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Empathetic knowledge: conceptualising modes of knowing within families marked by illness

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ABSTRACT

While many sociologists have conceptualised medical and experiential modes of knowing health and illness, less attention has been given to the concept of empathetic knowledge. That is, knowledge derived from close association with others living with a particular condition. This article investigates empathetic modes of knowing among families marked by illness, drawing on 52 h of video recordings of support group sessions for children of parents with mental illness in Denmark and interviews with 11 participating children. Inspired by the sociology of empathy, the analysis shows that empathetic knowledge involves knowing illness from the outside (through observations of the ill person's body) and from the inside (through the affective impressions left on the next of kin's own body). This empathetic knowledge is relational, bodily and affective, and, together with other ways of knowing, it shapes everyday lives and projects imagined futures. The article demonstrates that the concept of empathetic knowledge can advance our sociological understandings of next of kin.

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Introduction

The sociology of health and illness have long been concerned with the different modes through which our body is known. In his seminal book *The absent body*, Drew Leder (1990) argues that, while the body is taken-for-granted and tends to disappear when functioning unproblematically, it often seises our attention strongly at times of dysfunction. An impressive amount of work has explored the different modes through which our body may be known when it is marked by illness (Arksey, 1994; Brosnan & Kirby, 2016; Mol & Law, 2004). In 1973, Foucault demonstrated how the discovery of pathological anatomy led to a radical epistemic shift in medical knowledge by enabling a scientific, objective and unquestionable description of illness (Foucault, 1973). Around the same time as Foucault's work, inspired by a rapid increase in self-help groups, Borkman

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(1976) introduced the concept of 'experiential knowledge' to capture 'truth [about illness] learned from personal experiences with a phenomenon' (p. 446). More recently, advances in genetic testing have given rise to studies of the ways in which medical technologies shape how we govern ourselves (Atkinson & Featherstone, 2013; Novas & Rose, 2010), and the last decade's upsurge of user involvement has resulted in a rapid increase in scholarly literature that explores the characteristics of experiential knowledge (Halloy et al., 2023; Kessing, 2022; Oborn et al., 2019).

While both medical knowledge and experiential knowledge have received extensive sociological attention, less is known about the concept of empathetic knowledge: knowledge derived from close association with others living with a particular condition. Abdel and Browner first coined the concept in 1998 to differentiate embodied knowledge from empathetic knowledge. While embodied knowledge refers to personal perceptions of one's own bodily experiences and sensations (e.g. the feeling of being pregnant or ill), empathetic knowledge is derived from close association with others living with a particular experience (e.g. from giving care to others). Thus, 'one derives from direct sensory experience, the other from close emotional ties between individuals' (Abel & Browner, 1998, p. 315). Abel and Brower do not elaborate further on the concept of empathetic knowledge and in the scholarly literature, the concept does not appear to have gained currency (For an exception see Boardman, 2017; D'Agincourt-Canning, 2005; Etchegary et al., 2008).

While many scholars do not make explicit reference to empathetic knowledge, some do touch upon how knowledge may derive from close association with others living with a condition. For example, studies of families with genetic risk have explored how people look to their ill kin and compare physical, mental and/or emotional resemblances, turning families into 'living laboratories' that provide clues about who is most at risk (Chilibeck et al., 2011; Leontini, 2006). Furthermore, since the mid-1990s, a vast literature has emerged focusing on 'expert carers' and 'young carers' (i.e. children and young people providing care to another family member). This literature shows that carers develop a special knowledge of the cared-for person's needs (Aldridge, 2018; Leane, 2019). While these scholarly fields provide insights into knowledge obtained through close ties with others living with a condition, their findings are situated within particular empirical and theoretical debates about 'risk' and 'care', limiting a more comprehensive understanding of this mode of knowing.

Drawing on Ruiz-Junco's sociology of empathy (2017, 2021), this article contributes to the development and consolidation of the concept of empathetic knowledge. Our empirical data consist of 52 h of video recordings of support group sessions for children of parents with mental illness and interviews with 11 participating children. Importantly, we acknowledge that the support group setting constitutes an interactional setting that may shape children's way of talking about their parent's illness. However, the support-group setting where children are encouraged to share their experience of others' illness still offers a unique opportunity to investigate children's (empathetic) knowledge of health and illness; a topic that has received little attention within medical sociology (Drummond & Drummond, 2010; Mayall, 1998; Redshaw, 2014).

The article proceeds as follows. First, we present our theoretical framework, followed by an elaboration of the study and methods on which this article is based. We then turn to our analysis. The first section demonstrates how empathetic knowledge entails

knowing illness from the outside and the inside, while the second section unfolds the ambiguities and constraints of this mode of knowing. The third section shows how empathetic knowledge may shape how we come to know ourselves, and the fourth section reflects on how this knowledge interacts with other ways of knowing.

Theoretical framework

The concept of empathetic knowledge comes from the fusion of two concepts: empathy and knowledge. Despite some scholarly interest in the concept, the epistemic and moral value of empathy is still contested (Campelia, 2017). Traditionally, psychologists have occupied the field of empathy research, but more recently, philosophers, anthropologists and sociologists have joined the conversation (Hochschild, 2013; Throop, 2008). Focusing on the biological aspects of empathy, psychologists have argued that human beings' ability to understand others' mental and affective states is a 'cornerstone of our lives as "social animals"' (Singer & Lamm, 2009, p. 81). However, within the philosophy of science, where the status of knowledge depends on its reliability and validity against certain criteria, many scholars have doubted or even dismissed empathy as something distinctly epistemic, arguing that it is impossible to know how others feel (Goldie, 2014). Falsely assuming that one is able to do so may be experienced as egoistic, paternalistic, trivialising and be interpersonally and societally detrimental (Code, 1995).

Within sociology, scholars have contested the view that emotions – and relatedly empathy – are primarily psychophysiological reactions, arguing that such an approach overlooks how emotions are constructed through social interactions and cultural norms (Harris, 2015). In support of such sociological thinking, this article draws Ruiz-Junco's (2017, 2021) conceptualisation of empathy as an interactional process. Building on Cooley's conceptualisation of sympathy (1909, 1922, 1926), Ruiz-Junco seeks to advance a sociology of empathy, approaching empathising as a process whereby the empathiser imagines and shares the thoughts and feelings of the empathy recipient. This does not entail that individuals have the same emotional experiences as others with whom they empathise. Rather, it involves an interpretive process through which the empathiser evokes in themselves thoughts and feelings similar to those of the recipient with the purpose of understanding them. The result is 'feeling *with*' others (Ruiz-Junco, 2017, p. 420). For Ruiz-Junco, the ability to understand and share the feelings of others rests on empathetic imagination, which comprises two interactional processes. First, to empathise, people engage in embodied communication. They use their body and senses – listening to another person's tone when they speak, observing their face and responding to their gestures. Second, as part of this embodied communication, people interpret the actions of others by imagining and sharing meanings. This interpretive process is not only about knowing the other; it is also a central part of knowing oneself. Hence, it is through what Ruiz-Junco calls 'interactional empathy' that we derive a sense of who we are.

Going beyond the interactional level – how people 'do' empathy – Ruiz-Junco (2017) argues that empathy is socially learned and performed in accordance with 'empathy rules'. This concept draws attention to the ways in which significant sociocultural and institutional norms structure how people empathise in a particular setting. While empathy may serve varied and potentially contradictory social ends with several social

consequences, the effects of what Cooley (1909) calls 'sympathetic influence' always depend on a larger context of power and status. While Ruiz-Junco develops this framework to address the role of empathy in a broader societal and political context, in this article, we employ her conceptualisation to unfold how we through empathy come to know others and ourselves in the context of intimate family relations marked by illness.

Data and methodology

In Denmark, support groups are offered by NGOs and state-sponsored social and mental health services. The groups aim to bring children of parents with mental illness together to increase their knowledge of mental illness, ability to practice self-care and build supportive relations between children with similar life circumstances. This article draws on 52 h of video recordings of support group sessions for children and interviews with 11 participating children. To gain access to the support groups, the first author contacted group facilitators and informed them about the study. If the facilitators agreed to participate in the study, they then asked parents and children for their consent for the researcher to be present at their introductory conversation. During this conversation, parents and children were informed of the data collection, ethics, and option to withdraw from the study. Parents and children each received an age-appropriate information sheet containing details about the study. All support-group participants and their parents gave their oral consent to participate. Particular attention was given to the children's willingness to participate in the study. Thus, throughout the data collection, a researcher was present in the room while the recordings took place. This enabled the researcher to pay attention to verbal and non-verbal signs of discomfort among the children directed towards the camera/researcher, and it allowed the children to familiarise themselves with the researcher and ask questions.

The video recordings were collected from three different support groups, resulting in a total of 23 participating children aged 8–14 years (group 1: 8–9 years; group 2: 10–11 years; and group 3: 10–14 years). In total, there was 13 girls and 10 boys, all of whom had one or two parent(s) with mental illness. The support groups consisted of an introductory conversation with the child and parent(s), 8–9 group session for children, one session for parents, one session for someone named as an important person by the child and, finally, a closing conversation with the child and parent(s). Two group facilitators who were trained to run support groups for children coordinated the groups. All group sessions where recorded by one or two cameras that focused on a fixed perspective of a table-centred activity (Luff & Heath, 2012, p. 262). When an activity was carried out on the floor, the camera(s) shifted angle accordingly. Children were recruited for interviews through the support groups. Using an age-appropriate interview guide, the children were asked to reflect on their family life in general, their parents' illness and their experiences with attending the support group.

All video recordings and interviews were transcribed in full. The concept of empathetic knowledge was not part of the original study, but an interest in the children's knowledge of their parents' illness emerged by watching and reading through the data. For the analysis, the first author read all transcripts of the video recordings and interviews, focusing on how the children described their parent's illness and its effect on themselves and their family lives. This process was guided by initial thematic codes such as 'understanding parent's illness', 'affective responses to parent's illness'

and 'talk about risk and the future'. The two authors then sought inspiration from sociological theories on knowledge and empathy before conducting a focused theoretical coding of the group sessions and interviews, using codes such as 'embodied communication', 'difficulties of knowing another' and 'knowing ourselves through others' (Charmaz, 2006). The codes were then analysed, and a representative sample of sequences and quotes was picked.

The Research Ethics Committee at VIVE (2022/8) and The Danish Data Protection Agency have approved the study. The ethical principles of childhood research (Farrell, 2005) and the ethical standards set by the British Sociological Association were followed with regard to data collection, publication and storage of data. All data extracts presented in the analysis have been anonymised.

Results

Knowing others' illness from the outside and the inside

Research has tended to conclude that children's knowledge of their parents' mental illness is inadequate and/or inaccurate with reference to these children's limited understanding of and ability to use medical terminology (Gladstone et al., 2011). However, even though these children have neither medical nor experiential knowledge of mental illness, studies have found that they are able to detect changes in their parents' behaviour, daily routines and overall well-being (Mordoch & Hall, 2008). In this section, we unpack how children come to know their parents' illness by employing the concept of 'empathetic imagination' (Ruiz-Junco, 2017).

In the interviews, the children explained that they knew their parents were not well when their parents were more tired, angry, sad, stressed or inattentive. Some children found that such changes in affect lasted several years or months, while others experienced that their parents' affective state shifted daily or sometimes even by the minute. When Eleanor (10 years) was asked how she could tell if her mother was not feeling well, she said: 'Her head starts to get really red and like, you can just see it on her. You are certain when you see it, but I can't explain it better than that'. The children's observations display their awareness of their parents' (dysfunctional) bodies. Eleanor's statement further captures how the children used embodied communication, employing their own body and senses – for example, their eyes ('you can just see it on her') – as a tool to imagine and interpret their parents' affective state. Her statement also taps into how this interpretive mode of knowing may be difficult to verbalise. It is something before – and maybe in some instances beyond – language (Campelia, 2017).

The children had learned to engage in fine-tuned embodied communication and imaginative practices through having lived their everyday lives in close association with a sick parent. In the group sessions, the children would recount situations in which they had observed that their parents were not well, turning these observations into explanations of how mental illness affected their parents. Such situations were for example presented during an activity where the children were instructed to use a variety of creative tools to model a situation that they had experienced as difficult in relation to their parents' illness. One of the children, John (10 years), had made a bed and a ping-pong table out of playdough. He explained the following about his model:

> I've made a model of my father, who's lying in bed. Before he got ill, we would play a lot [at the ping-pong table], but then he got sick and he got very tired. Now we aren't able to play that much anymore.

Another child, Freddie (12 years), made a model of a caravan, recounting a situation that occurred the last time he and his family went camping. He explained that they were packing up their things, trying to avoid a massive rain shower that was rapidly approaching. His father was having trouble packing their tent, which made him stressed and frustrated, and he ended up throwing a chair at Freddie, his little sister and stepmother. Freddie adds that the situation was too much for his father who, because of his mental illness does not cope well with stressful situations. In both John's and Freddie's examples, we see that the children engage in an interactional process that enable them to understand their parents. Using their empathetic imagination (Ruiz-Junco, 2017), John and Freddie observe a change in their fathers' affective state (he is tired / he is stressed) and from there, they imagine and interpret the cause of these changes (because of the illness) and its effects (he cannot play ping-pong / he throws a chair). Hence, instead of using diagnostic tools and technologies as physicians would do, the children rely on their own bodies, senses and imagination as a tool to extrapolate knowledge about their parents' well-being.

Throughout the group sessions, it became apparent that these illnesses were not only known from the outside, but also from the inside through the affective impressions that they made on the children's own bodies:

> [The children are sitting in a circle on the floor. The group facilitators invite them to share their experiences of growing up with an ill parent.]

GF1: What do you notice when the illness is dominant in your families?
Eleanor: I feel tired and like I can't do anything.
Simon: I get nervous.
Eleanor: I get sad.
Simon: Me too.
Carla: I feel forgotten.
Eleanor: I feel broken.
Aya: I feel lonely.
Carla: Me too.

The sequence demonstrates the ways in which the children become affected by their parents' condition. Living with a parent with mental illness, then, is also an experience of living with pain and suffering. Even though the children and parents do not have the same experiences of what it means to live with mental illness, the children do to some extent 'feel *with*' (Ruiz-Junco, 2017, p. 420) their sick parents, as Iris's (10 years) interview excerpt captures:

Interviewer: So, did you notice when your father wasn't feeling well?
Iris: My father got extra sad and didn't want to do anything.
Interviewer: And how did that make you feel?
Iris: I got sad.
Interviewer: And what did you do when you got sad?
Iris: I didn't want to do anything either, so I would just lay on the couch with my iPad.

Following Ruiz-Junco (2017), it could be argued that Iris engages in an interpretive and imaginative process through which she evokes in herself thoughts and feelings that are similar to those of her father. We do not assume that Iris and her father had the same emotional experiences of mental illness. Rather, we approach the affective impressions made on the children's bodies as means of knowing the illness from the inside – an intimate knowledge tied to the children's everyday lives and relationships with their parents, a mode of knowing that is not available to, for example, their parents' physicians. However, while the children used their empathetic abilities to know their parents' illness, the illness itself still inhabited a body other than their own. In the following section, we explore how this created certain conditions for the children's empathetic knowledge.

'The empathic body' and 'the ill body'

While the (functional) body may only be marginally available to experiences, the body always has a determinate stance; it is the 'orientational center' in relation to which everything else takes place (Leder, 1990, p. 22). During our everyday lives, the body is actualised when we gaze and touch ourselves, and its presence becomes fleshed out by continuous bodily sensations coming from our internal organs, the layers of our skin and the movement of our joints and muscles. A distinct characteristic of the children's empathetic knowledge was that it concerned their parent's ill body; a body whose presence the children could not gaze upon, touch and sense in a similar manner to their own. To unpack the dilemmas of using empathetic imagination (Ruiz-Junco, 2017) to know another's body, we introduce the distinction between 'the empathic body' (the body that has an empathic experience of illness) and 'the ill body' (the body that has an embodied experience of illness).

Throughout the group sessions, it became apparent that some aspects of the parents' illness and treatment remained unclear or unknown to the children:

GF1:	Do you know if anyone is helping your father, Max?
Max (9):	No. [Max shakes his head from side to side]
GF1:	No. [Ava raises her hand]. Ava?
Ava (8):	I haven't seen my dad in a year, so I don't know if anyone is helping him. But I HOPE that someone is helping him.
GF1:	Yes. [GF1 tilts her head to the side]. You hope that someone is helping him. I get that. [Leo raises his hand]. Leo?
Leo (9):	My dad speaks on the phone with someone.
GF1:	Do you know if it's friends or someone who/
Leo:	/No, it's just someone who helps with stuff. I don't know.

This interaction taps into how knowledge obtained through embodied communication may render certain aspects of 'the ill body' unknown. Like Ava, some children in the group had no current contact with their ill parent; others were from divorced families and only saw their ill parent at weekends, while some lived together. The bodily proximity as well as relational ties between children and their parents shaped the level and nature of the children's empathetic knowledge.

However, the distinction between 'the empathic body' and 'the ill body' not only challenged the children's knowledge of the illness itself, but also their ability to act on knowledge of care practice that they believed supported their parents' health. As studies of

carers have revealed, negotiating care practices and responsibilities in family relations marked by illness presents carers with moral dilemmas and choices (Leane, 2019). Throughout the group sessions, the children relayed empathetic understandings of their parents' care needs and the challenges they encountered when trying to care for their parents. For example, Oliver (14 years) noticed that his father felt better when he took his medication (which he sometimes did not do), and he struggled with how he could get his father to stay medicated. Eleanor (10 years) knew that it helped her mother to rest, but she found that her mother got angry when she asked her to do so. Both Simon (11 years) and Ava (8 years) recounted that neither they nor anybody else could help their parents, because their parents did not believe they suffered from a mental illness. As the following sequence demonstrates, trying to act on empathetic knowledge was often experienced as emotionally draining:

GF2:	[The children have written anonymous questions to each other, GF2 reads a question aloud]. 'Can you help your parents?' [Freddie, who is lying on the floor, raises his hand.]
Freddie (12):	Both yes and no. You can help them a tiny little bit [sits up], but it takes an extreme amount of energy from you. Trust me [said in a loud voice], I'm an expert on this.
GF2:	Why can you only help them a little bit? [GF 2 holds up two fingers close to each other.]
Freddie:	It takes up so much of your energy that you're not able to make them better before your own energy runs out.

Borrowing the term of 'sympathetic influence' (Cooley, 1909; Ruiz-Junco, 2017), we see that because the illness inhabits another body than the one who holds empathetic knowledge, the sense of agency tied to this mode of knowing is experienced as constrained. When trying to utilise this limited agency to care for their parents' bodies, the children risk overstepping the boundaries and capacities of their own bodies.

So far, the analysis has focused on the way in which children come to know the thoughts and feelings of their parents who suffer from a condition. In the following section, we direct our attention towards the ways in which empathetic knowledge shapes how the children come to know themselves.

Knowing ourselves through others

According to Ruiz-Junco (2017), empathetic imagination is not only about knowing the other; it is also a central part of knowing one's self. Hence, it is through 'interactional empathy' that we derive a sense of who we are. Thus, as the following interaction from a support group session illuminates, the children's orientation towards their parents not only related to their present condition but also stretched into the children's own imagined futures:

[The children have watched a film about conflicts in families. Unrelated to the content of the film, Simon makes the following statement.]

Simon (11 years):	Sometimes I think I have my father's illness. [Simon has his arms around his knees, pressing them into his chest, while he moves slightly back and forth.]

GF1:	Why do you think that?
Simon:	Because sometimes I hear voices.
GF1:	Sometimes you hear voices [GF 1 nods her head]. And so does your father? [Simon nods his head] […]
Carla (10 years):	My father thinks that I have ADHD. [Carla looks at GF1]
GF1:	Your father thinks you have ADHD. [GF 1 nods her head] Like him?
Carla:	Yes, he says that there're many things pointing in that direction.
Thomas (11 years):	My mother says the same to me. [Thomas looks at the floor]

While the children in the sequences above speak of the probability of them developing mental health challenges because they see themselves – or are seen by others – as similar to their parents, other children drew attention to differences between their parents and themselves to make it more probable that they would not become ill. Hence, the children's families turn into 'living laboratories' (Chilibeck et al., 2011) from where the children draw knowledge about themselves and their risk of developing mental illness based on comparison to their next of kin. While many of these imagined futures were based on thoughts and feelings deriving from fear, others were based on horizons of hope. For example, in his interview Freddie (12 years) said:

Freddie:	If I have children, I hope to become a good father and show my child the real world.
Interviewer:	Show your child the real world?
Freddie:	Yes, how you live a good life and what is important in life. You know, I have had these issues with my family. There are many bad things, which I would like to do differently, so my children don't have to feel like me.
Interviewer:	So, you want your children/
Freddie:	/I want them to have a better life than what I've had, that's for sure.

Like Freddie, the children used their empathetic knowledge to envision different lives for themselves as they grow up and start families of their own – creating an opening to imagine futures without mental illness. The children's imagined futures illustrate how 'interactional empathy'(Ruiz-Junco, 2017), in the context of health and illness, does not necessarily offer the opportunity to know oneself in indefinite ways, but rather opens up for knowing oneself in a particular way. Hence, in this study, the children's empathetic knowledge enabled them to know their future selves with or without the mental illness that had marked their parents and childhood.

Importantly, when the children spoke of their hopes and dreams for the future, it became apparent that their empathetic knowledge of illness was used to project only one among many possible futures. Hence, Eleanor (10 years) explained that she wanted to become a YouTuber, Max (9 years) wanted to work as a physicist and Theo (11 years) dreamt of getting a dog. All of these hopes and dreams were not directly linked to the illness and the children's childhood experiences. This hints towards the fact that empathetic knowledge is not an isolated object. Rather, as our final section will demonstrate, it develops and interacts alongside other ways of knowing.

Empathetic knowledge and other ways of knowing

The children's empathetic knowledge was continuously developed through the settings they came to inhabit during their everyday lives. As this section demonstrates, the

support groups constituted such a setting, introducing the children to other ways of knowing the illness and themselves that could potentially (re)structure their way of 'doing empathy' (Ruiz-Junco, 2017). In the following excerpt, the children played a game in which they were divided into teams and given two signs saying 'yes' and 'no', respectively. One of the group facilitators read a statement aloud and the children had to pick a response. As the following sequences demonstrate, the answer to some of these statements challenged the children's empathetic knowledge:

GF1:	[GF1 reads a statement aloud from a manual] Most people with mental illness are admitted to a psychiatric hospital. [The children talk with their partners, pick a card and GF1 ask them to turn it around. All of the groups have picked the sign saying 'yes']. Do any of you want to explain why you picked yes?
Emma (10 years):	We talked about how my mother has been hospitalised for two months.
Iris (10 years):	And my father has tried it.
Alice (10 years):	My father has tried it.
Freddie (12 years):	I also think my father has tried it.
Tommy (13 years):	My father has tried it twice.
John (10 years):	My father has tried it.
Oliver (14 years):	My mother and father have tried it. Many times.
GF1:	Then I really do understand that you all answered 'yes'/
Alice:	/It's pretty obvious/
GF1:	/But, you know what, the right answer is 'no'.
Everybody at once:	What? No? Really? [Some of the children open their mouths and look around to one another]
GF1:	Since all of your parents have been hospitalised, I really understand why you think it's 'yes' […]. Most people can actually be helped through medication and therapy. They do not need to go to hospital, and I guess that also says something about how ill your parents have been.

Through such activities, the children came to know and empathise with their parent's illness in new ways – as a phenomenon that other bodies may have encountered and experienced in diverse ways. The simple setup of answering yes or no signals that the knowledge provided through the game is solid, reliable and non-debatable, which contrasts with the affective and interactional nature of empathetic knowledge. Like empathetic knowledge, this other way of knowing was not only about knowing the other, but also about knowing oneself. This is illustrated by the following sequence where the group facilitators in response to a request by the children initiated a talk about the risk of developing mental illness:

GF1:	Now we will try to explain what affects people's mental health in general and maybe you in particular because you have parents with mental illness [GF1 looks at a manual that depicts a model and reads aloud. GF2 begins to draw the model on a whiteboard]. […] There's a biological factor in your lives. There's such a factor in everybody's life. So, there is something of your parents' illness that you might inherit, but we actually don't know if you will get the illness because of that [looks up from the manual and at the children]. [Looks at the manual, continues reading] You do not inherit the illness itself, you inherit the risk of getting it. […] Biology, heredity,

	is not the only thing that makes you ill. There are other factors too. Eleanor?
Eleanor (10 years):	It's just because my granddad, he has stress like my mother, and my uncle does to, so he has to live with my grandparents.
GF1:	Yes [GF1 nods her head]. That's right. There is the risk that one might get the same illness and that is why we really want to help you understand what you yourself can do to prevent yourself from getting the illness.

The group facilitator goes on to introduce social as well as psychological factors that may affect the children's mental health and repeats the phrase 'there needs to be more than one factor', signalling the complexities of knowing how mental illness is developed. In this session, the children's empathetic knowledge of hereditary effects is confronted with other ways of knowing. While children like Eleanor are informed through their family biography that mental illness may spread and 'infect' other family members, the group facilitators draw on a biopsychosocial model to convey that even though some mental illnesses are hereditary, it is not certain that other family members will suffer from mental illness. The discussion about risk encourages the children to follow certain 'empathy rules' (e.g. they need to practice self-empathy) (Ruiz-Junco, 2017) and to know themselves in new ways as persons that are 'genetically at risk' (Novas & Rose, 2010). This new form of personhood does not imply resignation in the face of a cruel biological destiny, but rather calls for new active relationships between the children's present and future, repositioning their empathetic knowledge within larger sociocultural and institutional communities of identification and obligation.

Discussion

Through an analysis of support groups for children of parents with mental illness, this article has contributed to the development and consolidation of the concept of empathetic knowledge (Abel & Browner, 1998). Inspired by Ruiz-Junco's (2017) framework for the study of empathy, the analysis demonstrates how children of parents with mental illness observe, sense and imagine that which they cannot know in an attempt to understand their parents' mental illness. We argue that this process results in empathetic knowledge: a relational, bodily, affective and composite mode of knowing through which the children come to understand both others and themselves. In the following, we highlight four central epistemological characteristics of empathy as a mode of knowing in the context of health and illness.

First, empathetic knowledge is relational. This characteristic distinguishes empathetic knowledge from both medical and experiential knowledge. While medical knowledge is acquired by discursive reasoning, observation or reflection of information provided by others, experiential knowledge is developed through personal experiences with a phenomenon (Borkman, 1976). As this article has demonstrated, empathy as a mode of knowing hinges on the relationship between the individual who is ill and those with whom they have close associations. Through an interactional process connected to their 'empathetic imagination' (Ruiz-Junco, 2017), the children in this study come to know the illness from both the outside (through observations of the affective state of the ill body) and from the inside (through affective impressions made on the empathiser's

own body). Hence, while medical professional knowledge involves knowing the illness from the outside in a public and scientific way and experiential knowledge entails knowing the illness from the inside in a private and personal way (Mol & Law, 2004), empathetic knowledge comprises a dynamic interpersonal process that allows for both outside and inside perspectives on illness.

Second, another central characteristic of empathetic knowledge is its bodily and affective properties. In the analysis, we introduce the distinction 'the empathic body' and 'the ill body', arguing the interplay that occurs between the children's and their parents' bodies and affective states is central for our understanding of empathetic knowledge. This distinction speaks to the way in which bodily boundaries continuously disappear and (re)appear as we attempt to know the thoughts and feelings of others. As we see in the analysis, the children's ability to 'feel *with*' (Ruiz-Junco, 2017, p. 420) their parents may temporarily dissolve the boundaries between their two bodies – with the boundaries re-emerging when the children seek to influence their parents' care practices. Hence, the children's 'sympathetic influence' (Cooley, 1909) is constrained by the fact that their knowledge concerns a body other than their own. While medical knowledge also involves knowing a body other than one's own, physicians are expected to take on the role as experts that make decisions about the patient's diagnosis, course of treatment and care needs. This gives physicians a great deal of professional authority and influence over decisions that are essential for patients' lives (Pilnick & Dingwall, 2011). The restricted sense of agency related to empathetic knowledge is also different from experiential knowledge, which has been described as enabling here-and-now action (i.e. a form of practical knowledge that patients can easily use in their daily life with disease) (Pols, 2014).

Third, in contrast to medical knowledge, which is concerned with knowing others, and experiential knowledge, which relates to knowing ourselves, empathetic knowledge involves getting to know both others *and* ourselves. As the findings from a study of siblings caring for siblings (Leane, 2019) also show, this suggests that a relational sense of self is a key element in understanding family relations marked by illness. In this study, the children used their empathetic knowledge to project imagined futures in the anticipation of an illness that they may never experience. Hence, empathetic knowledge in the context of health and illness does not necessarily offer the opportunity to know oneself in indefinite ways, but rather opens up for knowing oneself in a particular way.

Fourth, empathetic knowledge is composite in nature and subject to what Halloy et al. (2023) call knowledge hybridisation. As studies of both people with lived experiences and healthcare professionals have demonstrated, individuals may have and use different sources of knowledge simultaneously (Järvinen & Kessing, 2023). In accordance with this, empathetic knowledge should not be understood as the only knowledge that next of kin hold. Rather, it develops over time in conjunction with other modes of knowing that occupy other social settings, such as support groups, educational institutions and the media. These other modes of knowing may involve specific 'empathy rules' that potentially (re)structure how empathy is done (Ruiz-Junco, 2017), highlighting the ongoing development of empathetic knowledge.

The article has developed these central epistemological characteristics by investigating children's empathetic knowledge of health and illness. To situate these findings in a larger context, it is important to foreground that children compose a particular social group. In accordance with Henze-Pedersen (2023), the article demonstrates that being a

child of someone not only entails being cared for and cared about, it also entails giving care, showing awareness of your parents' needs and expressing responsibility for their well-being. Children, then, are intimately intertwined with their parents, and this relationship creates interdependencies that shape their everyday lives, understanding of self and empathetic knowledge. Thus, the particular kind of embodied communication, affective impressions and agentic capabilities analysed in this paper is likely embedded within the parent–child dyad. For example, a spouse might have more interaction with healthcare professionals than children, rendering them a greater sense of agency. Similarly, the sense of self – and imagined futures – that derives from our knowledge of others will unequivocally depend on particular family constellations. Thus, these findings call for studies to explore the particularities of empathetic knowledge of next of kin in other family constellations.

Nearly three decades ago, Popay and Williams (1996) argued that the rejection of experiential knowledge in the name of science would lead to the exclusion of certain stakeholders and modes of knowledge production from the healthcare debate. Today, despite its subjective and personal properties, experiential knowledge is widely recognised as a resource in healthcare (Oborn et al., 2019). In comparison, the empathetic knowledge of next of kin – in particular, when they are children – remains at the fringes of our healthcare services. Campelia (2017) has argued that the resistance to accept empathy as something distinctly epistemic has to do with the fact that empathetic activities are 'widely recognised as emotional, dependent on social relations and norms, discovered in verbal and nonverbal communication, and culturally normalised as something feminine' (2017, p. 532). However, as this article has demonstrated, to reject this mode of knowing on account of it not having a scientific basis would be to silence the voices of next of kin and to neglect the fact that while illness itself only inhabits one body, it moves and affects others too.

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Ethics approval statement

The Research Ethics Committee at The Danish Center for Social Science Research (2022/8) and The Danish Data Protection Agency have approved the study.

Data availability statement

Research data are not shared due to privacy and ethical restrictions.

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