

A Negotiation Model of Empathy

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Despite the prevalence of the empathy construct and its relevance to a number of applied and theoretical endeavors, it remains a concept whose definition lacks consensus; ". . . a broad, somewhat slippery concept . . . that has provoked speculation, excitement, and confusion" (Eisenberg and Strager, 1987, p.3). Nevertheless, it is the aim of this paper to suggest that most perspectives on this concept are related; referring to some part of a larger communicative process. This process involves the negotiation of communicative goals between two interactants. Empathy will be achieved to the extent that participants' goals are mutually accomplished. It is important to note that the communicative acts that occur between doctors and their patients constitute a special set of interactions characterized by an asymmetry of participant roles and responsibilities. As such, they will require additional considerations to the final model presented.

Empathy as a decoding process - Perhaps the most common perspective on empathy focuses on the recipient of a communicated message and his or her ability to apprehend or decode the state of the other interactant. Here definitions diverge to include apprehending in a purely cognitive capacity (perception, understanding), or as affective responses (vicarious emotional reactions), or as some combination of the two. The following two definitions typify the cognitive focus:

Empathy is the capacity to take the role of the other and to adopt alternative perspectives vis-a-vis oneself. (Mead, 1934, p. 27)

. . . empathy means the intellectual or imaginative apprehension of another's condition or state of mind without actually experiencing that person's feelings . . . (it) refers only to the act of constructing for oneself another person's mental state . . . (Hogan, 1969, p. 308).

The following two definitions typify the affective or emotional focus:

. . . affective sensitivity (empathy) is conceptualized as the ability to detect and describe the immediate affective state of another, or, in terms of communication theory, the ability to receive and decode affective communication (Danish and Kagan, 1971, p. 51).

. . . empathy is . . . a vicarious affective response . . . that is more appropriate to someone else's situation than to one's own situation . . . (Hoffman, 1982, p. 281).

Some researchers have endeavored to distinguish the cognitive and affective components of a decoded message with a change in terminology. So, for example, Harrigan and Rosenthal (1986) have suggested that the purely affective component is more like sympathy than empathy.

Putting one's self in the place of the other requires a cognitive process. The affective dimension of empathy may be more akin to sympathy in which the observer identifies with another's emotional state because of similarities in their situations. In experiencing sympathy, observers lose their separate identities, take on the other's feelings and circumstances, and become preoccupied with their own feelings. Sympathy or a mere affective response to another's emotional state does not signify empathy because the element of objective understanding and the possibility of being helpful is missing (Eisenberg and Fabes, 1991, p. 40).

In tracing the history of the development of the concepts of sympathy and empathy, Wispe (1986) bemoans the definitional confusion surrounding both of these terms and offers the following distinction as a solution:

Briefly, sympathy refers to the heightened awareness of another's plight as something to be alleviated. Empathy refers to the attempt of one self-aware self to understand the subjective experiences of another self. Sympathy is a way of relating. Empathy is a way of knowing (p. 314).

An oft-cited definition of empathy that attempts to include both a cognitive and (sort of) emotional component is one of Rogers' (1959) early uses of the term as:

. . . to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the "as if" condition (p. 210-211).

Whether or not one can apprehend another's state without actually experiencing that person's affect is an important issue that has received much attention, but unfortunately is beyond the scope of this paper. (See Hoffman, 1984, for a good review of these concerns.)

A final issue to consider regarding the decoding model of empathy is whether or not the other interactant with whom I am empathizing need necessarily share my insight into his or her state. The psychodynamic tradition champions the perspective that empathetic decoders might apprehend more about their interacting partners than their partners are themselves aware. So, for example, while Norell (1987) highlights the importance of "insight into the patient's condition," he goes on to argue that "Whether or not patients themselves need insight before they can be helped is another matter" (p. 7). Balint-Edmonds (1984) explains why a patient might be lacking this insight: "Our work is based on the idea that human beings, whether doctors or patients, unconsciously defend themselves against certain thoughts or ideas" (p. 4). The physician should be open to the idea that things are not always as they seem. Of course, one can argue, sometimes things ARE as they seem. The decoder's skill may exist in an ability to know the difference. Empathy as an encoding process - Encoding involves the creation of a message by a sender. In the literature on doctor-patient interaction, the importance of encoding an empathic message typically is discussed from the perspective of the physician as message-sender and usually takes the form of what may be called a **feedback goal**, which may be represented as the message, "I am attempting to understand you." As Norell (1987) argues, ". . . it is not enough that the doctor should be concerned, attentive, and caring. Like justice, these things must be seen to be done" (p. 7). Brock and Salinsky (1993) claim that ". . . if the physician is perceived as trying to understand how the patient feels, this in itself is therapeutic" (p. 247). Truax and Carkhuff, (1967) describe this notion of empathic feedback as part of the skill of empathy, explaining that, "Accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings" (p. 46).

It is equally appropriate to consider how the patient creates and sends a message. In fact, a general **encoding goal**, which may be shared by both interactants, can be represented by the message, "I am attempting to be understood." In the literature on speech act theory, the general approach of interactants to be good encoders is recognized by what Grice (1975) refers to as the *Cooperative Principle*. Speech act theorists argue that our ability to create and convey meaning hinges on our assumption that the other interactant is attempting to be informative, honest, relevant, and clear.

Empathy as an interactive process - We now have the elements necessary to begin discussing empathy from a communicative framework. Hogan (1975) has done just that by distinguishing between **the empathetic actor** (who would here be referred to as an encoder); namely, one whose performance is tailored to the needs and requirements of the audience; and the **empathetic audience person** (the decoder); who is a ". . . tactful and appreciative listener, skillfully encouraging others in their performances, thereby providing an accepting and generally rewarding context for interaction" (p. 15).

Notice that in the interactive process model of empathy, doctor and patient continually exchange roles as sender and receiver, and both contribute to the success or failure of an empathic communicative act. This model, an adaptation of Shannon and Weaver's (1949) classic information theory communication model, suggests several avenues of empirical exploration of the empathy construct. So, for example, Hogan (1969) asked subjects to describe the five items most characteristic of an empathic person; being socially perceptive, a decoding skill, topped the list. The characteristic least typical of an empathetic person was a tendency to relate to everyone in the same way, a deficient encoding skill. Innumerable studies of the verbal and nonverbal behaviors,

subject variables, and situational factors associated with the accurate encoding and decoding of empathic messages have been conducted. (See Blanck, Buck, and Rosenthal, 1986, for a review.) Although we have learned much, something still is missing from our concept of empathy.

A negotiation model of empathy - Many questions still remain regarding the nature of an empathic message. Let us say, for the moment, that I have apprehended some aspect of your true state. Have I decoded the full nature of your state, or just a part? How large a part? Is this an important part of your state, or a peripheral manifestation? Is this a message that you intended? Suppose that you encounter someone whom you come to understand as a poor, untalented, unlikable fellow. He feels terrible about his state; you can tell. (Perhaps you even feel similarly on his behalf.) What is more, he can tell that you have apprehended this part of his situation and feelings. But let us suppose that this was just part of his true state; that, in fact, the message he had intended for you to receive was that he was a new man, willing and able to change. Or, perhaps, as your patient, the important message he had hoped to convey to you was that he was unafraid to die, but terrified of becoming disabled. You may have apprehended something about the patient and his feelings, but missed his intended and/or most important message. Have you been empathic?

It has become commonplace in discussions of pragmatic aspects of language use to consider the transmission of meaningful information between two parties as a process of negotiation (cf. Garfinkel, 1967). In this model, meaning does not exist but rather emerges through the feedback system that characterizes conversational turn-taking. In the negotiation of meaning, parties to the interaction may differ in the extent to which they feel they have influenced the course or direction of the exchange; that is, the nature of the emerging meaning. In the ideal, successful communication takes place when both interactants believe that their communicative goals or needs have been successfully negotiated. Successful communication of this sort may be equated with the empathic process. Empathy, then, exists neither in the head of the sender nor the receiver, but in the emerging interaction that takes place between them. As such, its nature may change from turn to turn. Our best, if not our only insight into the empathic process resides in the interactants' assessment of the successful negotiation of their communicative goals or needs.

So, for example, as my physician, you may not have accomplished the goal with which you began our interview (that I must quit smoking), but you may have realized, through a process of negotiation that entailed your enhanced perception of my "true" state, that this was not the most important goal after all. As for me, the patient, I may not have elicited from you the "clean bill of health" that was my original communicative goal, but I have determined from you that it is a goal attainable in the future. The empathic process occurs in the emergence of changed needs and communicative goals; goals that we have both influenced to our mutual satisfaction.

There is ample evidence and argument for the importance of negotiated goals (expectations) in the medical context. Garrity and Lawson (1989) summarize an extensive body of research demonstrating the association between patients' expectations not being met and non-compliance with treatment regimens. In a review of negotiation tactics, Hayes-Bautista (1976) argues that patient non-compliance is a means of asserting control when goals have not been successfully negotiated. Eventually, if either or both parties are dissatisfied with efforts to negotiate goals, it is likely that the therapeutic relationship will be terminated by one of the parties.

In sum, empathy as defined in the negotiation model is not a thing encoded or decoded but a process of successful negotiation of communicative goals and needs. It cannot emerge from the interaction unless both parties to the communication participate in the negotiation. This implies that the goals of both patient and physician are likely to be changed in the emerging process; not surprising for those who view change as the *raison d'être* of communication itself.

The special case of doctor-patient interactions - The negotiation of communicative goals/needs in the doctor-patient interaction is a special case of the empathic process in general for at least two reasons. First of all, the importance of the goals/needs that emerge here is probably greater than that of most everyday interactions. In a social exchange between us in the hallway, we

may both share (and therefore easily negotiate) the goal of a short and pleasant interaction. Goals of the physician in the doctor-patient exchange may involve important behavioral changes on the part of the patient; goals of the patient may involve strong needs for understanding, for coping with important changes in everyday life, and the like. Secondly, the nature of the negotiation process itself is necessarily different in an asymmetrical role-relationship. There exists in this relationship an implied agreement of the patient to defer to the physician's expert knowledge. Balint (1957) recognized the power of this role relationship, characterizing the doctor himself as the most frequently used drug in general practice. As Salinsky (1984) has explained, a Balint-trained physician " . . . will also understand how important a person he is in your life and will be aware that this is a big responsibility" (p. 29). Howard Brody (1992) underscores the need for an appreciation of the physician's special role with the following argument:

The central ethical problem in medicine is the responsible use of power. Physicians have considerable power to alter the course of illness. But this same power can, with only subtle redirection, be used against the patient instead of against the disease on the patient's behalf. The problem is to empower physicians for the performance of their essential tasks while protecting the patient from the potential misuses and abuses of power (p. 36).

Maintaining the empathic equilibrium - It might appear from the negotiation model of the empathic process that the overriding goal is to maintain an equilibrium of goal accomplishment between interactants. In fact, because the physician-patient relationship is an asymmetric one, any equilibrium that is achieved must rely upon the physician's ability to balance a conflicting set of personal goals brought to the interaction. Several theorists, although occasionally differing in their terminology, have discussed this dialectical dimension of empathy wherein one must couple identification with detachment. Enid Balint, for example, using the term identification in a manner apparently synonymous with empathy, advises physicians to ". . . identify, and then . . . withdraw from that identification, and become an objective, professional observer again . . ." (p. 97, 1987).

Theodore Reik (1949), lists four phases of the empathic process, beginning and ending with the two extremes noted above: (1) identification - projecting our being into the other, becoming absorbed in contemplating the other person and that person's experiences; (2) incorporation - introjecting the other into ourself, (3) reverberation - interplaying of our own and the other's experience, and (4) detachment - withdrawing from subjective involvement and using the methods of reason and scrutiny. This last stage of Reik's model, it is argued here, is particularly important in interactions characterized by a role asymmetry, as in the doctor-patient interaction. The patient (novice) has a need to interact with the physician (expert), who has a contractual obligation to attempt to fulfill the need. Many role relationships fit this characterization; including teacher-student; therapist-client; clergy-parishioner; even, on occasion, parent-child. In each case, one interactant is depending upon the other for analysis, interpretation, guidance, or the like. The ability to balance the conflicting demands of passive receptivity and active intervention are aspects of the empathic process that are sure to concern responsible parties in the expert role.

Another way to conceptualize the antithetical nature of this empathic process that is particularly relevant to asymmetric relationships is to consider the relative advantages and disadvantages entailed by expert knowledge (or any relevant prior experience). Whether they are referred to as preconceptions, expectations, cognitive biases or some similar term, they can enhance or detract from our information-processing abilities. So, for example, Weyrauch, et al. (1994) point out that:

. . . one disadvantage of using the personal knowledge of previous patterns of disease or patient behavior is that the physician could close himself to other possibilities for diagnosis and treatment that could be more appropriate for any particular patient or situation. Instead of attending to the clinical data obtainable **at the moment** by appropriate history-taking and physical diagnosis, the practitioner might make assumptions based on prior assessments, experiences and expectations; that is, on his personal knowledge of the patient. Either the failure to diagnose and treat what is present, or, the attribution of an

incorrect diagnosis to uncertain findings could result from this situation" (p. 14; emphasis added).

It appears that Weyrauch is describing a case wherein the receptive aspect of the empathic process was outweighed by the detached and objective aspect. Obviously, prior expectations based on expert knowledge and/or past experience are likely to be beneficial; in fact, they are constitutive of the interactional asymmetry being described here. If there were no benefits to a physician's expert knowledge, there would be no patients. Even in commonplace symmetrical-role interactions, the need to diminish the effects of prior experience as part of the empathic process has been recognized. In Keefe's (1976) stage model of empathy, for example (after first perceiving the other interactant and then allowing a direct feeling response to arise), one should hold distorting cognitive biases in abeyance. Once again, part of the empathic skill is to be able to recognize which biases are distorting and which are not. In some respects, the negotiation process that has been described as taking place between interactants becomes an internal, intra-empathetic process. Physicians must not only negotiate goals with their patients, but also within themselves; between their empathetic identification with a patient and a detached utilization of their expert knowledge. These tasks, while difficult, are nonetheless essential to the successful doctor-patient interaction. Any efforts that advance us toward these goals are worthy of our attention.

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