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I address you today with joyful gratitude for this fantastic honor. Thank you! For almost half a century, I have practiced occupational therapy with a focus on brain injury. During the past year, I have reflected on my career and the defining characteristics that have shaped my practice and my life. Upon reflection, I have concluded that positive, empathic interpersonal interactions have been one of the most important factors in my personal and professional development. Empathy is one of the basic ingredients responsible for changes that occur during intervention. There is evidence in the occupational therapy literature that supports the need for further training in and understanding of this important process. In this lecture, I will provide a brief review of empathic interactions as they relate to occupational therapy, discuss interdisciplinary knowledge from positive psychology and social neuroscience that can enhance our understanding and use of these interactions, and offer my reflections on positive empathic interactions in my practice.

I identify six positive interactions that are guided by six corresponding questions, implicitly generated by the client. The six positive interactions were, to a large degree, determined during my clinical practice. They were also shaped by many other factors, such as my Hispanic culture with its Puerto Rican roots and my roles as mentor, educator, and researcher. I trust that this lecture will heighten awareness of the importance of empathy and foster a clearer and broader perspective on this elusive process as applied to the brain-injured population. I believe that focused reflections on empathic care can illuminate the art and science of occupational therapy and promote our development as well as that of the people we serve.

Introduction

One of the guiding beliefs of occupational therapy is that, through positive empathic interactions, we reach out in a caring manner, trusting that the people we work with will find their own strength (Baum, 1980). However, a national survey conducted by Taylor, Lee, Kielhofner, and Kertkar (2009) of 568 practicing occupational therapists in the United States found that although more than 80% of the participants reported a high value for the therapeutic relationship and use of self, they felt that they were inadequately trained and that the field lacked sufficient knowledge in these areas. Only 4% of these therapists reported that they took courses specifically on the therapeutic use of self. Taylor (2008) has conceptualized empathy as a means for practitioners to...
establish the therapeutic use of self, and in another survey, Taylor, Lee, and Kielhofner (2011) found that empathy was the least used mode during the therapeutic relationship. These surveys’ results highlight the fact that training in the empathic process needs to be expanded.

For this lecture, empathy is defined as a multidimensional, complex, emotional, cognitive, and movement process that emerges from an objective and subjective impression of another person’s emotional state or perspective (Davis, 1983; Decety & Batson, 2007). People engaging in the empathic process use their abilities to feel, detect, imitate, and express emotions and to communicate verbal and nonverbal signals to understand each other. Empathy is an imaginative, creative, and imitative process that depends on four factors: (1) willingness to enter the other person’s emotional state, (2) desire to use the self as a motivational agent of change, (3) competencies for language expression, and (4) readability of social communications (Watt, 2005).

Following in Carl Rogers’ (1951) tradition, many occupational therapists believe that empathy is the basic ingredient for promoting change during the intervention process. Empathy promotes humanistic or person-centered practice and may foster a positive and improved understanding of social interactions (Rogers, 1951).

Empathy in Occupational Therapy

Affirmations of empathy care and humanistic practice with a focus on emotion, optimism, and clients’ strengths are present in the occupational therapy literature and in numerous Slagle Lectures (J. C. Rogers & Holm, 1991; Rosa & Hasselkus, 2005; Yuen, 1997). Many scholars agree that empathic interactions and accentuating a positive perspective are critical for competent and compassionate health care. In her 1975 Slagle Lecture, Josephine Moore proposed a focus on the emotional component of behavior as a guiding principle for neuroscientific-based practice (Moore, 1976). She suggested that practitioners perfect their ability to relate to others on an emotional or limbic level instead of functioning entirely in an intellectual manner.

Carolyn Baum, in her 1980 Slagle Lecture, called us to recommit to empathic care in the health system. She stated, “Through our professional relationships we reach out and with empathy show that we care hoping that from this caring that the person will find his or her own strength” (Baum, 1980, p. 515).

In a similar fashion, Winnie Dunn, in her 2001 Slagle Lecture, advocated an accentuation of a child’s positive tendencies to balance the image of children with sensory processing problems (Dunn, 2001). Wendy Coster, in her 2008 Slagle Lecture, also promoted an accentuation of the positive when she suggested that occupational therapy measures have the power to positively shape the story that others hear about the persons we assess (Coster, 2008). She advised therapists to persuade others to tap the strengths of clients to develop comprehensive interventions.

The discussion of positive empathic interactions has been led by Suzanne Peloquin (1995), who has used empathy as a value and a means of reclaiming the profession’s heart. Her numerous writings on empathy serve as our profession’s inner voice that inspires us and calls us back to the art of practice. Her 2005 Slagle Lecture was an expose of beliefs that guide our practice. Her call relies on positive empathic interactions as a critical value (Peloquin, 2005).

Dr. Peloquin’s writings on empathy have helped me articulate what I believe has been my underground clinical practice. She believes that the empathic process requires being sensitive, respectful of differences, and fully present to the other person. She asserted that empathy enables the act of doing with so that it becomes an expression of being with (Peloquin, 1995). Both therapeutic actions empower and encourage each other.

In general, our scholars have described empathy as a creative skill (Peloquin, 1989). Anne Mosey (1981) referred to the art of practice as the capacity to empathize with another individual. Charlotte Royeen, in her 2003 Slagle Lecture, described and promoted the habits inherent in the art of practice (Royeen, 2003). Florence Clark’s 1993 Slagle Lecture encouraged positive interpersonal interactions such as friendship, rapport, and equality to help clients define and find solutions for their problems (Clark, 1993). Janice Burke, in her 2010 Slagle Lecture, portrayed therapists as choreographers of the therapeutic encounter. She illustrated important distinctions between what is said and what is done in practice (Burke, 2010).

Although abundant affirmations of empathy exist in the literature, there is limited evidence for the measurement and the development of empathy as a foundation for improved therapeutic interactions. As early as 1977, Charles Christiansen compared the empathy ratings of occupational therapy students with those of peers and faculty using the Hogan Empathy Scale. The results revealed a significant correlation between measured empathy and the perceived ability to empathize (Christiansen, 1977). More recently, Froman and Peloquin (2001) suggested rethinking the use of the Hogan Empathy Scale (Cross & Sharpley, 1982) after a critical psychometric
analysis revealed poor internal and discriminant validity of this scale (Froman & Peloquin, 2001).

Another empathy measure used in occupational therapy was the Kagan Empathy Scale (Campbell, Kagan, & Krathwoh, 1971) used by Bethany Wise and Marilyn Page (1980). When researchers administered the scale to students before and after completing a seminar and a group process course, they found that the course had positively affected the student’s empathy (Wise & Page, 1980).

A 2010 study of Australian occupational therapy students by Brown and colleagues using the Jefferson Scale of Physician Empathy (Hojat et al., 2001) and the Medical Condition Regard Scale (Christison, Haviland, & Riggs, 2002) found that the students showed variable empathy levels depending on the diagnoses of their clients. The students held substance abuse in comparatively low regard as compared with other conditions such as stroke, traumatic brain injury, and cerebral palsy. This result provides further support for the need for more training in the area of empathy.

There are few empathy studies focusing on the client’s perspective. Although phenomenological in nature and rooted in the traditions of the humanities, Peloquin’s exploration in the 1990s of the narratives of clients sought to better define their perceptions of the meaning of empathy as well as its absence, often called depersonalization (Peloquin, 1993, 1996). Peloquin proposed that stories of effective empathy could guide interventions and practitioners.

A 2010 follow-up qualitative study by Sharon Myers, a counseling psychologist, and Catherine White, an occupational therapist in Canada, confirmed that empathy can act as a catalyst of personal growth. They found that 10 yr after treatment, clients continued to credit the empathic therapeutic relationship as the basis for their personal growth (Myers & White, 2010). Two predominant themes emerged: (1) Therapeutic relationships were a foundation for change, and (2) they led to affirmation and enhancement of the personal agency of clients.

In another study by Cordier and colleagues (Cordier, Bundy, Hocking, & Einfeld, 2010) in Australia, researchers used the Test of Playfulness (Bundy, Nelson, Metzger, & Bingaman, 2001) to compare play in children with attention deficits with typically developing children. Results suggested that children with attention deficits seemed to lack empathy in play due to their egocentric responses.

The work of these scholars supports the need to expand research on the measurement and development of empathy as a foundation for improved therapeutic interactions. Support for empathy as an important contributor also comes from positive psychology and social neuroscience.

Interdisciplinary Knowledge From Positive Psychology

The literature in both positive psychology and social neuroscience yields abundant and compelling support for the breadth, characteristic actions, and benefits of empathy. Knowledge derived from these disciplines is valuable in exploring how to improve our interpersonal communications in occupational therapy.

In 1998, Martin Seligman, then president of the American Psychological Association, introduced positive psychology as a novel scientific study of strengths, personal well-being, and optimal functioning (Seligman & Csikszentmihalyi, 2000). He stated that the aim of positive psychology is to improve health at three levels—the subjective, group, and individual states. The aims at the subjective level include fostering hope, optimism, flow, and happiness; at the group level they include fostering civic virtues, citizenship, tolerance, and work ethics; and at the individual level they include promoting the capacity for interpersonal skills, perseverance, forgiveness, and wisdom (Seligman, 2005).

Research in positive psychology has provided evidence that empathic experiences and expressions of positive emotions are related to health, success, and longevity. Barbara Fredrickson (2004) proposed the broaden-and-build theory of positive emotions and suggested that optimistic feelings expand attention and thinking, undo lingering negative emotional states, encourage resilience, and build personal resources for optimal well-being. Positive emotions stimulate the urge to play and increase the range of thoughts and actions (Fredrickson, 2004). By contrast, negative emotions narrow the range.

The literature in positive psychology also supports that attitudes, values, knowledge, and responses related to empathy may be affected by gender, age, and culture. Studies support the view that women are more likely than men to express positive emotions. Because gender-related expressions are influenced by established social norms, we must be cautious to not reaffirm gender stereotypes. Some observers have ascribed male and female expressions of emotion as different values (Barrett & Bliss-Moreau, 2009). Observers in this study described female emotions with internal characteristics of the person but described male emotions with external characteristics of the situation. For example, when describing a similar heated discussion, observers depicted the female emotion as “she is hysterical” versus the male emotion as “he is having a bad day.”

In another study, Castelblanque and colleagues (Castelblanque, Cuñat, & Martínez Pérez, 2005) found that women performed more activities associated with service
to others than men did. Researchers described this difference as a clear indication of the established gender roles in society in which women perform more caretaking roles than men and may be perceived as being more empathic.

Age is also associated with positive emotions. Many older adults experience positive emotions and well-being in paradoxical contrast with the cognitive and physical declines associated with aging. Ostir and colleagues have shown that positive emotions are associated with lower blood pressure, delay the onset of frailty, and increase functional recovery and resilience after stroke (Ostir, Berges, Markides, & Ottenbacher, 2006; Ostir, Berges, Ottenbacher, Clow, & Ottenbacher, 2008; Ostir, Markides, Peek, & Goodwin, 2001; Ostir, Ottenbacher, & Markides, 2004; Seale, Berges, Ottenbacher, & Ostir, 2010). Maintaining a positive sense of well-being may be seen as a component of successful aging (Diener, Ng, Harter, & Arora, 2010).

Positive psychology also shows that our web of personal and professional social relations shapes the way we define ourselves, positive emotions, and empathy. Cultures are described in many ways, including collectivistic or individualistic attitudes and poor or wealthy status. Some collectivistic cultures emphasize both hierarchy and humility for their group members. A member’s identity is strongly defined by other people’s judgments (Vogeley & Roepstorff, 2009). On the other hand, individualistic cultures emphasize autonomy and equality, and members’ identities are not strongly identified by the opinions of others. Individualistic cultures are thought to weigh positive emotions associated with self-esteem more heavily than collectivistic cultures do (Vogeley & Roepstorff, 2009). Some researchers have found that wealthy cultures associate positive emotions with love and self-esteem needs, and poorer cultures associate these emotions with safety needs (Oishi, Diener, Lucas, & Suh, 1999). These findings indicate that positive emotions differ across cultures, depending on salient needs and values. Positive emotions affect empathic interactions.

In general, positive psychology continues to provide evidence of the effectiveness of a positive empathic approach. Social neuroscience is another interdisciplinary field that has shed much light on the role of empathy in positive interpersonal interactions.

**Interdisciplinary Knowledge From Social Neuroscience**

Social neuroscience has provided scientific evidence for a neurobiological perspective on empathy. In 1992, John Cacioppo and Gary Bernston introduced social neuro-science as an interdisciplinary field that focuses on and integrates aspects of social psychology and neuroscience at different levels of analysis (Adolphs, 2010; Cacioppo & Bernston, 1992). At the microscopic level of analysis, research focuses on brain mapping and other bodily functions, and at the macroscopic level it focuses on the biological mechanisms involved in social perception, cultural determinations, cognitive perspectives, and emotional responses. Social neuroscience also provides evidence of how age, gender, and culture affect empathy. These studies specify the neural, hormonal, cellular, and genetic mechanisms that underlie social behavior to understand the relationships between social and biological levels of organization (Cacioppo, Bernston, & Decety, 2010; Decety, 2010).

At the micro level, studies with animals and humans have suggested that the neural network related to enacting various aspects of empathy consists of the “mirror–neuron system,” insula, and limbic system (Bernston et al., 2011; Rizzolatti, Fogassi, & Gallese, 2001). Brain imaging studies reveal the mirror system as consisting of specialized visual–motor neurons, including the inferior parietal cortex, the ventral premotor cortex, and the posterior part of the inferior frontal gyrus (Rizzolatti & Craighero, 2004). The function of the mirror system is to assist in understanding performance of self and other during goal-directed actions. These brain imaging studies allowed researchers to actually see the brain thinking, or in this case, empathizing.

Kramer and colleagues (Kramer, Mohammadi, Donamayor, Samii, & Munte, 2010) found that additional areas of the brain were also related to empathy. They neurologically differentiated two empathy-related responses: (1) emotion and (2) social cognition. They found that the brain areas related to emotional processing are the ventro-medial and ventro-lateral prefrontal cortex and, for social–cognitive processes, the medial prefrontal cortex and the superior temporal sulcus. Kramer and colleagues suggested that empathy causes increased activity in various other regions of the brain as well.

On the behavioral level, the mirror system plays a significant role in empathy through the perception of self and other as well as its facilitation, imitation, and communication. For example, the automatic tendency to imitate facial expressions, body posture, and language is believed to improve social communication among individuals. Through imitation and the simulation of emotions and postures, we verbally and nonverbally communicate, making inferences from visible actions of personal and emotional states. This process enables us to respond in a more empathic manner to other people.
Social neuroscientists have proposed that mirror system impairments may account for social disorders observed in autism (Martineau, Andersson, Barthelemy, Cottier, & Destrieux, 2010; Perkins, Stokes, McGillivray, & Bittar, 2010). Charman and colleagues (1997) reported that 20-mo-old children with autism were specifically impaired in some aspects of empathy, attention, and imitation. Infants with autism failed to use social gaze in the assigned empathy and joint attention tasks.

Very early signs of empathic development occur in the cry of one newborn in response to the cry of another (Geangu, Benga, Stahl, & Striano, 2010). Infants can perceive and respond to another person's emotional state. At 1 yr of age, infants can show signs that they are able to comfort others in distress, and by 14–18 mo of age some children display spontaneous helping behaviors (Decety, 2010).

Dosch and colleagues (Dosch, Loenneker, Bucher, Martin, & Klaver, 2010) suggested that prefrontal cortex activation is important to empathy in adults and that it is also associated with empathy in children as young as 6 yr of age. The prefrontal cortex develops further and reaches maturation late in adolescence (Bunge, Dudukovic, Thomason, Vaidya, & Gabrieli, 2002). This brain maturation affects executive function and language, two higher cognitive abilities that influence empathic responses (Decety & Michalska, 2010). This later development explains why teenagers sometimes seem to display poor judgment and problem-solving skills and appear to lack empathy.

Gender differences have been reported in the social neuroscience literature. Some reports indicate that women activate more brain regions related to emotion, whereas men activate a different brain network associated with cognitive evaluation, mentalizing (i.e., mindreading), and behavioral anticipation (Derrnt et al., 2010). Other research maintains that women show a stronger eye gaze cueing effect than men do, implying that women may have an enhanced tendency to empathize, as observing a person's eyes can lead to interpretations of that person's emotions and intentions (Alwall, Johansson, & Hansen, 2010). However, whether the human mirror–neuron system exhibits gender differences is not yet clear.

Cultural context has been viewed as a source of information that shapes empathy through teaching, imitation, and other forms of social transmission (Richerson, Boyd, & Bettinger, 2009). One of the goals of social neuroscience is to investigate the biological mechanisms that underlie culture (Cacioppo & Decety, 2011). Social neuroscientists believe that culture is a dynamic and heterogeneous grouping capable of affecting change and evolution. The increasing global mobility of people and the information explosion have created automatic and conscious cultural patterns (Roepstorff, Niewohner, & Beck, 2010; Vogeley & Roepstorff, 2009). Scientists view the brain as the structure that empowers the individual to create and change culture. They also believe that culture can, in turn, shape the brain. Indeed, some scientists have revised their views to consider the brain itself as both an artifact of culture and a cultural artifact (Mithen & Parsons, 2008).

I believe that the interdisciplinary knowledge gained from positive psychology and neuroscience can help us expand our understanding of empathy. I think that such knowledge can encourage collaboration as well as the translation of knowledge into occupational therapy practice.

During my practice, I have consistently combined the micro (medical) and macro (social) models, moving from one to another to promote empathy in rehabilitation (Abreu & Peloquin, 2005; Abreu & Toglia, 1987). Through reflection, I have deepened my understanding of the client's achievements, humor, and resiliency. This deepening has enriched my heart and soul. I have reflected on positive empathic interactions in my clinical practice, and I will now share those thoughts with you.

Reflections on Positive Empathic Interactions

With experience, I realized that various interactions in rehabilitation were affected by the empathic process. I came to understand that with each interaction there was an implicit question being asked by the client. That underlying question alerted me to the client's needs and guided my action.

I will discuss six positive interactions and the six corresponding questions and provide examples of how I accentuated the positive in an empathic process. Initially, when I thought of how to diagram my six positive interactions, I considered a circle. I was coaching and helping others regain symmetry and balance to live a fuller life after brain injury, so the circle seemed appropriate. However, I realized that in clinical practice we do not always regain symmetry. The image representing the empathic process needed to be asymmetrical yet retain a sense of balance, strength, and beauty. I chose to use the image of *ikebana*, the Japanese flower arrangement style that is always asymmetrical yet balanced and beautiful. Figure 1 shows an arrangement of my six positive interactions in an asymmetrical yet balanced configuration. Figure 2 details the associated guiding questions.

During my reflections, I remembered the joy I experienced when I shared resilience stories as a source of
inspiration and motivation. This was the first of the six positive empathic interactions. I used a sampling of diverse stories about people with hardships and their remarkable abilities to defy adversity and move forward with strength. The stories showed how people transformed hardships into varying degrees of hope and triumph. I listened and heard the clients’ guiding question, How do others like me cope and adapt?

During my interventions, I frequently shared short versions of these motivational narratives about virtue, passion, triumph, and strength. I attended to the client’s trajectory of illness and his or her acceptance level in an attempt to match a salient story. I found additional inspirational narratives in qualitative studies about people with brain injury. I was also part of a group that conducted a qualitative meta-analysis study that was presented at the American Occupational Therapy Association Annual Conference & Expo (Abreu, Reistetter, Ottenbacher, & Sangole, 2006). This study was particularly useful because it revealed themes that I later used for discussion about the underestimated positive adaptation of clients to chronic disability after brain injury. Through sharing stories and asking clients about their own resilience stories, I learned more and expanded my repertoire of inspirations and motivators. These stories enriched my life as well as the lives of the people I worked with.

I also remembered pleasure with the second positive interaction, when I had the willingness to enter into the other person’s emotional state and perspective. Here I sought a positive answer to the client’s guiding question, Are you sure you want to enter my world?

During the healing journey, I felt a sense of adventure when engaging with another person, even when it required my acceptance and courage to do so. Each individual circumstance was unique and harbored many challenges. Three encounters that required significant adjustments on my part as I entered into client worlds were (1) fostering serenity among persons who were agitated, (2) being realistically hopeful during rehabilitation, and (3) maintaining dignity during intensely private daily routines.

After brain injury, people can show changes in emotions and behaviors in two polar directions. Some people become aggressive and even violent, and others become caring and even passive in some cases. Therefore, interpersonal interactions need to be flexible and confluent with the person, situation, and environment. During interactions with people who were agitated and aggressive, I learned to down-regulate my emotions of fear, raise my low expectations, and practice an empathic communication style. I noticed that clients empathically mirrored my behavior, body language, gestures, and tone of voice. I found that my own emotional state could significantly escalate or reduce the clients’ agitation.

Different interactional adjustments were required for people with chronic conditions. I often up-regulated my positive emotions and found ways to help the people cope and adapt. I also attempted to help clients and their families lessen the burden of care and achieve a more balanced interdependence. My interventions as well as my interactions frequently promoted a better quality of life and increased leisure and relaxation. In addition, I taught compensatory strategies in a realistic but positive and humanistic manner. One example was to teach the client to hold a spastic nonfunctional hand in his or her pocket to minimize the attention of others. I have witnessed remarkable hidden abilities among clients that defy the predicted rehabilitation outcomes; I have witnessed the unexpected adaptation of many clients.

Other challenging interactions that required empathic adjustments to the other person’s world were bathing, showering, and using the toilet. These activities of daily living are shaped by culture, economic forces, and

Figure 1. Six positive interactions.

Figure 2. Guiding questions.
technological innovation. They tap unique personal habits and practices.

I tried to maintain discretion and psychological safety, even when privacy was limited but when communication and training were still required. To better understand and personalize occupational therapy services in this sensitive performance, I became part of a group that conducted a shower study (Reistetter, Chang, & Abreu, 2009). Our research findings suggested that the participants with brain injury had a different showering pattern compared with those of people without brain injury. Those with brain injury took longer showers with fewer steps, repeated or skipped body parts, and used fewer products. Although all participants with brain injury were ambulatory, 50% used either grab bars or the wall for support while showering. None of the participants without brain injury required postural support. All participants stated that they showered daily and that this process was meaningful for cleanliness and relaxation. Both groups favored warm water and used copious quantities.

This information helped me personalize the shower-training sessions in the care of clients with brain injury. The responses to bathroom training were very emotional; some people cried, and others moaned with joy. Many clients who longed for the resumption of washing their hair, taking a long shower or bath, or cleaning their intimate body parts willingly granted permission for therapists to share and occupy their private space. Empathic interactions during these private training interventions are essential.

A third positive empathic interaction that caused me delight was when I was able to read the clients’ actions and language patterns, variations, or prosody. The often silent but guiding question from clients focused on communication issues: How can you better understand our language? Language carries emotions in a variety of ways. One is by the expressed content or what is said during the exchange, and another is by the prosody or how we say it. Prosodic cues convey the tone and intensity of our emotions. I tried to attend at a deep level to prosody and patterns of language to include intonations and gestures that often transcended the content of communication. My own accent and Latina prosody helped because I had to take extra care to verify that the other person understood what I was trying to convey. I believe that we all have different accents and that we all should be concerned with the issues inherent in effective communication.

Let me elaborate here. After brain injury, people may have an impaired understanding of empathic cues, making it difficult for them to understand and convey what is meaningful. Therefore, I consciously used and reframed verbal and nonverbal communications using three modifiers: (1) the client, (2) the environment, and (3) the therapist. With the client, I considered the effects of changes in awareness, safety, error detection or correction, social environment, postural readiness, organizational strategies, and medications (Abreu, 1981; Abreu et al., 2001).

With the environment, I considered factors such as the sensory modalities and the complexity, speed, and duration of stimulus presentation. As a therapist, I also considered my use of self in terms of my voice tone, type of feedback, explanations I was given, my expectations, and my clinical reasoning. Attending to the three modifiers affected my ability to read clients and communicate more effectively with them. After brain injury, there may be slow reaction and movement–time responses. Therefore, I frequently repeated instructions and gave the person at least 15 seconds to respond. I had to repeatedly take responsibility for initiating or maintaining the flow of the conversation.

I used nonverbal communication subtleties, including information from the client’s eyes, head, hands, and bodily movements for improved responses during intervention. I gave great attention to the person’s eyes, which I feel act as the hands of the face in grasping details in the environment and in helping us express emotions. I found that some motor impairment, including asymmetrical weight bearing, limited trunk movements, and impaired kinematics, could cloud communication (Abreu, 1995; Abreu, Reistetter, Bear-Lehman, & Ottenbacher, 2009; Nakamura, Abreu, Patterson, Buford, & Ottenbacher, 2008). For example, some clients were erroneously described as passive or detached when they were unable to use their extremity movements to express emotion and enhance communication.

A fourth positive interaction caused me humility as I struggled to promote the other person’s hope and strength. The guiding question here was, What can my hope and strength be? I tried to focus my attention on future possibilities for clients and their caretakers and positively accentuate the clients’ assets. It was essential that I always use a best practice approach with the same intensity, even though some clients had poorer anticipated rehabilitation outcomes.

Clients with cognitive impairment and severe chronic disabilities are particularly vulnerable when their capacity is questioned. Two cases in which vulnerabilities were clear came to mind. In the first, a young man with chronic alcoholism accidentally killed his father in a car accident. He sustained only minimal brain injury. In the other case, a habitually abusive mother hit her baby with a milk bottle.
when the baby would not stop crying. The child was severely brain injured, but the state returned the child to the mother’s care. In both cases, the capacity of these individuals for change and their rehabilitation outcomes were questioned by the team. The young man’s biggest strength was his family and the support system of his friends. He was able to reintegrate into the community. The mother’s strength was her organizational skills, but she had no social support system. After discharge, the mother hit the baby again, this time killing the child. We cannot predict outcomes with accuracy, and we are not always successful in helping clients turn to their strengths for adaptation, but it is our duty to accentuate strengths and implement best practice, regardless of the circumstances.

Through the years, I found myself constantly reframing my thinking and either down-regulating or up-regulating my emotions to focus on a client’s potential for hope and strength. I learned to use positive psychology strategies, such as encouraging clients and their caretakers to examine the situation from all sides, to complete small steps and partial goals in the face of conflict, to think about the best results, and to work as if the client and caretaker could achieve the goals.

In addition, I always asked each client and caretaker to write down their five greatest strengths and the five things that they were grateful for, including any positive aspects of their lives. During each treatment visit, they were encouraged to share and discuss strengths and positive things for which they were grateful. These strategies expanded my understanding of their strengths to a high degree. I gained more emotional courage and compassion that helped me facilitate decision making in complex and uncertain conditions. I used dancing and charade competitions in a lighthearted manner to promote humor and relaxation. The clients became the judges and the therapists were the contestants. The clients made the contest rules and assigned disability roles to each therapist. These activities softened the drama of life and therapy.

Because I was interested in how our rehabilitation team promoted the client’s hope and strength, I participated in a qualitative study that explored interactions during 51 interdisciplinary meetings that included people with brain injury (Abreu, Zhang, Seale, Primeau, & Jones, 2002). Four themes emerged: (1) The meetings acted as a transformation ritual, (2) the case managers shaped the meetings, (3) the professional interdisciplinary team members were collaborators, and (4) the clients were like ghosts. One of the most significant findings was that clients were not actively included in the discussion, even though they were present at the meetings.

Interdisciplinary team members did not empathetically interact with the clients. Clinicians often emphasized the positive rehabilitation outcomes in lengthy reports that some clients could not comprehend because of their cognitive dysfunction. This study was a very humbling experience. The results were published in the Journal of Brain Injury, and the rehabilitation team implemented a quality improvement action plan. As a result of the study, our team established a series of in-service training programs using role-playing and role reversal to improve and humanize our interactions with clients. The study supported the fact that focusing on strengths and positive outcomes does not automatically lead to positive or person-centered interventions.

A fifth positive interaction that was very rewarding was teaching and using reflection and self-regulation. These performance skills are a form of mental introspection and problem solving and are dependent on the person’s higher cortical executive function, which includes metacognitive skill or thinking about self, goal, and strategy. The guiding question from clients here was, How can I problem solve more effectively?

I taught clients to engage in conscious prediction, monitoring, and planning of their occupations with a focus on their capacities, the demands of the task, and the strategy or rules of behaviors. Problem solving was, at times, generated by the client by using “self-talk” such as saying or thinking, “If I slow down, I will be able to finish my dinner quickly and safely.” Other times, feedback was externally generated by using language cues, checklists, signs, and pictures. Two externally generated strategies were the use of laminated cooking instructions and the use of customized virtual reality programs (Christiansen et al., 1998; Zhang et al., 2003).

During my career, I witnessed the most moving of client reflections during periodic graduation ceremonies conducted upon discharge from one rehabilitation program. The clients told a 10-min gratitude story from the stage to families, friends, and staff. The stories were amazing. There was never, ever a dry eye. All clients spoke with deep emotion, remembering the trauma and drama and sharing their gratitude for those who encouraged their strength and fostered them to reclaim a new self. These stories revealed the fact that many people developed posttraumatic growth perspectives. Even after severe brain injury, they found new meaning in their lives and appreciation for their family, friends, and religious affiliations.

The sixth positive interaction that was satisfying to remember was when I was able to use creativity and imagination in therapy. The guiding question here was,
Can we have fun today? Occupational therapy is an art as well as a science. Suzanne Peloquin and I have compared our practices to a dance that moves to a harmonious song originating from a blend of artistic and scientific voices (Abreu & Peloquin, 2004). In therapy, I frequently used a right-brain approach associated with creativity, imagination, and the intuitive use of music and art. I found that the clients were totally absorbed, motivated, and happy when playing games, singing songs, writing poems, drawing, and making jewelry.

In an unpublished study, I asked clients to draw pictures that represented positive relationships. Three themes emerged. One was friendship, represented by images of people and prayers. Another theme was cooperation, represented by diverse images such as a bird feeding her young, a person coaching another to the finish line, two lucky horse shoes attracting each other, and a key unlocking a bolt. The third and most frequent theme was love, represented by hearts and the word love.

It is my belief that positive empathic interactions are critical in promoting healthier and fuller lives. Positive emotions and empathy rest on the values that characterize one’s culture. I have largely presented a Western conception of optimism and empathy. I also suggest retaining a realistic focus at the impairment, disability, and participation. Positivity without grounding in reality distorts and insulates us from critical reflection and can interfere with best practice.

Conclusion
During my time as an occupational therapist, I chose to focus on brain injury as my specialty. The choice has been rewarding and humbling. The more I learned, the more I found there was to learn. For every rule or recommendation, there was an exception. With every tragedy, there was some ray of hope. At times, when I thought I found the best practice, I found more questions. It was difficult to synthesize my experience to present six positive interactions, but it was not at all difficult to determine that empathy was the critical ingredient that played the most influential role. I hope that I have been able to bring more awareness of the role of empathy in the art and science of occupational therapy. We need to continue to foster our science while we reclaim our art of practice. When we accentuate the positive, we begin that reclamation. Gracias! ▲

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References


