other person empathy, at its best, "preserves yet seeks to know the 'strangeness'" of the other person; empathy "respects the boundaries between self and other" and it does not "seek to assimilate or obliterate the 'freedom'" of the other into itself.[59] In empathetic exchanges, Bubandt and Willerslev maintain that the recognition of difference between persons is something which is "indispensable" and is "deliberately maintained" rather than something "completely dissolved" and I believe asymmetrical reciprocity satisfies this requirement better than symmetrical reciprocity.[60] With respect to members of groups who have been historically marginalized and discriminated against by dominant groups (e.g. the discrimination experienced by persons living with mental health challenges), it is important for persons in positions of power and privilege to not only respect the other person by not violating or undermining their autonomous choices pertaining to their health care, but persons in power should not to assimilate, or co-opt, the experiences of others. As Kain (1998) argues denying the existence of others, and denying the uniqueness of their subjectivities,[61] can be an effective way of "locking them into their subordination."[62] Extending his argument, I think that by failing to acknowledge the differences which exist between different groups in the name of symmetry and reversibility, Benhabib's approach has the potential of causing harm and/or epistemic violence to these groups.[63] If we try to minimize or refuse to see difference and treat people as equals, he argues that our tendency will be to "deny their otherness, treat them as identical to us, *assimilate* them, see ourselves in them, and negate their own different reality."[64] But if we recognize their otherness *too* much it will be very difficult to see them as our equals since we will "tend to rank them - and probably as inferior."[65] As a result we need a certain amount of *otherness* but we also need a certain amount

of *identity*. This approach, I argue, is more consistent with Young's theory than Benhabib's theory.[66]

Although the focus of the ethics of care is on the particular relationships it helps cultivate, Gilligan (1993) maintains that a universal aspect of care lies in its "condemnation of exploitation and hurt."[67] While Benhabib and Young both highlight the importance of dialogue in their respective theories, as discussed earlier, the risk of perspective-taking found in Benhabib's symmetrical reciprocity is that it could potentially exploit the other person and contribute to further marginalization. But practicing asymmetrical reciprocity can overcome this worry. Standing in relations of asymmetry and irreversibility with others allows for more fruitful engagement to occur because it requires caregivers to keep respectful distance from their patients and allow their patients the opportunity to share their own experiences. As mentioned above, in order to communicate effectively another aspect of developing reciprocal relationships between patients and caregivers rests on the willingness to listen to the opinions and perspectives of others.[68] Respectful listening involves "attentive and interested questioning"[69] and instead of presuming that we can take the other person's perspective as our own for the purposes of entering into a dialogue with them, it is more appropriate to approach these situations with a stance of "moral humility."[70] Through open dialogue and respectful questioning, people can sometimes understand each other across difference without reversing perspectives or identifying with each other. But speakers cannot communicate with each other "unless there is a space differentiating them and across which they communicate."[71] Since it does *not* attempt to *eliminate* differences entirely, asymmetrical reciprocity provides this space more effectively.

7.2 How Asymmetrical Reciprocity Prevents "Compassion Fatigue"

Whenever the notion of "care" is evoked in conversation, I think it is a common assumption for some that the image of a "caring person" is one which is typically one-sided and, perhaps, self-sacrificial. But according to Pettersen (2011), understanding care based on an "individualistic ontology" like this is problematic, especially in a mental health care setting, because it tends to view the act of care as a "mono-directional activity" and something which is "transferred" from the carer to the care recipient.[72] Viewing care in this way is problematic because the caregiver's interests can be severely neglected since they are doing all the work and receiving little in return. The advantage of an ethics of care, however, is that it views caring relationships as inherently reciprocal and, by doing so, it exposes caring to be a relational process in which both sides participate together.[73]

That said, in response to the second objection that empathy can result in empathic over-arousal and 'compassion fatigue,' Code argues that *responsible* empathy is a "self-reflexive skill" and when it is well-developed and practiced in an appropriate way, it "incorporates a capacity to assess its own aptness: a capacity that enables its practitioners to judge the kind and degree of empathy a situation, a person, or a group of people requires."[74] As she suggests, empathy at its best calls for "a finely tuned sensitivity both in its cognitive moments (working out how much one can/should know) and in its active ones."[75] In other words, if cultivated properly, responsible caregivers would *know* the limits of their empathetic practices. To avoid the problem of compassion fatigue mental health caregivers must, on the one hand, be willing to "intellectually and emotionally identify, connect, and relate" with their patients but, at the same time, they must also caution themselves against becoming excessively empathetic by maintaining awareness of themselves as distinct from their patients.[76] Asymmetrical reciprocity can aid in this process more effectively, and can help prevent caregivers from overstepping their boundaries, because it insists

on engaging with others in a respectful manner and remains adamant that we do not go too far into the subjective experiences of the other. In this way, the identity of the caregiver is not lost and it can help address the issue of becoming compassionately fatigued. Even though the feeling of empathic over-arousal and compassion fatigue often comes as a result of a caregiver feeling powerless to help others in need, one way to limit this problem is for caregivers to focus less on how one is powerless and more time on the ways in which they can help make a positive impact on the lives of their patients.[77] This is where the collaboration and relationship-building found in an ethics of care can play a significant role in fostering reciprocity between individuals. Building positive relationships with patients and their families, treating patients with respect and recognizing their fundamental dignity and humanity, avoiding paternalistic and dismissive attitudes, and taking the necessary steps to support patient empowerment are all ways in which professional caregivers can not only help their patients improve their health outcomes but also can help prevent emotionally exhausting themselves in the process.

Conclusion

An ethics of mental health care should embody several key components. An ethics of mental health care should foster communication between caregivers and patients, it should involve the development of empathetic capacities and it should be grounded on respect for others in order to create reciprocal relationships based on trust and care. The relationship between mental health care professionals and patients living with mental health challenges is asymmetrical in its nature. Due to many years of training and cultivating medical expertise pertaining to treating people with mental health challenges, some may argue that mental health caregivers possess the skills, training, and knowledge of mental illness that their patients may not necessarily have and, as a result, some

may worry that this asymmetry is based on power positions and differences in epistemic privilege. But it is important to note that epistemic privilege is a notion that applies to the patient as well, and the doctor is as epistemically dependent upon the patient for successful treatment as is the patient on the doctor. Given the long history of how stigma impacts our perceptions of persons living with mental health challenges, it is important to note that doctors, nurses, and therapists can learn a great deal from the actual lived experiences of their patients, information not neatly defined in medical handbooks, training manuals, or the *DSM*. Patient narratives and testimonies offer valuable sources of knowledge which can help those not living with mental health challenges to gain a better understanding and appreciation of those unique experiences. This is another reason why a collaborative, relational approach can be very promising for improving patient outcomes and helping to preserve patient dignity.

In addition to treating whatever illness a patient has it should be the caregiver's responsibility to actively try and reach out to their patients in a caring, empathetic way. And instead of using that position of privilege to create further distance between themselves and their patients, they should take the initiative and try to bridge the gap between themselves and those they are responsible for as caregivers. I acknowledge that the gap between the caregiver and the patient can be extremely wide precisely because, unless you have first-hand experience of living with a particular mental illness, it is impossible to fully understand with the situation of the other person. However, a caregiver who treats their patients with respect, kindness, and demonstrates genuine interest in listening to and understanding the life experiences of the patient, that commitment to engagement will go a long way in bridging that gap with many patients. These core values and aims are what constitute the kinds of relationships which are fostered via an ethic of care. Perhaps trying to engage in a more thorough and "caring" approach is an ethical boundary that some

therapists and caregivers may not wish to cross. But unless they are willing to engage with their patients and take the time necessary for learning more about their subjective experiences, it will be difficult to develop empathy in a meaningful and personal level.

However, if mental health care professionals adopt an ethics of care that is informed by a practice of asymmetrical reciprocity, I think this is possible and improvements in the patient/caregiver relationship will emerge. An ethics of care motivated by asymmetrical reciprocity makes an effort to reach out to and understand the other in an inclusive manner, which is why I believe this framework can be suitably implemented into mental health care. Despite some issues associated with it empathy is still a valuable attitude to cultivate because it has numerous benefits for patients who are recipients of medical care. Empathetic knowing requires a lot of work develop correctly and it places a great deal of responsibility on caregivers who are using it. But in order for caregivers to become better able to reach out and meet the needs of those who need it the most, adopting a stance of asymmetrical reciprocity—and the willingness to get to know the other person in a responsible manner via an ethics of care—is a good first step.

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Endnotes

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[2] Bubandt and Willerslev 2015, 10; Mercer and Reynolds 2002, 9.

[3] Mercer and Reynolds 2002, 9.

[4] Code 1995, 124-125, 121. In fact Mercer and Reynolds note that "[t]he culture of medicine and of medical training may be such that empathy is undervalued and under-taught" (Mercer and Reynolds 11). While I think progress has been made in medical training over the past decade, and more attention is given to the cultivation of empathy, these kinds of attitudes must change in order to improve the quality of care that persons with mental health challenges receive.

[5] Coplan 2011, 9. Although there are variations most simulationist accounts of empathy presume that, in order to empathize with others, we need to be able to know their experiences (De Vignemont 2010, Goldie 2011, Goldman 2006, Gordon 1995, Kögler and Stueber 2000, Stueber 2006). This typically involves using one's own cognitive resources to replicate the experiences of other people by imagining being in their situation. This is problematic both because it suggests that we might not be able to empathize with people with mental illnesses and because it encourages us, in our attempts to empathize with them, to co-opt their experiences and substitute our own. To address this issue we need a kind of empathy that allows for interpersonal engagement while avoiding the assimilation of others' experiences. As I argue in my dissertation, a phenomenological account of empathy, as articulated by Edith Stein (1964), is better suited for this task. While simulationist theories assume that successful empathy requires first-person replication of someone's experiences, a phenomenological approach recognizes that empathy is not a feeling of oneness with another, nor does it involve simulating their experiences and projecting it back at them. Rather empathy involves appreciating someone's experiences as it is for them which is achieved by adopting an other-directed attitude (Ratcliffe 2015/2012, Meneses and Larkin 2012). This type of empathy can be cultivated through dialogue and by actively listening to patient narratives.

[6] Hollan and Throop 2008, 389; cited in Bubandt and Willerslev 2015, 11.

[7] Karp and Tanarugsachock 2000, 13. I also address this specific objection in my paper, "Applying Lugones' Concept of 'World Travelling' to Reduce Stigma Associated with Schizophrenia," *Proceedings of the Sixth World Metaphysics Conference* (2018), forthcoming.

[8] Scheff 2012, 87.

[9] Karp and Tanarugsachock 2000, 13-14. That being said, if the caregiver has had similar experiences or if the caregiver and patient possess the same language and the caregiver is willing

to listen and ask the right questions, then perhaps the argument could be made that it is not thoroughly inaccessible. In particular, I am thinking of L.A. Paul's (2014) discussion of transformative experiences. Evoked in the field of critical disability studies, a transformative experience occurs when someone experiences a significant event or moment which fundamentally changes their values, interests, and the way they understand and experience the world. It is plausible to suggest that the onset of any type of mental health challenge constitutes a transformative experience. One significant feature of a transformative experience is that it is something that cannot be fully known, or understood, unless it is experienced firsthand. Thus, if a caregiver has experience living with a particular mental health challenge (either directly or indirectly through a family member, a close friend, etc.) then that caregiver would be better able to empathetically engage with their patients because they would know the right questions to ask, and they would have more insight into the types of support they can offer to their patients.

[10] Simmons 2014, 98.

[11] Simmons 2014, 104, 99-100. Although he is skeptical about empathy's role in motivating ethical behaviour Jesse Prinz (2011) argues that empathy involves a kind of "emotional mimicry" (219, 212).

[12] Slote 2007, 13; Hoffman 2000, 198, cited in Simmons 2014, 100.

[13] Hoffman 2000, 198; cited in Simmons 2014, 100.

[14] Hoffman 2000, 199-200, cited in Simmons 2014, 100; see also Hodges and Biswas-Diener 2007, 401. A similar phenomena is "burn out" and based on conversations I have had with healthcare professionals, including nurses, one of the biggest areas of healthcare where burn out is a significant problem is in emergency rooms, where the caregiver is constantly dealing with difficult and emotionally draining situations on a regular basis.

[15] Held 2006, 10.

[16] Held 2006, 10.

[17] Held 2006, 13. On a similar note, I have argued elsewhere that relational autonomy is very important within the context of mental health care because a relational approach undermines the traditional view of autonomy which characterizes "autonomous" agents as being totally free, rational, atomistic figures and replaces it with a view which emphasizes our intersubjectivity and dependency on others. See Molas, Andrew. "Silent Voices, Hidden Knowledge: Ecological Thinking and the Role of Mental Health Advocacy." *Dialogue: Canadian Philosophical Review* 55.1 (March 2016): 87-105. For a greater discussion on the importance of viewing autonomy as a relational concept, see Catriona Mackenzie and Natalie Stoljar's *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Self* (Oxford University Press, 2000).

[18] Held 2006, 15-16 emphasis added.

[19] Noddings (1984), referenced in Slote 2007, 10-11.

[20] Held 2006, 31. As Pettersen correctly notes, one of the keys in ensuring a healthy caring relationship is realizing that "what might seem good and right...to one, might look differently to the other" (2011, 62). Once more this emphasizes the importance of caregivers approaching each patient in a unique way and refusing to adopt a one-size-fits-all model of care. This requires cultivating sensitivity towards the needs of others and the ethics of care can help.

[21] Held 2006, 33.

[22] Sandhu et al. 2015, 463.

[23] Pelto-Piri et al. 2013, 2.

[24] Pelto-Piri et al. 2013, 6-7.

[25] La Caze 2008, 119; Young 1997, 342.

[26] As I indicated earlier, I am ultimately rejecting simulationist accounts of empathy precisely because I do not think it is possible for us to fully *know* the experiences of others. I think it is more appropriate to respect the lived experiences of persons living with mental health challenges and consult with them *directly* in order to get a better understanding of their experiences.

[27] Young 1997, 342.

[28] Benhabib 1991, 32, 137.

[29] La Caze 2008, 119.

[30] Young 1997, 346.

[31] Young 1997, 343.

[32] Clohesy 2013, 3.

[33] Young 1997, 349; La Caze 2008, 118.

[34] For an in-depth discussion on situated knowledges, see Haraway's "Situated Knowledges: The Science Question In Feminism And The Privilege Of Partial Perspective." *Feminist Studies* (1988): 575-599.

[35] Young 1997, 350.

[36] Schulze and Angermeyer 2003, 304. For a discussion on the structural and institutional limitations on mental health care services, see my paper "Defending the CRPD: Dignity, Flourishing, and the Universal Right to Mental Health." *The International Journal of Human Rights* 20.8 (Dec. 2016): 1264-1276.

[37] Young 1997, 350. Code (1995) shares a similar worry. As I discuss in greater length in my other works, while empathy is valuable Code explains that *therapeutic empathy* is unique because it "is marked from the outset by an asymmetry in the power of its participants" and, as a result, while the claim "I know just how you feel" is potentially "caring, supportive, [and] affirmative of mutuality," if practiced irresponsibly empathy can also be "coercive, intrusive, [and] cooptive" (130). Even though empathy can inclusive and be used to reach out to patients in order to get to know them in a responsible, dialogical manner, empathy is also a "double-edged phenomena" because if a caregiver is capable of *knowing* just how *I* feel then, given her medical expertise, my personal narrative and testimony could be deemed irrelevant because that expert would have a better understanding of my situation than I do (121, 134). As a result, the worry with empathy is the possibility for a kind of 'emotional colonialism' to emerge, where the medical expert appropriates the experiences of the patient and the patient's voice is silenced because someone else is speaking for her. This is precisely the kind of approach I wish to avoid and I believe Young's asymmetrical reciprocity can prevent it from happening.

[38] La Caze 2008, 120. In regards to empathy or any moral theory which involves identifying with others, Clohesy argues that any account which claims that we can *know* the mind of another is "inimical to ethics, which demands that recognition must always fall short in this respect" (Clohesy 83). Although I do not believe that is Benhabib's intention through her endorsement of symmetrical reciprocity, any attempt to know the other person in this intimate manner potentially runs into this objection.

[39] La Caze 2008, 119; Young 1997, 341, 360.

[40] La Caze 2008, 119.

[41] La Caze 2008, 121; Young 1997, 350, 358.

[42] Young 1997, 357. I believe Lugones' concept of playfulness is similar to wonder, in the sense that it requires people to more open-minded and less dismissive of the view points of others. See her article "Playfulness, 'World'-Travelling, and Loving Perception." *Hypatia* 2.2 (1987): 3-18.

[43] Nancy Nyquist Potter (2003) illustrates this with an example taken from clinician Lauren Slater's book, *Welcome to My Country* (Random House, 1996). Slater describes an experience of engaging with her patient with schizophrenia and participates in his delusions in a playful, engaging manner (Potter 209). The caregiver's open-mindedness and receptiveness towards new experiences resulted in increased dialogue and interaction between patient and caregiver, and ultimately helped in the therapeutic process. This is precisely the kind of connection I believe asymmetrical reciprocity and an ethics of care achieves.

[44] Young 1997, 357; La Caze 2008, 121.

[45] Young 1997, 357; La Caze 2008, 121.

[46] La Caze 2008, 122.

[47] La Caze 2008, 121.

[48] La Caze 2008, 127.

[49] La Caze 2008, 127, 119. Similarly Wispé (1990) argues that "[t]o be with another in this way means that for the time being you lay aside the views and values you hold for yourself in order to enter another world without prejudice" (Wispé 1990, 28 cited in Clohesy 2013, 15).

[50] La Caze 2008, 127. Projection only becomes morally problematic if you are projecting your own experiences as a substitute for the experiences of the other. But I agree with one commentator's suggestion that not all projection is bad because it can help bridge a connection between the self and the other, which I hope to demonstrate with the following example. Suppose you are a caregiver and one of your patients, who is living with bipolarism, is committed to a mental health inpatient ward against her will. While we cannot understand what it is like to be living with bipolarism if we do not share the same diagnosis, it is still possible to recognize that, in this situation, she is no longer being treated as a self-determining individual. We can recognize that she is no longer seen as a trusted reporter of her own experiences, and that her judgements about what is best *for her*, given *her* experience of living with bipolarism, is deemed irrelevant to the treatment being administered. In other words, while we cannot identify with these feelings directly, we can still get a general sense of what it would be like to be unable to make a decision on your own, or to have your decisions and behaviours questioned and viewed with suspicion from 'medical experts.' If caregivers do at least this much imagining of the other's perspective, the caregiver and the patient will be on their way to an empathic and respectful relationship which has some chance of making a difference in the life of the patient. It is necessary to have some understanding of the mental health patient's experience of being treated like they are non-autonomous and irrational. Unless the patient feels that this perspective is understood, or at the very least acknowledged, they will not likely be very cooperative with any course of treatment and will undoubtedly be perceived as being completely misunderstood and disrespected by the medical team attempting to care for them.

[51] Code 1995, 123.

[52] Sandhu et al. 2015, 466, 468; Pettersen 2011, 62; Code 1995, 142.

[53] Young 1997, 359.

[54] Code 1995, 126 emphasis added.

[55] Sandhu et al. 2015, 465-466. Furthermore, they argue that conversations between patients and therapists in reciprocal relationships consisted of sharing "emotive experiences, such as personal shortcomings and happy occasions" and these conversations were valuable and were regarded as part of the process for "reducing the emotional distance needed for reciprocity" (Sandhu et al. 2015, 466).

[56] Sandhu et al. 2015, 461.

[57] Pettersen 2011, 62-63.

[58] Pettersen 2011, 62-63. Interestingly enough, Pettersen argues that the ethics of care conceives agents as "mutually interconnected, vulnerable and dependent, often in *asymmetric* ways" (52, emphasis added). This is another indication that Young's theory is applicable to an ethics of mental health care because of the asymmetry found between patients and health care professionals.

[59] Code 1995, 141.

[60] Bubandt and Willerslev 2015, 19.

[61] But as one reviewer correctly points out it is unlikely that, in the case of a mental health patient, the caregiver denies either their existence or their uniqueness since it is precisely this uniqueness that brings the patient to the attention of the mental health provider. In many cases, the other presents as someone who is not conforming to social norms and his/her 'unique' behaviours are identified as symptoms of their mental health challenges. Nevertheless, empathy can become problematic if the caregiver makes the empathetic exchange all about themselves or their own experiences. Empathy can become dangerous if it turns into a one-person activity, where the patient's experiences are ignored or discounted.

[62] Kain 1998, 122. While I do not want to claim that persons living with mental health challenges are, in any way, "subordinate" in relation to persons who are not diagnosed with any mental health issues, I want to acknowledge that Kain's article focuses on the struggle between the lord and bondsman in Hegel's *Phenomenology of Spirit*. However, I think he makes a very good point about how attempting to overlook the differences of others can deny certain unique features of their identities.

[63] For further discussion on epistemic harm and violence see Kristie Dotson's "Tracking Epistemic Violence, Tracking Practices of Silencing." *Hypatia* 26.2 (2011): 236-257.

[64] Kain 1998, 120, emphasis added. Still, I believe this potential worry is more prevalent in simulationist views of empathy. The empathizer often will have to rely on their *own* experiences in order to "simulate" the experiences of the other person. But given that we all have unique histories which are shaped by our own unique experiences—experiences which often emerge from the factors and circumstances of our lives, including socio-economic class, health, talents and abilities, and opportunities available to us—there is no way to get a fully *accurate* description of the subjective experiences of the other person.

[65] Kain 1998, 120.

[66] Kain 1998, 120. For Kain it seems to be a balancing act recognizing the similarities which exist between persons but nonetheless refusing to completely assimilate the other's differences or uniqueness into oneself.

[67] Gilligan 1993, 74.

[68] Sandhu et al. 2015, 465-466.

[69] Young 1997, 358. But as Young points out, even if a caregiver is responsible and sensitive in her questioning "answers are always gifts" and that "[t]he transcendence of the other person always means that she can remain silent, or tell only part of her story, for her own reasons" (Young 1997, 358). A responsible caregiver cannot *force* the patient to answer their questions informed by respect and care. But I believe a caregiver should do as much as they can to ensure that they foster a safe space where the patient feels comfortable to reciprocate.

[70] Young 1997, 350. For psychologist Carl Rogers, one important aspect of empathy is that it requires practitioners check the accuracy of their sensing of the other person's feelings/experiences, through initiating conversation and dialogue, and being guided by the other

person's response (Clohesy 2013, 15). This process is similar to Young's position on the positives associated with asking questions in order to better understand others.

[71] Young 1997, 352.

[72] Pettersen 2011, 56.

[73] Pettersen 2011, 55.

[74] Code 1995, 126.

[75] Code 1995, 126. Similarly, Simmons draws on the Aristotelian notion of moderation and maintains that "[a] mature and virtuous empathy must aim for the middle" (Simmons 2014, 109-110). Perhaps with proper guidance and training caregivers can *learn* to practice more empathy in appropriate ways to avoid these issues. Nevertheless, I believe empathy is an important component of good mental health care and it must be available for the benefit of the patient.

[76] Simmons 2014, 109-110. Although sharing in the emotional experiences of others is an important way to build trusting and reciprocal relationships of care, Sandhu et al. note that the shared affect in the professional mental health care relationship "entail[s] a balanced approach to emotional involvement "by having as much concern for oneself as for the other" but also maintaining a "distinct sense of self from the other" at the same time (2015, 466; see also Simmons 2014, 109-110; Pettersen 2011, 59).

[77] Hoffman 2000, cited in Simmons 2014, 109-110.