Corresponding Author:

Adam Henley, RN, BScN, CCHN(C), PGCert(Psych.)

E-Mail  ahenley@consortiacare.ca

Phone   (780) 851-9717, x. 101

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This open-source document is intended to support health and social services professionals in enhancing their awareness of brief empathy interventions using a trauma-informed approach.

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Definitions

**Affirmation** involves communicating respect for others, by sharing something positive and true about that person.

**Allostatic load** describes the damage caused by exposure to repeated or chronic stressors.

**Ambivalence** involves having conflicting reactions, beliefs or feelings towards some action, object or event.

**Assertiveness** involves being self-assured and confident without being aggressive.

**Chronic stress** is the response to emotional pressure over a prolonged period, in which the person often perceives they have limited control over the outcome of events. It involves the release of endocrine mediators – such as cortisol – which cause metabolic and behavioural changes.

**Complex human behaviours** result from a complex interplay of biological, psychological, sociocultural, innate and learned behaviours. The causes of complex behaviours are frequently misattributed and misunderstood.

**Cooperation** is the process of having common interests or working together to the same end.

**Critical theory** an epistemological viewpoint that seeks to confront social, political, cultural and historical forces and structures.

**Disarming technique** involves seeking and finding some truth in what the other person is saying, even if this seems totally unreasonable or unfair to you.

**Emotional contagion** involves having one person’s emotions and affective behaviours directly trigger similar emotions and behaviours in others.

**Empathic concern** involves emotions for other people, in part based on the perceived needs and welfare of the other person.

**Empathic Joy Hypothesis** claims that people help others because it is intrinsically rewarding and provides a sense of accomplishment.

**Empathy** involves coming to understand another person’s experience, which includes understanding their perceptions, ideas, meanings and the emotional-affective components connected with these things.

**Feeling empathy** acknowledges how someone might feel in a given situation, and lets them respond.

**Healthism** asserts that individuals are responsible for their own health or disease outcomes.

**Mental contrasting** is a visualization technique that contrasts the desired outcome against possible obstacles to achieving that goal.

**Mentalization** involves cognitions and thoughts that help us think about a concept.

**Mirror neurons** is a neuron that fires when that person performs a behaviour and when that same person simply observes the action being performed. Mirror neurons exist among many animals, including humans.
Motivational models are concerned with processes that explain how human behavior is activated and sustained.

Mutual liking is a process whereby two people come to like one another by finding similarities, sharing genuine complements, and cooperating.

Presence is the state or act of existing, occurring, or being present with a place or thing.

Reciprocity is a two-way exchange of support between individuals for mutual benefit.

Similarity helps facilitate agreement and bilateral trust and is a key part of forming kinships.

Simulation Theory of Empathy asserts that people make sense of the behaviours of others by activating brain pathways that, if carried into action, would product similar behaviour.

Social construct is an idea that appears real to people who accept it, but which may or may not represent reality. Social constructs are socially constructed to reduce ambiguity and meaning.

Social empathy is the ability to understand people by perceiving or experiencing real-world situations, in order to understand a person’s interactions with the social environment.

Social Impact Theory asserts that people form social identities that then influence behaviour.

Somatization is the common experience of feeling emotions and feelings in the form of bodily (or somatic) symptoms. This process shows the interconnected nature of mind and body.

Strategic interrupting advanced clinical conversations, using subtle techniques to guide the topic of conversation.

Theory of Mind describes the human ability to distinguish between what thoughts – including emotions, values and knowledge – are part of oneself versus external to themselves.

Therapeutic alliance refers to the relationship between a health profession and patient, where both would like to work together to achieve beneficial change for the patient.

Thought empathy involves paraphrasing what people have just said to show they were heard.

Trauma is a deeply distressing, injurious or disturbing experience.
Why TiE™ Exists: An introduction

You may be thinking that you already know enough about empathy. Maybe you’ve taken a university course in psychology. Or, you work within a family centred model of care at your workplace. Still others may have completed training modules on cultural sensitivity and trauma-informed care. In a world that is highly interconnected, we are continually challenged to understand others. And, as a result, we have come to filter the concept of empathy through different lenses.

This course does not teach the values of empathy, but rather chooses to explore the emerging science behind human connection. We strive to highlight your core beliefs, and ask questions like: Do you value quick judgements or slow appraisals of others? Is there a single truth in the world, or do we all see things a little differently? Can you predict a person’s future behaviour or are people rather unpredictable? All of these core beliefs influence our values around empathy.

The word “empathy” is rather young, first used in the late 1800’s. It was derived from the Greek words em-” (in) and “pathos-” (feeling), because the process of empathy involves understanding another person’s emotions to some extent. In the late 1800’s, early German psychologists had been conducting experiments on the feelings produced in response to different sensory experiences. Einfühlung (a.k.a. empathy) described the emotional experiences people felt as they connected with these sensory experiences, like an abstract painting. To this day, somatization research continues to inform empathy techniques and strategies.

Empathy, however, is now better understood as a social phenomenon and a biological reality. We now know that a common culture – or shared understandings – are required before people can form new groups and relationships. Empathy is not only fundamental to how we relate to others, but also how we heal others. We have come to understand that empathy is a pre-requisite to virtually all effective counselling strategies. By the 1990’s, empathy was no longer defined as a human experience. Emerging research found that most mammals had some capacity for empathy. For example. researchers like Jane Goodall had meticulously documented how primates also formed altruistic and affectionate attachments. It was then that empathy began to find a strong neurobiological basis. We now know that virtually all mammals connect with others in predictably irrational ways, and feelings of safety are key to a person’s capacity to connect (Decety, 2015).
Empathy is about opening ourselves to others. Paradoxically, a sense of safety is required for people to share their inner life and achieve openness. The deliberate act of presence facilitates this by providing a sense of safety for others. In fact, presence is a deliberate process of inviting people to connect by remaining open to the present moment (Finfgeld-Connett, 2006).

According to Stockmann (2018), the act of presence includes the therapeutic use of self, a high-degree of availability and therapeutic communication. People who choose to remain present typically “lean in” or acknowledge uncomfortable moments, which requires a level of vulnerability in social interactions (Finfgeld-Connett, 2006). Thankfully, health professionals have significant control over their presence. Table 1 lists some behaviours which signal invitational presence.

While presence requires some level of vulnerability, people will no longer be present when seeking safety. Think of trying to actively listen when you are worried about saying the wrong thing. By seeking safety, professionals may unintentionally avoid another person’s suffering or make “small talk” to avoid weighty topics of conversation. It is natural for us all to search for safety. If fact, our emotional brain drives us to scan for safety in social interactions. However, safety-seeking behaviours also create distance which impedes empathy – see Figure 1.

<table>
<thead>
<tr>
<th>INVITATIONAL PRESENCE</th>
<th>SEEKING SAFETY</th>
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<tbody>
<tr>
<td>• Acknowledges uncomfortable topics</td>
<td>• Avoids uncomfortable topics</td>
</tr>
<tr>
<td>• Leaning towards other person</td>
<td>• Looking away from other person</td>
</tr>
<tr>
<td>• Staying in close proximity</td>
<td>• Physically distancing from other person</td>
</tr>
<tr>
<td>• Listening feels graceful and easy</td>
<td>• Listening feeling purposeful and filtered</td>
</tr>
<tr>
<td>• Asks curious questions</td>
<td>• Silent or appears uninterested</td>
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Table 1. Invitational Presence versus Seeking Safety

Figure 1
Safety-seeking behaviours (such as crossed arms) can create distance during interpersonal interactions. Rejection is often perceived when people minimize their own vulnerability and engage in safety behaviours.

Image Source: City of Edmonton
INVASIVE VS. SAFE QUESTIONS

Effective questions are the most powerful tool health professionals have to sustain empathy. However, the process of asking questions should also be considered a potentially invasive procedure with the potential to erode the patient-provider relationship – see Figure 2.

If asked injudiciously, people will often respond with the safest possible answer (a.k.a. deception) in order to regain a sense of safety in their clinical interaction. In response, many professionals seeking empathy will simply ask more questions so they can judge the veracity of the information provided. In this scenario, the clinician must temporarily stop asking questions so they can develop a more effective strategy to build connection with the client.

**Strategy - Assume Positive Intent**

**Healthism** is a common ideology which asserts that individuals are responsible for their own health or disease outcomes. As a result, health providers can end up blaming people – or assume they are fully responsible – for their health condition. This comes out in subtle ways during questioning, often causing clinicians to create distance when asking important questions. For example, simply asking whether a patient is physically active can quickly turn into an invasive question. In most cases, it is preferable to reframe questions so that they assume the best of the person’s intentions. This can include assumptions that the person:

- Wants to be healthy;
- Is struggling and came to you for help;
- Has a lot of competing priorities in their life; and
- Knows what fits best in their life.

**Invasive Question (Assumes Negative Intent):** “Have you thought about committing suicide this month?”

**Safe Question (Assumes Positive Intent):** “Given how hard life is, have you been thinking about killing or harming yourself over the past month?”

**Strategy - Ask Clarifying Questions**

Invasive questions often unconsciously blame people. For example, a simple “why” question may evoke people to find reasons for their health condition. You will find most people will resist answering “why” questions directly, as they feel threatening or like they are being called to determine a cause for their condition. It is better to ask “what” or “how” questions when looking for a more accurate answer from someone.
**Invasive Question (Asking Why):** “Why do you skip breakfast?”

**Safe Question (Asking What or How):** “What do you think causes you to skip breakfast?”

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**Strategy - Mental Contrasting**

**Mental contrasting** is a visualization technique that contrasts the desired outcome against possible obstacles to achieving that goal. The process of mental contrasting is helpful because it coaches us to think more strategically about our goals (Oettingen & Wittchen, 2013). Because mental contrasting is helpful, clinicians who ask questions in a way that is consistent with this approach are likely to build motivation for change. This helps build a patient-provider **therapeutic alliance**, which is a key part of empathy.

**Invasive Question (Goal only):** “In three months, what would you like to see change about your diabetes?”

**Safe Question (Contrasts goal against barriers):** “I noticed that you want to reverse your diabetes in three months with lifestyle changes. Do you know anything that might get in the way of your success?”

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**MUTUAL LIKING**

Because our emotional brain is hard-wired to seek safety in social interactions, almost everyone has a difficult time connecting with people who they perceive are different from them. Creating a **therapeutic alliance**, therefore, is essential to help professionals build relationships of trust. Research has examined the social cues people rely upon and suggests that mutual liking involves:

1. **Finding similarities** (a.k.a. “in group” favouritism) to facilitate agreement and trust;
2. **Genuine complements** to demonstrate unconditional positive regard and intention; and
3. **Cooperation** to highlight common interests and willingness to provide support.

A therapeutic alliance is often built upon a sense of similarity between each person’s interests (Park, Schaller, & Van Vugt, 2008). Two shortcuts to demonstrating similarity are **group conformity** and **mirroring** – see Figure 3. Cialdini et al. (1997) also found that empathy is enhanced when people (1) provide preferred treatment to the person of interest, and (2) engage in reciprocity. **Reciprocity** is a two-way exchange of support between individuals for mutual benefit.

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**Figure 3**

**Mirroring** is a common behaviour where one person subconsciously – sometimes consciously – imitates the gesture, speech pattern, or attitude of another person.
Eliminating Stress to Enhance Empathy

People behave differently after almost any stressful event (Scott, Melhorn, & Sakai, 2012). Since our brain is built on top of ancient architecture, our default emotional reactions are heavily influenced by stress-linked pathways – see Figure 4. **Chronic stress** results in prolonged activation these brain pathways which, in turn, increase a person’s emotionality. Simultaneously, chronic stress also impairs “higher order” brain processes like language. The result is that people exposed to chronic stress literally feel different. **Somatization** describes the experience of feeling emotions and feelings in the form of bodily (or somatic) symptoms. The process of somatization in the face of prolonged stressful exposures often motivates people to avoid stressful situations. In many cases, people exposed to chronic stress are more sensitive to feeling their emotions within their body. Persons with elevated exposures to stress, therefore, are more physically reactive to unsafe environments (van der Kolk, 2014; McCall & Singer, 2013).

Like all mammals, we are more likely to distance ourselves from people who live in a state of prolonged stress. This is partly why clients report experiences of neglect and lack of compassion from others during many moments of vulnerability. For example, people living with obesity typically report stigma (i.e. fat shaming) on the part of specialists treating their condition (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). This unfortunately common experience transcends well beyond just weight management. Empathy is frequently impaired by stress, yet it is the most powerful tool to obliterate stress in almost all contexts. Establishing empathy and rapport, therefore, is even more essential when it becomes more difficult to attain.

**EXPOSURE TO PAST TRAUMA AND EMPATHY**

A person’s capacity for empathy is also deeply connected to their sense of safety in social interactions. Perhaps as no surprise, exposure to past **psychological trauma** and **chronic stress** all affect the empathy response. Even trauma in very early life can affect a person’s stress response during clinical interactions (Tousignant, Eugène, & Jackson, 2017). People exposed to stress are also more likely to report increased threat reactivity in environments they perceive as unsafe (Najavits, 2002; van der Kolk, 2014). Stress and trauma, therefore, enhance a person’s...
response to threatening vs. safe environments. When seeking to build a collaborative relationship, this fundamental difference can actually make it harder to understand some people who have been affected by adverse experiences:

“Two of the biggest things that I had to do in frontline practice were to really learn about the people that I was working with because we didn’t necessarily share a culture or a socio-historical background. So a lot of what I was seeing happening, particularly with the highly vulnerable people was foreign to me, and I didn’t know how to respond to it. And in a lot of cases by happenstance a lot of what they were struggling with was a response to a system that hadn’t been caring, had even further traumatized, and I happened to be part of that system, so I was a recipient of a lot of anger. So the thing that I had to learn was understanding, understanding where they were coming from, and trying to put myself into that place, of going to where they are, I had to understand that it’s not about me.”

(BC Provincial Mental Health and Substance Use, 2013, May, p. 27)

**MINORITY STRESS AND “SAFE ZONES”**

Assumptions form the basis of most communication, and yet a person’s assumptions about you can impede the process of connecting. Minorities commonly experience increased stress in social interactions, often from feeling different from the assumptions commonly hold about them. For example, many obese persons experience negative clinical outcomes as a result of feeling lectured, advised and mocked when they interact with health professionals (Vadiveloo & Mattei, 2017). It is, therefore, critically important to take time to build a supportive environment for all people. The best environments assume that people might feel unsafe and aim to build an environment of safety. This can include:

- Avoiding private conversations in the lobby
- Warm and inviting staff
- Relaxing music
- Accessible washrooms and bathrooms

Think about your environment more intently. Are you inviting or rejecting people to have meaningful conversations with you?
Basic Theories of Empathy

SIMULATION THEORY OF EMPATHY

The Simulation Theory of Empathy was initially developed by philosophers, who theorized that people understand the behaviour of others by simulating the mental processes of others in their own mind. With the discovery of mirror neurons, simulation theory has become the primary explanation for empathetic behaviours. Brain scans show similar patterns of emotional arousal, independent of whether that person observed or conducted a activity (Gallese, Keysers, & Rizzolatti, 2004). For example, watching video clips of specific feelings activates similar emotions among participants (Wicker, et al., 2003). The concept of emotional contagion is consistent with simulation theory, which describes instances where affective cues and behaviours directly trigger similar emotions and behaviours in others – see Figure 5.

Figure 5

Mammals are social animals. As a result, many mammals are sensitive to the emotional cues of others. In many cases, empathic emotions simply serve as a source of social information (Batson, Turk, Shaw, & Klein, 1995). Horses, for example, readily sense others’ emotions to determine herd leadership characteristics. As a result of relying on social emotions to guide behaviour, horses are highly empathic animals.

Image Source: David Blaikie, Flickr (CC-BY-2.0).

THEORY OF MIND

Theory of Mind describes the human ability to categorize thoughts – including emotions, values, and knowledge – as part of their own mind versus external to themselves. To accurately differentiate between internal and external mental processes, people must create the mental construct of the self being separate from others. This, in turn, produces a deeply personal understanding of the self called the mind. Theory of Mind is the predominant model to explain empathy and social skills deficits, with extensive research within autism spectrum disorders, adult ADHD and schizophrenia (Gweon & Saxe, 2013).

Mentalization involves cognitions and thoughts that help us think about a concept. In relation to empathy, mentalization relates to the popular expression: “Before you judge someone, walk a mile in their shoes”. In this case, this idiom implies that people can understand another person’s reality by thinking more intently about their life circumstances. The Theory of Mind is a theory of mentalization, where highly empathetic persons are thought to think more accurately about another person’s social reality. Recent research suggests that, although we often can appreciate another person’s perspective, people also have limits to using Theory of Mind to inform behaviour. For example, even though participants knew a speaker lacked knowledge on the subject they were speaking about, most participants did not change their receptivity to the message (Keysar, Lin, & Barr, 2003). Research also consistently shows that adults hold predictably irrational beliefs when judging other people or considering their
perspective (Royzman, Cassidy, & Baron, 2003; Lamm, Bukowski, & Silani, 2015). These findings are consistent with research into common cognitive biases, such as fundamental attribution error.
The Ethics of Empathy

It may surprise you to hear that empathy does not predict helping behaviours. Helping behaviours are better predicted by a person’s sense of kinship and social connectedness (Levine & Manning, 2013). For example, you are more likely to help your family before a stranger. This is likely because you have a close sense of connectedness with your family, and not with a stranger. In this way, empathy may exist towards a stranger but you may be unmotivated to help them in most situations. While empathy is necessary to form productive relationships, some popular thinkers (e.g. M. Scott Peck in *People of the Lie*) have also associated empathy with negative human traits like evil.

**INCENTIVIZING HELPING BEHAVIOURS**

Cialdini, Baumann and Kenrick (1981) originally developed the **Negative State Relief Model**, which described how people help others so they can feel better about themselves when they see people in need of help. Since this time, we have all heard about concepts like the Bystander Effect and deference to authority (obedience). More recent research suggests that people help others for more selfish reasons. People appear to help others in order to alleviate unrelated negative feelings and improve their own mood (Dietrich & Berkowitz, 1997). These findings are consistent with the **Empathic Joy Hypothesis**, where people help others because it is intrinsically rewarding and provides a personal sense of accomplishment. Empathy so often provides a reward for helping, but is not sufficient impetus for action. Furthermore, when positive feedback and rewards do not exist, people are unlikely to act altruistically at all (Smith, Keating, & Stotland, 1989).

Value-based models of empathy are one attempt to incentivize the process of helping others. For example, values-based models are common within many health disciplines. Professions like nursing were founded on the ideal of an ethic of care (Nightingale, 1859). In this view, nurses are incentivized to act with near limitless empathy. A nurse who lacked empathy also lacked an ethic of care, which is a foundational skill within the nursing profession.

Empathy can be incentivized by making it part of:

- Moral virtues
- Positive intentions
- Vocation/service

**VALUES-BASED MODELS OF EMPATHY**

Values-based models of empathy examine a person’s internal and external motivations to connect with others. People simultaneously have both external and internal motivations to connect – or not connect – with others. Any discrepancy between these factors will produce **ambivalence**. This is why values-based models of empathy typically examine topics like:

- Burnout and moral distress
- Caregiver strain or compassion fatigue
- Ethics of care and professionalism
- Role modelling
Cognitive Behavioural Approaches to Empathy

Since the late-1980’s, the field of psychology has defined empathy as the state of mentalizing or making sense of social information (Batson, Turk, Shaw, & Klein, 1995). Empathy skills, therefore, are thought to be a core component of Emotional Intelligence. Popularized in a relationship self-help book, Burns (2008) operationalized empathy to include three cognitive appraisals:

1. Empathetic statements
2. Assertive communication
3. Respectful interactions

From a cognitive perspective, Dr. Burns found it was nearly impossible for others to feel understood by others when the other person didn’t also communicate assertively and with respect (Burns & Auerbach, 1996). Burns’ five communication techniques are now considered foundational Cognitive Behavioural Therapy (CBT) skills and continue to be taught as a core component of CBT training. Impressively, these cognitive empathy approaches have been shown to enhance recovery from depression in comparison to CBT alone (Burns & Nolen-Hoeksema, 1992).

THE DISARMING TECHNIQUE

People disagree about what is correct – or true – in every high-stakes conversation. It is also our natural inclination to defend our beliefs, expecting others to adopt our view. However, a defensive approach may not acknowledge a person’s own set of beliefs and experiences. We all have our own truth to share. The Disarming technique requires coaching to develop, but essentially involves seeking and finding some truth in what the other person is saying, even if this seems totally unreasonable or unfair to you.

Example:

Patient: “I have tried so many diets, and nothing works. To be honest, I have no confidence that talking about my diet will make any difference in my health. I am not eating too much food. I actually skip some meals, and then snack later in the day because I am hungry. It’s not easy.”

Provider: “I’m sorry, [Patient]. I owe you an apology. I implied you were eating too much and didn’t even ask if you were skipping meals which is a common challenge among people trying to lose weight. Do you mind if we pause to talk about that for a bit?”

FEELING EMPATHY

It is important to clarify how a person feels in a given situation. We have all seen the power of this technique when we hear someone state how we might feel in a situation. People have emotional responses to almost all types of events, and we need to elucidate their feelings to better understand their experience. Feeling empathy acknowledges how someone might feel in a given situation, and lets the person respond.
**Example:**

*Patient*: “I have tried so many diets, and nothing works. To be honest, I have no confidence that talking about my diet will make any difference in my health. I am not eating too much food. I actually skip some meals, and then snack later in the day because I am hungry. It’s not easy.”

*Provider*: “Gaining weight while skipping meals must make you feel frustrated. I’m not sure... do you feel annoyed or something else?”

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**THOUGHT EMPATHY**

We often communicate with the purpose of being heard. To show someone was heard, we can paraphrase what people have said – being careful not to simply parrot back their words – to demonstrate we understand their perspective. Key to communicating with thought empathy is to avoid missing parts of the person’s story which are “inconvenient” to recall.

**Example:**

*Patient*: “I have tried so many diets, and nothing works. To be honest, I have no confidence that talking about my diet will make any difference in my health. I am not eating too much food. I actually skip some meals, and then snack later in the day because I am hungry. It’s not easy.”

*Provider*: “So you feel nothing works, because you’ve tried so many diets already and failed to loose weight. No wonder you don’t think dieting will impact your health.”

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**INQUIRY**

The art of asking uncomfortable questions is, perhaps, the most crucial assessment skill you will develop. It fits well with an assertive communication style, because the most important questions so often so unasked. Asking uncomfortable questions is an art because they can either reaffirm or challenge our assumptions. Some questions will build connection, and others will distance you from the person’s experience.

**Example:**

*Patient*: “I have tried so many diets, and nothing works. To be honest, I have no confidence that talking about my diet will make any difference in my health. I am not eating too much food. I actually skip some meals, and then snack later in the day because I am hungry. It’s not easy.”

*Provider*: “It sounds like you have expended a lot of energy and effort to change your diet. Do you mind if I ask how you feel about skipping meals?”
‘I FEEL’ STATEMENTS

We often think empathy requires us to listen to the person exclusively. However, it is important to reciprocate the sharing of feelings to also build connection. “I feel” statements allow you to share your perspective, while clearly labelling it as your interpretation. Avoiding use of “you” statements helps to avoid blame.

Example:

Patient: “I have tried so many diets, and nothing works. To be honest, I have no confidence that talking about my diet will make any difference in my health. I am not eating too much food. I actually skip some meals, and then snack later in the day because I am hungry. It’s not easy.”

Provider: “[Patient], I feel really embarrassed because I just assumed that you were eating larger portions and didn’t even ask about your diet.”

AFFIRMATION

When we communicate respectfully, we are often communicating positively with a person. Affirmation involves finding something genuinely positive to say to the other person, even in a moment of disagreement. It conveys utmost respect – and opportunity for connection – when you can communicate respect while also disagreeing with the other person. In this way, conflict becomes an opportunity to demonstrate your respect for the therapeutic alliance.

Example:

Patient: “I have tried so many diets, and nothing works. To be honest, I have no confidence that talking about my diet will make any difference in my health. I am not eating too much food. I actually skip some meals, and then snack later in the day because I am hungry. It’s not easy.”

Provider: “You know, [Patient], I am impressed by your dedication to this. We may disagree on the value of adhering to a healthy diet, but I can see you are already working hard on this. That’s impressive!”

Strategy - Use Affirmation with Care

People who say niceties or clichés – or give meaningless complements – will not be taken seriously and may even damage their therapeutic alliance. That is because, according to rational-emotive theories of emotion, people only believe positive thoughts when they are (1) more powerful than negative thoughts, and (2) substantially true. Therefore, it is important that affirmation is used carefully to communicate in the direction of truth and mutual liking. For example:

Incorrect Use of Affirmation: “It’s amazing how easy weight loss is for you. Way to go!”

Correct Use of Affirmation: “I can see how hard you are working to lose weight. Way to go!”
Critical Approaches to Empathy

While social influence is beneficial for some people, lacking influence also produces disadvantageous outcomes like marginalization, prejudice and stereotyping. Emerging research asserts that people with greater similarity – especially where there is equal power dynamics – tend to have more empathy for one another. This is partly explained by factors like stereotyping, which interfere with the process of relating (Foddy, Platow, & Yamagishi, 2009).

Critical perspectives often aim to correct power imbalances and social structures that impede human connection – see Table 2. While critical-relational models of empathy are predominant within the field of social work, they can also be applied across disciplines. Critical theory reminds clinicians that empathy is not only about understanding people, but also protecting persons from distancing behaviours (e.g. dehumanization and marginalization) as a means to increasing connection with others. For example, Social Impact Theory asserts that people influence other’s thoughts and emotions through factors such as strength, immediacy and number of adherents (Latané, 1981). Critical approaches would utilize this knowledge to better relate to people who may lack social influence.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>LIMITATIONS</th>
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<tbody>
<tr>
<td>Professionals strategically decide who</td>
<td>Social structures (e.g. hierarchy) prevents full</td>
</tr>
<tr>
<td>requires empathy and when (equity focus).</td>
<td>connection with some people.</td>
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<tr>
<td>Provider is aware of systemic barriers and</td>
<td>Personal values and beliefs cause provider to</td>
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<tr>
<td>experiences that effect interactions.</td>
<td>openly judge people and events.</td>
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<tr>
<td>Health professional enhances their</td>
<td>Health professional may cause conflict or</td>
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<tr>
<td>professional power as an advocate.</td>
<td>disagreement within health systems.</td>
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*Table 2. Benefits and Limitations of Critical Approaches to Empathy*

**RELEVANCE**

Process comments – a form of mental contrasting – can be used strategically to create transparency and highlight power imbalances or boundaries. Process comments highlight discrepancies between the goal of a conversation and actual conversation. Because it highlights power dynamics, this strategy helps avoid creating a “fake friend” relationship with people.

*Example:*

**Patient:** “I’m not sure about starting on insulin. I feel so tired all the time, and really don’t have the energy to do anything. I haven’t done a lot of things lately, and my friends have really noticed. My best friend has diabetes, and we talk about how much a pain it is. It’s probably more important for us to exercise to control diabetes…”

**Provider:** “I’m really curious now... does your friend affect your readiness to start on insulin today?”
STRATEGIC INTERRUPTING

Both the patient and provider understand that they need to make efficient use of time. Patients are also in a dependent relationship when interacting with clinicians, in that they expect health care providers to ask questions and guide the topics of conversation. The onus, therefore, is on the clinician to advance the conversation in a timely manner. One method of strategic interrupting is to paraphrase what the person just said (thought empathy) and then shift to a related topic. This communicates assertiveness and respect which, in turn, improves the therapeutic alliance.

Example:

Patient: “I’m not sure about starting on insulin. I feel so tired all the time, and really don’t have the energy to do anything. I haven’t done a lot of things lately, and my friends have really noticed. My best friend has diabetes, and we talk about how much a pain it is. It’s probably more important for us to exercise to control diabetes...”

Provider: “So you are tired all the time and really struggling to get a lot of things done. How’s your sleep?”

ASK PERMISSION AND ADVISE

Because health providers are in a position of power, they should always ask permission before discussing sensitive topics that are not the main reason for referral (e.g. weight). This promotes autonomy and communicates mutual liking and respect.

Asking permission is also a key feature of the 5-A’s Model for Health Change, as it can enhance patient motivation for change (Glasgow, et al., 1999). Even if someone is not interested in discussing the topic at hand, the health care provider remains in a position of power and is still expected to act in accordance with their professional obligations. Therefore, people expect health care providers to advise them on recommended care options when their behaviours diverge from best practices or medical recommendations (Glasgow, et al., 1999).

Example:

Patient: “I’m not sure about starting on insulin. I feel so tired all the time, and really don’t have the energy to do anything. I haven’t done a lot of things lately, and my friends have really noticed. My best friend has diabetes, and we talk about how much a pain it is. It’s probably more important for us to exercise to control diabetes...”

Provider: “It sounds like you don’t know if you want to start on insulin today. Are you o.k. to talk about starting on insulin today?”

Patient: “I’d prefer not to.”

Provider: “No problem. But, before we move on, I should mention that there is an increased risk of diabetes complications and urgently high blood sugars without starting on insulin. Book a visit in the future if you want to talk about this further. For now, I’m really concerned about your low energy. How you are sleeping?”
References


