



Wilma L. West Library Resource Notes

Empathy

June 2002

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Two weeks ago, we celebrated Memorial Day. For some, this holiday means a three-day weekend, the first trip of the season to the beach, or an opportunity for great sales. For veterans and for those whose husband, father, son, sibling, or friend died while serving his/her country, it is a time to remember and to honor those individuals and all their comrades.

While reading some of the newspaper stories, I was struck by such responses as: "Now it is personal." "For the first time, I feel the significance of Memorial Day." The accounts were about the burial of a young man killed in the fighting in Afghanistan, and of individuals, young and old, who came from various parts of the U.S. to visit the graves of relatives or friends in the Arlington National Cemetery, outside of Washington DC. The events of September 11 added to the pathos and significance of this Memorial Day.

Why did these statements touch a core in me? Would I be as seemingly unsympathetic if not for the death of my twin brother in Vietnam? Is it only because of this personal loss that Memorial Day been meaningful to me and that I want a "call to arms" to be the last option to aggression?

No. It was because it made me ask myself: "Do I have to experience a loss, an illness, an insult, before I can empathize with a fellow human being?" If so, and if I am the norm, rather than the exception, then I am terrified for our future, locally or globally. I do not deny, however, that personal experiences do heighten our sensitivity to pain, both physical and psychological. Fortunately, though, I believe the majority of us can feel empathy for the homeless, for the members of both sides of the Middle East conflict, for victims of minefield explosions, for the masses of humanity who are starving, without having experienced these situations ourselves. Further, most of us make a contribution in time or treasure, or both, to alleviate world suffering and to persuade our governments to make decisions that will move us towards peaceful coexistence.

This ruminating led me to wonder about the role of personal experience and/or empathy in the interaction between the health care professional and the patient/client? I looked for the meaning of the word empathy and found this definition in an on-line dictionary:

“Empathy: Definition 1: identification with or sharing of another's feelings, situation, or attitudes. Definition 2: the attribution of one's personal feelings or attitudes to an external object. Related Words: condolence, understanding, and compassion.”

In searching in [MEDLINE/PubMed](#), I discovered the term “Wounded Healer.”

Jackson, S.W. (2001). The wounded healer. *Bulletin of the History of Medicine*, 75(1), 1-36.

ABSTRACT: This paper deals with the emergence, elaboration, and use of the concept of "the wounded healer." The term refers to a person whose personal experience of illness and/or trauma has left lingering effects on him--in the form of lessons learned that later served him in ministering to other sufferers, or in the form of symptoms or characteristics that usefully influenced his therapeutic endeavors. While such persons and their actions have been noted across the ages, in other cultures, and in many contexts, it was not until the early twentieth century that the patterns in the behaviors of such persons were recognized, named, explained, and categorized as "healing." Early in the century, the concept was commonly used in the fields of pastoral counseling and analytical psychology; by the end of the century it had been vastly expanded and extended and no longer referred mainly to a healer of psychological suffering. The term wounded healer is now in common use in areas such as rehabilitation medicine, medical-career choice, Alcoholics Anonymous and the self-help movement, and chronic-illness support groups, as well as in the original areas of psychotherapy and pastoral care.

Means, J.J. (2002). Mighty prophet/wounded healer. *Journal of Pastoral Care*, 56(1), 41-9.

ABSTRACT: The concept of wounded healer is revisited from the perspective of a pastoral counselor working in a pastoral counseling center, and this experience is generalized to pastoral caregivers working in other settings. Three types of wounds are reviewed: wounds resulting from the life experience of the caregiver, wounds resulting from listening to and containing the horrendous content and emotionally laden nature of client stories, and wounds brought about by doing our work within an unsupportive culture. Properly dealt with, these wounds offer a foundation of shared life experience connecting us with our clients. Coupled with messages clients bring us about hurtful and destructive aspects of our culture, these wounds also call us to become mighty prophets. In this role, we are urged to move outside our normal practice contexts into the larger community, and to speak out against social forces that hurt and destroy the selves and souls of persons.

Glaz, M. (1995). Can a healer be too wounded to heal? *Second opinion (Park Ridge, Ill.)*, 20(3), 45-57.

One can find studies or personal accounts of the effects of health care professional's own experiences with illness on their future relationships with their patients. Here are a few recent ones.

Chabner, B.A. (1997). Cancer: A Personal Journey. Notes from the Edge. *The Diary of Peter J. Morgan, M.D. Oncologist*, 2(4), 206-207.

ABSTRACT: It is a mistake to think that all personal experiences with cancer are the same. For certain, all cancer patients do confront the possibility of an early death and the prospect of pain and suffering due to the tumor and its treatment. But the specific emotional issues differ with each patient and each family, and the responses to these issues take many forms. In an eloquent and moving film, "Cancer: A Personal Journey. Notes from the Edge," we are given the privilege of accompanying a remarkable young physician, Peter J. Morgan, on his journey with

cancer, a two and one-half year journey that ended with his death at age 31. At age 29, Dr. Morgan, an internist-in-training who intended to pursue a career in hematology and oncology, noted a mass on his leg. Tragically, metastasis to the lungs had already taken place at the time of diagnosis of a synovial sarcoma. There followed the all-too-familiar story of chemotherapy and experimental treatments, pain, debilitation, and ultimately demise, and in itself this experience would move us with the sorrow of a precious life lost. What makes this particular story so remarkable are the insights of this young physician and the struggle for survival of a spirit that would not succumb to the "chaos" of cancer. In the two-year period of his life as a cancer patient, Peter Morgan kept a diary that records his thoughts, his emotional turmoil, and his reflections on life and an untimely death. In particular, we are able to understand the need for his spiritual self to remain alive and to grow despite the deterioration of his physical being. And we see that spiritual triumph in his compelling relationships with his family and his colleagues, in his reflections on art and music and nature, and most of all in his writings and his appreciation of the immense possibilities for joy in life. This is not an easy journey to watch, but the intense sadness of his experience is balanced by his friendships and the great satisfaction he derived from patient care until the end of his own illness. We hear accounts of his leaving his hospital bed in New York City, where he has received an infusion of chemotherapy, and driving across Long Island to volunteer at a university out-patient clinic in Stonybrook. During the last year of his life, he becomes a beloved teacher and attending physician in this clinic. One is left with the feeling that Peter Morgan has learned a great deal about what is important and beautiful in this life. The filmmaker, Ruth Yorkin Drazen, and the narrator, Matthew Broderick, have created a masterpiece. I can remember only one other movie, "Shadowland," the story of C.S. Lewis's marriage and the loss of his wife due to cancer, that speaks as eloquently to the confrontation with cancer. In that film, one is left with the overwhelming sorrow of the husband. The present film goes far beyond many of the personal narratives about cancer experiences that one finds so often in the media, simply because it allows a remarkable individual to speak to us about what was most precious in his life. For those of us in the medical profession, his message is particularly meaningful: his work as a physician was at the top of his list.

Dornhoefer, J.D. (2001). Deconstructing the ailment: one health care professional's experience as the patient. *Social Work in Health Care*, 33(2), 105-11.

ABSTRACT: This essay explores an illness in a health care professional through lenses of role flexibility and professional accountability. It highlights the process of contemplation about the dual identifications implicit in the experience of being both a professional and a patient within one health care delivery system. This can be a position of standing on the borders of possibility. Thus, the dilemma of a "wounded healer" may challenge some assumptions inherent in the giving and receiving of care as well as grant us some regard for the power shifts within the management of our patients and of ourselves. The experience that one's ailment can be an opportunity-to explore notions of sickness and health or to help to tease out the limits or the potential impact of our responsibility toward that which we name disease and cure-may be the more salient message.

Holm, K., Cohen, F., Dudas, S., Medema, P.G. & Allen, B.L. (1989). Effect of personal pain experience on pain assessment. *Image--the journal of nursing scholarship*, 21(2), 72-5.

ABSTRACT: The purpose of this study was to determine the effect of nurses' personal pain experiences on the assessment of their patients' pain. The sample consisted of 134 registered nurses employed in three Midwestern hospitals. In response to a personal pain history questionnaire, pain with headache, menstrual distress and dental events were cited most frequently. Most also reported that a family member had experienced pain in their presence

(cancer, surgery, orthopedic injuries). Responses to the Standard Measure of Inferences of Suffering (Davitz & Davitz, 1981) showed significant differences between intensity of pain experienced by the nurse and overall perceived patient psychological distress. Furthermore, the intensity of pain experienced by the nurse was the only variable that predicted significantly perceptions of patients' physical suffering and psychological distress. While additional study is warranted, the findings support the notion that nurses who have experienced intense pain are more sympathetic to the patient in pain.

Maulen, B. (2002). [How physicians experience their illness. The vulnerable healer]. *MMW Fortschritte der Medizin*, 143(31-32), 25-8. [Article in German]

ABSTRACT: The reports of sick physicians presented here, cover a wide range of suffering, perception of illness, the struggle to regain health, and efforts to come to terms with fate. In many cases, writing serves as a means of more readily coping with relevant problems, but also of helping others. In his own personal experience of the "dark side" of modern high-performance medicine, many a doctor comes to recognize what is lacking from comprehensive care. Such a lack is often balanced by family, friends, self-help groups, but also by the application of alternative methods and the search for spiritual answers. Acceptance of his role as patient is initially difficult for the physician, and he frequently gets little help from his medical care-provider who may himself be uncertain and prejudiced. Those treating sick physicians should be better informed about the psychological processes of coping with illness, and should learn to handle emotional upsets with patience. More than any other group of patients, sick physicians wish to have a say in the diagnostic and therapeutic processes. As a result of this, a number of sick physicians discover a new type of medicine, and become reformers of their own specialty, while others experience a higher quality of life after recovering from their illness.

Silagy, C. (2001). A view from the other side. A doctor's experience of having lymphoma. *Australian Family Physician*, 30(6), 547-9.

ABSTRACT: BACKGROUND: Most doctors will at some point in their lives find themselves 'on the other side' in the role of patient. This may pose particular challenges both for the individual and for those involved in their treatment. **OBJECTIVE:** To document the personal experience of a doctor becoming a patient grappling with the potentially life threatening condition of non-Hodgkins lymphoma. **DISCUSSION:** Being a doctor with a life threatening condition brings all of the familiar personal emotional challenges and reactions of any other patient. However, this is further compounded by the complex and unfamiliar nature of the relationship between the doctor as a patient and their own treating health professionals. Developing sound, trusting, and mutually respectful professional relationships is essential to ensuring doctors receiving the same high quality of care when they find themselves in the patient role.

Occupational therapy practitioners have also studied or shared personal experiences of injuries, illness, or disabilities.

_____. (1987). 'Disability' is not handicap to Florida OT. *OT Week*, 1(12): 12-13.

Batty, J. (1988). Experience with Disability Leads Women to Career in OT. *OT Week*, 2(21), 8.

Carr, S.H. (1991). Case Report: Adaptation to loss: Occupational therapy as a way of life. *The American Journal of Occupational Therapy*, 45(2), 167-170.

Cotton, S.M. (1998). Brief report: Experiencing one-handedness as an occupational therapist. *Australian Occupational Therapy Journal*, 45(4), 144-148.

ABSTRACT: The author is an experienced occupational therapist who inadvertently became one handed for a 2 month period. In the present paper, the author explores her personal experience of one-handedness, analyses the effectiveness of one-handed techniques and gives some practical suggestions to occupational therapists working with clients who have the use of only one hand.

Joe, BE. (1997). Bumps in the road. *OT Week*, 11(36): 12-13.

ABSTRACT: For OT practitioners with disabilities, the path to a successful career can sometimes be littered with obstacles

Joe, BE. (1997). Healing by example. *OT Week*, 11(36): 14.

ABSTRACT: Often using her own disability as a motivating force, and OT practitioner helps others face an uncertain future.

Joe, BE. 1995). When life changes in a split second. *OT Week*, 9(36), 22-23.

ABSTARCT: When a young, promising concert musician loss the use of her hand, other avenues of expressions opened – including a career in OT.

Pinol, N. (1988). Pageant offers therapist chance to promote OT. *OT Week*, 2(51), 4, 30-31.

Rosenthal, S.B. (1995). Living with low vision: A personal and professional perspective. *The American Journal of Occupational Therapy*, 49(9), 861-864.

ABSTRACT: Unlike most readers of this special issue, I have been both a consumer and provider of rehabilitation services. A retinal hemorrhage that occurred when I was in my late twenties signaled the beginning of delayed-onset retinopathy of prematurity - a condition that has been further complicated since that time. In this article, I offer a glimpse of what living with low vision is like by describing activities in my own life and accommodations I have made. My hope is that therapists will learn more about the realities of living with low vision and will seek out additional information that they will incorporate into their practice.

Scheinholtz, M. (2000). Invisible no more. *OT Practice*, 5, 20-22.

ABSTRACT: Despite their backgrounds in mental health, many practitioners do not acknowledge psychiatric disabilities among their peers. Marian Scheinholtz shares her story of being an accomplished OT with a mood disorder and begins to break the silence surrounding mental illness.

Stewart, C. (1989). Raising children from a wheelchair. *Physical Disabilities Special Interest Section Newsletter*, 12(2), 5-7.

Velde, B.P. (2000). The experience of being an occupational therapist with a disability. *The American Journal of Occupational Therapy*, 54(2), 183-188.

ABSTRACT: OBJECTIVE: This study addressed what it is like to practice as an occupational therapist with a disability. METHOD. Open-ended interviews using a phenomenological approach were conducted with 10 participants until data saturation was achieved. Each transcribed interview was coded for categories, and the common themes across transcripts were identified. RESULTS. These major themes were identified: "I am sensitive to their needs"; "The issue is how to cope with life"; and "Recognize your own strengths and limits." Each theme had several subcategories. CONCLUSIONS. Occupational therapists with disabilities approach

their practice from a unique perspective and may be able to motivate and challenge clients in a different manner than therapists without disabilities. Therapists with disabilities perceive themselves as uniquely skilled persons who have developed successful strategies to cope with the experience of disability.

Whitney, R.V. (1995). Don't say you know how I feel: A client's perspective. *OT Week*, 9(27), 20-21.

ABSTRACT: Being the recipient of occupational therapy widened this COTA's perspective on therapy, enhanced her ability to connect with her own clients, and made her realize that even the most empathetic therapist has no clue to what a client actually goes through.

Whitney, R.V. (1995). Healing begins with faith. *OT Week*, 9(36), 21.

ABSTRACT: Part 1 of a two-part series, a COTA develops poignant and sometimes humorous insight to the process of rehabilitation when she ends up on the receiving side of health care.

Whitney, R.V. (1995). Healing begins with faith. *OT Week*, 9(37), 24-25.

ABSTRACT: Part 2 of a two-part series. A COTA develops poignant and sometimes humorous insight to the process of rehabilitation when she ends up on the receiving side of health care.

Another way that health care professionals have the opportunity "to walk a mile in the shoes" of their patients and the patients' families is to share their experiences when they watching a loved one go through the health care system or are the caregiver.

Chen, F.M., Rhodes, L.A. & Green L.A. (2001). Family physicians' personal experiences of their fathers' health care. *The Journal of Family Practice*, 50(9), 762-6.

ABSTRACT: OBJECTIVES: The American health care system is complicated and can be difficult to navigate. The physician who observes the care of a family member has a uniquely informed perspective on this system. We hoped to gain insight into some of the shortcomings of the health care system from the personal experiences of physician family members. STUDY DESIGN: Using a key informant technique, we invited by E-mail any of the chairpersons of US academic departments of family medicine to describe their recent personal experiences with the health care system when their parent was seriously ill. In-depth semi-structured telephone interviews were conducted with each of the study participants. The interviews were transcribed, coded, and labeled for themes. POPULATION: Eight family physicians responded to the E-mail, and each was interviewed. These physicians had been in practice for an average of 19 years, were nationally distributed, and included both men and women. Each discussed their father's experience. RESULTS: All participants spoke of the importance of an advocate for their fathers who would coordinate medical care. These physicians witnessed various obstacles in their father's care, such as poor communication and fragmented care. As a result, many of them felt compelled to intervene in their fathers' care. The physicians expressed concern about the care their fathers received, believing that the system does not operate the way it should.

CONCLUSIONS: Even patients with a knowledgeable physician family member face challenges in receiving optimal medical care. Patients might receive better care if health care systems reinforced the role of an accountable attending physician, encouraged continuity of care, and emphasized the value of knowing the patient as a person.

(Comment in: *The Journal of Family Practice*, 2001, 50(11), 995-6.)

Hasselkus, B.R. (1993). Death in very old age: A personal journey of caregiving. *The American Journal of Occupational Therapy*, 47, 717-723.

ABSTRACT: This paper describes a personal journey of caregiving for a very old family member

during dying and death. The phenomenology of caregiving reveals the inner struggle experienced by all caregivers, lay and professional, between the needs to support both the living and the dying of the terminally ill person. The lived experience unfolds in phases of caregiving that support a stage theory of development in professionals' work with dying persons. The concept of presencing or connecting is a vital component of terminal care and has implications for occupational therapy practice. Occupational therapists can use their knowledge and understanding of occupation to bring about connecting in the dying experience. The contributions of all participants in the dying experience-family caregivers, the dying person, and health professionals-are important as sources of mutual support in the work of dying.

Finally, the occupational therapy literature does address the importance of empathy in practitioners. As early as 1977, Charles Christiansen, EdD, OTR, OT(C), FAOTA, the 1999 Eleanor Clarke Slagle Lecturer, looked at empathy in occupational therapy students.

Christiansen, C.H. (1977). Measuring empathy in occupational therapy students. *The American Journal of Occupational Therapy*, 31(1): 19-22.

ABSTRACT: Empathy is one interpersonal skill dimension that contributes to the occupational therapy process. This paper explores the concept of empathy and briefly recapitulates some of the assessment devices used in an attempt to measure the skill. It further describes an investigation involving 23 occupational therapy students in a basic master's program. The students were administered the Hogan Empathy Scale, and scores were correlated with peer and faculty empathy ratings. The results revealed a significant correlation between measured empathy and perceived ability to empathize. Possibilities are discussed for using the Hogan Empathy Scale in occupational therapy education.

Three years later, *AJOT* published another study of empathy in occupational therapy students.

Wise, B.L. & Page, M.S. (1980). Empathy levels of occupational therapy students. *The American Journal of Occupational Therapy*, 34(10), 676-679.

ABSTRACT: For occupational therapy educators to determine success at developing and/or maintaining among students empathy levels that are conducive to understanding and helping patients, educators must be able to measure changes in affective sensitivity. This paper briefly discusses methods of altering empathy levels and describes the use of Kagan's Affective Sensitivity Scale to measure changes in empathy levels of occupational therapy students. Students were evaluated before and after completing a clinical practicum and a group process course and again one year later. The first Level I clinical practicum did not have the anticipated impact upon empathy scores, but the group process approach might have positively affected empathy levels. The significance of permanent changes in empathy scores might correlate with the intensity of the group process course. Kagan's Affective Sensitivity Scale is useful for measuring changes in empathy levels.

And still more recently is:

Froman, R.D. & Peloquin S.M. (2001). Rethinking the use of the Hogan Empathy Scale: A critical psychometric analysis. *The American Journal of Occupational Therapy*, 55(5):566-72.

ABSTRACT: Objective. The purpose of this research was to study the stability, internal consistency, factor structure, and convergent and discriminate validity of the Hogan Empathy Scale (EM) when used longitudinally with occupational therapy students. Method. More than 300 occupational therapy students completed the EM once; 192 completed it twice over a 12month interval; and 56 completed a third administration at intervals ranging from 3 years to 6

years. The Fieldwork Performance Evaluation, (FWPE) was rated twice for students after fieldwork rotations in the occupational therapy program. Data on grade point average, gender, and age were collected. Results. Stability was estimated at .41 over a 12month interval and from .30 to .38 over longer intervals. Internal consistency was estimated at .57, and factor structures hypothesized previously were not replicable. Students' biographical variables explained only trivial amounts of variance in EM scores in regression equations ($R = .08$ and $.21$). Correlations between EM and FWPE scores did not support convergent validity ($r = -.01$ -.18). Conclusion. The reliability estimates for the EM as a measure of a trait-like construct are not encouraging and do not replicate previous estimates. Validity evidence was equally disappointing, raising questions about what the EM is measuring and cautioning against its continued, uncritical use as a measure of empathy.

In some occupational therapy curricula, the faculty attempts to awaken empathy in their students through personal "experience" of a disability or other means.

Bland, M. (1995). Innovative practice: A walk in their shoes. *OT Week*, 9 (Spring Student), 18. ABSTRACT: As OT students, you are learning how to help people in wheelchairs adapt to life, but do you really understand what it is like to use a wheelchair?

Breidenbach, S., Jordheim, M., Kapaun, J., Koerner, J., Morris, K., Seitz, R. & Waltman, K. (1994). Teaching students empathy. *OT Week*, 8(42), 18. ABSTRACT: A sensory loss assimilation lab is teaching students in North Dakota more about their clients.

Siler, K. (1997). Lessons in empathy. *OT Week for Today's Student*, 4, 22-23. ABSTRACT: Empathy means walking in someone else's shoes. Each semester, students in our introductory OT course participate in a disability-simulation exercise. Students acquire their "disabilities" by lottery and are required to spend at least three hours with that disability while performing daily activities. They are encouraged to keep a journal or audiotape of their thoughts during the experience to use in a later write-up describing the equipment or props utilized, problems encountered, and responses of others. Students are also asked to discuss their own feelings and reactions to this learning experience.

Additional resources in the occupational therapy literature are:

Crepeau, E.B. (1991). Achieving intersubjective understanding: Examples from an occupational therapy treatment session. *The American Journal of Occupational Therapy*, 45(11), 1016-1025. ABSTRACT: occupational therapists, like other health care professionals, must balance their application of treatment techniques with an understanding of their patients' life experiences. This paper reviews the literature from interpretive and medical sociology regarding the interplay between professional power and the achievement of an understanding of another person. It analyzes how an occupational therapist, during a single treatment session, enters into her patient's life-world and simultaneously controls and manages the treatment process. The concepts of knowledge schemata (the expectations and beliefs people bring to a situation) and footings (the shifts in alignment, or focus, which occur during interaction) are central to this analysis. The process of achieving a balance between professional power and an understanding of the patient's experience may be fostered in education and in clinical supervision through increased emphasis

on the importance of understanding the values and beliefs of patients and on the development and refinement of interactive skills.

Llorens, L.A., Umphred, D.B., Burton, G.U. & Glogoski-Williams, C. (1993). Ethnogeriatrics: Implications for occupational therapy and physical therapy. *Physical & Occupational Therapy in Geriatrics*, 11(3), 59-69.

ABSTRACT: A model of ethnogeriatrics is presented. The implications for occupational therapy and physical therapy with elders of diverse ethnicities are described with emphasis on empathic listening, respect for cultural traditions, and utilization of family and community support systems. Examples of clinical application in interpersonal communication and interaction are discussed.

Lloyd, C. & Maas, F. (1990). Empathy. *Journal of the New Zealand Association of Occupational Therapists*, 40(2), 18-21.

Lloyd, C. & Maas, F. (1992). The relationship between Carkhuff's Helping Dimensions and occupational therapy. *Australian Occupational Therapy Journal*, 39(3), 17-22.

ABSTRACT: The aim of this study was to determine the relationships between Carkhuff's (1969) four core dimensions (empathy, respect, genuineness, concreteness) on the one hand, with the total mark on a modified American Fieldwork Performance Report (FWPR), total score on the communication section of the FWPR, score on a single item of "Communication with clients" on the FWPR and Factor A (warmth) of the Sixteen Personality Factor Questionnaire (16PF) on the other. Subjects were 42 female and 4 male final year occupational therapy students at an Australian university. Multiple regression analyses and bivariate correlation coefficients failed to reveal any significant relationships. Contrary to original expectations, it was hypothesized post hoc that a positive relationship exists between communication with clients on the modified FWPR and Factor E (assertiveness) of the 16 PF. This post hoc hypothesis was confirmed for psychosocial settings ($R(44) = .35, p < .05$) but was not supported for physical settings. Whether emphasis on assertiveness rather than the helping dimensions is acceptable depends on one's professional and personal perspective. For those with a commitment to the wholeness and uniqueness of the individual, this emphasis is a matter of concern.

Peloquin, S.M. (1991). *Art in practice: When art becomes caring*. Galveston, TX: The University of Texas Medical Branch. (Doctoral Dissertation)

ABSTRACT: This work gives meaning to the metaphor Art in Practice as it explores the dilemma of a health care practice said to be depersonalized. The theme of caring that courses through writings about health care, the history of medicine, art, and literature yields this suggestion: there is an art to health care practice whose enactment requires fellow-feeling, sensitivity, and suppleness of response. Depersonalization reflects a popular disregard for the emotional and imaginative aspects of illness and care, and the disregard follows a longstanding preference in Western culture for reason over emotions. Health care practitioners treat those who are ill with highly rationalized skills that fall short of understanding. Helpers see patients and their experiences of illness through the model of technical rationality, a narrow misconstrual of science that misses the personal aspects of illness and care. . .

Peloquin, S.M. (1995). The fullness of empathy: Reflections and illustrations. *The American Journal of Occupational Therapy*, 49(1), 24-31.

ABSTRACT: Seven core values are said to undergird the profession of occupational therapy, with empathy serving as a hallmark of one of those values - personal dignity. This inquiry explores the meaning of empathy within a practice that holds occupation at its center. The literature on empathy in both philosophy and the behavioral sciences yields cogent thoughts

about the fullness of empathy and its characteristic actions. The Healing Heart, the biography of a pioneer therapist, Ora Ruggles, shows the manner in which occupational therapists can be empathic in their practice. These reflections and illustrations serve to sharpen the vision of occupational therapists as persons who reach for both the hands and the hearts of others.

Peloquin, S.M. (1996). Art: An occupation with promise for developing empathy. *The American Journal of Occupational Therapy*, 50(8), 655-661.

ABSTRACT: Empathy is central to the interactions of occupational therapists who value personal dignity. Persons from various sectors of the behavioral sciences and the medical humanities have proposed that engagement with the arts can develop empathy, an assumption that prompted this inquiry. The observations of artists and art philosophers suggest that the assumption that art may develop empathy is grounded in the kindred natures of the two practices and in the actions that occur when a person engages with a work of art. The assumption that art may develop empathy is grounded in the kinship of the actions common to both practices: response, emotion, and connection. Artists and art philosophers' observations of human practices have uncovered three rules of art that may dispose one toward empathy: reliance on bodily senses, use of metaphor, and occupation by virtual worlds. Analysis of art's potential suggests that a person who would derive empathy from art must (a) use the senses to grasp feeling, (b) stretch the imagination to see a new perspective, and (c) invite an occupation that enhances understanding. Persons who hope to develop empathy must pursue an experience that evokes the fellow feeling that inspires it. Art can offer this experience.

Compiled by Mary Binderman, MLS, Director of Information Resources,
The American Occupational Therapy Foundation, Bethesda, MD.
June 10, 2002

Dear friends:

Robinette J. Amaker, LTC, SP, OTR/L, Ph.D., CHT, rightly reminded me that wives, mothers, sisters, daughters, aunt, and female friends are actively serving in the armed forces or are veterans. More to the point of my musings, some of these women made the same ultimate sacrifice in the service of their country. I honor them and grieve with their families or friends for their loss.

It is impossible for me to express my chagrin at this oversight and my appreciation for Lieutenant Colonel Amaker's heart felt message to me. My deserved embarrassment for such a sexist statement is compounded by the reality that I wrote it in a library named after a veteran, Wilma West. Both Ruth Robinson and Eloise Strand served in the position of Chief of the Army Medical Specialist Corps. My dear colleague, Nedra Gillette, served in the Navy. Beginning with the Reconstruction Aides in World War I, occupational therapy practitioners have cared for their wounded colleagues in every conflict or war. I admire the courage and dedication of these women who live the multiple roles of soldier, occupational therapy practitioner, wife, mother, sister, daughter, aunt, and friend. Where was my head?

"Mea Culpa, Mea Culpa, Mea maxima culpa."

Mary Binderman